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THE NURSING HOME INITIATIVE: RESULTS AT YEAR ONE

HEARING

BEFORE THE

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CONTENTS

	Page
Opening statement of Senator Charles E. Grassley	1
Statement of Senator John Breaux	4
Statement of Senator Tim Hutchinson	5
Statement of Senator Richard Bryan	5

PANEL I

Rachel Block, Deputy Director, Center for Medicaid and State Operations, Health Care Financing Administration, Baltimore, MD	6
William J. Scanlon, Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, United States General Accounting Office, Washington, DC	18
Catherine G. Morris, president-elect, Association of Health Facilities Survey Agencies, and director, Long-Term Care Assessment and Survey, New Jersey Department of Health, Senior Services, Trenton, NJ	40

PANEL II

David Zimmerman, director, Center for Health Systems Research and Analysis, University of Wisconsin, Madison, WI	89
Andrew Kramer, M.D., professor of Geriatrics Medicine, University of Colorado Health Sciences Center, Denver, CO	104
Charlene Harrington, professor of Nursing and Sociology, University of California, San Francisco, CA	110

APPENDIX

Rachel Block responses to Senator Grassley's questions	135
Rachel Block responses to Senator Kohl's questions	137
William Scanlon response to Senator Kohl's question	138
AHFSA response to Senator Kohl's question	139
Dr. Kramers response to Senator Kohl's question	140
Comments submitted by the National Senior Citizens Law Center	141
Statement submitted on behalf of The American Occupational Therapy Association, Inc.	153
Testimony submitted by the American Health Care Association	159

THE NURSING HOME INITIATIVE: RESULTS AT YEAR ONE

WEDNESDAY, JUNE 30, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m., in room SH–216, Hart Senate Office Building, Hon. Charles E. Grassley (Chairman of the Committee) presiding.

Present: Senators Grassley, Hutchinson, Breaux, Kohl, and Bryan.

OPENING STATEMENT OF SENATOR CHARLES E. GRASSLEY, CHAIRMAN

The CHAIRMAN. Good morning, everybody. I thank such a large group for turning out on a very important issue that is of continuing interest to this committee, and even after today's hearing will still be of prime interest to this committee.

I say particularly thanks to witnesses who are on panel two who have traveled a long way to be with us here and, of course, thanks to members of our first panel who have extremely busy schedules and heavy responsibilities for working hard on their testimony and joining us today. And, of course, as I have already said, our entire committee extends a special welcome to everybody from the public.

Today's hearing is the third that this committee has devoted to quality of care in nursing homes and the Health Care Financing Administration, which I am going to refer to as HCFA, and HCFA's implementation of the Nursing Home Reform Act, the public law enacted to guarantee high-quality care in our nursing homes.

In July of last year, this committee convened a 2-day hearing to explore the findings of the General Accounting Office report that found unacceptable conditions of care in California nursing homes. These conditions were present despite billions of Federal and State dollars being spent on the care of residents.

A week before last July's hearing, President Clinton announced a package of 17 initiatives to improve nursing home quality. This announcement was not only a response to this committee's pending hearings, but also directly related to a report issued by HCFA that showed that the quality of care problems in nursing homes were much more systemic than what could be determined by the General Accounting Office report which focused only at that point on the State of California.

At that hearing, Deputy Administrator of HCFA Mike Hash's pledge was that the agency would take immediate action to address the urgent matter of improving nursing home care. Since that time, the General Accounting Office and the Inspector General of the Department of Health and Human Services have reported further on the status of nursing home quality and Federal enforcement of the Nursing Home Reform Act by HCFA.

At our hearing in March of this year, we learned of other breakdowns of Federal oversight of nursing homes. HCFA was ordered not to appear at our hearing, but responded to these findings of the Federal watchdog agency by incorporating additional items into its Nursing Home Initiative. These new initiatives address stricter enforcement and improved responsiveness to complaints.

Today's hearing will be different from the first two. It will be different because a relatively rare thing has happened here in Washington. As a consequence of this committee's work and the President's initiative, there is general agreement that although a majority of nursing homes around the country provide good care, there is a minority of homes that do not.

Furthermore, there is agreement about what to do about this situation. In fact, not only is there agreement about what needs to be done, but action is being taken. I am speaking about the Nursing Home Initiative currently being implemented by HCFA. I believe that as a consequence of this committee's work and the administration's willingness to respond to critical findings of the General Accounting Office, work already in progress at HCFA was greatly accelerated and additional initiatives were undertaken. And I think that this represents a major departure from business as usual.

Now, taken together, these two events constitute one of the most hopeful developments I have seen in Washington in a long time, and it is attributable to the willingness of all parties to focus on resolving a problem rather than seeking advantage.

It has been almost a year since the Nursing Home Initiative was launched. At that time, in July, at a hearing of this committee on the quality of care in California nursing homes, I stated—and I would like to quote myself from that time—"We have to remember that the initiatives themselves are only 50 percent of the solution. The other 50 percent is getting them implemented . . ." That is what I said last July. So, that is the purpose of today's hearing, to assess the degree to which the initiatives are being implemented to fix the quality of care problem.

We are going to hear, as I indicated, from two sets of speakers, two panels. The first panel will include representatives from HCFA, the General Accounting Office, and the President-Elect of the Association of Health Facilities Survey Agencies, which represents the 50 State survey offices.

HCFA will testify on the progress that it has made to date on the Nursing Home Initiative. Following their testimony, we will hear a report from the General Accounting Office with its assessment of the agency's effectiveness in carrying out those initiatives which HCFA tells us that it has completed. Next, we will hear testimony from the perspective of the State surveyors. She will tell us

whether HCFA's work is actually taking hold at the State level and what else needs to be done from the State perspective.

We will learn from this panel whether HCFA has made progress in implementing the initiative. We will also learn whether what has been done by HCFA has been done as effectively as it could have been done or should have been done.

Now, our second panel will be more forward-looking. It will address the longer-term, but absolutely vital matters of redesign of the survey system and development of quality indicators. In addition, the topic of what information is now available through the Internet and what could be added to the Internet to help consumers make better choices when they are selecting a nursing home for a loved one—those issues will be discussed. This panel will lay out the promise of ongoing work at HCFA, work that, in my view, is absolutely essential to complete as quickly as it is humanly possible.

In conclusion, I would like to say that we must not ever forget the history of efforts to make high-quality nursing home care commonplace has tended to be a history of false starts and failures, probably both from the standpoint of what State and Federal agencies have done, particularly the exposures before this committee by other chairmen and other members 10 or more years ago.

We have the quality of care problems that the General Accounting Office and the IG have documented. They have been with us before the Institute of Medicine began its work in 1987. Somehow, these don't seem to go away. Somehow, as the leader of this committee, and with the constitutional responsibility of oversight, we have to do better, and the hearings we had 12 months ago demonstrated that conclusively. We have to make sure that the departure of business as usual in HCFA's work characterizes every aspect of these initiatives so that we can have complete confidence that the quality of care in nursing homes improves and stays improved.

We have an opportunity that has been missed by other Congresses and other regulatory agencies. So I think we have a historic opportunity to do the right thing, and to do it in the right way and to do it forever, not just for a short period of time or with some sort of good feeling in our mind that changes are being made when they might not actually be made, and then believing the false promises, but seeing the quality of care of people in nursing homes not really being improved in the way that was well-intended. So I hope that we are all up to this challenge. The human cost of another failed effort in this area is too costly to contemplate.

Senator BREAUX. And then I will go to Senator Hutchinson and then Senator Bryan.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman. I will try and be very brief. You have correctly outlined the procedures for the hearing today and the subject matter, and what we are trying to learn is basically to follow up on the President's initiative to try and improve and change the way the nursing home oversight process has worked and needs to be handled in the future.

We can pass all the regulations and all the laws and all the statutes that the Congress could possibly pass requiring nursing homes to provide quality health care for our Nation's seniors, but unless we follow up and make sure that the rules and regulations are being complied with, the laws will not be worth the paper that they are written on. They will just gather dust in a library somewhere.

So the process that we are looking at through the Aging Committee is to see how do we evaluate nursing homes, what do we judge them by, what are the standards; is the State doing their job with the inspections, and how can we improve the process to ensure that today's seniors, when they go into a nursing home, can be guaranteed the quality that they rightfully have come to expect.

This is particularly important, Mr. Chairman, when we are on the verge of a real huge explosion in the number of people needing the services of skilled nursing facilities and other types of assisted living facilities. The 77 million baby-boomers that are out there are going to be in the not too distant future entering into the realm of eligibility for these programs, and they also want to know that the facilities that they will be utilizing in the future are going to be first-class facilities that operate as the law requires them to operate. So this is what this is all about, to see what progress we have made in guaranteeing that the facilities are doing what they are supposed to do.

We have had some of our staff in Louisiana nursing homes doing some inspections and we have found, as you might imagine, good nursing homes, not so good nursing homes, and bad nursing homes. That is not a surprise; it is probably true for all States. Our job is to make sure that they all are properly evaluated and that they are properly inspected and that the laws are enforced.

A final comment is this. We can't do enough of this as a Government to protect everybody when they go to nursing homes. We have to empower the consumer with adequate, quality information that they can utilize in making decisions about which home they will use for their parents or their family or even for themselves.

We have to empower the consumer through the Internet and through computers and through other means of providing knowledge so that they can, so to speak, vote with their feet. They can go to the nursing homes that are good and not go to the nursing homes that are bad. That is the power of the marketplace and the power of competition. But no information or bad information doesn't help, so we have to find a way to collect the information and make it more accessible and available to more people so that they can make the right decisions about which nursing home they will choose.

Nursing homes have an obligation to publish information about their performance so that they can make the right information available for consumers. I have said this before. We have more in-

formation in many cases about the quality of toaster ovens and microwave ovens by reading Consumer Reports than we do on the health facilities in this country, about which ones are good, which ones are not so good, and which ones are poor. We certainly ought to have this industry and all health delivery providers have the information on how they perform available to everyone so we can make the right decisions. Hopefully, this hearing will give us information that will lead us to that conclusion.

Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Huthinson.

STATEMENT OF SENATOR TIM HUTCHINSON

Senator HUTCHINSON. Thank you, Mr. Chairman. I would only commend you for calling the hearing today and compliment your leadership on this committee. I think the Special Committee on Aging has demonstrated the impact that a select committee can have through rigorous oversight, and the hearing that you conducted almost a year ago, 11 months ago, revealed and exposed serious lapses in the quality of care in nursing homes in this country and has brought about an initiative by HCFA and by the administration to rectify this problem.

Today's will help us to see exactly how the implementation of that initiative and other reforms is going. Once again, I'd like to emphasize how important the role is that this committee is playing in ensuring an improvement in the quality of care for those whom we all care about, our senior citizens. So I commend you on calling the hearing today.

The CHAIRMAN. Thank you, Senator Hutchinson.

Senator Bryan.

STATEMENT OF SENATOR RICHARD H. BRYAN

Senator BRYAN. Thank you very much, Mr. Chairman. I would join with Senator Hutchinson and others in commending you and Senator Breaux for continuing your legacy of leadership in making sure that our oversight responsibilities with respect to the Nation's nursing homes continues.

I think all of us hope that we will never wind up in a nursing home, but the probability is that many will, and we are there when we are most vulnerable and when families are most vulnerable. As a former Governor, I have spent many, many hours in nursing homes within my own State. I have seen the tragic consequences when we have failed in our oversight responsibilities.

So I think both you and Senator Breaux, Mr. Chairman, have put your finger on it. It is not just enacting a new overlay of regulations and feeling good about that. It is, I think, first and foremost, to make sure the regulations we have are properly implemented, and our oversight responsibilities are constant and attentive to this issue.

I look forward to hearing our witnesses this morning and working with you and Senator Breaux, Mr. Chairman, in making sure we continue our primary responsibility to the Nation's elderly who find themselves in our nursing homes.

The CHAIRMAN. A couple of announcements before we start with panel one. One, would be that all testimony that is longer than the time that you have been given to testify will be printed in the record as you submit it to us in its entirety, and that would be for both panels.

Second, including even the members who are here today, we may not have a chance to ask all the questions orally that we want answered. And particularly from members who aren't here, we would submit questions for answer in writing and would appreciate a response within 2 weeks. And those of you who are not familiar with that process, the staff of the Aging Committee, both the Republican and Democratic staff, will help you with that process.

Now, I would like to have Rachel Block, Dr. Scanlon and Ms. Morris come forward while I introduce you.

Rachel Block is the Deputy Director of the Center of Medicaid and State Operations at HCFA, and has the lead responsibility for the Nursing Home Initiative. She reports directly to the Administrator for purposes of this Initiative. Ms. Block will report on HCFA's progress to date on their initiatives on enforcement that were announced in July 1998.

Then we will hear from Dr. William Scanlon, of the General Accounting Office. The General Accounting Office was charged by this committee in late 1997 to investigate this subject. They reported during the summer of 1998 to us. And we asked, then, after HCFA's implementation of the initiatives, the General Accounting Office to monitor that implementation.

My perception is that Dr. Scanlon has been spending more time testifying before Congress than he does at his office. In any case, Dr. Scanlon will report today on the General Accounting Office's review of HCFA's progress in implementing these initiatives.

Then the final witness on panel one is Ms. Catherine Morris. She is president-elect of the Association of Health Facilities Survey Agencies, but is also the director for her State of New Jersey's Long-Term Care Assessment and Survey in their Department of Health. We have asked her, though, to testify in her capacity as president-elect of the surveyor association. She will give us the perspective of the State survey offices around the country on HCFA's implementation of the Nursing Home Initiative.

Would you please start, Ms. Block.

STATEMENT OF RACHEL BLOCK, DEPUTY DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Ms. BLOCK. Thank very much. Thank you, Mr. Chairman, Senator Breaux, and other members of the committee. I want to first thank you for inviting HCFA to discuss our efforts to implement these very key improvements in the process to oversee quality of care in nursing homes, and I would like to reinforce the fact that we view your efforts, the committee's efforts, as an integral part of the overall process of making sure that we are, in fact, successful in meeting those goals.

We also welcome and continue to welcome the efforts of the General Accounting Office with regard to the study and analysis of both the problems that exist in nursing homes as well as our ef-

forts and the efforts of the States to effectively address those problems.

This hearing does come at an opportune time because we are, in effect, moving into the second phase, or the second year since the announcement of the President's Nursing Home Initiative last July. We have spent that time in vigorous efforts to develop and implement new policies, to clarify the existing rules, and also to get guidance out to States. During that time, we have also attempted to ensure that we had participation from a wide variety of stakeholders in all of those activities.

We are now increasing our efforts to monitor the States' efforts to implement the Initiative and to determine where we need further action. But some lessons, as you will hear from the testimony today, are already clear. First, there is some unevenness in terms of the degree to which States have implemented the policies that HCFA articulated under the Initiative. Many States have not begun the process of investigating complaints relating to actual harm within 10 days, consistent with the policy that we articulated a few months ago. The most common reason that they cite is lack of time and resources to do that. But we also feel that there is a general commitment on the part of the States to work with us to ensure that they can meet that standard.

Some States have also been unable to conduct the kinds of unscheduled or weekend surveys that are a key part of the Initiative, again in part because of lack of resources, the lack of time to effectively utilize the resources that are available, and to a certain extent, in some States, existing labor agreements, which take some time to change, in order to do this.

We have, as you know, and with your assistance, provided States with significant additional resources in the fiscal year 1999 budget in order to accomplish these goals, and the President has requested an additional $60 million in his fiscal year 2000 budget to enhance many aspects of our nursing home enforcement efforts. But clearly the issue of resources needs continued attention. I believe you will hear testimony to that effect from others as well.

Another early lesson is that we need to make sure that we get a consistent message out to the States and to the provider community in terms of what our expectations are. We have noted, as has GAO, that there have been inconsistent messages in terms of getting the word out to the States. We are addressing that.

We are also planning to issue guidance to the States very soon regarding the more effective use of civil monetary penalty funds, an issue which the committee has also indicated its interest in. And I am pleased to announce, and we will provide to the Chair and the Ranking Member of this committee, the beginning of a pilot program to place posters and cards in nursing homes in 10 States. We will then evaluate that experience and move on from there, to assist in providing consumers with information about how to identify and report suspected instances of abuse. This is an integral part of our consumer information strategy.

We are, as you know, about to implement the use of quality indicators as an integral part of the survey process. You will have additional testimony on that topic from the second panel. We view this as a very critical effort to improve the survey process over the long

haul and to make sure that the surveyors are, in fact, focusing on those issues that most directly relate to the care provided and outcomes for residents of nursing homes. It is a key initiative.

The CHAIRMAN. I think maybe this clock is just a little bit too quick for you. Take a few more minutes.

Ms. BLOCK. I was simply going to conclude by saying that we acknowledge——

The CHAIRMAN. Well, if you are going to conclude, I will let you conclude.

Ms. BLOCK [continuing]. That there is much more to do. We welcome your input, along with input from all interested parties in terms of how we can improve and double our efforts to be vigorous in the implementation of these initiatives. But I think you also recognize that this is a partnership activity, that we need to work with the States, with the providers, and with representatives of consumers, in addition to, of course, this committee, in order to accomplish our goals. In that partnership, we can meet our goal of trying to ensure, as you have stated, that nursing home residents have the most appropriate care that they possibly can.

I thank you.

The CHAIRMAN. In the 10 States that will have that project that you just announced for identifying and reporting abuse, will that be in every nursing home of those 10 States?

Ms. BLOCK. It will be a voluntary effort. We are working in collaboration with the ombudsmen in those States and other consumer groups. We hope that we will get full participation from the nursing homes in those States, but it will be a voluntary effort for them to participate.

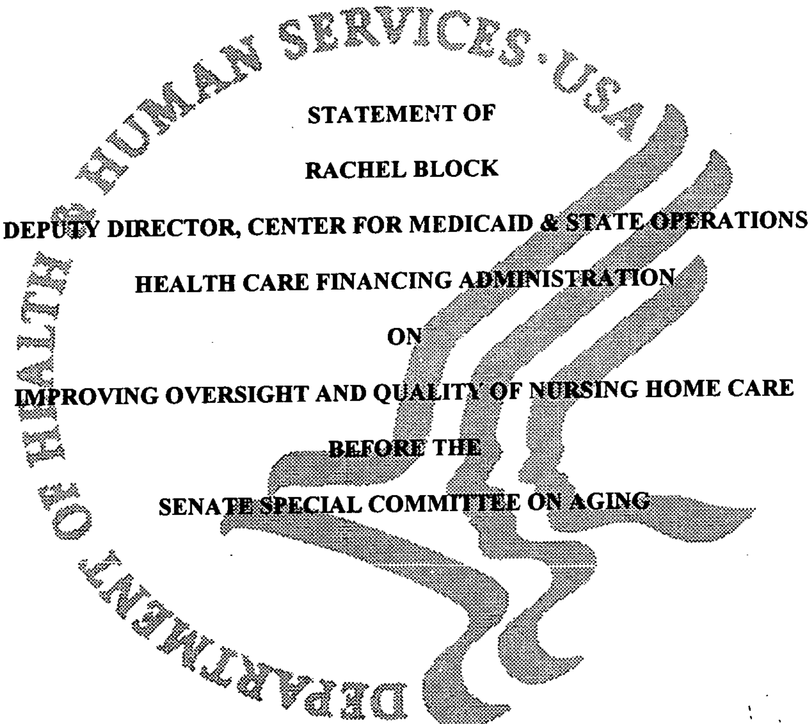
The CHAIRMAN. When will that be started?

Ms. BLOCK. We are distributing the materials beginning today and it will go out from there.

The CHAIRMAN. OK. Let's say maybe 3 months from now—and my staff can follow up on this—I would like to know what percentage of nursing homes in each one of those States are doing that.

Ms. BLOCK. OK.

[The prepared statement of Ms. Block follows:]



STATEMENT OF

RACHEL BLOCK

DEPUTY DIRECTOR, CENTER FOR MEDICAID & STATE OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

ON

IMPROVING OVERSIGHT AND QUALITY OF NURSING HOME CARE

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

JUNE 30, 1999

Testimony of
RACHEL BLOCK, DEPUTY DIRECTOR
CENTER FOR MEDICAID & STATE OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION
on
IMPROVING OVERSIGHT AND QUALITY OF NURSING HOME CARE
before the
SENATE SPECIAL COMMITTEE ON AGING
June 30, 1999

Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting me to discuss our efforts to improve oversight and quality of care for America's 1.6 million nursing home residents. I would also like to thank the General Accounting Office (GAO) for its continued involvement and evaluation.

Last July, President Clinton announced a major initiative to increase protections for vulnerable nursing home residents and crack down on problem providers. Since then, we have worked diligently with your Committee, the GAO, States, providers, advocates, residents and their families to implement and build upon the initiative's many essential provisions.

This hearing comes at an opportune time as we are, in effect, moving into a second phase of the initiative. We have spent the last 12 months primarily designing and implementing the initiative by establishing new policies, clarifying rules and getting guidance out to States on how they should proceed. We are now increasing efforts to monitor how States are acting on specific provisions and determine where we need to take further action to ensure effective implementation. Some lessons are already becoming clear.

- Many States have not begun investigating consumer complaints within 10 days.
- Some States have been unable to begin conducting surveys on evenings and weekends, often because of existing labor agreements.
- More needs to be done to ensure that the initiative is implemented evenly across the country.

We are taking steps to make sure providers and State survey agencies in all parts of the country receive uniform instructions on how to proceed. And some State legislatures are addressing resource and other issues that may be barriers to success.

We greatly appreciate the interest and assistance of this Committee in our initiative. We know you appreciate the challenge of implementing its 30 distinct, often complicated, and interrelated provisions. The task requires dozens of agencies and thousands of individuals across the country to literally and substantially change the way they conduct the business of protecting vulnerable nursing home residents. There is much left to do, but we are committed to taking all these and any additional actions that will help build upon our efforts. By continuing to work with you, the GAO, States, advocates and providers, we will together put an end to the intolerable situations that have caused this most vulnerable population to needlessly suffer.

BACKGROUND

Protecting nursing home residents is a priority for this Administration and our agency. We are committed to working with States, which have the primary responsibility for conducting inspections and protecting resident safety. Some 1.6 million elderly and disabled Americans receive care in approximately 16,800 nursing homes across the United States. Through the Medicare and Medicaid programs, the federal government provides funding to the States to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that violate health and safety rules.

In July 1995 the Clinton Administration implemented the toughest nursing home regulations ever, and they brought about marked improvements. However, both we and the GAO found that many nursing homes were not meeting the requirements, and that many States were not sufficiently monitoring and penalizing facilities that failed to provide adequate care and protection.

Therefore, in July 1998, President Clinton announced a broad and aggressive initiative to improve State inspections and enforcement, and crack down on problem providers. We have provided

monthly reports to the Special Committee on Aging and the GAO on our progress with this initiative. To strengthen enforcement, we have:

- expanded the definition of facilities subject to immediate enforcement action without an opportunity to correct problems before sanctions are imposed. The guidance to States made clear that such "grace periods" should only be for violations that do not cause actual harm to residents at facilities that do not have a history of recurring problems;
- identified facilities with the worst compliance records in each State, and each State has chosen two of these "special focus facilities" for frequent inspection and intense monitoring, and monthly status reports. Through closer scrutiny and immediate sanctions, we are working to prevent "yo-yo" compliance, in which problems are fixed only temporarily and are cited again in subsequent surveys;
- provided comprehensive training and guidance to States on enforcement, use of quality indicators in surveys, medication review during surveys, and prevention of pressures sores, dehydration, weight loss, and abuse;
- instructed States to stagger surveys and conduct a set amount on weekends, early mornings and evenings, when quality and safety and staffing problems often occur, and so facilities can no longer predict inspections;
- instructed States to look at an entire chain's performance when serious problems are identified in any facility that is part of a chain, begun developing further guidelines for sanctioning facilities within problem chains, and begun collecting State contingency plan data in case of chain financial problems;
- required State surveyors to revisit facilities to confirm in person that violations have been corrected before lifting sanctions; and
- instructed State surveyors to investigate consumer complaints within 10 days;
- developed new regulations to enable States to impose civil money penalties for each serious incident and supplement current rules that link penalties only to the number of days that a facility was out of compliance with regulations;
- begun working with the Department of Justice to improve referral of egregious cases where residents have been harmed for potential prosecution; and

- met with the Department's Departmental Appeals Board to discuss increased work load due to the nursing home initiative.

To follow through on the new requirements that have been placed on State survey agencies, we have established a new monitoring system for evaluating State survey teams' adherence to Federally mandated procedures and policies using a standardized assessment tool.

We also are now beginning to use quality indicators in conjunction with the Minimum Data Set that facilities maintain for each resident. These quality indicators furnish continuous data about the quality of care in each facility. That will allow State surveyors to focus on possible problems during inspections, and it will help nursing homes identify areas that need improvement.

We are beginning to get information from this new monitoring system, and wili soon be getting data based on the quality indicators. We will use this new information to work with States to strengthen any weaknesses in their enforcement activities. However, we also have made clear that States will lose federal funding if they fail to adequately perform surveys and protect residents. We can and we will contract with other entities, if necessary, to make sure those functions are performed properly.

Consumer Focus

Our initiative also includes efforts to increase nursing home accountability by making information on each facility's care and safety record available to residents, their families, care givers, and advocates. We have:

- created a new Internet site, Nursing Home Compare, at *www.medicare.gov*, which allows consumers to compare survey results and safety records when choosing a nursing home, and which has so far received approximately 1,387,191 page views since Nursing Home Compare went live September 30, 1998;
- posted best practice guidelines at *www.hcfa.gov/medicaid/siq/siqhmpg.htm* on how to care for residents at risk of weight loss and dehydration;

- begun pilot testing a wide range of initiatives to detect and prevent bed sores, dehydration, and malnutrition in ten states. We worked with outside experts to develop a systematic, data driven process to identify problems and provide focus for in-depth on-site assessments. We are taking interim steps this year, and expect to complete the new system by the end of 2000;
- worked with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for preventing these problems. And we will begin a national campaign to educate consumers and nursing home staff about the risks of malnutrition and dehydration and nursing home residents' rights to quality care this year; and
- begun a study on nursing home staffing that will consider the costs and benefits of establishing minimum staffing levels, and is expected to be completed by early next year.

We expect in the near future to:

- implement a new survey protocol we developed with a national abuse and neglect forum for evaluating nursing homes' abuse and neglect prevention processes;
- publish new survey procedures on clearer guidance on key quality of life/quality of care issues including nutrition, hydration, and pressure sores effective early July 1999; and
- publish new survey procedures for evaluating the use of effective drugs.

In addition, we will continue to develop and expand our consumer information to increase awareness regarding nursing home issues. We are now conducting a national consumer education campaign on preventing and detecting abuse. It features a visually compelling poster for public display, and is currently being pilot tested in 10 States. We also are planning national campaigns to educate residents, families, nursing homes and the public at large about the risks of malnutrition and dehydration, nursing home residents' rights to quality care, and the prevention of resident abuse and neglect.

Complaint Investigations

A key addition to our initiative includes provisions designed to address problems with State survey agency response to complaints. These provisions include:

- requiring all State survey agencies to investigate any complaint alleging harm to a resident within 10 working days;
- reiterating to States that complaints alleging immediate jeopardy to residents must be investigated within two days;
- stressing to States that they must enter complaint information into our data system promptly;
- developing additional standards, including maximum time frames, for the prompt investigation of serious complaints alleging non-immediate jeopardy harm to residents and for complaints deferred until the next survey;
- strengthening federal oversight of complaint investigations by incorporating complaint responsiveness and complaint data as performance measures; and
- requiring that substantiated results of complaint investigations be included in Federal data systems or accessible by Federal officials.

As mentioned above, many States are having difficulty meeting the new requirement to investigate consumer complaints alleging actual harm to residents within 10 days. The primary reason cited is a lack of resources to carry out the work. This is troubling, as your Committee and the GAO have documented serious lapses in State investigation of complaints regarding truly intolerable situations. We are working with the States to assess whether additional resources are needed and to make sure they understand the requirements and are receiving consistent guidance.

Some States are allocating additional resources of their own to meet the 10 day requirement. Maryland, for example, plans to almost double the number of surveyors. Florida also has enacted legislation to increase nursing home oversight staff and funding. And some States were already meeting or exceeding the requirement. Others, however, indicate that their State legislatures are not likely to provide addditional funding.

We have provided States with an additional $8 million for fiscal 1999 to help comply with this and other nursing home initiative provisions. The President has requested an additional $60.1 million

in his fiscal 2000 budget for nursing home enforcement efforts, which will help States comply with the mandate. However, it is clear that States must also recognize the importance of these efforts in their own allocation of resources.

Staggered Surveys

Another important provision in the initiative requires States to conduct standard surveys during "off" hours. This is already widely implemented, and surveyors report that their appearance at 5:00 a.m. or on Saturday has indeed caught staff off guard. One State agency projects that the total number of problems found in these off-hours inspections will be about 10 percent higher than in previous inspections.

However, as with consumer complaints, not all States are successfully implementing the new requirement to stagger surveys and conduct some on nights and weekends in order to end the predictability that had minimized survey effectiveness. In some States there are labor issues where existing contracts preclude evening and weekend work assignments.

We intend to monitor this situation closely, and to work with States to help them comply. But, again, we must reiterate that States will lose federal funding if they fail to adequately perform surveys and protect residents. We can and we will contract with other entities, if necessary, to make sure all functions are performed properly.

Improving Consistency

To ensure more consistent success across the country, we are strengthening communication with our Regional Offices and make sure that providers and State survey agencies in all parts of the country receive uniform instructions on how to proceed. We are conducting cross-regional surveys to identify and address inconsistencies in survey findings among Regions. And we have three workgroups of staff from our Central and Regional Offices collaborating to address specific problems areas.

One workgroup has found that inconsistencies in the survey process are largely due to a need for more training on both the State and Federal level. It also proposed systems for tracking enforcement results and reports that could be used to provide feedback on the State Agency's Survey Performance. It developed several recommendations to address inconsistencies in the enforcement process. And it is working to evaluate and provide guidance on efforts to minimize trauma to residents when they must relocate due to facility closures.

A second workgroup is collecting data to evaluate the budgetary and resource impact of initiative provisions such as staggered surveys, special focus facilities, and use of new quality of care information and enhanced survey protocols. They also have recommended system changes that are needed to monitor and evaluate initiative activities.

And a third workgroup has developed strategies to develop better coordination with the State survey agencies and Administration on Aging ombudsmen. For example, they have recommended more interaction, through regular conference calls and face to face meetings, to discuss current and future goals. The have also recommended convening a Leadership Conference with key partners to develop more effective ways of combining our resources to achieve success.

CONCLUSION

We are continuing to push for full implementation of our nursing home initiative. Solid progress is being made, and nursing homes clearly have received the message that we are serious about protecting vulnerable nursing home residents. We are committed to ensuring that the initiative is fully implemented, and to evaluating its impact and making any necessary adjustments or additions. We look forward to continuing to work with you, the GAO, providers, advocates, nursing home residents and families as we proceed. And, I am happy to answer your questions.

# # #

The CHAIRMAN. Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. It is always a pleasure to be here, even more so today as you deal with this very important topic on which this committee has shown incredible leadership.

Nursing home quality of care problems had remained largely hidden from public view until you initiated a series of hearings and oversight. The committee's earlier hearings called attention to major concerns regarding the prevalence of poor quality care, the inadequate responses to complaints from residents and others alleging serious quality concerns, and the failure to enforce Medicare and Medicaid requirements for nursing homes.

My remarks today are based on the monitoring we have done at your request of HCFA and the States' progress in responding to our earlier recommendations, as well as to several initiatives HCFA began as a result of its study of nursing home quality released last July. I will also highlight findings from a report that we are releasing today based on work that we did for you that examines the merits of HCFA's proposal for enhanced oversight and enforcement for nursing homes with repeated deficiencies involving actual harm to residents.

As you have heard, HCFA has developed about 30 nursing home initiatives over the last year. The many components of these initiatives will obviously require varying amounts of time and effort to develop and implement. Our assessment of some of the longer-term efforts, such as improving the use of quality indicators and sampling techniques in the survey process, and the redesign of HCFA's management information system, are included in my written statement.

I would like to focus now on several initiatives that in the short term are aimed to help assure an appropriate Federal and State response to homes that are found to have serious and recurring problems.

We reviewed the status of several of HCFA's initiatives in 10 States, the largest State in each of HCFA's 10 regions. What we found was that not all have fully implemented the revised policies. For example, HCFA now requires that more frequent revisits occur for homes that have deficiencies involving harm to residents to guarantee that those deficiencies are corrected. It also requires prompter investigation of complaints alleging actual harm to residents.

The States we contacted provided a mixture of responses. Some already had comparable policies in place, others were implementing the new policies, and some were only partially or not implementing them at all. As you have heard, in the area of complaints a significant concern is about the resources required to respond promptly to complaints. What has happened across all States, though, at this point is unknown. HCFA's regional offices have not gathered consistent information on States' implementation of the initiatives.

Other HCFA initiatives involved revised policies to focus survey and enforcement efforts on homes with recurring serious deficiencies. As you will recall from our earlier work, HCFA's data show that in one in four homes nationwide, there are serious deficiencies resulting in harm to residents, and about 40 percent of these homes had such deficiencies on successive surveys.

To date, HCFA's efforts have not significantly increased the number of such homes receiving more intensive scrutiny and stricter enforcement. For example, HCFA has focused on 100 homes nationwide, 2 per State, that have poor compliance records. These homes are to be monitored more frequently, but the very narrow scope of the initiative means that many homes providing poor care are not included.

Moreover, States and others have questioned HCFA for its criteria for selecting the homes, as well as for not varying the number across States that have very different numbers of total nursing homes. They also questioned HCFA's lack of criteria for adding or removing homes from the list.

HCFA has also proposed that homes with deficiencies on consecutive surveys involving actual harm to at least one resident, known as G-level deficiencies in HCFA's scope and severity lexicon, be classified as poor performers and no longer allowed a grace period to correct their deficiencies. Instead, they would face immediate referral to HCFA for appropriate sanctions. We estimate that if this revised definition had been in effect as of April 1999, the number of homes classified as poorly performing would have significantly increased from about 137 to over 2,000, or about 15 percent of all homes nationwide.

Some nursing homes claim that G-level deficiencies are not sufficiently severe to warrant increased scrutiny and immediate sanctions, that homes are cited for actual harm because of over-zealous surveyors rather than real harm to residents.

We reviewed a random sample of over 100 homes that received at least one G-level deficiency and found that in virtually all cases, 98 percent of the homes, that the survey included a deficiency that was documented and that we strongly believe caused actual harm to one or more residents. The deficiencies most typically included failure to prevent pressure sores, failure to prevent accidents, failure to ensure adequate nutrition, and failure to care for dependent residents left lying for hours in their own bodily wastes. Two-thirds of these homes had repeated consecutive deficiencies resulting in harm to residents.

In the report being released today, we have provided a summary of each G-level deficiency reviewed. Everyone can read those summaries and make their own judgments about the seriousness of the deficiencies and the care problems in our nursing homes. We believe these findings indicate HCFA's proposal to increase oversight of such poor-performing homes is an appropriate step to bring the large share of homes with recurring serious deficiencies into sustained compliance with Federal standards.

In closing, Mr. Chairman, I would like to acknowledge that HCFA is giving these issues a high priority even among its many other pressing priorities. The Administrator's response to our findings has consistently been swift and specific, but in many cases

this is only a start. HCFA cannot simply assume that its initiatives and reforms will uniformly be embraced and put into place. HCFA will need to continue to work in partnership with States to effect real change and to ensure it has mechanisms in place to consistently monitor the extent to which its initiatives are achieving their intended purposes.

Additionally, we believe that continued vigilance and support from the Congress will be essential to ensure that real reform takes place and to better ensure the health and safety of frail and dependent nursing home residents. We look forward to working with you and the committee on this vitally important endeavor.

Thank you very much, Mr. Chairman. I would be happy to answer any questions you or others might have.

The CHAIRMAN. That survey of G-level deficiencies was random, right?

Mr. SCANLON. It was random. We selected from the 10 States that we had done our other work in. So this is the largest State in each of the 10 HCFA regions that represent about 46 percent of all nursing homes in the county. And from those 46 percent of the homes, the ones that had G-level deficiencies, we picked a strictly random sample.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, June 30, 1999

NURSING HOMES

HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-155

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Health Care Financing Administration's (HCFA) progress in implementing its recent initiatives to strengthen efforts to ensure the quality of care provided by the nation's nursing homes. The nearly 1.6 million Americans who rely on the nation's nursing homes for their care are among the sickest and most vulnerable populations. They frequently depend on extensive assistance in basic activities, such as dressing, grooming, and using the bathroom, and many require skilled nursing or rehabilitative care. The federal government will pay a projected $39 billion for nursing home care in 1999 and, in partnership with the states, plays a key role in ensuring that nursing home residents receive quality care.

Quality-of-care problems in the nation's nursing homes had gone largely unnoticed until you initiated your recent inquiries, including requesting studies from us, and began your series of hearings and oversight. The Committee's earlier hearings, held in July 1998 and March 1999, called attention to major concerns regarding poor quality of care, inadequate response to complaints alleging serious quality concerns, and the lack of enforcement of Medicare and Medicaid requirements in the nation's nursing homes.

During these hearings, we released three reports that focused on problems in California nursing homes as well as the enforcement and complaint investigation processes nationwide, and made a series of recommendations intended to improve HCFA's role as the principal federal entity responsible for nursing home oversight.[1] Major findings in the three reports include the following:

- One-fourth of the more than 17,000 nursing homes nationwide had serious deficiencies that caused actual harm to residents or placed them at risk of death or serious injury;
- 40 percent of these homes had repeated serious deficiencies;
- the extent of serious care problems portrayed in federal and state data is likely to be understated;
- complaints alleging serious care problems often remain uninvestigated for weeks or months; and
- even when serious deficiencies are identified, state and federal enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected.

[1] See California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998); Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999); and Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, Mar. 22, 1999).

HCFA concurred with virtually all of our recommendations and has developed about 30 initiatives to strengthen federal standards, oversight, and enforcement for nursing homes. As you requested, my remarks today will focus on HCFA's progress in implementing these initiatives. In particular, I will discuss

- the overall scope of HCFA's initiatives,
- early implementation experience for initiatives for which HCFA has already issued revised guidance to the states,
- the implications of a proposed expansion of the category of nursing homes that would face more intensive review and immediate sanctions for deficiencies, and
- initiatives that will require a longer-term commitment for HCFA to implement.

In summary, HCFA has undertaken a wide array of changes in its nursing home oversight that can be summarized in three key areas: (1) strengthening the survey process to be better able to identify violations of federal standards, (2) more strictly enforcing sanctions for nursing homes that do not sustain compliance with these standards, and (3) better educating consumers and nursing home administrators regarding quality of care.

HCFA has provided directives to state agencies on six initiatives, but we found that states have only partially adopted these revised HCFA policies. While in some cases the states have largely implemented these directives, in other cases the directives have not resulted in major changes in state practices because states often indicated they already had similar practices in place, considered the guidance as optional, or lacked the resources to implement certain directives. Furthermore, some of the directives have not had an appreciable effect on the number of homes receiving focused reviews and stricter enforcement.

One of the most controversial changes proposed relates to the revised definition of homes that would be categorized as "poorly performing" and would subject them to immediate sanctions for deficiencies. The revised definition, which HCFA plans to implement later this year, would include homes that have had deficiencies on consecutive surveys involving actual harm to at least one resident--a "G" level deficiency in HCFA's scope and severity lexicon—which previously had not been subject to immediate sanctions. We estimate that if this change in definition had been in effect for the most recent 15-month period ending April 1999, it would have significantly increased the number of homes classified as poorly performing and thus facing stricter enforcement from about 137, or about 1 percent, to 2,275, or 15 percent. Some homes claim that such deficiencies are not sufficiently severe to warrant increased scrutiny and immediate sanctions. Our review of a random sample of over 100 homes that received at least one G-level deficiency found that in virtually all cases the home had a deficiency that represented a serious problem in the nursing home's care that resulted in documented actual harm to at least one resident. These deficiencies most typically included failure to prevent pressure sores, failure to prevent accidents, failure to ensure adequate nutrition, and leaving dependent residents lying for hours in their bodily wastes.

Other HCFA initiatives will require longer-term efforts to develop and implement. For example, HCFA has issued a contract to improve the methodology that state surveyors use to sample residents for intensive review during annual on-site surveys. The improved methodology will use a more rigorous and more targeted sampling technique. This will better enable surveyors to identify potential care problems in nursing homes–including poor nutrition, dehydration, neglect and abuse, and pressure sores--and to determine the prevalence of such problems when they are found. HCFA will soon start providing quality indicator information on homes to surveyors to consider when selecting sample cases. But implementation of a more rigorous sampling methodology that will better permit identifying a problem's prevalence will not take place until mid-2000. Furthermore, while much of HCFA's enforcement and oversight efforts depend on complete, accurate, and timely data, our previous reports highlighted many flaws with its survey and certification management information system. HCFA is still planning the redesign of this system, and implementation of a redesigned system for nursing homes is unlikely before 2002.

BACKGROUND

On the basis of statutory requirements, HCFA, within the Department of Health and Human Services, defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The annual survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review to determine whether care and services meet the assessed needs of the residents. HCFA establishes specific protocols for state surveyors to use in conducting these comprehensive reviews. In addition, when a complaint is filed against a home by a resident, his or her family or friends, the concerned public, or nursing home employees, a complaint investigation may be conducted that involves a targeted review of the specific complaint.

HCFA classifies nursing home deficiencies by their scope—the number of residents potentially or actually affected—and severity—the potential for more than minimal harm; actual harm; or serious injury, death, or its potential ("immediate jeopardy"). Deficiencies are classified in one of 12 categories labeled "A" through "L." The most serious category (L) is for a widespread deficiency that causes death or serious injury or creates the potential for death or serious injury to residents; the least serious category (A) is for an isolated deficiency that poses no actual harm and has potential only for minimum harm. (See table 1.) Homes with deficiencies that do not exceed the C level are considered in "substantial compliance," and as such are deemed to be providing an acceptable level of care.

Table 1: HCFA's Scope and Severity Grid for Medicare and Medicaid Compliance Deficiencies

	Scope			Sanction[a]	
Severity category	Isolated	Pattern	Widespread	Required	Optional
Actual or potential for death/serious injury[b]	J	K	L	Group 3	Group 1 or 2
Other actual harm	G	H	I	Group 2	Group 1[c]
Potential for more than minimal harm	D	E	F	Group 1 for categories D and E; group 2 for category F	Group 2 for categories D and E; group 1 for category F
Potential for minimal harm (substantial compliance)	A	B	C	None	None

[a]Group 1 sanctions are a directed plan of correction, directed in-service training, and/or state monitoring. Group 2 sanctions are denial of payment for new admissions or all individuals and/or civil monetary penalties of $50 to $3,000 per day of noncompliance. Group 3 sanctions are the appointment of a temporary manager, termination from the Medicare and Medicaid programs, and/or civil monetary penalties of $3,050 to $10,000 per day of noncompliance.

[b]This category is referred to in regulations as "immediate jeopardy."

[c]Sanctions for this category also include the option for a temporary manager.

The federal government has the authority to impose a variety of sanctions if homes are found to have a deficiency, including fines, denying Medicare or Medicaid payment for new or all residents, or ultimately terminating the home from participation in Medicare and Medicaid. The scope and severity of a deficiency determine the types of applicable sanctions and whether they are required or optional. Under their shared contractual responsibility for Medicare-certified nursing homes, state agencies identify and categorize deficiencies and make referrals with proposed sanctions to HCFA. Under HCFA's current policies, most homes are given a grace period, usually 30 to 60 days, to correct deficiencies. States do not refer homes to HCFA for sanctions unless the homes fail to correct their deficiencies within the grace period. Exceptions are provided for homes with deficiencies at the highest level of severity (J, K, or L) and for homes that meet HCFA's definition of a "poorly performing facility"–a special category of homes with repeat serious deficiencies. HCFA policies call for states to refer these homes immediately for sanction. HCFA also provides a notice period of 15 days before a sanction takes effect, and if homes come into compliance during this time, the sanction is waived.[2]

[2]Only civil monetary penalties can be assessed retroactively even if a home corrects the problem. For homes found to have a deficiency at the highest severity level (J, K, or L), HCFA may put a sanction into effect after a 2-day notice period.

HCFA HAS UNDERTAKEN A BROAD ARRAY OF INITIATIVES IN RESPONSE TO IDENTIFIED CONCERNS

HCFA has undertaken about 30 initiatives intended to improve nursing home oversight and enforcement and has provided monthly status reports to this Committee since last year. HCFA's efforts over the past year can be categorized in three broad categories:

- **Improved survey processes** intended to result in better detection of noncompliance with federal requirements. HCFA has already provided revised guidance to states in some survey process areas, such as requiring them to respond more rapidly to complaints alleging harm to residents and requiring states to begin some of their inspections on weekends or after normal working hours. Over the longer term, HCFA is changing the standard inspection process to focus the sample of residents selected for review on problem areas identified using patient-specific data reported by the nursing home. However, this major change will require time to design the new sampling methodology and train state surveyors in it.

- **Stricter enforcement** aimed at ensuring that nursing homes maintain compliance with federal requirements. HCFA's initiatives include requiring states to conduct more "revisits" to better ensure that homes correct serious deficiencies found in a prior survey and targeting a limited number of nursing homes with particularly poor compliance records for more frequent inspections. In addition, HCFA has proposed broadening the category of homes that are defined as poor performers and thereby not granted a grace period to correct their deficiencies. HCFA has also recently begun expanding the use of civil monetary penalties to apply penalties on a per-instance basis in addition to per day. It is also reevaluating policies relating to terminated homes. This includes developing standards (1) ensuring that federal payments are made to terminated homes only if they are actively transferring residents to other settings, (2) providing guidance on the appropriate length of a "reasonable assurance period" in which a home demonstrates it has eliminated deficiencies before the home is allowed to reenter the Medicare program, and (3) ensuring that a home's pre-termination compliance history is considered in any subsequent enforcement actions after it has been readmitted.

- **Better information** to track homes' compliance status and assess quality of care as well as to educate consumers and nursing home administrators. HCFA has begun posting the results of recent surveys for each nursing home in the nation on the Internet to enable consumers searching for a nursing home to better distinguish among homes on the basis of quality. In addition, HCFA has initiated educational programs for nursing home administrators to better enable them to meet federal requirements. Examples include developing and posting on the Internet best practice guidelines for caring for residents at risk for weight loss and dehydration and engaging in national efforts promoting awareness on prevention abuse, such as developing educational posters and other materials. Finally, HCFA has embarked on a major redesign of its survey and certification management information systems. This will include a redesign of its management information system–the On-Line Survey, Certification, and Reporting (OSCAR) system--and development of a system to track chain ownership of providers, including nursing homes. These projects are just beginning and will require several years to complete.

See table I.1 for a complete list of HCFA initiatives and their status.

STATES HAVE PARTIALLY ADOPTED REVISED HCFA GUIDANCE

Over the past year, HCFA has issued revised directives and guidance to the states implementing several of the survey improvement and enforcement initiatives. In order to determine states' responses to these initiatives and HCFA's monitoring of their implementation, we requested information from each of the 10 HCFA regional offices and the largest state in each region.[3] Some states have revised their practices in response to several of the initiatives. Other states reported that the new HCFA guidance has not resulted in changed practices because they believed existing state practices accomplished similar goals or they chose not to implement the HCFA policy. States also highlighted some concerns or operational difficulties, including resource constraints, associated with specific initiatives. To date, HCFA has conducted only limited monitoring of states' implementation of these initiatives.

Several Initiatives Require States to Significantly Increase Survey Activity

Three of the initiatives that HCFA instructed the states to implement can require a significant increase or modification in states' nursing home survey activity. For each initiative, some of the 10 states we polled indicated that their existing practices were similar to the change required by HCFA and thus they implemented no new practices. States that did not have similar existing practices often cited that resources were a significant barrier to compliance.

Revisits for Serious Deficiencies

In July 1998, we reported that states often accepted homes' self-reports that they had corrected serious deficiencies without performing an independent, on-site follow-up. In some cases, we found that these deficiencies had not been corrected despite the home's self-report. We recommended that, for homes with recurring serious violations, HCFA require state surveyors to substantiate by an on-site review that the home has achieved compliance. In response, HCFA issued a policy letter in August 1998 directing state agencies to perform revisits for all deficiencies where harm to one or more residents was found until the state was assured that the deficiencies were fully corrected.[4]

More than half of the states we contacted informed us that prior to the new HCFA policy they had been verifying that homes corrected serious deficiencies through a revisit. Additionally, Florida, Massachusetts, and Texas indicated that they had implemented this new policy, and California indicated that it had partially done so. California and Massachusetts reported that this change has led to a sharp increase in the number of revisits they conduct and requires additional resources. As a result, their ability to timely meet requirements for other types of surveys, such as complaint investigations and annual surveys, may be restricted.

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[3]The states we contacted were the largest in each HCFA region as measured by the number of certified nursing home beds: California, Colorado, Florida, Illinois, Massachusetts, Missouri, New York, Pennsylvania, Texas, and Washington. These states represent 46 percent of all certified nursing home beds nationwide.

[4]Under earlier practice, if at the first revisit the state agency found that the deficiency, while not fully corrected, continued at a severity level of less than actual harm to a resident, it could accept the nursing home's written assertion that it had corrected all identified problems as evidence of correction without performing another state on-site revisit.

Complaints Alleging Actual Harm to Residents

In response to our March 22, 1999, report finding that states often did not investigate serious complaints for weeks or months, HCFA issued a policy letter in March 1999 instructing states to investigate any complaint alleging actual harm within 10 workdays. We found that many states expressed concern that they would need substantial additional resources to implement it. Of the 10 states we contacted, 4 reported that they were meeting this requirement. For example, in response to a state auditor's report, Pennsylvania had begun investigating all complaints within 2 calendar days. Three other states, California, Illinois, and Washington, also had state requirements that serious complaints be investigated within 10 workdays (7 calendar days for Illinois), but California and Washington acknowledged that they were not fully able to investigate all complaints within this time frame without additional resources. Washington, for example, estimated that it would require nine additional surveyors to meet the 10-workday requirement in all cases.[5] The remaining three states–Colorado, Massachusetts, and Missouri–indicated that they had not implemented the more stringent 10-day investigation requirement for complaints alleging actual harm situations, generally indicating that they were awaiting clarification on this policy from HCFA before implementing it. HCFA continues to develop additional guidance for states regarding which complaints should appropriately be considered as alleging actual harm and thereby be investigated within 10 workdays.

Evening and Weekend Surveys

We previously reported that annual surveys are often predictable, allowing nursing homes to prepare for surveys in ways that did not represent the normal course of business or care, and we recommended that HCFA require the states to stagger the starting months of surveys in a way that reduces their predictability. Although HCFA disagreed that surveys are predictable and has not directly acted on this recommendation, it issued instructions effective in January 1999 requiring that 10 percent of annual surveys be started on weekends or outside normal working hours. Because homes are often staffed differently and exhibit different care environments on weekends, evenings, and nights, this initiative is intended to allow state surveyors a better opportunity to identify the actual operating conditions of homes. Eight of the 10 states we contacted indicated that they had fully implemented this new policy. One state noted that it had previously conducted surveys during evening and weekend hours but had not necessarily started the surveys at these times as required by the new HCFA guidance. However, several states also indicated that conducting more surveys during these hours has posed labor issues, including increased overtime pay, and may make it more difficult to recruit or retain surveyors.

Of the two states that had not fully implemented the revised HCFA policy, Texas indicated that existing state policy requires that 20 percent of inspections be done during "off" hours but that this included complaint investigations and permitted a less stringent definition of "off" hours than HCFA's requirement. Pennsylvania had not implemented this HCFA policy, but commented that its aggressive complaint investigation policy has resulted in increased surveillance of nursing homes on weekends, evenings, and holidays.

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[5]In our March 22, 1999, report, we found that Washington categorized over 80 percent of its complaints in the priority level requiring an investigation within 10 days, but the state met this time frame for only about half of such complaints.

Recent Initiatives Targeting Poorly Performing Homes Have Focused on Few Additional Homes

Three HCFA initiatives were intended to enhance monitoring of, and impose more immediate sanctions on, homes with records of poor performance. However, to date, these initiatives have not significantly increased the number of homes receiving closer scrutiny. The impact of these initiatives has been limited because the first was designed to target only a small number of homes; the second, partially implemented initiative has not yet significantly changed the number of homes considered poorly performing; and the third was optional, and most states chose not to implement it.

Special-Focus Facilities

In January 1999, HCFA implemented its program for enhanced monitoring of 100 "special-focus" nursing homes–two per state–with records of poor care. HCFA identified four homes in each state with persistently poor compliance records, and each state agency was expected to select two of these homes for enhanced monitoring, including conducting standard surveys every 6 months rather than annually. Although worthwhile, the very narrow scope of this initiative excluded many homes providing poor care.

All 10 states we contacted indicated that they had begun enhanced monitoring of the special-focus facilities in their state. Several indicated that the additional resources required to focus on two homes were minimal. However, some states questioned HCFA's selection criteria and indicated that they would have identified homes other than those identified by HCFA as more appropriately warranting increased scrutiny. Some also suggested that HCFA should develop clear criteria as to when a home should no longer be considered a special-focus facility and replaced by another selected for focused monitoring. Also, a HCFA regional office questioned the appropriateness of having an equal number of homes per state, regardless of a state's total number of nursing homes. For example, Washington, with 284 homes, is focusing on the same number of homes as Alaska, which has 15 homes. Two states noted that they had begun increased monitoring of a larger number of homes: Illinois intends to include all 4 HCFA-suggested homes in its enhanced monitoring efforts, and California indicated that it had identified 34 nursing homes for increased survey activity.

Redefinition of Poorly Performing Homes

In July 1998, we recommended that, for homes cited for repeated serious violations, HCFA eliminate the grace period in which homes were allowed to correct deficiencies without a sanction being imposed. In September 1998, HCFA modified its former policy accordingly by expanding its definition of a poorly performing facility to include those with recurring actual harm deficiencies. However, HCFA initially included only recurring actual harm deficiencies that involved a pattern or were widespread in scope (H-level or higher). HCFA postponed including homes with isolated actual harm deficiencies (G-level) in two consecutive surveys when it recognized that the number of homes designated as poor performers and the associated costs to states of dealing with them would increase significantly. Thus, HCFA currently considers any home a poorly performing facility if it had been cited with a deficiency for a pattern of actual harm to several residents (H-level) or worse in two consecutive annual surveys or any intervening revisit or complaint investigation. Nursing homes given this designation are

60-346 00 - 2

automatically denied an opportunity to correct deficiencies before sanctions are applied and are referred immediately to HCFA for sanction.[6]

Eight of the 10 states we contacted said that they had implemented the policy including recurring H-level and higher deficiencies. Most of these states indicated that the revision has not significantly changed the number of nursing homes designated as poorly performing. Our analysis of HCFA data nationwide also indicated that the new definition, if it had been in effect for the 15-month period prior to April 1999, would have actually reduced slightly the number of homes meeting the definition of poor performers from about 146 homes to 137 homes (about 1 percent of homes).[7] Of the two states that had not implemented the interim HCFA guidance, California reiterated that it has implemented its own focused enforcement program for 34 homes with a poor compliance history, and New York, while it is not complying with this requirement, said that it is using the new HCFA criteria to impose state fines.

Poorly Performing Chains

Also in September 1998, HCFA issued interim guidance to states allowing but not requiring them to immediately refer chain-owned homes with actual harm deficiencies for sanctions if any of the chain's homes had poor performance records. Of the 10 states we contacted, only Pennsylvania indicated that it had implemented this guidance, and Massachusetts and Florida said that they had "partially" implemented it because they were already taking some action against problem nursing home chains. However, none of the three states had referred any homes to HCFA for sanctions because they belonged to poorly performing chains. Some states, such as California and Florida, indicated that they are using other approaches, such as denying state licensure, to limit chains with poor compliance records from expanding in their states. The other states indicated that they chose not to implement this guidance or found HCFA's guidance to be unclear and were awaiting further clarification of HCFA's policy. Some were concerned that referrals to HCFA that are based partially on the performance of other homes, even with common ownership, are unfair or that the practice could lead to increased informal dispute resolution[8] requests by homes.

One significant barrier to implementing this initiative is that HCFA is unable to reliably identify homes that belong to nursing home chains and does not keep statistics on nursing home

[6]When states find serious violations of federal standards in a Medicare-certified nursing home, they must refer the home to HCFA for imposition of a sanction.

[7]The previous definition of a poorly performing facility required that a home be cited on its current standard survey for substandard quality of care and cited in one of its two previous standard surveys for substandard quality of care or immediate jeopardy violations. Violations are classified as substandard quality of care if (1) the deficiencies are in one of three requirement categories—quality of care, quality of life, or resident behavior and facility practices; and (2) their scope is widespread and they have a potential for harming residents (F-level), or they have harmed more than a limited number of residents or put the health and safety of one or more residents in immediate jeopardy (H-level or higher).

[8]Nursing homes that disagree with surveyor-identified deficiencies have one informal opportunity to dispute the citations when they receive the official deficiency report. This process, called informal dispute resolution, involves the nursing home and the state and may be used to refute the deficiency. Nursing homes may appeal to the Department of Health and Human Services' Departmental Appeals Board any sanctions imposed as a result of deficiencies identified by the state agency.

enforcement actions according to ownership. HCFA estimates that ownership information will not be consistently and completely tracked for several years.

HCFA Does Not Consistently Monitor State Implementation of Its New Policies

HCFA's 10 regional offices are charged with monitoring state implementation of its policies and directives related to enforcement of federal nursing home requirements. When we asked the regional offices how they were monitoring states' implementation of these initiatives, their responses ranged from no monitoring of most of the implemented initiatives to requiring states to submit special reports. For example, the Dallas regional office stated that it does not routinely monitor state implementation of any of these HCFA initiatives. The Denver regional office said that it was monitoring most of these initiatives through the normal course of business. In contrast, the Boston regional office said that it was requiring states in its region to submit monthly reports on how they were implementing several of these initiatives.

Because of these uneven monitoring practices, HCFA is not well informed on what the states are doing with regard to these initiatives. For example, all regions reported to the HCFA central office that the states in their region had implemented instructions to reduce the predictability of surveys. However, as noted, of the 10 states we contacted, one indicated that it had not implemented, and another said that it had partially implemented, this policy. Furthermore, a HCFA central office official told us that, although the regional offices had reported that all states had implemented this policy, the board of the Association of Health Facility Survey Agencies, representing the state survey agencies, had told HCFA that 12 states had not done so. A HCFA official acknowledged that no action has been taken regarding states that have not complied with HCFA's initiatives.

PROPOSED EXPANSION OF "POOR PERFORMER" CATEGORY IS CONTROVERSIAL BUT HAS MERIT

HCFA's proposed expansion of the definition of a poorly performing facility to include homes with G-level deficiencies in two consecutive annual surveys or an intervening survey would greatly increase the number of poorly performing homes that are immediately referred to HCFA for sanction without a grace period to correct deficiencies. If this revised definition had been in effect for the most recent 15-month period ending April 1999, we estimate that nearly 15 percent of all homes nationwide, or 2,275 homes, would have been subject to immediate sanction, compared with about 1 percent under the current definition. Industry representatives contend that the proposed definition would inappropriately penalize homes, because G-level deficiencies are often less serious problems not involving harm to residents. However, on the basis of our review of the G-level deficiencies in over 100 surveys of randomly selected homes with such deficiencies, we found that the vast majority appropriately documented actual harm to at least one resident.[9]

[9]We analyzed a sample of 107 annual and complaint surveys with G-level deficiencies using HCFA's OSCAR data. These surveys were randomly chosen from surveys with G-level deficiencies performed in 10 states during fiscal year 1998. The states were the largest state in each of the 10 HCFA regions, as measured by the number of certified nursing home beds--California, Colorado, Florida, Illinois, Massachusetts, Missouri, New York, Pennsylvania, Texas, and Washington. We requested copies of the survey reports from the state survey agencies and abstracted

Of the 107 surveys with G-level deficiencies that we reviewed, 98 percent (all but 2 surveys) involved care or lack of care that harmed residents.[10] Most commonly, these deficiencies related to failure to prevent pressure sores (23 percent); accidents that resulted in fractures, abrasions, or other injury (14 percent); poor nutrition (8 percent); abuse (4 percent); or other quality-of-care concerns (6 percent). Quality-of-life deficiencies, such as failing to protect resident dignity and rights to self-determination, were found to have harmed residents in about 4 percent of these deficiencies. Of the 107 homes with G-level deficiencies we reviewed, about two-thirds would have been categorized as a poorly performing facility if the proposed redefinition had been in effect in 1998.

Some states are concerned that the broader definition could result in increased enforcement activity, and more actual harm deficiencies being contested through the informal dispute resolution process and subsequent sanctions being appealed to the Department of Health and Human Services' Departmental Appeals Board. However, our analysis suggests that almost all G-level deficiencies in fact involve documented harm to residents, justifying increased enforcement activity for homes with a history of them. For those few cases where harm to the resident is uncertain, mechanisms exist for homes to request reconsideration of the initial surveyor's deficiency citations.

SEVERAL KEY INITIATIVES WILL REQUIRE HCFA'S LONG-TERM COMMITMENT

Several HCFA initiatives will require a longer-term commitment to fully implement than those just discussed. These initiatives involve major changes to HCFA's nursing home survey process to enhance its ability to detect and estimate the prevalence of serious quality-related deficiencies and the enhancement of HCFA's management information system to enable better tracking of homes' compliance histories. While these reforms are critical for improving the effectiveness of HCFA's oversight and setting accurate baseline measures of nursing home quality, their complexity means that these initiatives will not be implemented until next year or several years thereafter.

Redesign of Survey Process Entails Several Components

HCFA has begun a major redesign of its nursing home survey process. A considerable portion of a nursing home's survey has involved selecting a sample of residents for focused review of their quality of care. This review may include examination of medical records, physical observation, and, where possible, resident interviews. In an earlier report to this Committee, we found that HCFA's surveys included too few residents not randomly selected, thereby precluding surveyors from easily determining the prevalence of identified problems. The inability to estimate prevalence makes it difficult for surveyors and state agencies to determine where a cited deficiency should fall in HCFA's nursing home deficiency scope and severity grid, which in turn determines whether a nursing home is offered an opportunity to correct before sanctions are applied and the level of sanctions. We recommended that HCFA revise its survey procedures to

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each of the 201 G-level deficiencies in these surveys. For more detail, see Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit (GAO/HEHS-99-157, June 30, 1999).

[10] Another eight surveys with G-level deficiencies had a deficiency that did not clearly document harm, but other G- or higher-level deficiencies on the same survey resulted in harm to residents.

instruct inspectors to take stratified random samples of resident cases and review sufficient numbers to permit surveyors to better detect problems and assess their prevalence.[11]

In response to our recommendation, HCFA has begun modifying the sampling methodology of its nursing home survey protocol. This change has two parts. First, effective July 1, HCFA will provide surveyors with quality indicators that include comparative information on areas such as nutrition, hydration, and pressure sores. It will also increase the sample size in areas of particular concern, including nutrition, dehydration, and pressure sores. However, the sample will continue to be nonrandom and in large part based on the judgment of the surveyors.

The second stage of this change will introduce a more rigorous sampling methodology, incorporating the quality indicators and other data derived from medical records in a two-stage sampling process designed to identify areas in which the nursing home departs significantly from the average of other homes. The methodology will target these areas for focused sampling and permit surveyors to make a reliable estimate of the prevalence of quality-of-care problems identified in the nursing home. This second stage is to be implemented during 2000. We believe that implementation of this stage is necessary for HCFA to fully respond to our recommendation and significantly improve the ability of surveys to effectively identify the existence and extent of deficiencies.

Redesign of HCFA's Management Information System Will Require 3 Years

In a recent report, we recommended that HCFA develop an improved management information system, which would help it track the status and history of deficiencies, integrate the results of complaint investigations, and monitor enforcement actions.[12] In response to this recommendation, HCFA embarked on a 3-year project to redesign its on-line management information system, the OSCAR system. This project is in its preliminary phase, with a contractor gathering broad requirements for what the system will be required to do as a first step in creating a system design. Initially, this new system will be brought on-line for a single provider type—home health agencies—and subsequently expanded to other providers, with nursing homes projected to come on-line second by the beginning of 2001. The final stage will be to link this system with other HCFA quality-related databases, such as the Minimum Data Set for nursing homes, by the end of January 2002.[13]

The Minimum Data Set is potentially a key source of information for tracking changes in quality of care. However, these data have some limitations, particularly in the short term. Because the reporting of these data has begun only recently, reporting is not consistent, and most states lack a baseline for comparison. Also, these data are self-reported by nursing homes and are used to adjust Medicare payments for level of care as well as serve as the basis for the quality indicators now being incorporated into the nursing home inspection process. These multiple uses create a complex set of reporting incentives for nursing homes, which suggests that unaudited

[11] GAO/HEHS-98-202, July 27, 1998, pp. 20, 30.

[12] GAO/HEHS-99-46, Mar. 18, 1999.

[13] The Minimum Data Set includes standardized information on a patient's medical and psychological status at a point in time that HCFA requires Medicare-certified providers, including nursing homes, to report. HCFA intends to use this information for adjusting reimbursement to Medicare providers as well as developing indicators of quality of care.

information from the Minimum Data Set should be treated with caution as a data source for tracking quality changes. Our earlier work indicated that nursing homes' medical records often inaccurately portray patient quality of care, suggesting that the Minimum Data Set information also may not accurately reflect quality issues.

In addition, HCFA plans to develop a database that will track nursing home ownership to permit better identification of chains. However, a HCFA official told us that HCFA cannot even begin to design this system until it develops the congressionally mandated national provider ID system, which will give each Medicare-certified provider a distinct tracking number. Implementation of an ownership tracking system is thus several years away.

CONCLUDING OBSERVATIONS

During the last year, increased congressional and administration attention to the inadequate care provided for many nursing home residents has resulted in significant efforts to improve conditions. Some HCFA initiatives have already been implemented, such as providing consumers with nursing home compliance information on the Internet, increasing the number of state surveys beginning on evenings and weekends, and allowing civil monetary penalties to be imposed for each instance of a violation. However, many other efforts are still in process and will require HCFA's further effort and commitment to complete. Also, since HCFA must depend on the states to implement many of these efforts, it will need to monitor state implementation to ensure that implementation is consistent and in line with HCFA's intentions. HCFA must further rely on the partnership between states and HCFA's regional offices to effectively implement its initiatives and monitor progress. But, at present, this is complicated by inconsistencies in the monitoring practices of the regional offices. At your request, we are now examining HCFA's regional office oversight of state agency performance in certifying nursing homes.

The purpose behind all these initiatives is, naturally, improvement of the care given to nursing home residents. Such improvements are difficult to measure, especially in the short run. Tracking the results of nursing home surveys, particularly in quality of care deficiencies such as pressure sores, nutrition, dehydration, and abuse, can potentially provide some insights. However, the changes being made in the survey process are intended to result in improved and more consistent detection of quality problems, potentially increasing the number reported. Thus, improvements to the survey methodology could create a false impression that quality of care is getting worse instead of better, because HCFA and the states will be better able to identify and document deficiencies. Nonetheless, these initiatives are important steps toward improving the quality of care America's nursing home residents receive. If well implemented, the initiatives should improve the effectiveness of the survey process, strengthen the enforcement process, enhance HCFA's management information systems, and provide better information to consumers and nursing home administrators. While in the short run it may be difficult to assess the degree to which these changes improve care to nursing home residents, over the long run HCFA and the Congress will be better able to monitor the care nursing home residents receive and determine what additional improvements are necessary. Continued commitment and oversight are also important elements of the endeavor to improve nursing home quality of care.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members of the Committee may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please contact me at (202) 512-7114 or John Dicken at (202) 512-7043. Gloria Eldridge, Terry Saiki, and Peter Schmidt also made key contributions to this testimony.

STATUS OF HCFA'S NURSING HOME INITIATIVES

Since July 1998, HCFA has undertaken about 30 initiatives intended to improve nursing home oversight and quality of care. Many of these initiatives respond to earlier GAO reports as well as concerns identified by HCFA and others. These initiatives can be broadly categorized as

- **improving the survey process** to better detect noncompliance with federal nursing home requirements through strengthening annual surveys and complaint investigations;
- **stricter enforcement** to better ensure that poorly performing nursing homes are identified and appropriate sanctions are imposed to achieve sustained compliance with federal nursing home requirements; and
- **better information** to track homes' compliance and assess quality of care as well as to educate consumers and nursing home administrators.

Table I.1 summarizes each of HCFA's nursing home initiatives within these categories and our assessment of the current status of implementation.

Table I.1: Current Implementation Status of HCFA's Nursing Home Initiatives

Initiative[a]	Current status
Improving the survey process	
Stagger or otherwise vary the scheduling of surveys to reduce the predictability of surveyor visits. GAO-1, HCFA-1(d)	HCFA instructed states on 1/1/99 to start 10 percent of annual surveys on weekends or outside of normal working hours. 8 of 10 states we contacted have implemented this revised policy, but some are concerned about added cost and labor issues. HCFA disagreed with our findings that annual surveys are predictable and has not acted on our recommendation that the date of the survey be varied.
Take stratified random samples of resident cases and review sufficient numbers and types of resident cases to establish prevalence of problems. GAO-2	HCFA has contracted to modify the survey process in two phases: --The first phase will incorporate quality indicators derived from the Minimum Data Set into the survey beginning 7/01/99. --The second phase will introduce a stratified random sampling methodology into the survey process in 2000.
Inspect 100 nursing homes with poor compliance histories more frequently without decreasing inspection frequency for other homes. HCFA-1(c)	HCFA has identified two "special-focus" homes per state and notified states on 1/5/99. The 10 states we contacted have begun surveying the two homes in their state every six months, but some are concerned about selection criteria and how homes are removed from list.
Provide training and other assistance to states, or terminate funding to states with inadequate survey functions. HCFA-2(a)	A HCFA work group is developing performance measures to assess state agencies' performance and related sanctions. HCFA has developed draft manual instructions on the assessment of state agency performance that are expected to be finalized 8/31/99.
Enhance HCFA review of state surveys. HCFA-2(b)	HCFA implemented changes to the federal monitoring survey process 9/30/98. Of the 5 percent of state surveys that HCFA regional offices must review, the new policy requires that at least one be an independent comparative survey, with the remaining federal reviews in the form of Federal Oversight/Support Survey (FOSS). A HCFA work group continues to refine FOSS protocols and scoring of state surveyor teams' performance. A forthcoming GAO report will further assess HCFA's review of state surveys.
Provide clearer guidance to surveyors on key quality-of-life/quality-of-care issues in order to assist them in identifying nutrition, hydration, and pressure sore care problems in nursing homes. HCFA-3(c)	New survey interpretive procedures have been developed in order to identify nutrition, hydration, and pressure sore issues within nursing homes. These new interpretive procedures are to be implemented 6/30/99 and are part of HCFA's surveyor training course.
Add survey task to assess a home's resident abuse intervention system. HCFA-4(a)	Incorporated new task into survey protocols that are to be implemented 6/30/99.
Develop standards for investigating allegations of actual harm. GAO-C1	HCFA instructed states on 3/16/99 to investigate any complaint alleging actual harm within 10 workdays. HCFA is developing additional guidance further clarifying this new policy. 4 of 10 states we contacted have not implemented the 10-workday policy, and 2 other states indicated that they are not fully meeting their existing 10-workday time frame. HCFA has established a Complaint Improvement Project to develop additional standards regarding complaint investigations, and has paired this project with an ongoing staffing study.
Strengthen federal oversight of state complaint investigations. GAO-C2	As of 7/31/99, some complaint investigations are to be reviewed in HCFA's federal monitoring survey process. HCFA will analyze the results of a survey of regional office complaint logs by 8/30/99 and assess what additional steps may be necessary. Performance measures on complaint responsiveness and complaint data are to be incorporated into draft manual instructions on inadequate survey performance (see HCFA-2(a)).
Require substantiated complaints to be entered in federal data systems. GAO-C3	HCFA directed states on 3/16/99 to cite federal deficiencies on complaint investigations and enter them into the federal data system even if also entered into a state licensure system. HCFA is developing a revised complaint form due 10/31/99. The OSCAR redesign, due 9/30/01, will incorporate needed changes in order to track information and deficiencies resulting from complaint investigations more accurately.

Initiative[a]	Current status
Strengthening enforcement	
Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly. GAO-3 (See HCFA-1(a) below.)	HCFA issued implementing memo to states on 9/22/98 to include homes cited with repeated pattern of actual harm (H-level or above) deficiencies in the poor-performing facilities category that are denied a grace period. HCFA proposes expanding the category of homes denied a grace period to include isolated actual harm (G-level) deficiencies later in 1999. HCFA is developing new manual instructions, with final instructions due by 9/30/99.
Revise definition of "poor performer." HCFA-1(a) (See GAO-3 above.)	See status of previous initiative. We estimate that adding G-level deficiencies to the current poor-performer category would increase nursing homes referred for immediate sanction from 1 percent to 15 percent of homes and could increase related informal dispute resolution hearings at the state level and appeals at the federal level.
Require on-site revisits for problem homes with recurring serious violations. GAO-4	HCFA issued revised revisit policy to states and regional offices on 8/20/98 and is monitoring implementation. 9 of the10 states we contacted have implemented the revised policy. Two states expressed the need for additional resources to conduct the large increase in required revisits.
Permit states to impose civil monetary penalties for "each instance." HCFA-1(b)	Final regulation went into effect 5/17/99 and final manual instructions are due 9/18/99. The American Health Care Association has filed litigation in court to enjoin the implementation of this new policy.
Focus enforcement efforts on nursing homes within chains that have a record of noncompliance with federal requirements. HCFA-1(e)	Issued optional implementing memo to states; final manual instructions due 8/31/99. Only 1 of 10 states we contacted has not fully implemented this guidance. HCFA's and states' lack of nursing home ownership data will hinder the effectiveness of this initiative. A HCFA ownership database will require several years to develop.
Prosecute egregious violations. HCFA-	Conference with the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice held 10/22/98. Although HCFA has listed this initiative as completed, HCFA and the Department of Justice have not yet established a formal agreement on when nursing homes should be referred to Justice for prosecution.
Reduce backlog of civil monetary penalty (CMP) appeals. GAO-E1	The Congress supplied a $1 million supplemental appropriation for FY 1999 for the HHS Departmental Appeals Board. HCFA has requested additional funds for the Board for FY 2000.
Continue federal payments to nursing homes past termination only if homes are transferring residents to alternative settings. GAO-E2(a)	HCFA is reviewing 30 involuntary termination cases from FY 1998 and will determine by 9/30/99 whether policy change is necessary.
Ensure that reasonable assurance periods are sufficient before readmitting a terminated nursing home so that the reason for termination will not recur. GAO-E2(b)	HCFA is developing additional examples of reasonable assurance periods for revised draft manual instructions due 9/30/99.
Consider pre-termination history in subsequent enforcement actions for terminated homes that are readmitted to the program. GAO-E2(c)	HCFA included this change in draft revised manual instructions, with final manual instructions due 9/30/99.
Require states to refer homes that contribute to a resident's death to HCFA for federal enforcement actions. GAO-E3	HCFA is providing training to states and added instruction to the enforcement manual that CMPs should be used for instances of past harm. HCFA is revising its data system to collect information about deaths for which no CMP is imposed, due 6/30/00.

Initiative[a]	Current status
Enhancing information and education	
Develop better management information systems. GAO-E4	Contract recently let for development of system requirements. Implementation of revised data system for nursing homes scheduled for 09/30/01 with final linkage to other data systems by 1/31/02.
Publish survey results on the Internet. HCFA-6	Internet site available as of 9/30/98, with public rollout completed 3/16/99. See http///www.medicare.gov/nursing/home.asp.
Develop repository of best practices guidelines for care for residents at risk of weight loss and dehydration. HCFA-3(a)	Internet site with guidelines made available 11/15/98 at http//www.hcfa.gov/medicaid/siq/siqhmpg.htm.
Develop a national campaign to increase awareness on the prevention of malnutrition and dehydration. HCFA-3(b)	A work group has been formed and a contract awarded to develop an information campaign scheduled to begin 8/16/99.
Establish guidelines and methods for using effective drugs. HCFA-3(d)	Manual instructions to be implemented 6/30/99 to assist nursing homes and surveyors to identify the appropriate method and proper administration of some drugs. A list of drugs that are not appropriate for use under most circumstances because there are better alternatives or other associated risks has also been developed and validated.
Develop an abuse intervention campaign. HCFA 4(b)	Abuse-related poster and messages have been developed. Pilot project in 10 states due to begin 7/15/99.
Develop legislative proposals for --criminal background checks, --national registry to incorporate state nursing assistant registries, and increasing the number of staff to feed residents. HCFA 7(a, b, and c)	HCFA submitted legislative language 7/29/98. HCFA considers these initiatives completed, although according to a HCFA official the 105th Congress did not approve relevant legislation and no legislation is pending in the current Congress.
Study staffing. 3/16/99 HCFA press release	HCFA is conducting a study of the potential costs and benefits of minimum staffing levels, scheduled for draft review in 1/2000.

[a]HCFA has developed a tracking and coding system to organize initiatives. These tracking codes follow the brief description of the initiative(s).

(101783)

The CHAIRMAN. Ms. Morris.

STATEMENT OF CATHERINE G. MORRIS, PRESIDENT-ELECT, ASSOCIATION OF HEALTH FACILITIES SURVEY AGENCIES, AND DIRECTOR, LONG-TERM CARE ASSESSMENT AND SURVEY, NEW JERSEY DEPARTMENT OF HEALTH, SENIOR SERVICES, TRENTON, NJ

Ms. MORRIS. Thank you, Senator, for providing this opportunity for the Association of Health Facilities Survey Agencies to participate in this hearing. I am Catherine Morris, the President-Elect of the Association, and each of us here today, the members of the committee, HCFA and the States, share a commitment to the goal of quality of care in nursing homes. The Presidential initiatives and the recommendations of the GAO, if implemented effectively, can contribute to improved care and increased compliance for providers.

There are six nursing home initiatives that have been completed by HCFA. A major concern of our Association is that completion by HCFA does not always equate to full implementation at the State level. Another concern is that implementation has not always been preceded by sufficient planning to ensure effective action.

One example is the implementation of the staggered nursing home survey schedules. HCFA issued final instructions to the States on December 29, 1998, with an effective date of January 1, 1999. However, implementation of this type of change cannot be instantaneous. Also, when the staggered surveys were first done, we found that the survey process required corresponding modification.

We believe that virtually all States are compliant with the staggered survey requirement, with the revisit policy, and with the extra monitoring of special focus facilities. A plan to deal with poor-performing nursing home chains has not been fully developed to date. The completion of poor-performing facility implementation to include G-level deficiencies is still pending. There is general support among States that G-level deficiencies represent actual harm and immediate imposition of penalties is appropriate for repeat violations.

The per-instance civil monetary penalty regulation became effective May 17, 1999. It is too soon to have a representative sense of its use or effectiveness. The new Federal On-site Survey and Support monitoring system has been in effect since October 1, 1998. However, the majority of States have not yet received any formal performance feedback at the management level.

The March directive from HCFA regarding complaint investigations is an area where States are not in compliance with HCFA's instructions. We are not aware of any States that were able to implement this directive if they had not already been investigating all alleged actual harm complaints within 10 days. To do this would require either directing staff away from other efforts and into investigating complaints or bringing on additional trained staff.

There are things that we believe are critical to the success of implementing the Presidential initiatives and the GAO recommendations to this committee. One is planning. We need collectively a clear vision of where we are headed 2, 3, 5 years away. Rather than month-to-month auditing of the number of visits to two spe-

cial-focus facilities, for example, let's decide how to measure the success of the special focus initiative. Is it improving quality? How and when are facilities going to move in and out of this designation? How will States have input into that discussion? And how will quality indicator reports contribute to this monitoring process?

Second, we need to remember that improved quality of care in nursing homes is the focus of our effort. Nursing homes serve a tremendous need in our society. Ultimately, our business ought to be about not just enforcement, but about improving the industry.

What is lacking in our current regulatory system is a clear, consistent idea of where we think nursing homes ought to be in terms of outcomes. For example, how are we doing in preventing in-house-acquired pressure sores today, what do we think is the best we can do toward preventing them, and what would be a reasonable goal for reducing these numbers in a period of 2 years?

A good example of an area where we have seen improvement is restraint use. Reducing restraint use in nursing homes has required enforcement, deficiency citations, plans of correction, and remedies, but it has also required a tremendous amount of education. Training and education of facilities and their staff are critical to the quality of care provided.

Publication of nursing home performance information is another very effective tool to promote quality in this competitive field. HCFA's publication of survey results on the Internet, the inclusion of comparison group percentages in the quality indicator reports, and State-specific performance information available on the Internet are all examples of information systems that can be built upon to improve care as well as to inform consumers.

Finally, resources are needed to accomplish these initiatives. In recent months, HCFA has been supportive in seeking supplemental funds for the initiatives, and hopefully for complaint investigations. However, this is never an issue that is addressed up front when changes are planned.

From fiscal year 1992 to 1998, survey and certification budgets for the States increased by slightly over 1 percent, while the number of certified providers increased by 62 percent, nursing homes by 39 percent, and the OBRA 1987 requirements went into effect.

States' bottom line resources are people, trained surveyors and support staff. From the time funding is made available to increase a State's allocation of FTEs, realistically it will be a year or longer before additional qualified staff are available to put to work, and the costs of initially training a single surveyor can be as high as $75,000. Again, we need to look at long-range options for better utilizing survey resources, such as more flexibility in the type of surveys, in the frequency, and in the use of data to target our survey efforts. States still need to monitor the quality of non-long-term care providers. So shifting resources from non-long-term care to long-term care is not an acceptable option.

Quality of care for nursing home residents is of critical concern to all of us involved in long-term care. The State survey and certification agencies have the expertise, the knowledge and experience to contribute to improvements in the process. Every member of our Association has statewide responsibility for protecting citizens in health care facilities. We continue to offer our expertise to HCFA

to fulfill our joint oversight responsibility. We hope that HCFA accepts us as true partners and asks for our input prior to taking actions that affect States.

I want to thank you for the opportunity to speak today. There are many strengths in the survey and enforcement process, many nursing homes that provide good quality of care to their residents, and many dedicated people at the Federal and State level working to promote quality long-term care. OBRA 1987 has resulted in notable successes in the improvement of care. The key now is to build on these strengths in a coordinated, organized manner that will improve outcomes.

Thank you.

[The prepared statement of Ms. Morris follows:]

Testimony of

Catherine G. Morris, President Elect

On behalf of

The Association of Health Facility Survey Agencies

Before the Senate Special Committee on Aging

June 30, 1999

Thank you for providing this opportunity for the Association of Health Facility Survey Agencies (AHFSA) to participate in this hearing. I am Catherine Morris, President Elect of the Association. Each of us here today, the members of the Committee, HCFA, and the states share a commitment to the goal of quality care in nursing homes. This Committee has brought the issue into the spotlight. While HCFA has been working diligently to respond to both the Presidential Initiatives and the recommendations presented to this Committee, the states have been implementing changes based on the initiatives.

I am here to testify about the concerns of state survey agencies. AHFSA represents the leaders of the state survey agencies across the country. AHFSA was established in 1970 to provide a forum for state directors to share information, to work in an organized fashion with HCFA, provider organizations, other government agencies, and to promote the highest quality health

care services within each state. The AHFSA mission statement, fact sheet and current board of directors are attached for your reference. State agencies monitor care through state licensing activities and as contractors with HCFA for federal survey and certification activities. Our responsibilities cover all categories of health care facilities licensed in our respective states as well as all categories certified for Medicare and Medicaid participation. Survey agencies play a pivotal role in monitoring and mandating quality. State surveys remain the best deterrent to poor care.

The Presidential Nursing Home Initiatives and the recommendations of the GAO, if implemented effectively, can contribute to improved care and increased compliance by providers. From the beginning of this process, AHFSA has been concerned about the rush to implement the Presidential Initiatives without adequate planning. As states, we have not been asked to participate in the development of the initiatives. Instead, the initiatives have been developed and communicated to the states by HCFA. The states have then had to react on very short notice to HCFA mandates. Although in recent months we have seen an improvement in the communication with HCFA and a commitment to work more closely as the process continues, we feel that the federal government can and should work more collaboratively with the states in the development and implementation of any new initiatives. It is through the collaboration and hard work of all of us that this activity will have a meaningful result for the residents of nursing homes.

There are six nursing home initiatives that have been completed by HCFA. HCFA has moved very quickly to implement the President's Initiatives and the recommendations of this committee. As a result, states have also been actively addressing the corresponding directives from HCFA. A major concern of our association is that completion by HCFA does not always equate to full implementation at the state level. Another concern is that implementation has not always been preceded by planning sufficient to insure effective action.

One example is the implementation of staggered nursing home survey schedules. HCFA issued final instructions on December 29, 1998, effective January 1, 1999. However, states were faced with numerous issues that had to be addressed to operationalize this policy directive. Conditions of employment, union contracts and funding for overtime and/or shift differential pay were considerations that almost 50% of our members have had to work through in order to stagger survey starting dates and times to include weekends and evenings. Implementation of this type of change can not be instantaneous. Also, when staggered surveys were first done, we found that the survey process required modification in areas such as the tour of resident units at night or the ability to obtain resident roster information in order to select a sample of residents for assessment. Additionally, to truly have surveys that are less predictable, which is the intent of the staggered survey initiative, the statutory requirement of a statewide 12-month average survey cycle and the one-size-fits-all nature of the required standard survey process deserve another look.

We believe that states are virtually all compliant with the requirement that 10% of surveys begin on nights and weekends, with the revisit policy and with extra monitoring of two special focus

facilities per state. A plan to deal with poor performing nursing home chains has not been fully developed to date. The states have not received instructions from HCFA about how to address this initiative, other than the original guidance memo of September 25, 1998,which was general in nature. Further work is needed to define what constitutes a nursing home chain among the various corporate structuring options and lease arrangements in the health care industry and to share chain information quickly across states.

The completion of poor performing facility implementation to include "G" level deficiencies is still pending. There is general support among states that "G" level deficiencies represent actual harm and immediate imposition of penalties are appropriate for a repeat violation, especially in the areas of resident rights, resident behavior and facility practice, quality of care and quality of life.

States generally are not opposed to increasing remedies against nursing homes, nor are we against increasing the circumstances under which nursing homes may have remedies imposed on them. AHFSA, in early 1995, expressed concerns about the opportunity to correct and the requirement for a revisit prior to issuing a sanction for non-compliance.

Strong arguments can be made - and have been made - that non-compliant nursing homes deserve greater enforcement. States need strong enforcement tools and strong remedies to assure that homes maintain compliance. But if we want to talk about changing institutional behavior, about altering the way nursing homes provide care, then remedies are only part of the solution.

When we ask questions such as, "Why do we still have nursing homes that grossly abuse and neglect residents?" or, "Why can't HCFA, or the states, prevent nursing home staff members from assaulting residents?" or, "How can a facility that has been repeatedly cited for allowing development of in-house acquired stage four pressure sores still be in business?" we often end up responding that we must not be doing a good enough job enforcing our rules and imposing penalties.

In fairness, there is much to criticize in the enforcement record against nursing homes. For example, it is not expedient to have a system that uses civil monetary penalties as a deterrent if a nursing home can appeal an imposition to an administrative law judge and by doing so avoid ever paying a single dime in penalties because the Department of Health and Human Services does not have enough ALJ's to hear all of the nursing home appeals that are filed. This has been a problem since CMP's were implemented in July 1995; it has been repeatedly voiced to this administration; it has been acknowledged by HCFA; yet it is a problem that remains uncorrected to date.

Additionally, the enforcement program has placed too heavy an emphasis on "opportunity to correct", has required multiple revisits before the imposition of serious remedies, and has permitted the rapid reentry into the Medicare and Medicaid programs of facilities whose serious violation resulted in their termination from the program.

There is much that can and should be done to make remedies more consistent, more certain and more severe against perpetually non-compliant facilities. And nursing homes that are unwilling

or unable to do what it takes to avoid consistent noncompliance should be closed. Everyone agrees with this. Immediate penalties for a finding of actual harm on the current survey and the previous standard survey or any intervening are consistent with the intent of OBRA '87 in preventing "yo-yo" compliance.

The per-instance CMP regulation became effective on May 17, 1999. It is too soon to have a representative sense of its use or effectiveness. Based on discussions at the federal training in April, additional clarification is needed on when and how to use the per-instance CMP to promote consistent enforcement.

The new Federal Onsight Survey and Support (FOSS) monitoring system has been in place since October 1, 1998. Although federal surveyors have been communicating with state survey teams individually in the field, the majority of states have received no formal feedback at the management level. This has been extremely frustrating since it prevents states from receiving feedback and taking corrective action. Oversight without any feedback is not effective in improving quality. This is one area where we look forward to improved communication with HCFA.

The March directive from HCFA regarding complaint investigations is an area where states are not in compliance with HCFA's instructions. We are not aware of any states that were able to implement this directive if they were not already investigating all alleged actual harm complaints within ten days. To do so would require either directing staff away from other efforts and into investigating complaints, or bringing on additional trained staff. Since no state to our knowledge

has been relieved of other HCFA requirements for conducting surveys, states that were non-compliant with this directive before it was issued will remain non-compliant until more trained staff are put on the front lines. Only after this directive was issued, did HCFA ask the states whether additional resources would be required. Not surprisingly, virtually every state gave a "Yes", answer to this inquiry. HCFA now has to find additional funds to implement this directive. Once funds are made available, it will be six months to one year before additional trained staff will be certified to conduct investigations. As a whole, the states are not even close to being able to comply with this requirement, and, until we know when additional funds will be available, we can't even predict how long it will take to become compliant. AHFSA has expressed these concerns directly to HCFA during face-to-face meetings and in the correspondence included as Attachment #6.

There are items we believe are critical to the success for implementing the Presidential Initiatives and the GAO recommendations to this Committee:

1. Planning

We need, collectively, a clear vision of where we are headed, two, three, five years away. Rather than month-to-month auditing of the number of visits to two special focus facilities, for example, let's decide how to measure the success of the special focus initiative. Is it just more visits to poor performing nursing homes or is it improving quality? Originally two facilities per state were identified for special focus, is two the correct number? Why not publish the criteria for selection and put every eligible facility on notice that they could be subject to extra scrutiny. How and when will facilities move in and out of this designation

and how will states have input into this decision. How can Quality Indicator reports contribute to this monitoring process?

We need to consider other changes beyond the Presidential Initiatives. For example, the reasonable assurance period before recertifying a terminated provider could be redefined to be at least as long as the period of non-compliance that preceded termination. This would keep non-complaint facilities from immediately re-entering the federal program. The HCFA 855 data, by identifying ownership, provides a new opportunity to restrict the expansion of poor performing chains.

2. Improving Quality

Improved quality of care in nursing homes is the focus of our efforts. We must also remember that nursing homes serve a tremendous need in our society. Ultimately, what our business ought to be about is not just putting nursing homes out of business, not just punishing bad actors, but about improving the industry.

Good care in nursing homes has been defined as the absence of bad events (Robert Kane, JAMA '95). What is lacking in our current regulatory system is a clear, consistent idea of what we think nursing home care ought to be in terms of outcomes, both in the short-and long-term. For example, how are we doing on preventing in-house acquired pressure sores today, what is the best we think we will ever be able to do toward preventing pressure sores, and what would be a reasonable goal for reducing our rate over the next two years?

A good example of an area that has seen improvement over the past five years is restraint use. Reducing restraint use in nursing homes has required enforcement--deficiency citations, plans of correction, and remedies. But it has also required a tremendous amount of education directed at facility staff to convince them that there are other, more appropriate ways to prevent injuries than restraining residents. Meaningful restraint reduction required efforts on both fronts.

Convincing nursing homes to do what we want them to do will not happen just by creating fear of the consequences of running afoul of us. We need to be able to explain to them why our system is a better system for them to follow. We need to articulate to nursing home staffs, to families, and to the public what nursing homes ought to be doing differently, and WHY. Training and education of facilities and their staff are critical to the quality of care provided. Many states are working with providers in training, best practices and quality improvement activities to improve care. AHFSA has a best practice session each year to help survey agencies learn from each other.

The Northeast Consortium Pressure Sore Prevention Initiative, which is just now nearing completion, is an example of education to impact quality that is a joint effort of states, PRO's and HCFA, which has been extremely well received by providers.

Publication of nursing home performance information is another very effective tool to promote quality in a competitive field such as long term care. HCFA's publication of survey results on the Internet, the inclusion of comparison group percentages on the quality indicator

reports, and state specific performance information available by Internet are examples of information systems to build upon to improve care as well as to inform consumers.

Improving the Long Term Care System is a broader issue than the Presidential Initiatives alone. Staffing resources in nursing homes are becoming a real issue. Reimbursement is at the forefront of provider concerns right now. Competition from assisted living and community-based alternatives are affecting nursing home operators. All of these factors affect quality of care and emphasize the need to initiate changes in a way so that states and providers are not always reacting to imposed changes.

AHFSA as an organization has undertaken several initiatives to improve the quality of the survey process. The best practice component of the annual training conference is one. The Association Quality Assurance and Training Committee, in conjunction with HCFA, developed the Principles of Documentation that are now incorporated into the HCFA deficiency writing software nationwide. AHFSA developed the quality review tool for the principles of documentation and the software addition. AHFSA has gone on to develop an Investigative Skills Course based on the Principles of Investigation to improve surveyor performance.

3. Resources

Resources are needed to accomplish these initiatives. In recent months, HCFA has been very supportive in seeking supplemental funds for the initiatives and hopefully for complaint investigations. However, this is never an issue that is addressed up front when changes are planned. Supplemental funding is never assured in subsequent fiscal years. Even changes that don't appear to be resource intensive, such as the immediate penalties for repeat "G" deficiencies, will increase state workloads for revisits, for Informal Dispute Resolutions (IDR) and for appeals. For the period from fiscal year 1992 through fiscal year 1998, federal survey and certification budget allocations for the states increased by slightly more than 1% while the number of certified providers increased by 62%. The number of nursing homes increased by 39% and the requirements of OBRA '87 went into effect during the same period. This information is presented in more detail in attachment #5.

When HCFA tells the states to undertake a new project, or to add new tasks to our survey protocols, or to conduct more surveys on nights and weekends, or to shorten time frames, typically a discussion will follow about whether the states have sufficient "resources" to do the job. Usually the discussion centers on money. However, money is just part of what we need. Our bottom line resources are people. Mostly, they are trained surveyors, but there are other necessary resources, such as supervisors and clerical support staff, as well as space, supplies, and equipment. Many states also need advance planning time to secure the state Medicaid portion of the money needed for new initiatives.

An increase in workload can only be accomplished by increasing the number of trained and experienced staff. THAT is the reason why states are often unable to immediately respond and implement a new initiative. Even if HCFA immediately provides funding, or a promise of funding, states will need time to recruit, hire, and train employees.

Surveying health care facilities is a highly specialized job. States hire licensed health care professionals under their own personnel and merit system rules, and those employees must be trained in the new skills necessary to be surveyors. From the time funding is made available to increase a state's allocation of FTE's, realistically it will be one year or longer before the state has additional qualified surveyors available to put to work. The costs of initially training a single surveyor can be as high as $75,000.00.

It is not unusual for HCFA to announce a new initiative, "effective immediately," which represents new required survey activity and an increase in workload. The states then raise the issue of resources to get the new work done. HCFA responds by conceding that additional resources are needed, and some informal poll is conducted to determine the costs of the new initiative. Eventually, new money is allocated or at least promised to the states, and the states hire and begin training new staff. In the meantime, the public has been lead to believe that the initiative has been implemented and the states labor under a mandate that is impossible to meet. This is counter productive and damages our sense of partnership with HCFA.

If state agencies could tell HCFA only one thing about resources, it would be this: tell us what you want us to do, allocate the money to pay new staff, and provide us the time to hire and train this staff before you announce that the initiative has been implemented and checked off from your "to do" list.

Again, we need to look long range at options for better utilizing survey resources, such as more flexibility in the type of survey conducted, in the frequency, or in the use of data to target survey efforts. States still need to monitor the quality of non long-term care providers, so shifting resources from non long-term care to long-term care is not an acceptable option. There are issues in hospitals and dialysis centers, for example, which require the same intense oversight as nursing homes. The current federal requirement to cover 10-50% of certified non-long term care providers translates to a survey every 2-10 years. There is no room for economy in the non-long term care programs.

The system of Medicare enforcement needs improvement. Quality of Care for nursing home residents is of critical concern to all of us involved in long term care. The state survey and certification agencies have the expertise, knowledge and experience to contribute to improvements in the process. We have been and continue to be the frontline to improving the quality of care in all areas of the health care delivery system. Every member of our Association has statewide responsibilities for protecting citizens in health care facilities.

We continue to offer our expertise to HCFA in order to fulfill our joint oversight responsibility. We have expressed our concerns to HCFA on the enforcement process (attachment #4), on resource and funding issues (attachment #5), and most recently on the complaint investigation process (attachment #6). Everything I have presented today has been discussed with HCFA.

We hope that HCFA fully accepts us as true partners and asks for state input prior to taking actions that impact or affect us. This will allow for stronger communication, better trust among the parties, and the ability to collectively plan appropriate and necessary changes to the system. We look forward to meeting with committee staff during our July board meeting.

Thank you for the opportunity to speak with you today. There are many strengths in the survey and enforcement process, many nursing homes that provide quality care to their residents, and many dedicated people at the federal and state level working to promote quality long term care. OBRA '87 has resulted in notable successes in improvement of nursing home care as illustrated nationally by declines in inappropriate use of restraints, in psychotropic drug use and in urinary catheter use. The key is to build on these strengths in a coordinated, organized manner that will improve outcomes.

ATTACHMENT #1

The mission of the Association of Health Facility Survey Agencies (AHFSA) is to strengthen the role of its member state agencies in advocating, establishing, overseeing and coordinating health care quality standards that will assure the highest practicable quality of health care for all state and federally-regulated health care providers. These goals are met through member advocacy to various organizations and agencies; through the gathering, communicating and exchanging of health related information; through advice and recommendation to Health Care Financing Administration (HCFA), Association of State and Territorial Health Officials, Inc. (ASTHO) and other health care agencies, associations and entities; through helping improve the quality of state and territorial health facility survey programs; and through the professional development of its members.

ATTACHMENT #2

FACT SHEET

THE ASSOCIATION OF HEALTH FACILITY SURVEY AGENCIES (AHFSA) IS A NOT-FOR -PROFIT ORGANIZATION THAT PROVIDES A FORUM FOR HEALTH CARE REGULATORY AGENCY DIRECTORS AND MANAGERS TO ADDRESS COMMON INTERESTS, CONCERNS, AND HEALTH CARE PROGRAM ISSUES. AHFSA MEMBER AGENCIES ARE RESPONSIBLE FOR IMPROVING THE QUALITY OF CARE AND SERVICES PROVIDED BY HEALTH CARE FACILITIES, AGENCIES AND PROGRAMS BY ENSURING THAT ESTABLISHED STANDARDS AND REGULATIONS ARE MET.

MEMBER AGENCIES PROMOTE PRACTICES TO IMPROVE THE QUALITY OF CARE AND THE QUALITY OF LIFE TO CONSUMERS OF HEALTH CARE SERVICES. AHFSA IS COMPRISED OF LEADERS FROM STATE SURVEY AND CERTIFICATION AGENCIES THAT REGULATE NURSING FACILITIES, HOSPITALS, MEDICAL LABORATORIES, INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED, HOME HEALTH AGENCIES, HOSPICE, RURAL HEALTH CLINICS, RENAL DIALYSIS CENTERS, AMBULATORY SURGICAL CENTERS, REHABILITATION SERVICES, NURSE AIDE TRAINING, COMPETENCY AND CERTIFICATION PROGRAMS AND AN ARRAY OF OTHER HEALTH CARE SERVICES.

AHFSA IS COMMITTED TO CREATING PARTNERSHIPS WITH VARIOUS ASSOCIATIONS AND AGENCIES BOTH PRIVATE AND PUBLIC TO PROMOTE OUR MISSION. THE ASSOCIATION OF HEALTH FACILITIES SURVEY AGENCIES STRIVES TO STRENGTHEN THE ROLE OF ITS MEMBER STATE AGENCIES IN ADVOCATING, ESTABLISHING, OVERSEEING AND COORDINATING HEALTH CARE QUALITY STANDARDS FOR ALL STATE AND FEDERALLY-REGULATED HEALTH CARE PROVIDERS. THE PURPOSES OF THE ASSOCIATION ARE:

- TO ADVOCATE FOR INFORMATION AND RESOURCES SO THAT HEALTH FACILITY SURVEY AGENCIES CAN ASSURE THE HIGHEST PRACTICABLE QUALITY OF HEALTH CARE;
- TO STRENGTHEN THE ROLE OF HEALTH FACILITY SURVEY AGENCIES WITH THEIR RESPECTIVE STATES AND TERRITORIES, WITH THE HEALTH CARE FINANCING ADMINISTRATION, WITH ADVOCACY ORGANIZATIONS, AND NATIONAL AND STATE HEALTH PROVIDER ASSOCIATIONS;
- TO PROVIDE FOR A FORUM FOR THE COMMUNICATION OF INFORMATION AND THE EXCHANGE OF EXPERIENCES AMONG STATE AND TERRITORIAL HEALTH FACILITY SURVEY AGENCIES AND BETWEEN SUCH AGENCIES AND THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, INC. (ASTHO), THE UNITED STATES CONGRESS, THE HEALTH CARE FINANCING ADMINISTRATIONS, ADVOCACY ORGANIZATIONS, AND NATIONAL HEALTH PROVIDER ASSOCIATIONS AND OTHER ORGANIZATIONS AS APPROPRIATE;
- TO IMPROVE THE QUALITY OF STATE AND TERRITORIAL HEALTH FACILITY SURVEY PROGRAMS AND TO COORDINATE THESE ACTIVITIES WITH RELATED ACTIVITIES WITHIN THE STATES AND TERRITORIES;
- TO PROMOTE THE PROFESSIONAL DEVELOPMENT OF ITS MEMBERS.

ATTACHED IS THE 1999 LEADERSHIP ROSTER FOR AHFSA. IF YOU HAVE ANY QUESTIONS, IDEAS FOR PARTNERING OR CONCERNS, PLEASE, DO NOT HESITATE TO CONTACT ANY OF OUR OFFICERS. AHFSA IS COMMITTED TO OUR MISSION BY THE DEVELOPMENT OF PARTNERSHIPS WITH AGENCIES AND ASSOCIATIONS SUCH AS YOURS.

Leadership Attachment #3

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Region II	Laura Leeds New York	Cathy Morris New Jersey
Region III	Carol Benner Maryland	Judy McPherson District of Columbia
Region IV	David Dunbar Georgia	Rebecca Cecil Kentucky
Region V	William Bell Illinois	Judy Fryback Wisconsin
Region VI	Ken Baker Louisiana	Rebecca Moore Oklahoma
Region VII	Bill Toenies Missouri	Darrell Hendrickson Missouri
Region VIII	Darleen Bartz North Dakota	Joan Bachman South Dakota
Region IX	Lisa Jones Nevada	Edd Welsh Arizona
Region X	Kathleen Smail Oregon	Brenda Klutz California

1999 PLAN AHFSA COMMITTEES

Responsibilities: Conference calls at least quarterly (or as needed) to discuss current issues or concerns. Additional committee members can be added to handled specific issues. Possible assignments to HCFA task groups such as MDS computerization, training and budget committees.

Co-Chair Responsibilities: Written committee reports submitted at AHFSA

60-346 00 - 3

February 13, 1995

Attachment #4

Anthony J. Tirone
Director
Office of Survey and Certification
Health Standards and Quality Bureau
Health Care Financing Administration
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Re: State Operations Manual provisions on enforcement

Dear Mr. Tirone:

The Association of Health Facility Survey Agencies (AHFSA) appreciates having representatives on the Technical Assistance Group (TAG), assisting HCFA in drafting the State Operations Manual (SOM) on enforcement of the Medicare and Medicaid regulations in skilled nursing facilities (SNFs) and nursing facilities (NFs). We also appreciate HCFA's February 8, 1995 meeting with the AHFSA Board of Directors to discuss our concerns with the present draft of the SOM. However, there remain several issues of utmost concern to AHFSA that we believe have not yet been satisfactorily resolved, as evidenced by the most recent draft of the SOM. We take this opportunity to comment on these concerns once again in the hope that HCFA will change its position and adopt AHFSA recommendations on these critical issues.

I. **The SOM as presently drafted will impede the effectiveness of the enforcement regulation by requiring a corrective period and revisit before imposition of remedies.**

Although the current draft of the SOM permits a State to directly impose a category 1 remedy (with Regional Office authority), it also provides that if a facility files a "credible allegation," a revisit must be conducted by the State before even a category 1 remedy can be imposed. (See pages 21 through 25 of SOM draft). In the case of category 2 remedies, the SOM draft provides that the State must always perform a revisit to determine if the deficiency has been corrected before sending either the Medicaid agency or HCFA a recommendation for implementation of a category 2 remedy. (See pages 23 through 25 of SOM draft).

AHFSA bases its objection to the requirement that revisits be conducted **before** imposition of an alternative remedy on two very significant grounds: 1) Such revisits will delay or prevent application of the alternative remedies in violation of the statutory requirement that the enforcement process "be designed so as to minimize the time between identification of violations and final imposition of the remedies," 42 U.S.C. § 1395I-3(h); and, 2) will place additional burdens on survey agencies by permitting facilities to essentially determine when revisits will take place and by likely causing multiple revisits.

HCFA's response to this objection has been that it is only reasonable to give facilities an opportunity to correct deficiencies before imposing an alternative remedy, that the revisit practice will not be different from what presently takes place, and that multiple visits are not likely because HCFA can revise the SOM to say that a facility will receive only one opportunity for credible allegation and revisit.

This response underscores a fundamental difference between AHFSA and HCFA as to the interpretation of the intent and mandate of OBRA 1987. AHFSA's understanding of the legislative intent behind OBRA is that the regulatory practice of citing deficiencies and then permitting corrective action before considering any type of sanction is no longer desirable, and that instead of the current practice, intermediate remedies should be imposed promptly after discovery so that facilities will be strongly motivated not only to correct deficiencies, but to maintain compliance between surveys. Our interpretation of OBRA is supported by the well known history of the passage of this nursing home reform legislation.

In its passage of OBRA 1987, Congress was greatly influenced by the Institute of Medicine's Committee on Nursing Home Regulation Report, Improving the Quality of Care in Nursing Homes, 1986, which was prepared at the request of HCFA. See e.g., H.R. Rep. No. 391(I), 100th Cong., at 452 (1987). The Institute of Medicine's report contains the following explicit discussion of the problems posed when remedies are delayed for the purpose of allowing facilities additional time to correct deficiencies and avoid sanctions:

> [Under current policies and procedures] [t]he survey agency must issue a notice to the operator of a substandard nursing home, giving the facility a period of time (usually 30 to 60 days) in which to correct deficiencies... The agency may apply formal sanctions only if the facility remains in violation beyond the deadline set for compliance. Consequently, the facility is not punished for violations directly, but rather for failing to carry out an administrative order by a certain date. Resort to formal sanctions... becomes the last step in a long series of follow-up visits and plans of correction...

> Substandard nursing homes apparently come into compliance long enough to be recertified, without penalty, but are again found out of compliance with the same or similar standards in one or more subsequent annual inspections...
>
> Although it may have been necessary to work with facilities to bring them into compliance when the federal regulations were new, the certification regulations have been in use for more than 10 years and the nursing home industry is much more sophisticated than it was. There is no longer a valid reason for facilities to operate with numerous and repeated deficiencies.

Improving Quality of Care in Nursing Homes, National Academy Press, at 148-49 (1986). Congress responded to the findings of the Institute of Medicine by expressly requiring a system of intermediate remedies or sanctions to be applied under HCFA criteria that **must** be designed to "minimize the time between the identification of violations and the final imposition of remedies." 42 U.S.C. § 1395l-3(h). See H.R. Conf. Rep. No. 495, 100th Cong., at 722-724 (1987); H.R. Rep. 391, 100th Cong., at 471-472 (1987). AHFSA's position is that the present SOM draft improperly preserves a built-in delay between the citing of deficiencies and the imposition of remedies, when the OBRA statute clearly requires an enforcement process that eliminates such delays.

Our extensive experience with the survey process leads us to believe that a system that provides for opportunity for correction prior to the imposition of almost every remedy, will result in repeated requests for revisits to the extent that alternative remedies will be imposed only in the most egregious of cases and after long delays, and that such a system will severely strain the resources of survey agencies. We are not assured by HCFA's suggestion that civil monetary penalties will be an adequate means of ensuring prompt enforcement, because the appeal mechanism will most likely mean that monetary penalties will not be paid for months, possibly years, after identification of violations. We also do not believe it practical, as suggested by HCFA, to limit facilities to one request for revisit.

AHFSA contends that the SOM should incorporate a process that permits states to promptly recommend a remedy appropriately tailored to the violations detected, that requires HCFA and the Medicaid agency to promptly act on that recommendation, and that authorizes survey agencies to determine the appropriate time for revisit **after** the remedy has been imposed.

II. The SOM process for evaluating survey agency performance fails to consider the additional burdens placed on state resources by the SOM process for enforcement.

AHFSA understands that substantial additional funding to implement the enforcement regulation is not likely. However, AHFSA finds HCFA's assurances that the new enforcement regulation is "budget neutral" and will not require addition resources, to be a naïve assessment of the work ahead of the States and HCFA. We believe that the implementation of the new regulation will result in many more informal dispute resolution proceedings and formal appeals. (As discussed above, we also believe that the revisit policy of the current SOM draft, if implemented, will require substantially more on-site time at facilities).

States have been on the front line in defending the citation of deficiencies and in resolution of disputes with facilities, and we know from experience that even the informal dispute resolution process is time intensive and requires additional preparation and work for both surveyors and their supervisors. Further, our experience with formal appeals is that they are even more time consuming and are often bitterly contested proceedings that require extensive preparation in order for the survey agency to be successful in defending correctly cited deficiencies.

While we understand that HCFA has hopes that changes in the survey process (as illustrated by the pilot projects), may result in time savings during the on-site survey, we are concerned that these savings will be negated by the additional resource demands incurred in the informal dispute resolution and formal appeals process.

Another heavy demand on funds and resources will be the necessity of training survey and certification staff on the requirements of the enforcement regulation. Since the "train the trainer" sessions presented by HCFA will not take place until April and May, that leaves a very small window of opportunity for states to train all their personnel in the new requirements. While our attention and resources are devoted to this effort, we will have to delay our actual survey activities.

We know that these additional burdens are both necessary and required if the implementation of the new enforcement regulation is to be successful in ensuring compliance. We simply wish for HCFA to acknowledge these enhanced burdens and structure its evaluation of state survey performance so as not to punish states when they cannot fully meet all their previous mandates along with this new mandate, because there is no increase in funding. If these new obligations take precedence, will states be punished if they cannot meet other important requirements, such as the requirement to maintain a 12 month average for survey of SNFs and NFs? Will states be penalized if hospital complaint investigations are not done in a timely fashion or if less than 100% of home health surveys are completed?

AHFSA is also concerned that the SOM draft relies so heavily upon the OSPATS process to evaluate the performance of the survey agency. In order to be a fair assessment of an agency's performance, other information and factors should be included. AHFSA representatives on the TAG will give further input on this issue at the next TAG meeting.

III. Conclusion

Our members of the TAG will be prepared with suggestions for clarifications and additions at the February 22-24 meeting. Regardless of the final determination of the SOM process by HCFA, AHFSA will remain ready to do its best to facilitate the implementation of the new enforcement regulation and to fully cooperate with HCFA and its directives. However, we wish to emphasize in the strongest terms possible that we believe the proposed SOM process for a corrective period and revisit before implementation of remedies is in contravention of the intent of OBRA, could be an administrative failure, and could result in residents receiving poorer, not better, care. A process which permits states to recommend prompt imposition of appropriate remedies, and receive prompt action on the recommendation from HCFA and the Medicaid agency, is essential to effective enforcement.

We also wish to register our objection to the SOM's current provisions for assessment of survey agency performance being based so heavily upon the OSPATS.

Thank you for the opportunity to submit these comments.

Sincerely,

L. O'Neal Green
President

LOG:cbf

Attachment #5

HCFA SURVEY AND CERTIFICATION BUDGET FACT SHEET

The Association of Health Facilities State Agencies is an association comprised of the State Agency Directors who administer the Medicaid and Medicare survey and certification program for the fifty states. The states have become increasingly concerned about the budget allocations over the last few years coupled with increases in workload demand (unfunded mandates).

Over the last seven years the amount of money allocated to the states has been as follows:

HCFA Budget Allocations 1992-1998

1992	145 Million
1993	141 Million
1994	136 Million
1995	138 Million
1996	138 Million
1997	144 Million
1998	147 Million

As you can see the amount represents only a 1% increase without additional monies in relation to the consumer price index, the number of providers, the number of certified beds and significant changes in the survey and certification process in home health agencies and nursing facilities.

During this same time period there have been a number of workload increases that have come to the states as unfunded mandates. These include:

a. There has been an increase in workload related to increase in the number of health care providers.

Medicare Provider Growth 1992-1998

FY Year	1992	1993	1994	1995	1996	1997	1998
Non-J Hosp.	1,341	1,326	1,354	1,389	1,417	1,412	1,440
SNFs	10,705	10,880	11,651	12,264	13,520	14,692	14,820
HHA	6,284	6,456	7,205	8,101	9,250	10,566	10,523
Hospice	1,166	1,223	1,443	1,682	1,950	2,626	2,286
OPT/SP	1,453	1,493	1,712	2,027	2,313	2,726	2,791
CORF	208	217	234	258	313	486	535
PXR	476	481	499	538	556	643	651
ESRD	2,289	2,324	2,489	2,658	2,880	3,392	3,360
RHCs	939	965	1,357	2,045	2,840	3,485	3,554
ASCs	1,494	1,530	1,715	1,909	2,138	2,447	2,494
Totals	26,355	26,895	29,659	33,231	37,177	42,011	42,454

This represents an overall increase in the number of facilities by 62% and a 39% increase in the number of nursing homes

b. There has been an increase in workload related to the new long term care enforcement process. Examples include management review of deficiencies and remedies to be imposed, the review of the facility's plan of correction and the informal dispute resolution process and litigation related to sanctions that have been imposed. On-site activities include increases in extended and expanded surveys. HCFA predicted that this would be a budget neutral process but this is simply not the case.

c. The State Agency Quality Improvement Projects which replaced the evaluation of the states by the regional offices with a quality improvement process by the states (this was a cooperative effort by the states and HCFA) has now added additional administrative burden to the states.

d. Transmission of the MDS (Multiple Data Set of the long term care Resident Assessment Instrument) and OASIS (for home health) has and will add additional workload to the states. HCFA has predicted some states will need an additional 4.5 staff to do just the MDS in long term care. This does not include tasks related to the survey process.

e. Other increases in workload include abuse and neglect, fraud investigations, and additional administrative workload transferred from the HCFA regional offices to the states.

HCFA has tried to offset the stagnant budget picture and increasing workload by changing the long-term care process and decreasing the non long-term care workload. In the case of home health the workload has been decreased from surveying home health agencies each year to surveying them once every three years. At this time, other non-long term care programs (hospitals, ESRDs, rural health clinics, hospices, etc.) are re-surveyed at a 10% rate per year. So, these facilities would receive an onsite survey once every ten years.

AHFSA sees this as a dangerous trend for beneficiaries if the survey process is to be seen as a deterrent to poor care in all health care settings. We do not believe, as some would contend, that market forces act upon the health care industry as they do on the purchasing of other commodities. We believe that regulation is effective and that you do not have to look any further that OBRA '87 and enforcement and the positive changes that continue to evolve in nursing home industry.

Attachment #6

Ms Sally K. Richardson
Director of Medicaid and State Operations
Health Care Financing Administration
7500 Security Blvd.
Baltimore Md. 21244

Dear Sally:

Thank your for taking the time to meet with members of our Association in Asheville on Tuesday to discuss general matters of mutual concern regarding the survey and certification program. We also appreciate the attendance and participation of the other HCFA central office and regional staff at our Board meeting.

As I told you during the meeting, the Board has asked that I follow-up with you in writing regarding our discussions about implementation of HCFA's recent policy on complaint investigations.

First of all, I hope it was clear to you during the meeting that the states are fully supportive of HCFA's efforts to improve the overall procedures for handling complaints, including, specifically, the policy that would require states to investigate complaints from residents, family members or others alleging actual harm within ten working days. In fact, rather than trying to limit the scope of the policy, there seems to be general consensus among the states that the complaint policy should be implemented in such a way that "investigate" means that an on-site visit is required within ten working days. And, that the term "actual harm" be defined consistently with its use in the enforcement process.

I hope that it was also clear that the states simply cannot implement this policy within the constraints of existing federal resources and HCFA's current national priorities for the use of these funds. Although the work group charged with "operationalizing" the new policy has conducted several teleconferences, they have yet to complete their work of defining the scope of work expectations or quantifying the resources necessary to carry out the additional workload requirements.

In this regard, we are asking that HCFA consider changing its current national priorities for long term care in order to allow states to utilize their existing long term care allocations, including additional funds that are being made available for the nursing home

initiatives. This will allow states to better implement the ten-day policy for investigating complaints alleging actual harm within ten working days. This approach would allow immediate implementation and, we believe that timely investigation of serious complaints is a more efficient use of limited resources that continuing to require full standard surveys on facilities with good compliance histories. It is noted that, in recommending a change in national program priorities, the Board is absolutely opposed to any change that would further reduce the funding allocated to non-long term care program activities.

If a change in current program priorities is not forthcoming, we would recommend that HCFA delay the implementation of its ten-day investigation policy for complaints until after it has finalized the assessment of the additional workload and funding requirements imposed by the policy and, then allocated the additional resources to the states necessary for implementation. In this regard, it is important to remember that states need sufficient lead-time to operationalize additional federal resources.

We recognize that the issues of program funding and program priority are complex and potentially controversial. However, we are becoming increasingly concerned that HCFA's continued adherence to the ten-day complaint investigation mandate, without providing the states the additional resources necessary to carry out that policy, serves only to raise false public expectations and further undermine public confidence in our current regulatory system.

Again, we appreciate your willingness to meet with us this week. We commend you and the HCFA staff on your continued efforts to strengthen the nursing home surveillance and enforcement processes. And, on behalf of our member states, we commit the continued cooperation and participation of the Association in working with you on both the policy development and implementation of these very important issues.

Sincerely,

Steve White, President
Association of Health Facility Survey Agencies

The CHAIRMAN. I will start with Dr. Scanlon. In your statement, you noted that a number of HCFA initiatives will take a longer-term commitment to fully implement than other initiatives that you have discussed. I would like to note that when this committee got into this project last July, we learned that many residents were facing immediate jeopardy because of quality of care problems, and we learned that as a result of your investigations. The implication of what we learned about the immediate jeopardy is that immediate improvement in the quality of care is needed.

Is there any evidence that this current set of initiatives have yet improved the quality of care in nursing facilities?

Mr. SCANLON. Well, Mr. Chairman, I think we need to look at the initiatives in terms of what we would anticipate to be the likely impact and then look at what we can measure at this point because they are two different aspects. And unfortunately, at this point, we need to look at the likely impact of the initiatives because we don't have the real measures of impact.

In our earlier work in California, what we discovered was that problems of care were occurring because surveyors would show up at expected times that homes would be able to anticipate, and therefore problems were not detected. They were not detected because very small and potentially non-optimal samples of residents were being reviewed. Problems were not being corrected because there were grace periods granted to virtually all homes, and there was very little use of sanctions.

All of those things are involved in some of the initiatives in terms of trying to change that way of doing business in a way that should create incentives for better detection of problems and improved correction. So we are positive from the perspective that the process is logical.

In terms of being able to measure, the impact, though, our difficulty is that we know the data on quality of care was not reliable in terms of detecting all the problems that existed. So it is not a good baseline. We don't have data from new improved inspections that we can use to compare to the old inspections.

We need to develop good, strong information that has been validated on what care is like, and then to track that over time. We are looking at the process that HCFA regional offices use in looking at State survey efforts to try and provide that kind of validated information so that we can begin to track the quality of nursing home care and know that we have positive improvement.

The CHAIRMAN. I would ask Ms. Block and then Ms. Morris—and this is not a question of high expectations. It is a question of getting from here to there. Last July we had testimony that indicated that in, albeit a minority, but a high minority of the nursing homes the residents were in immediate jeopardy.

As a result of your initiatives, when will conditions in nursing homes actually improve, and how will we know that? In other words, how would you come to us and say, because of these initiatives, we have accomplished this and there are less nursing home residents whose lives are in jeopardy?

Ms. BLOCK. Well, I think there are some immediate indicators that we would hope to see once there was sufficient time to really assess the results. But also I think that you will be hearing some

more detail later about what we would see would be the longer-term indicators that would be available once the quality indicator data are integrated as part of the survey process.

Dr. Scanlon mentioned that among the things that we might expect is just knowing that there would be more vigorous and less predictable efforts to look at quality would result in general improvement of quality of care. I don't know if we could really rigorously measure that, but we might see that by way of some more general assessment of the data that we do have available to us.

We in HCFA have—it has not been prominent in terms of being a specific initiative that we have listed in the tracking that we have given you, but I think you recognized we have really used our regional office resources as a strong complement to the Initiative. And notwithstanding some of the inconsistencies among States in terms of how the Initiative has been implemented, we ourselves have been out in many States working very much hands-on, onsite in many instances in nursing homes where there was immediate jeopardy or there were significant problems in actual direct patient care.

We have played an extremely vigorous role onsite, and I think that is an effort that has really increased in the past year, and I would like to think has improved the outcome in terms of preventing the need for more drastic measures with those facilities in terms of terminations. And so through our efforts, we have tried a more proactive approach to also try to avert some of the more severe measures that might be necessary if improvement is not seen.

So there are, I think, longer-term ways that we will be able to measure this better. I think that we would expect to be able to see some general improvements and we would be very open to ideas that the committee would have in terms of how we can use our existing data to assess that. In the meantime, we really have used our regional office staff and worked closely with the States to try to have a more hands-on and vigorous approach in those instances where we have found immediate jeopardy or patterns of serious problems in direct patient care.

The CHAIRMAN. Could you respond, Ms. Morris, for us?

Ms. MORRIS. Yes, thank you. I would like to say that, in general, the States throughout the country are working very hard to implement the initiatives that have come from HCFA. All of this has been happening in a very quick timeframe and we are all at various stages of coming into compliance with each of the initiatives, depending on State resources and other variables.

I think one of the key things is the ability to have enforcement available immediately where there is actual harm and jeopardy to residents. We have for a long time as an Association expressed concerns about the opportunity given to correct on the part of poor-performing facilities and the numerous revisits that a facility is entitled to before any enforcement action actually takes place. So I think this is going to be an important addition to the system in those cases where there are repeat and unwilling non-compliant facilities. I also think that the more we can do in terms of sharing information and having data available will have a very positive impact, as well, as on improving the quality of care.

The CHAIRMAN. We will go now to Senator Breaux, and then Senator Bryan.

Senator BREAUX. Thank you very much. I thank the panel for their excellent testimony.

Ms. Block, I like your abuse chart. Put it up again and just show it to me.

Ms. BLOCK. Sure.

Senator BREAUX. Would there be any requirement that the nursing home display those abuse charts, or can they put it in the closet and close the door?

Ms. BLOCK. The pilot program, as I indicated before, will be voluntary. However, I believe the expectation is that we, in conjunction in the ombudsmen in the participating States, will be assessing really two things. One is determining whether and how useful this information has been to consumers through a consumer survey and other techniques such as that, and also I think as part of that to determine over some period of time whether the posters are there, whether the cards are still there for people to use.

Senator BREAUX. That chart is not a report card on the nursing home itself, is it?

Ms. BLOCK. No, it is not. What the card indicates is some fairly basic indicators of what are the signs of abuse, some of which, as has been mentioned earlier, may not be so obvious.

Senator BREAUX. I am interested in how does the consumer know that a nursing home in their area is good, not so good, or bad. My cracker jack staff back here was showing me some wonderful stuff. If I wanted to find a nursing home for my father in Louisiana, I asked could I go to the computer and just get some kind of information on it. And, of course, the answer is really yes.

I mean, they have Nursing Home Compare, Nursing Home Search. I just plugged in search results for Louisiana nursing homes and I got a report, the first one starting with the letter "A." It is a for-profit corporation; they take Medicaid patients only. It is 184 beds. The date of last inspection was May 7, 1999, and then they have a list for health deficiencies.

It says this one, in particular—average number of health deficiencies in the State were 4, I guess, on a scale from zero to 33. That is the average number in the State. The total number of health deficiencies for this particular one was 6, and then the second page is the actual type of deficiencies and it is all listed on the computer.

I guess the question is how reliable is this information.

Ms. BLOCK. The information that you are referring to, Nursing Home Compare, is something that is now available through HCFA's Web site. The Web site went live back in September. As indicated in our written remarks, we have received more than a million hits on that Web page. It is the single most widely used facet of HCFA's Web page today. So I think that speaks to the value that people have seen in getting that information.

It is now actually in its second iteration. We have refined and tried to make some of the terminology and the categories that are listed there a little bit more user-friendly for consumers.

Senator BREAUX. Yes. I had a little bit of a problem looking at the little charts and the blocks and everything. But I think this is

an important step because not only the people in nursing homes, I guess, who are thinking about it for themselves are more comfortable with the process; I mean certainly their children and their grandchildren in trying to find some safe place and secure place for grandmother or mom or dad are more comfortable using this.

Let me just talk for a second about the whole question of the definition of poor-performing nursing homes. The industry told us that they were very concerned about the new definition of a poor performer, saying that a lot of these deficiencies were minor deficiencies. I remember the explanation that they could be given a deficiency by just canceling a painting class.

Dr. Scanlon, have you all looked at this? We got some information on checking out what a poor performer is. I want to know two things. First, how is the new definition of poor performer working? Anybody can answer that.

Second, if you are labeled a poor performer, I mean do you get a big "x" on your front door so that, you know, somebody driving by would say, look, that is a poor performer, don't stop here? Or do you have to go into a library and find this information out?

Mr. SCANLON. Well, Senator Breaux, we did look into the issue of what constitutes a G violation, which would be the threshold for becoming a poor performer, exactly because of the type of concerns raised by the industry, issues such as painting classes being canceled, or at an earlier time a broom against the wall representing an accident hazard.

As I have indicated, we examined a sample of over 100 homes with approximately 200 G deficiencies. In 98 percent of the homes, we felt very comfortable that there was at least one G deficiency that involved real, actual harm, things like a person not receiving the care that was prescribed and therefore developing a pressure sore, things——

Senator BREAUX. This is not potential harm.

Mr. SCANLON. This is not potential harm. This is actual harm occurring. In the quality of life area, which has also been cited as one in which there may be smaller abuses that are being cited, we didn't identify examples like canceled painting classes. We identified cases where individuals were left, while toileting, exposed to people walking by in the hall. We identified people who were not given adequate clothing to cover themselves. These were the kind of quality of life abuses that we identified.

We didn't think ten out of over 200 G-level deficiencies were justified, not necessarily because the type of citation or the type of violation was not serious, but because there wasn't enough documentation of it. There was a case in which an individual was a diabetic and her blood sugar dropped but her doctor wasn't notified. We didn't know if there was a consequence of her doctor not being notified, but it is not necessarily good care. So it is those kinds of things where actual harm wasn't fully documented.

The full sample depresses one in terms of the seriousness of these violations. So we think it is an appropriate thing to cite these facilities and say if you do it twice on successive surveys, we want to single you out and hold you accountable so that you are not going to continue this. Whether we apply the label "poor performer" is another issue, and I know that HCFA is considering not using

that label, per se, but applying another term. It is really an issue of bringing this facility and holding it accountable, given that it has a record of this kind of poor care.

Senator BREAUX. The second part of the question—maybe, Ms. Block, you could answer that. What happens when a facility is labeled a poor performer? How does the public know that, or do they have an opportunity to know that at all?

Ms. BLOCK. The immediate consequence, as Dr. Scanlon indicated, is that under the new policies that we will be implementing, they would not have the opportunity to correct before a remedy was imposed. We see that as a very integral part of getting the attention of the individual nursing home as to the seriousness of the deficiency, and also the consequences associated with that. One of the previous criticisms of the system was that it just took too long to have any consequences for the kinds of problems that nursing homes——

Senator BREAUX. That is a very serious potential detriment to a nursing home itself. But the question is does the public have a chance to know any of this information to help them in making their selection or not. I take it they really don't have that information.

Ms. BLOCK. Well, I think that it would be the sort of opportunity to access that information at a point when it would be most useful and helpful to that consumer. We envision the Internet site as being one step forward, particularly in terms of being able to assess the general patterns of care in a particular facility if you have somebody who is a resident there now or if you are looking for information to help direct your choice.

But it clearly does group the information. It doesn't cite quite the detail involved in where there are two G-level deficiencies. Again, we also have tried to make the information through the Website a little bit more user-friendly and use some terminology that the public would be more likely to understand and relate to. There are some tradeoffs in terms of exactly what type of information and the immediacy of that information.

I believe, however—and Cathy could probably give you some more indication—that generally speaking, if you had a question about a specific nursing home in a given State, the State survey agency and/or the Ombudsman in that State ought to be able to tell you right off the bat whether there are deficiencies, when the last survey was, basic information that you can get off of the survey data system that we maintain. Also, our offices often provide liaison for the public to the States to get that kind of information when a consumer might have that question.

Is all current information readily available to consumers at their fingertips? No. We see the Internet site as an important advance. We have to learn more about how consumers use it and what they find most useful. But in the meantime, if a consumer or a family member had a desire to know information about an individual nursing home, I believe that information is readily accessible, and we will do whatever we can to help the public get that information when we are asked.

Senator BREAUX. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman.

Ms. Block, I am not sure I understood all of your answers to Senator Breaux, so let me try again to make sure that I understood. The fact we have this information, as the Senator has indicated, on the Web is extremely helpful, but not everybody is computer-literate, as you know. There are still millions of people who really are intimidated by it.

For example, I am looking for a nursing home to place an elderly parent. Do all States have information, in the form of a pamphlet, in which this survey information is available in some kind of a written form? Can I simply write the State Division of Aging, or whatever State agency it is that has the monitoring responsibility? Is the survey information uniformly available by each State?

Ms. BLOCK. I don't believe so.

Senator BRYAN. So, in other words, in a particular given State I might literally have little or no ability to make a determination as to what a nursing home's track record is in terms of health and safety violations?

Ms. BLOCK. In the form that you have described in terms of a pamphlet that one might either be able to go to a local senior center or call up and get. I believe if you called the ombudsman, the hotline, there are a variety of ways in which I believe the States have tried to advertise the availability of a telephone contact.

Senator BRYAN. And does every State have an Ombudsman, Ms. Block?

Ms. BLOCK. Yes.

Senator BRYAN. Every State has an Ombudsman and every State has at least some type of a survey agency?

Ms. BLOCK. Yes.

Senator BRYAN. And does the survey information that you have indicated, although it may not be totally current, does it have a record of what violations occur? Is the information formatted in such a way that the average person, who doesn't have the sophistication of the three of you about surveys could he or she look at that information and tell what is a serious health and safety violation?

Obviously, they may not have posted some information that is required by law and that would be a violation. A technical violation, I would call it. The kind of violation that Dr. Scanlon has been talking about are the things I think most of us would be most concerned about in terms of placement, of a member of our family the health and safety violations. You referred to them as G-level violations. To the average person, a G-level violation versus an X level versus an A level is about as helpful as providing information in a foreign language. It means nothing.

Tell us what your experience is with respect to how understandable this format is.

Ms. BLOCK. The actual survey report is something that you would expect to see from a government-oriented process. It is technical.

Senator BRYAN. That is not terribly encouraging.

Ms. BLOCK. The actual reports themselves are highly technical. I am not sure if I would understand every bit of information that was in them. That is exactly why, though, we have put the time

and effort into designing the approach to arraying and accumulating the information that is available through the Website.

We certainly understand that not everyone has direct access to the Web site, but I would certainly hope and expect that those same community resources—ombudsmen and community programs—which would have access to that Website could now more readily print out for you that page about a nursing home.

Senator BRYAN. Tell us, if you would—and I invite any other panel member to respond—what are we doing to require this information be more intelligently formatted? Just on the Web site, but in some type of informational source, a pamphlet, or calling the ombudsman or something, so the information you get back is something that the average intelligent person would understand? What are we doing in that area?

Ms. BLOCK. Well, I think, as I said, we viewed the Web site as the first step in our efforts to make that information available.

Senator BRYAN. Beyond the Web site, then, Ms. Block.

Ms. BLOCK. We now have the abuse campaign. We have another initiative which I did not describe.

Senator BRYAN. Can you talk more specifically, not bureaucratic—specifically, what is being done? I mean, do we have a regulation or a format that says, look, you must provide this kind of information through the Ombudsman or the division of aging, or however it is provided? I am not trying to be unfair. I am just trying to get an answer.

Ms. BLOCK. We also do have a document which we published and we have made available throughout the country on how to select a nursing home, which is another initiative.

No, I don't think that there is a regulation, per se, although we all are operating under requirements now to do whatever we do in plainer language, as you probably know. However, I would mention that there are a variety of efforts that we have underway to assess what are ways that we could achieve the kinds of goals that you are describing by consulting with consumer groups, by contracting to have focus groups done. It takes a certain amount of effort, frankly, to come up with those kinds of materials.

Senator BRYAN. I understand that. In Nevada, when I was Governor, we had a report card for every nursing home. I am not suggesting the format is an ideal for the Nation, but you didn't have to be either a rocket scientist or a nursing home evaluator to understand it. "A" generally means pretty good in America; "B," there is room for improvement; "C," average; "D" is less; "F," you flunk the course. You wouldn't want to put your worst friend in a facility like that. It is a fairly easy format to work with, and I just suggest maybe we need to do that.

A last question, if I may, Mr. Chairman. Dr. Scanlon, you get a nursing home that gets a G violation and then there is a repeat of that violation again. What sanctions attach; that is to say, what occurs to that nursing home? Is there a fine, is there a suspension of license, is there a revocation? What did your evaluation indicate in that area?

Mr. SCANLON. Well, the Nursing Home Reform Act of 1987 is where the sanctions have been specified. The most common sanc-

tion, that would be applied in the context of two G-level deficiencies would probably be a civil monetary penalty or fine.

Senator BRYAN. Is that required under the regs?

Mr. SCANLON. It is in the regs. At this point in time, though, a home does not have to be referred for the sanction to be imposed. It is given an opportunity to correct the deficiency. That is what is being proposed by HCFA, to change that so that a home with two successive G violations is referred for the sanction, and then it is determined whether the sanction will be imposed.

Alternative sanctions would be to stop paying for new Medicare or Medicaid admissions, or to stop paying for Medicare or Medicaid residents and terminate the facility from participating in the program. They are still going to be allowed to be nursing homes under State licensing laws. From a HCFA perspective, it is an issue of whether you can participate in Medicare and Medicaid.

Senator BRYAN. Are the sanctions you are talking about Federal sanctions?

Mr. SCANLON. They are Federal sanctions. In addition to that, there are States that impose their own sanctions. In California and New York and other States that we have looked at, there are State fines that are imposed, and they can be imposed independently or instead of the Federal sanctions.

Senator BRYAN. Mr. Chairman, thank you very much for indulging me to go beyond my time.

The CHAIRMAN. I want to follow up on just what you were discussing and what Senator Breaux was discussing. So I think it is valuable that you took the time to do that.

Obviously, this is one of the more controversial of HCFA's initiatives to move to sanctions for those facilities that receive two consecutive G-level deficiencies in any one survey.

So, Dr. Scanlon, your staff at GAO reviewed G-level deficiencies in these 110 facilities that you talked about and found some 200 of those deficiencies. Can you tell us how generalized those findings are in the larger universe of G-level deficiencies?

Mr. SCANLON. Yes, Mr. Chairman. The sample was picked randomly from 10 States, and these States were the largest States in each of the 10 HCFA regions. So for those 10 States, we feel very comfortable that the sample is generalizable for those 10 States. Those 10 States comprise about 46 percent of nursing homes in the country. We can't say anything about the other States because it was not a pure random sample for the entire country. But, again, we are talking about being representative for nearly half the nursing homes in the country.

The CHAIRMAN. Maybe, Ms. Morris, I could ask you to comment on the same question.

Ms. MORRIS. Thank you. HCFA has a very clear definition of a G deficiency that indicates isolated actual harm to a resident or residents, and I think if that definition is interpreted consistently across the country, then the findings of the GAO will be consistent throughout the country.

The CHAIRMAN. Now, a second criticism and one that I even hear frequently in my own State is that there is a great variation from State to State in the number of G-level deficiencies cited. You could have a situation in one State where a very large percentage of fa-

cilities might end up as poor performers, while in another it would be a small percentage.

Dr. Scanlon, in your work, how much variation did you find from State to State in the number of poor performers found under this criteria? And let me follow that up immediately. If there is a wide variation, does it tend to subvert the utility of this definition of poor performer? And by that I would mean is it at least possible that facilities providing essentially the same quality of care might be categorized very differently? This would seem to mean that the classification then would not be reliable.

Mr. SCANLON. Well, Mr. Chairman, in the 10 States that we were working in, there was a wide range in terms of the percentage of homes that are cited for G-level deficiencies, and it is reflective of the situation nationwide. I think that, though, it is important to recognize what we found in terms of looking at the individual G-level deficiencies.

We were not finding that the States that had a higher proportion of homes cited for G-level deficiencies had any more errors in terms of being over-zealous and citing things that weren't involving actual harm. So if anything is the case, it would seem that in some of the States we either have very good-quality homes or we are understating the number of G's.

Now, that raises the question of whether we have a measure that is being applied inconsistently across States. That is something that we want to correct, but in the meantime we have identified homes that have serious problems in their care. And to ignore that because we haven't been able to identify the same serious problems other places when they exist is irresponsible. We need to move forward on correcting the problems where we have identified them, and we need to move forward in improving our scrutiny of all homes to make sure that we identify the maximum number of problems that we can.

The CHAIRMAN. Ms. Block, is there that sort of variation across States, as I have described and even heard about in my own State—I should say between States or among States?

Ms. BLOCK. We certainly have noted variations among States. It is one of the reasons that we have put additional resources into the process of the Federal monitoring survey. As the Association has indicated, while we have put more resources into it, we haven't necessarily done as good a job as we can to give States the feedback that they need from that process.

We also have significantly increased our resources and efforts in the area of training for State surveyors, particularly around the new procedures and processes, so that we might hope that we could begin to see less variation across the country when it comes to actually looking at the same kinds of apples-and-apples facts.

The CHAIRMAN. Ms. Morris, from your standpoint, if you agree that there is that variation, is that a concern of your members?

Ms. MORRIS. I would agree that there is a variation across the country in the number of deficiencies and number of G deficiencies cited, and it is a concern to our members. We look forward to working with HCFA as they try to get consistent information and training out across the country. There are inconsistencies between States and between Federal regional offices that oversee those

States. But we have also as an Association done numerous things in terms of training for our members and developing documentation tools and training tools to improve upon the degree of inconsistency.

The CHAIRMAN. Ms. Block, the two G policies still pending at your agency, when does HCFA plan to implement them?

Ms. BLOCK. September.

The CHAIRMAN. Senator Breaux asked something that I want to return to. Dr. Scanlon responded. It has also been alleged—and this is for you, Dr. Scanlon—that the G-level deficiencies are not serious enough to merit being used to define a facility as a poor performing facility. In your statement, you summarized your findings. I note that you have prepared a separate document detailing the G-level deficiencies you found in a sample of facilities you reviewed. Could you just read two or three that might be typical?

Mr. SCANLON. Sure. I would be happy to, Mr. Chairman. This is one that we would think of as typical with respect to the development of pressure sores. The nursing home failed to ensure that residents with pressure sores received appropriate treatment and services to promote healing and prevent infection, and that new residents without pressure sores did not develop them.

One resident with multiple pressure sores was not properly monitored and did not receive treatment in accordance with physician orders. Although dressings were ordered for both heels, the surveyor observed that the right heel did not have a dressing and that the dressing on the left heel was stuck to the pressure sore.

Another resident was admitted in August 1997 without pressure sores, but was identified as being at high risk for pressure sores. By October, the resident was noted to have developed a moderate pressure sore on her sacral area. In mid-November, the resident was transferred to an acute care hospital with a high fever and loss of consciousness resulting from a systemic infection caused by the infected pressure sore.

To give you a sense of something at perhaps the extreme with respect to pressure sores—this is still a G-level deficiency, though—the nursing home failed to ensure a resident received appropriate treatment for his infected pressure sores. The resident had a severe pressure sore with tunneling and drainage with strong odor, as well as irritated, open areas with yellow and green drainage on his scrotum and penis.

He was admitted to a hospital. Hospital personnel described him as dry and dehydrated on admission, with a large wound with odorous drainage on the left hip, necrosis on the back of his scrotum, thick purulent draining from around his catheter, and feces caked on the soles of his feet. One hospital staff person described his condition as a picture of neglect.

To give you a sense of a quality of life violation, the nursing home failed to provide care in a manner that maintained each resident's dignity. A nursing assistant shampooed a resident's hair by holding the sprayer directly over her head and allowing the shampoo and water to pour down over her eyes, nose and mouth. The assistant then proceeded to vigorously scrub the resident while the resident cried audibly. Despite the resident's distress, the assistant offered no reassurance or comfort.

Also, five residents were observed in hospital gowns so worn and so thin that they failed to provide sufficient coverage to maintain resident dignity; that is, breasts were visible through the thin material.

The CHAIRMAN. Thank you. Ms. Block, has HCFA made any separate analysis of this question of the degree of seriousness of G-level deficiencies?

Ms. BLOCK. I am not sure if I understand your question.

The CHAIRMAN. Well, not just as evidenced by what Dr. Scanlon read, but the extent to which you would supervise a very direct and in-depth analysis of how serious the question is about the G-level deficiencies in regard to one versus the other, one type versus another type of seriousness.

Ms. BLOCK. I don't think—and I am going to look to my staff—that we have done any sort of separate analysis as to that. Again, one of the things we are focusing on in the Federal monitoring survey is to ensure, among other things, that States find the same types of circumstances and cite them at the same level.

One of the concerns in the past has been whether you would cite something at a lower level or a higher level, and if there was any consistency in terms of how that was done from State to State or from surveyor to surveyor. So, that is more in the background of a variety of studies and analyses that the agency has either conducted or used from other sources.

I think we viewed the GAO's findings as a validation of the policy because we believed, based on our experience, that the G level was a serious level, one that reflected an actual personal indicator of poor quality of care that in itself really should not be in dispute. And I think that some of the examples cited in the report really bear that out.

The CHAIRMAN. Ms. Morris, could you comment also on the question of whether you and your members agree with moving to two consecutive G-level deficiencies to trigger more immediate sanctions?

Ms. MORRIS. The general opinion of the Association membership is in support of moving to the two level-G's for an immediate penalty action. I think one or two States have expressed concern, but it is primarily based on the resource impact that that move will have on the survey workloads, not on any philosophical disagreement with the seriousness of a level G deficiency.

I will turn now to Senator Breaux.

Senator BREAUX. Ms. Morris, let me ask a couple of questions. You talk in your testimony about yo-yo compliance, and you talk about the problems of using civil money penalties as a deterrent to nursing homes. And the problem is that they can just go into an appeals process, go to an administrative law judge and drag it out for so long that nothing ever happens. They are in and they are out, they are in and they are out. I mean, how many nursing homes are actually closed because of non-performance?

Ms. MORRIS. I don't have a number to share with you, but it is not a large number. It is a small number of nursing homes that are actually closed.

Senator BREAUX. When you say a small number, nationwide how many are you talking about, out of how many nursing homes?

Ms. Block, can you help me with that? Does anybody know?

Ms. BLOCK. I think that in the last year or so, there were about 30.

Senator BREAUX. Out of how many?

Ms. BLOCK. Seventeen thousand, more or less.

Senator BREAUX. And what is the problem, Ms. Morris, about this yo-yo compliance that you refer to? Is it just that they drag it out through an appeal? Everybody has a right to appeal. I don't want to take those rights away, but I mean does it have a negative impact on ultimately being able to enforce anything?

Ms. MORRIS. There are two issues. One is that facilities given an opportunity to correct a deficiency before a penalty is imposed will take advantage of that. There will be a citation of a finding. They will be given an opportunity to correct. The State survey agency will make a revisit and, in fact, verify that they have corrected that problem. And in that case, no sanction will be taken.

Then the next complaint comes in or the next survey, and the survey team goes back to that facility and finds them out of compliance again. And, again, under certain scenarios now they are given an opportunity to correct and another reinspection before any sanction is imposed.

Senator BREAUX. Just continue this for a fairly long time until this new poor performance standard becomes operative?

Ms. MORRIS. That is correct, yes.

Senator BREAUX. Is this aimed at correcting that type of yo-yo compliance?

Ms. MORRIS. Yes, it should correct it considerably.

Senator BREAUX. And the last question: you talked about the March directive from HCFA regarding complaint investigations is an area where the States are not in compliance with HCFA's instructions. Elaborate on that.

Ms. MORRIS. States are not in compliance with investigating all complaints of alleged actual harm within 10 days of receipt. That is true of a majority of States around the country. There are some States that do meet that criteria, and did so before it was a HCFA directive. They did it as an ongoing State policy.

The concern is not that this is not a good policy. It is an excellent policy. I think our members would fully agree that complaints give us some of the best information about care in a facility. And complaint investigations are not predictable survey visits, so they give us good information on how a nursing home operates. The reality is that States do not have the resources to respond that quickly in every case.

Senator BREAUX. Where does the complaint go? Suppose, you know, a daughter fees that her father is being mistreated at a nursing home. Does she just go up to the front desk and file the complaint, or do you file it with a State agency or a State ombudsman, or who gets the complaint?

Ms. MORRIS. Complaints come to State survey agencies and complaints of abuse come to State ombudsmen's offices.

Senator BREAUX. I would imagine that a lot of people don't know that.

Ms. MORRIS. States, in general, have made great efforts to publish this information. In fact, in nursing homes, the nursing home

is required to post the survey findings and where someone can go to file a complaint.

Senator BREAUX. Yes, unless they post it in the attic.

The CHAIRMAN. In my State, we must have an 800 number where the ombudsman can be called. About 18 months ago, I happened to be visiting a nursing home in northwest Iowa and the manager was taking me around and visiting with patients and she was describing the home. And she got a call from the office. She had to go back to the office, and she came back and told me that a State inspector showed up because over the weekend—and this was a Monday morning—over the weekend, there had been a call into our State office. And there are a certain number of hours that they have to be there to look into that, and so she had to spend the rest of my period of time there with this State inspector that had just come around because of this call over the weekend about, presumably, somebody not being treated right or something. I don't know what it was.

But she also wanted me to know the amount of time that she spends doing things like that that she claims takes time away from administering effectively her home. In fact, she even asked me if I would sit in on just a little bit of it so I could hear what it was, and I did that. But I still think it is very necessary; we have to encourage that sort of reporting.

Senator Bryan had some questions.

Senator BRYAN. Thank you very much, Mr. Chairman. It really was just kind of a follow-on to what Senator Breaux began.

If I might ask you, Ms. Morris, help us to understand what the procedure is. The complaint is filed; that is the first step. Tell us what happens. Let's assume the complaint would be something that, if established, would be a G-level complaint. Tell us what the procedure is after the complaint is filed; what the average length of time is; what penalty, if any, occurs. And then let's assume, for the purposes of this question hypothetically, we have another G violation that is filed. What happens in that context?

Ms. MORRIS. In general—and I should say that every State has slightly different State licensure laws, in addition to Federal requirements. So the process varies slightly.

Every State has a mechanism for receiving complaints. Almost everyone has an 800 number, if not everyone, in the State survey agency as well as in the ombudsman's office. When a complaint comes in, it is generally prioritized in some way. Any allegation of immediate jeopardy of residents is handled immediately, within 24 or 48 hours. The majority of States have the ability to respond on weekends or evenings, 24 hours a day.

Other than immediate jeopardy, complaints are triaged in priority according to the apparent seriousness of them as they are reported to the States. And we have to go on that information to judge initially how serious they are. They are then investigated, as prioritized. As I said, some States do investigate all allegations of actual harm within 10 days. I would say the majority of States do not at this point in time.

The complaint is investigated. If there are violations by the facility, they receive citations through the same type of abbreviated survey process that is very similar to the standard survey process.

And in addition to requiring correction on the part of the facility, a response is given to the person who filed the complaint.

Senator BRYAN. And that would be true when a G violation is found? If the citation is a G violation, then after the investigation is completed, the citation is issued? Then the nursing home has the opportunity to correct the deficiency?

Ms. MORRIS. Under the current Federal enforcement scheme, yes, they have an opportunity.

Senator BRYAN. And I take it, if the deficiency is corrected, then no sanction, no fine, no penalty of any kind attaches?

Ms. MORRIS. It does not attach. No Federal sanction attaches immediately, pending a revisit to the facility. I can speak from my own personal State experience, and I know it is not unique. Many States take State licensure action at a level G. A large number of complaints that result in a substantiated finding are, in fact, G-level-deficient problems because that relative or that family member has seen something of harm happen to their resident loved one.

Senator BRYAN. Let's again suppose there is a G violation. Corrective action is taken, and within a very short period of time another G-level violation, same nursing home, occurs. And let's suppose there is kind of a pattern; you know, this nursing home has had several of these within a 6-month or a 12-month period of time. May the nursing home escape Federal sanction in each instance by simply saying, oops, sorry about that, we will correct it?

Ms. MORRIS. With in the timing of the scenario such that a complaint investigation results in a G-level finding, a revisit results in correction and compliance, then the next G-level deficiency starts that cycle again. If there is continued non-compliance—in other words, if we get a second complaint allegation that is validated before the first one is corrected, then we have some authority to take more stringent action.

If a facility is out of compliance for a period of time, we can restrict all new payment for all new Medicare and Medicaid clients, or denial of payment for all residents in the facility.

Senator BRYAN. But if I am understanding, Ms. Morris, you are saying in theory, you could have a nursing home that would have many, many G violations. But if the timing was such that they took the corrective action before the new complaint was filed, in theory, you could have a place that over a period of several years—and tell me if I am misunderstanding what you are saying—you could have a track record of a lot of G violations which would tell the average person as a layman this is not exactly where I would want to have a loved one, but no sanctions under Federal law would attach if indeed each of those violations, G as they are, are corrected before the next G violation is filed. Am I understanding that correctly?

Ms. MORRIS. Yes, you are understanding it correctly under the current Federal enforcement scenario.

Senator BRYAN. I must say, Mr. Chairman, I am new to the Committee, but this just strikes me—and I appreciate Ms. Morris' candor—this just strikes me as terrible. I mean, you could have an outfit with 12 violations in the course of a year and no Federal sanction, and they had 12 the previous year. That just doesn't make much sense to me.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank you, Senator Bryan.

Would Senator Kohl like to ask questions?

Senator KOHL. No, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kohl, for coming.

I know you have been at the table a long time. Let me take just a few more minutes to kind of close up here. I might have one question. It happens, as chairman, I receive a fair amount of correspondence from family members from all over the country with concerns about the quality of care at some specific facility where a family member or friend is living.

So, for Ms. Block or Ms. Morris, my normal course of events is to refer that to the State inspector of that State or the long-term care ombudsman or to some consumer organization. You might have something you want to suggest other than that. That is not the most important question, but what if there is a breakdown even at these levels? What would you suggest?

Ms. BLOCK. A breakdown in terms of the——

The CHAIRMAN. In other words, where we aren't getting results as a matter of referring them to a State or a long-term care ombudsman or to consumer organizations.

Ms. BLOCK. Well, I think that is where the Federal Government comes in. That is at least part of my response. I also would think at that point, if you were aware of a breakdown in terms of the lack of response to a consumer complaint or a concern regarding quality that you yourself would probably contact State officials at higher levels to follow up on that.

If we were aware of an instance where a complaint was filed that appeared legitimate and no action was taken, and so forth, it is fairly routine for our regional offices, and even sometimes for our central office staff to follow up on specific individual cases such as that. Fortunately, I don't think that we get those kinds of calls too often, but we certainly are available to assist if that occurred.

The CHAIRMAN. Ms. Morris.

Ms. MORRIS. State survey agencies frequently get referrals of complaints from HCFA through the regional offices, also from our Governor's office, from our Senators and Congressmen, and from our State legislative representatives. Any of them, regardless of the source that they came in from, are followed up on and investigated.

The CHAIRMAN. HCFA has a nursing home staffing study underway. I would like to ask the expected date for the completion of that study, and could you give me a brief description of the scope of the study? Could you respond to that, this study that Congress mandated that you have on staffing?

Ms. BLOCK. We are expecting at this point that the technical work will be completed by the end of the year, and we are assuming at this point a public release shortly thereafter. In terms of the scope of the study, I can speak to it in general terms and we would be happy to provide additional information, although I suspect that we may already have done so recently. But, essentially, what the study is intended to focus on is, I believe, the level and variation of staffing that currently exists in nursing homes and how that relates to various indicators of the quality of care in those nursing homes.

The CHAIRMAN. The Aging Committee will be holding a forum, not a regular committee meeting, on this important topic of staffing. And I would wonder if you could send somebody representing your agency to participate in that.

Ms. BLOCK. Absolutely. I am sure we would be pleased to.

The CHAIRMAN. I am done with asking you questions, but I would like to announce not only for your benefit, but for the committee's and for the audience, that I am going to be convening another forum. I use the word "forum" so that you know it is not a committee hearing like this, a more informal approach, to hear from family members of residents and other consumer advocates about quality of care.

Usually, this committee would begin its hearings by hearing from citizen witnesses. I want to make clear that this hearing was an exception due to the nature of the hearing. But I don't want to let anybody think that we lose sight of the fact that the objective of the Nursing Home Initiative is to improve conditions in nursing homes, and family members are one of the most valuable sources in terms of feedback on that, and hence we will use a forum-type approach to get updates as they see it.

Thank you all very much for participating today.

Now, would our second panel come forward as I introduce you? We have three nationally known experts on the quality of care in nursing facilities. All three have been retained at various times by HCFA to help with projects related to improving the quality of care in nursing homes.

Our first witness is Dr. David Zimmerman, director of the Center of Health Systems Research, University of Wisconsin-Madison. He is currently working with HCFA on quality indicators, a key piece of the redesign of the survey system which is critical to the Nursing Home Initiative effort that was announced in July of last year.

The second person is Dr. Andrew Kramer, research director, Center on Aging, University of Colorado Health Sciences Center at Denver. Dr. Kramer testified at this committee's hearing in July last year and was a member of the GAO team which reported last year to this committee on the quality of care in California nursing homes. He is here today as one of the principal developers of the redesigned survey system, a critical nursing home initiative. Drs. Zimmerman and Kramer are currently working on contract with HCFA to develop a more accurate nursing home survey.

Dr. Charlene Harrington is a professor in the Department of Social and Behavioral Sciences in the School Nursing, University of California-San Francisco. She has been involved in research in nursing home quality of care since at least 1975. She testified at this committee's hearing last year, as well, on the situation in California nursing homes. She is currently working on a project funded by the Agency for Health Care Policy and Research to design a consumer information system for nursing homes. Today, she will address the status of improving consumer information on nursing home quality.

I think it is also fair for me to single her out as a person who was the lead researcher and proponent of consumer information. And HCFA's ability to move last July to an active Web site is largely due, I think, to your urging them to do that, and I thank you

for that. I think Senator Breaux has pointed out the value of that and the 1.3 million hits that it has had.

I would start with Dr. Zimmerman.

STATEMENT OF DAVID ZIMMERMAN, DIRECTOR, CENTER FOR HEALTH SYSTEMS RESEARCH AND ANALYSIS, UNIVERSITY OF WISCONSIN, MADISON, WI

Mr. ZIMMERMAN. Thank you, Mr. Chairman. My name is David Zimmerman and I am the director of the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. I am pleased to represent the researchers at our Center who have had the lead in the development of the nursing home MDS quality indicators.

HCFA is about to launch a major piece of its strategy to implement the nursing home quality of care initiatives. The revisions to the survey process that will be implemented can have an important positive impact on how well we ensure the care provided to our Nation's most vulnerable population. They also represent a tangible manifestation of HCFA's long-term commitment to fixing the quality assurance system.

A critical element in HCFA's first set of changes is the systematic use of the MDS quality indicators. The MDS QIs, as they are called, were developed by researchers at our Center as a part of the multi-State nursing home case mix and quality demonstration. The indicators were developed through an iterative process of data analysis and clinical input from panels representing the primary disciplines involved in nursing home care. The product of this effort is a set of 24 quality indicators covering 11 domains or dimensions of care.

The QIs, as they are called, provide information on resident condition and processes of care. They cover areas reflecting the physical functioning ability of residents; their cognitive and emotional status—for example, whether they are suffering from depression, and if so whether they are receiving anti-depressant therapy; whether they are on anti-psychotic medication; whether they have skin care problems such as pressure sores; whether they are incontinent, and if so whether they are receiving some form of toileting program; and many other aspects of resident care and care process.

The QI information is provided to facility staff and surveyors in the form of reports that permit the user to compare a specific facility with other facilities in the State, and to obtain more detailed information on each resident.

Systems researchers at our Center have also developed software that enables both surveyors and facility staff members to instantaneously access quality indicator reports on a facility through a Web site access mechanism. State survey agency staff can access reports on any facility in their State. The software is currently being deployed in State survey agencies throughout the country.

The quality indicator reports will permit surveyors to identify areas of care that should receive special attention in the survey, to identify individual residents that might be good candidates for in-depth review, to better document care problems, to make more defensible quality of care decisions, and to conduct more effective follow-up activities.

The indicators have the potential to significantly enhance our capability to identify and correct care problems, but only if the commitment to their use is sustained over the long haul. A lesson must be learned here from the unfortunate experience in the aforementioned case mix and quality demonstration, where the Office of Research and Demonstrations at HCFA first strongly supported the development and testing of the quality indicators and then virtually abandoned that support when it came time to integrate them into the survey process.

We believe this will not happen in the national implementation of quality indicators, and it must not happen. There must be continued training to truly integrate the use of the QI information into survey activities. There must be diligent, extensive monitoring of the implementation process to identify what is working well and what is not, and to make necessary refinements in the process.

Remember, also, that the introduction of the quality indicators is only a beginning. The entire survey process needs more structure and more rigor, including the onsite activities where the evidence of good or bad quality is actually found and the compliance of facilities to laws and regulations is actually determined.

On a more general level, we need to see improvement in the following other areas. First of all, funding. Funding for nursing home quality assurance is piecemeal and inadequate. Each year, it becomes a game of guesswork about how much money will be in the pot, and the ultimate answer is too often not much and not enough.

As a point of contrast, some of us look with envy on the peer review organization program, with millions and millions of dollars reserved each year for quality improvement activities. Because the PRO funding is so convenient and easily accessible, in some cases important decisions about nursing home quality assurance activities and who will assist HCFA in developing them are made on the basis of the availability and convenience of PRO funding mechanisms rather than on the basis of merit. This is simply wrong. These decisions must be made on how best to get the job done and not which pot of money happens to be available.

The second issue is commitment. There has been a strong commitment on the part of HCFA to the implementation of the indicators. We believe that there must be a strong and sustained commitment from HCFA at all levels if we are to be successful in the nursing home initiatives. This commitment must be reflected in a high profile throughout the agency and an evidence that both HCFA staff and its contractors have the necessary technical skills, content knowledge and management ability to carry out the critical assignments.

Third is consistency and efficiency. There needs to be more consistency in the outcomes and the process of the survey system, and more efficiency in the use of the resources in that system.

Fourth is involvement. There must be formal, explicit involvement of three critical constituencies—consumers, the provider community, and the State survey agencies that operate as HCFA's close partners. All three parties have much to contribute and all three have a desire to participate.

The last item is a broader perspective. We must take a broader look at the long-term care quality assurance process. We need to

look for innovative and feasible ways to do two important tasks—identify those providers who have demonstrated their lack of commitment to adequate long-term care of the elderly and get them straightened out immediately or get them out of the system, and then find more effective ways to truly work in a partnership with consumers, providers, and regulatory professionals to institute programs that provide, first, information and then appropriate incentives to identify care problems and fix them for good.

There can be no retreat from standards of care that we demand or the responsibility of providers to meet them, but we need to undertake the task more effectively in a way that energizes and fortifies the commitment of those who must make it happen.

I want to thank the committee for the opportunity to participate in this hearing. In closing, let me say that much of what ails the system in this country is a direct consequence of the fact that long-term care, in general, has been a second-class citizen in the health care world. It is true in the resources devoted to long-term care, in the low esteem in which it is held by both consumers and care professionals, in the education and training of those professionals, and in the attention and resources devoted to assuring its quality. It is time to change that situation. Long-term care and those whose lives are enhanced by it must be a first-class citizen and nothing less.

Thank you.

The CHAIRMAN. Thank you, Dr. Zimmerman.

[The prepared statement of Mr. Zimmerman follows:]

United States Senate Special Committee on Aging

Testimony Prepared By
David R. Zimmerman, Ph.D.
June 30, 1999

My name is David Zimmerman and I am the Director of the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. I want to thank the Committee for giving me the opportunity to participate in this important hearing. I am pleased to represent the researchers at the University of Wisconsin Center for Health Systems Research and Analysis, who led the development of the nursing home MDS quality indicators, which will be the primary subject of my remarks today.

We are at a critical juncture in the effort to improve the quality of care in America's nursing homes, and to improve the quality assurance process itself. Tomorrow, the Health Care Financing Administration launches a major piece of its broad strategy to implement the nursing home quality of care initiatives formulated by Congress and the President. Substantial revisions to the survey process will be implemented starting July 1. These revisions—if implemented effectively and with sustained commitment—can have an important, positive impact on how well we ensure the care provided to our nation's most vulnerable population. More importantly, they represent a tangible manifestation of HCFA's commitment to continue fixing the quality assurance system in the future.

This point should not be missed. Our nation's commitment to an overhaul of the nursing home quality assurance process is a marathon, not a sprint. HCFA's support for this principle is reflected in the fact that its long run project to accomplish this task—a project in which all three of this panel's speakers are integrally involved—has been organized within three phases to facilitate both short run and long run objectives. I will be reporting on the first phase of that effort, the systematic integration of a set of quality indicators into the survey process as a way of providing more structure to those activities.

A critical element in HCFA's first set of changes to the survey process is the systematic use of the MDS Quality Indicators in that process. The MDS Quality Indicators were developed by researchers at the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison in the early and mid-1990's, as part of the Multi-State Nursing Home Case Mix and Quality Demonstration. The MDS QI's, as they are called, are based entirely on information in the Minimum Data Set (MDS), which is part of the Resident Assessment Instrument, an assessment process mandated for use with all nursing home residents in the United States. The MDS QI's were developed through an iterative process of data analysis and clinical input. Seven national clinical panels representing the primary disciplines involved in nursing home care provided clinical input throughout the development process. Researchers at CHSRA analyzed MDS data from several million MDS records covering six states in the course of the development process. The product of this effort was the formulation of 30 quality indicators covering 12 domains or dimensions of care. The 30 indicators were subjected to pilot testing to determine their feasibility for use in the

quality assurance process. Validation studies were also conducted to determine the accuracy of the MDS items comprising the QI's, and the validity of the indicators in predicting quality of care problems. Accuracy rates were quite high, in the 70-90% range, and the indicators were found to substantially increase the likelihood of identifying a care problem when one existed in a facility. The MDS QI's were later reduced to 24, covering 11 domains of care, when a new version of the MDS and quarterly supplement was implemented.

The MDS QI's provide information on resident condition and processes of care at the individual resident level and they provide overall facility rates as well. The QI's provide information on a variety of aspects of resident status and care processes. They cover areas reflecting the physical functioning ability of residents; their cognitive and emotional status, for example whether they are suffering from depression and, if so, whether the resident is receiving antidepressant therapy; whether the resident is on antipsychotic medication, whether they are physically restrained, whether they have skin care problems such as pressure sores, whether they are incontinent, and if so whether they are receiving some form of toileting program, and many other aspects of resident status and processes of care. Some of the QI's are adjusted to take into account the fact that residents may be at higher or lower "risk" of having the condition reflected in the QI. Most of the QI's provide information on the number of residents who have the relevant condition at a particular point in time, but a few of them reflect a change in condition over time.

3

The MDS QI information is provided to users in the form of reports at both the facility and individual resident levels. The facility Quality Indicator reports provide information on the number of residents who have the condition reflected in the QI, as well as information on the overall proportion of residents having the QI. The reports also provide information on the average proportion of residents with each QI at other facilities in the state (i.e., a peer group). This enables the user to determine how each facility compares with others in the state. A ranking of facilities is provided such that the user can determine what proportion of facilities in the peer group have a higher or lower proportion of residents with the condition, which enables the user to determine whether a facility is an outlier, that is, if it has a much higher (or lower) rate than others in the state peer group. The individual resident QI reports provide information, for each resident, on whether that resident has each of the QI conditions, as well as whether the resident is at high or low risk for the condition for those QI's that are risk adjusted. Thus, the user can get an overview of the status and processes of care for each resident.

An important corollary to the development of the QI's has been the development of software to permit facilities and state survey agencies to create and run Quality Indicator reports instantaneously. Under the direction of project leader Richard Ross, systems researchers at the Center for Health Systems Research and Analysis have developed software that enables facility staff members to access both facility and individual Quality Indicator reports on their facility through a web site access mechanism. State survey agency staff can access reports on any facility in the state in the same manner. A pilot test of the software was

conducted in the state of New Jersey this spring, and the software is currently being deployed in state survey agencies throughout the country. This software will become an integral part of both the state survey agency quality assurance process, and individual provider quality improvement initiatives.

Through the use of this software, state survey agencies will incorporate the MDS Quality Indicators into the survey process. The Quality Indicator facility and individual resident reports will permit surveyors:

- to identify areas of care that should receive special attention in the survey process;
- to identify individual residents that might be good candidates for in-depth review as part of the resident sample;
- to provide a structure for the onsite review and observation process;
- to better document potential and identified care problems;
- to help reach more defensible decisions about the quality of care and compliance with federal and state regulations; and
- to provide a better basis for follow up activities, including monitoring of the situation in facilities through analysis of future Quality Indicator reports.

Over the past two months, training in the use of the Quality Indicator reports and the software has been provided to state survey agency trainers and to some facility staff members.

The MDS Quality Indicators are ready for use. They have the potential to significantly enhance the capability of the survey process to identify and correct problems in the care of residents.

The potential of the Quality Indicators should not be underestimated. They can be a valuable addition to the survey process in its external quality assurance role, and to the provider community in taking on more responsibility for internal efforts to improve quality on a continuous basis. But this potential can only be achieved if the commitment to their use is sustained over the long haul. In this regard, a lesson must be learned from the lack of a sustained commitment that occurred in the implementation of the QI's during the aforementioned Case Mix and Quality Demonstration. In that situation, after a period in which HCFA strongly supported the development and testing of the Quality Indicators, when it came time to integrate them into the survey process in the demonstration states, that commitment dissipated. After one initial round of training of state surveyors in the demonstration states, there were essentially no additional resources forthcoming to provide additional training or conduct the necessary monitoring of the implementation process in order to make necessary refinements in the system. Virtually no monitoring was undertaken, no resources were provided for follow-up activities, and the process was, for all intents and purposes, abandoned. It was left to the states to proceed with implementation, and without encouragement or resources from the federal level it is no surprise that the effort virtually disintegrated.

This must not happen in the national implementation of the Quality Indicators. There must be continued training to truly integrate the use of the Quality Indicator information into the survey activities, at both the pre-visit and on site stages. There must be careful, intensive monitoring of the implementation process, to identify what is working well and what is not, and to make necessary refinements in the process to fix the latter. This monitoring needs to examine strengths and weaknesses in both the measures themselves and the manner in which they are used in survey activities. This monitoring must also include concomitant actions such as intensive retraining—or even sanctions—if revised survey activities are not properly implemented. Finally, this monitoring must also provide reconnaissance information on how the Quality Indicators can be smoothly integrated with more highly structured onsite survey procedures, in order to inform our future development efforts in that area. The Quality Indicators can have a positive, significant impact, but only if the support for and commitment to their use—which has been visible and strong to date—is sustained.

We must also remember that the introduction of the MDS Quality Indicators is only a beginning. As my colleague Dr. Kramer will discuss, the entire survey process needs more structure and more rigor—including the onsite activities, where the evidence of good or bad quality care is actually found and the compliance of facilities to federal and state laws and regulations is actually determined. Given successful implementation of these first phase changes, we will have accomplished much—but we are far from finished.

Permit me to take this opportunity to offer a few other thoughts and recommendations about improving nursing home quality of care, and improving the process that accomplishes that goal. These are based on our current project efforts, but they also reflect my 15 years of research in this area.

We need to see substantial improvement in the following areas:

1. **Funding**—it is easy, of course, to appeal to the almighty dollar as the solution to the systems ills; but in this case the lack of funding is a major contributor to the set of factors explaining the dismal situation of nursing home quality assurance. Funding for survey operations and other quality assurance activities is piecemeal and inadequate. Each year it becomes a game of guesswork about how much money will be in the pot, and the ultimate answer is typically, "not much" and "not enough".

As a point of contrast, consider the Peer Review Organization program, with its millions and millions of dollars perennially reserved for quality improvement activities, and protected, at least to some extent, from the political process—all, I might add, with precious little oversight. Interestingly, it appears that PRO funding has had an impact on the way decisions are made even in the nursing home quality assurance area—and there are those of us who have come to view that impact as problematic. I have found that because the PRO funding is so "convenient" and easily accessible, in too many cases important decisions about program development activities and contractors—in nursing home quality assurance--are

made on the basis of the availability and convenience of PRO funding mechanisms rather than on the basis of merit. Decisions about how quality assurance development money is spent, and who provides the services under contract, must be based on how to best get the job done, and not which pot of money happens to be available for that purpose.

With no disrespect to its important activities, the PRO program is a proverbial cornucopia, as in "horn of plenty". The nursing home quality assurance process is in perpetual poverty. The disparity seems obvious. Adequate funding of quality assurance is a prerequisite to the success of the nursing home initiatives.

2. **Commitment**--A strong and sustained commitment from HCFA—at all levels—is critical to the success of the nursing home initiatives. HCFA must continue to recognize, on a continuing basis, the importance of the mission—and that recognition must be reflected in the provision of adequate funding, competent staff and contractors, and a high profile structure that can ensure that the nursing home quality assurance process is on the front burner with the flame turned on "high". As I have noted, in the short run, a good litmus test of this commitment is the attention paid to the implementation of the MDS quality indicators, in terms of continued training, adequate monitoring effort, making necessary refinements in the process, and ensuring that all relevant constituencies, including consumers, providers, and the state agency partners, are integrally involved in the effort. The same goes for Phase 2 activities—HCFA needs to provide strong support for and commitment to increasing the structure and rigor of the entire survey process. Throughout this effort, HCFA must ensure

that both its staff and its contractors have the necessary technical skills, content knowledge, and management ability to carry out the critical assignments.

3. **Consistency**--There needs to be more consistency in the outcomes and the process of the survey system, at both the state and federal level. Currently, there is widespread variation in survey process and outcomes, including the enforcement actions and penalties imposed, across and even within states. Reducing this variation will require more training—and more standardized training—on investigative techniques, the process of reaching a decision about compliance, and the documentation of findings. It will require strong monitoring efforts to ensure that surveys are consistently and effectively conducted. And it will also require more consistency in policy directives, and better communication between the federal level and the state level.

4. **Efficiency**--There also needs to be greater efficiency in the survey process. Currently, there is unacceptably widespread state variation in the resources devoted to survey activities, the costs associated with these activities, and the manner in which the activities are performed. More consistency across states and regions is needed. The funding situation referred to above underscores the need for more efficiency in the system.

5. **Involvement**--There must be more formal, explicit involvement of all the relevant constituencies in the survey and quality assurance process. In particular, there needs to be greater formal involvement of three critical groups: (a) consumers, (b) the provider

community, and (c) the state survey agencies that operate as HCFA's close partners. HCFA cannot operate in a vacuum as it seeks to maintain the proper direction of the quality assurance process, while having to respond to the constantly changing long term care and political environment. Consumers, providers, and state agency partners have a responsibility (and I believe a desire) to participate—and all three parties have much to contribute. It is time to bring them into the process, formally and explicitly.

6. **A broader perspective**--Despite the obvious pressing nature of the current initiatives, it is nonetheless time to take a broader look at the long term care quality assurance process, expanding "beyond the box" in currently fashionable nomenclature. Some have argued that this broader look is a long run objective. But we cannot afford to wait for the long run. We need to look for innovative and feasible ways to:

(A) Identify those providers who have demonstrated their lack of commitment to adequate long term care of the elderly, and implement effective methods to get them straightened out—immediately—or get them out of the system; and then

(B) Find effective ways to truly work with consumers, providers, and regulatory professionals at both the state and federal level to institute programs that can provide (1) information and (2) appropriate incentives to identify care problems and fix them, and to engage in meaningful quality improvement as a first order commitment. There can be no retreat from the standards of care that we demand

or the responsibility of providers to meet them—but we need to find a more effective way to make the improvements in a way that energizes and fortifies the commitment of those who must make it happen.

The level of frustration with the system is high, so the motivation to take a broader perspective is there. It is, therefore, a propitious time to seize the moment.

Again, I thank the Committee for the opportunity to participate in this effort. In conclusion, let me say that much of what ails the system is a direct consequence of the fact that long term care in general, and with it long term care quality assurance, has long been a second class citizen in the health care world. It is true in the resources devoted long term care, in the low esteem in which it is held by both consumers and care professionals, in the education and training of those professionals, and in the attention and resources devoted to assuring its quality of care. It is time to change that situation. Long term care—and those whose lives are enhanced by it—must be first class citizens, and nothing less.

The CHAIRMAN. Dr. Kramer.

STATEMENT OF ANDREW KRAMER, M.D., PROFESSOR OF GERIATRIC MEDICINE, UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER, DENVER, CO

Dr. KRAMER. I am Andrew Kramer and I am a professor of geriatric medicine at the University of Colorado. I provided testimony last July relating to limitations in the State survey process and methods that we used in the GAO study to detect quality of care problems.

Today, I would like to cover four issues. First, quality of care in nursing homes continues to be a major problem. Second, attempts to improve quality of care in nursing homes over the past decade have met with limited success. Third, a major change is required in the process by which quality of nursing home care is assessed and assured. And, fourth, several major steps are necessary for such a change to occur.

Let us not become complacent. Problems our Center found in at least one-third of nursing homes in 1998 included malnutrition, pressure sores, losses in physical function, falls, and poor response to acute illness. In at least 20 percent of facilities, we found problems relating to pain management, incontinence care, restraint use, anti-psychotic use, personal care, and rehabilitation. For many of these problems, effective care strategies exist, but are not implemented.

Taking pressure ulcers or bed sores, for example, as indicated in Exhibit 1, data over the last 10 years from numerous investigations show that 11 percent of residents develop pressure ulcers, often in the first 6 months of nursing home admission. They cause pain, infection, and sometimes death.

However, proven strategies to prevent pressure ulcers are available, and widely accepted treatment guidelines exist. Some nursing homes are able to achieve pressure ulcer rates of zero among high-risk patients, proving that pressure ulcers can be prevented with good care. Other nursing homes have rates over 35 percent.

Attempts to assess and improve quality of nursing home care have met with little success, as this committee's hearings of last July revealed. Illustrative of this chronic problem, let us return to the example of pressure ulcers. As seen in Exhibit 2, remembering that pressure ulcers are conspicuous and largely preventable, a study of OBRA 1987 found that the nursing home survey missed quality of care problems in 64 percent of nursing homes. The information generated by the survey that Senator Breaux indicated was on the Web suffers from this limitation.

A State, Federal and private sector initiative in Ohio to prevent pressure ulcers involving feedback of MDS data had absolutely no effect on pressure ulcer rates. The Joint Commission survey did not detect pressure ulcer problems in any of four facilities where such problems were found by an independent survey. And the HCFA demonstration using MDS data, to which Dr. Zimmerman just referred, had a minimal effect on improving the detection of pressure ulcer quality problems.

Thus, a major change to the survey process is required to assure quality of care. This conclusion was reached by this committee

nearly a year ago, and we must remain committed to this major change if we are serious about improving quality of care. We need a new method for sampling residents, a rigorous and standardized approach for collecting resident level information, and a decision-making process that is driven by documented, well-organized information.

As indicated in Exhibit 3, essential elements would include methodical sampling, including high-risk and random samples of current residents and new admissions; a very structured first-stage information acquisition from records, staff and residents; information synthesis and comparison with norms using laptop computers; a more targeted second-stage case review to determine if and where care problems occurred; and a clear report to facilities and other stakeholders on care problems.

This approach assures that all quality of care indicators are included in the survey. It standardizes the approach among surveyors and across facilities, and it provides the basis for the facility to be evaluated relative to others.

What is necessary for this change? Our team and the University of Wisconsin team have been selected to assist HCFA in developing this survey, and this effort is in its very early stages. However, if such a major change is going to be made, a more concerted effort will be required. As indicated in Exhibit 4, this will require commitment at the most senior levels of HCFA and additional staff whose sole responsibility is this fundamental, longer-term change in the survey. Continued support from Congress will be necessary.

To illustrate the complexity of this work, refinement and testing of all methods involving surveyors is necessary on a large-scale basis. This will require commitment and resources. While software is available from our prior work, further software development is necessary, and laptops are required in all States. Strategic planning must begin now to engage surveyors, the industry and other stakeholders. And, finally, State agencies need to be informed that this change is on the way and how to prepare for it.

Let me leave you with a couple thoughts. Of people 65 years of age, 43 percent will spend some time in a nursing home. I wish I could say that small changes in the nursing home survey can lead to big improvements in quality of care, but the evidence indicates just the opposite. We need a major change in the survey process. The quality of care survey the University of Colorado has been conducting for the past 5 years suggests that a more thorough and consistent process is within our reach, but it will take resources and commitment to make the changes that are necessary.

Thank you.

The CHAIRMAN. Thank you, Dr. Kramer.

[The prepared statement of Dr. Kramer follows:]

The Nursing Home Initiative: Results at Year 1
June 30, 1999

Testimony of: Andrew Kramer, M.D.
Professor of Geriatric Medicine
University of Colorado Health Sciences Center

Mr. Chairman and Members of the Committee,

My name is Dr. Andrew Kramer and I am a Professor of Geriatric Medicine at the University of Colorado Health Sciences Center. I provided testimony last July in relation to activities that our research team conducted in support of the GAO report on quality of care in California nursing homes. I discussed limitations in the state survey process and methods that we used in the GAO study to detect quality of care problems in nursing homes. Today I would like to cover four points. First, quality of care in nursing homes continues to be a major problem. Second, attempts to assess and improve quality of care in nursing homes over the past decade have met with little success. Third, a major change is required in the process by which quality of nursing home care is assessed and assured. Fourth, several steps are necessary for such a major change to occur.

1. Quality of care problems in nursing homes.
   Quality of care remains a major problem in U.S. nursing homes. Problems our Center found in at least one-third of facilities in 1998 include malnutrition, pressure ulcer care, losses in physical function, falls, and response to acute illness. In at least 20% of facilities, significant problems were found relating to pain management, incontinence care, restraint use, antipsychotic use, personal care, and rehabilitation. For many of these problems, effective care management strategies exist, but are not implemented.

   Taking pressure ulcers for example, data over the last 10 years from numerous investigations show that 11% of nursing home residents develop pressure ulcers often in the first six months of nursing home residence (Chart 1). Pressure ulcers cause pain in over half of the affected individuals and are associated with increased morbidity such as infections and sometimes death. However, proven strategies to prevent pressure ulcers are available and widely accepted treatment guidelines exist that could substantially reduce the problem of pressure ulcers. While some nursing homes are able to achieve pressure ulcer rates of zero among high-risk patients -- proving that pressure ulcers can be prevented with good care -- other nursing homes have rates over 35%. And pressure ulcers are an easier problem to identify and treat than many other nursing home quality problems such as malnutrition.

2. Attempts to assess and improve quality of nursing home care have met with little success.
   With more than 17,000 nursing homes in the U.S. - three times as many nursing homes as acute care hospitals - assuring quality of care is a formidable task. Of the 1.8 million residents in nursing homes, more than 50% have dementia, many have no

living relatives, and on average they are dependent in 3 to 4 personal care activities, making them extremely vulnerable and unable to advocate for themselves. Federal regulatory efforts such as the Nursing Home Reform Act (OBRA 1987) have had some effect on use of physical restraints and psychotropic medications, but there is little evidence for an effect on overall quality of care, as this Committee's hearings of last June revealed.

An illustrative example of this chronic failure can be found in the area of pressure ulcers. Remembering that pressure ulcers are conspicuous and largely preventable, a study of OBRA 1987 found that the nursing home survey missed quality of care problems in 64% of the nursing homes where an independent survey found problems (Chart 2). A state, federal, and private sector initiative in Ohio to prevent pressure ulcers involving feedback of MDS data had absolutely no effect on pressure ulcer rates. The Joint Commission on Accreditation of Healthcare Organizations survey did not detect pressure ulcer problems in any of four facilities where such problems were found by an independent survey. Finally, a HCFA demonstration using MDS data in the survey process had a minimal effect on the detection of pressure ulcer quality problems. Implementation was a major problem in four of the six states, but even in the two states that used MDS data, the ability of the survey to detect quality of care problems was only marginally improved. Thus, pressure ulcer rates remain unnecessarily high and detection of quality problems remains unacceptably low.

3. <u>A major change to the survey process is required to assure quality of care.</u>
This conclusion was reached by this committee nearly a year ago. And we must remain committed to a major change in the survey process if we are serious about improving quality of nursing home care. We need a new method for sampling residents, a rigorous and standardized approach for collecting resident-level information and a decision-making process that is driven by documented, well-organized information (Chart 3).

On-site activities in the survey should begin with selection of both random and high-risk resident samples, including new admissions to the facility, for collection of standardized information on all relevant quality indicators. Surveyors should record responses to specific questions from chart review, staff interviews, resident interviews, and observations. This approach assures that all quality of care indicators are included in the survey; it standardizes the approach among surveyors and across facilities; and it provides the basis for the facility to be evaluated relative to other facilities. Comparison with national norms, that would be contained on surveyors' laptop computers, then provides the basis for focusing the review in each facility on adverse outcomes that occur at higher rates than expected. Following this initial comprehensive assessment, where problem areas are identified, a standardized, in-depth review of residents experiencing adverse outcomes should be conducted to establish the link to the underlying care that led to the adverse outcome. The findings should then be synthesized using a laptop computer such that scope and severity of problems are more consistently assessed and a facility report is generated that yields specific information on adverse outcomes and the related care. Such protocols that

structure survey activities and decisions are necessary to ensure that surveyors systematically assess quality of care in each facility.

4. What is necessary for this major change.
Our University of Colorado research team and the University of Wisconsin team have been selected to assist HCFA in developing this new survey. This effort is in the very early stage of development. However, if such a major change is going to be made in the survey process by the end of the year 2000, a much more concerted effort will be required (Chart 4). This will require commitment at the most senior levels of HCFA and additional HCFA staff whose sole responsibility is this fundamental, longer-term change in the survey process. Continued support from Congress will be necessary throughout the project.

   To illustrate the complexity of this work, refinement and testing of all methods involving surveyors is necessary on a large scale before national implementation. This will require commitment and resources. While a software package is available, further software development is necessary and laptops are required in all states. Strategic planning must begin now to engage surveyors, the industry, and other stakeholders to understand their needs and responsibilities. Finally, state agencies need to be informed that this change is on the way and how to prepare for it.

Let me leave you with a couple thoughts. Of people 65 years of age, 43% will spend some time in a nursing home. I wish I could say that small changes in the nursing home survey process can lead to big improvements in quality of care, but the evidence indicates just the opposite. We need a major change in the survey process. The quality of care survey that UCHSC has been conducting for the past five years suggests that a more thorough and consistent survey process is within our reach. But it will take resources and commitment to make the changes that are necessary to improve quality of care for the elderly in this country. Let us not waste any time.

[handwritten] ...ibits to Kramer

Pressure Ulcers (Bed Sores): Example of a Frequent But Preventable Nursing Home Quality Problem

- Develop in about 11% of NH residents
- Associated with pain, infection, and death
- Widely accepted guidelines exist for prevention
- Some facilities have 0% in high-risk groups
- Other facilities have rates of 35%
- Easy to identify

Unsuccessful Attempts to Assess and Improve Quality of Care for Pressure Ulcers

- OBRA 1987 (1991) - No effect: missed problems in 64%
- Ohio Pressure Ulcer Prevention Initiative using MDS data feedback (1996) - No effect on pressure ulcer rates
- JCAHO (1998) - No effect: missed problems in 100%
- HCFA Quality Assurance Demonstration using MDS data in survey process (1998) - Minimal effect: missed problems in 62%; 55% in 2 states that implemented use of MDS
- Overall: No change in pressure ulcer rates (still 11-12%) and in the detection of quality problems

Essential Elements of Structured Survey Process

- Methodical sampling including: high-risk and random samples of current residents and new admissions
- Structured first stage information acquisition from records, staff, and residents
- Information synthesis and comparison with norms
- Targeted second stage case review to determine if and where care problems occurred
- Clear report to facility on care problems

What is Necessary for Major Survey Change

- Commitment at senior levels of HCFA
- HCFA staff resources devoted to fundamental, longer-term changes
- Refinement and testing of all methods
- Software development and laptop capability in states
- Strategic plan to engage surveyors, industry and stakeholders - starting now
- Preparations at the state agency level

The CHAIRMAN. Dr. Harrington.

STATEMENT OF CHARLENE HARRINGTON, PROFESSOR OF NURSING AND SOCIOLOGY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Ms. HARRINGTON. Thank you. My name is Charlene Harrington and I am a professor of nursing and sociology at the University of California-San Francisco. As you mentioned, for the past 5 years I have been developing a consumer information system for nursing homes, funded by the Agency for Health Care Policy and Research, along with my colleagues, Dr. Joseph Mullen, Dr. David Zimmerman, and Sara Burger.

An Internet information system is a top priority so that the public will know what is going on behind the closed doors of the Nation's nursing homes. In July 1998, President Clinton and HCFA officials announced that they would provide a consumer information system about nursing homes on the Internet, as my colleagues and I have long advocated. Since that time, we have been working with HCFA officials on an informal basis to make this happen.

As was discussed in the earlier panel, HCFA did post information on all the Federal deficiencies found in each nursing home in the U.S. on its Web site in the fall of 1998. These data are from the Online Survey Certification and Reporting system, or OSCAR as we fondly call it. HCFA has agreed to add OSCAR information on the scope and severity of each deficiency to its Web site by the end of July, and then the next step is to begin to group the deficiencies into related and meaningful categories.

The problem is, as Senator Breaux raised earlier, the enforcement actions, meaning the fines and the suspensions findings and other things, are not on the information system. Moreover, the findings from the complaint investigations are not on the Web site, and this has yet to be planned by HCFA. Finally, HCFA should add a short abstract of each violation to the Web site, much like the abstracts that Dr. Scanlon read to you this morning, because those would be more informative and valuable than simply a listing of the Federal deficiencies.

HCFA does plan to add new OSCAR information on facility characteristics to its Web site in July 1999. This would include the number of residents, the occupancy rates, and the ownership type. In July, HCFA has also agreed to add information about residents from the OSCAR information system. In other words, users would be able to select three facilities at a time to compare the resident characteristics, such as the percent of residents who have weight loss, physical restraints, and pressure sores.

By the year 2001, HCFA may replace the OSCAR resident information system with the 24 quality indicators that were developed by David Zimmerman at the University of Wisconsin. But, again, plans for this process have not been developed by HCFA entirely. So we hope that HCFA can speed up the process to put the quality indicators on the Web site before that time.

Finally, nurse staffing levels are critical indicators, and HCFA has agreed to add basic nurse staffing information to its Web site in July 1999. Three facilities would be able to be compared on their nursing minutes, and this will show the public that there are real

and substantial differences in the amount of care delivered by facilities. And I think this would be a very important step forward.

Turning now to the issue of accuracy and management of the information system, now that OSCAR is going on the Internet, HCFA must monitor the data to ensure accuracy and to prevent falsification of data. Currently, HCFA does not have extensive procedures to review and audit the OSCAR data. The staffing data, in particular, should be audited as a part of the regular surveys of facilities. Whenever poor staffing and poor quality of care is identified by State surveyors, the payroll records of those facilities should be examined. Penalties should be issued for inadequate staffing and for false and inaccurate data reporting.

At the present time, HCFA does not have an effective system for information management and monitoring of the OSCAR data. For the past 5 years, we have found duplicate facility records and errors in the total number of beds, residents, and staffing data. HCFA should give the OSCAR information system a top priority and allocate appropriate resources and management to ensure immediate improvement in the system.

Finally, a long-range plan is needed for the consumer information system. We suggest that five additional new data elements are needed for the information system. First, HCFA should require facilities to report staffing on a quarterly basis so that the staffing can be compared with the resident data to ensure that adequate services are provided.

Second, facility staff turnover rates should be reported and added to the system. Third, the average facility wages and benefits for different types of staff should be added to the Web site from the Medicare and Medicaid cost reports.

Fourth, consumers want to know how facilities spend their resources, especially since the average facility only spends 36 percent of its total dollars on nursing staff and it spends a shocking 27 percent on administrative costs. Key elements from the Medicare and Medicaid cost reports should be placed on the HCFA Web site. And, finally, the names of facility owners should be collected and made available on the HCFA Web site.

In closing, more information is needed about the quality of care so that we can ensure that good nursing home care is not a myth. Information is the first step in the quality improvement process so that all individuals in our Nation's nursing homes will have the right to a high quality of care, quality of life, and human dignity.

Thank you.

[The prepared statement of Ms. Harrington follows:]

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U.S. Senate Special Committee on Aging
Testimony Prepared By
Charlene Harrington, Ph.D.
June 30, 1999

My name is Charlene Harrington and I am a professor of nursing and sociology at the University of California, San Francisco, CA (UCSF). The focus of my remarks today will be on providing consumers with information about nursing homes as a strategy for improving quality. An Internet information system about nursing homes will allow consumers to make choices among the various nursing facilities and to obtain periodic information the quality of care in specific facilities. In the long run, having a consumer information system may encourage facilities to improve the quality of care they deliver in order to be more competitive. An Internet information system will bring poor quality into full public view so that the public will know what is going on behind the closed doors of the nation's nursing homes.

For the past five years, I have been developing a consumer information system for nursing homes, funded by the Agency for Health Care Policy & Research. My colleagues on this consumer information system project are Dr. Joseph Mullan at UCSF, Dr. David Zimmerman at the University of Wisconsin, and Sara Burger, Executive Director of the National Citizens' Coalition for Nursing Home Reform. My recommendations today are based on our research experience and findings from this project.

In July 1998, President Clinton and HCFA officials announced that they would provide a consumer information system on the Internet, as my colleagues and I have long proposed. We were extremely pleased that HCFA has expressed a willingness to develop such as system and we have been working with HCFA officials on an informal basis, using the HCFA On-Line Survey Certification and Reporting System (OSCAR) data.

Deficiency Information

In the fall of 1999, HCFA posted the information on federal deficiencies for each nursing home in the US on the Internet under www/Medicare.nursinghome.compare. This Web site information is very popular because it allows the public to call up information on any nursing home in the country to determine every facility's most recent violations of the federal survey and certification regulations. There are 185 federal standards on quality that each nursing home must meet. If a facility fails to meet one of these minimum federal standards, the state surveyors issue a deficiency.

State surveyors rate each deficiency by scope and severity using federal guidelines. HCFA has agreed to add the information about the scope and severity of deficiencies to its Web site system by July, 1999.

The next step in improving the deficiency information is to group the 185 deficiency standards into related and meaningful groups that are more easily understood by the public than a simple listing of all deficiencies. We have proposed that all the deficiencies should be presented under one of eight quality dimensions, based on a factor analysis of the deficiency data that Dr. Joe Mullan and I conducted at UCSF.[1] The first dimension, Quality of Care, includes standards that were all related to providing direct care to residents, for example, residents receiving necessary services to maintain their functional status, or receiving care for pressure sores. The next dimension, Mistreatment, includes standards that refer to behaviors associated with potential abuse, for example, using unnecessary restraints, or involuntary seclusion. The third dimension, Assessment, includes standards referring to facilities' procedures for accurate resident assessment, for example, making comprehensive assessments, and developing comprehensive care plans. The fourth dimension, Residents Rights, includes standards about protecting the right to privacy and confidentiality of personal and clinical

records and generally respecting the dignity of each resident. The fifth dimension, Environment, includes standards such as providing a safe, clean environment, or maintaining effective pest control programs. The sixth dimension, Nutrition, includes standards concerning nutritional policies, such as generally meeting nutritional needs, and providing attractive substitutes for residents who refuse food. The seventh dimension, Pharmacy, includes standards such as being free from use of unnecessary drugs and for providing pharmacy services to meet resident needs. The eighth dimension, Administrative, includes standards that refer to facility training and monitoring of staff, for example, proper maintenance of clinical records, and having regular meetings of a quality assurance committee. HCFA officials state that they plan to improve the presentation and grouping of the deficiency data in the year 2000 after the Y2K problems are resolved.

This information is important to the public because, tragically, many nursing homes do not meet these minimal standards according to the findings by state surveyors. One-fifth of the almost 16,000 nursing facilities received deficiencies for inadequate food sanitation and for the failure to conduct appropriate resident assessments and care plans in 1997.[2,3] 16 percent of facilities failed to prevent accidents and and 15 percent received deficiencies for improper care of pressure sores in 1997.[2,3] The average facility received 5 deficiencies, but some received as many as 175 deficiencies. It is unfortunate that most families and residents are generally unaware of the numbers of violations that facilities have received. The new HCFA information system makes the deficiency data more accessible to the public.

Enforcement Actions. Some violations are so severe that facilities receive fines for placing the health and safety of residents in jeopardy. In a recent example, when a nursing home resident developed a urinary infection with a high fever, the attending physician was not notified. The resident was finally admitted to a hospital intensive care, unconscious and in critical

condition, and died 3 days later. The state found that the nursing and medical care was negligent and that death was entirely preventable. The state must report the specific enforcement actions that it will take against facilities that have violations of the standards such as civil monetary penalties, suspension of admissions, and decertification.

HCFA has not made the information on civil monetary penalties and other enforcement actions available to the public on its information system. In part, states have not been systematic in reporting the enforcement actions. HCFA is trying to ensure that states are fully reporting the enforcement actions in a systematic way, but this reporting is not yet satisfactory to HCFA. **HCFA should add all enforcement actions for each facility to its HCFA Web site information system as soon as possible,**

Complaint Information. Another concern has been that states have not been systematically investigating complaints about quality. Not only has the investigation of complaints been poor, but the complaint survey reports have not been systematically entered into the OSCAR information system. HCFA reported a new initiative for state agencies to improve the complaint investigation process in March,1999, and HCFA is now requiring states to improve the reporting of complaint investigations. **Within the coming year, HCFA should include the information on complaint investigations on its consumer information system Web site for all nursing homes.**

Facility Characteristics

HCFA plans to add new information on facility characteristics to its consumer information system Web site by the end of July 1999. Consumers will be able to select and compare data from 3 facilities at a time with state and national averages. **The information should include the name and location of each facility, plus its number of beds, number of residents, average occupancy rate, ownership type (nonprofit, for-profit, or government),**

whether it is part of a chain, payer sources (Medicare and Medicaid), and whether it has resident and/or family councils. These are all important basic facts that consumers need to know about nursing facilities.

Resident Conditions.

HCFA has agreed to add information about residents from OSCAR to its Web site information system at the end of July 1999. **Facilities should be compared on resident characteristics including: the percent of residents who are very dependent or are bedfast (in bed most of the time) and those who have contractures, weight loss, tube feedings, physical restraints, pressure sores, bladder or bowel incontinence, catheters, behavioral problems, and psychotropic drugs.** We have created a text description for each specific resident condition to be presented on the HCFA Web site that will explain each resident condition in plain English.

The OSCAR data show that half of nursing home residents are incontinent and almost half are placed on psychotropic drugs that often serve as chemical restraints to keep residents quiet.[2,3] Most residents are unable to bathe, dress and feed themselves. Many residents have contractures (immobile joints from lack of movement) and pressure ulcers (from unrelieved pressure on the skin). Many have lost weight and some residents are given tube feedings. Good nursing care could prevent and/or reduce most of these widespread problems in nursing homes.

Surprisingly, facilities often vary dramatically in the way they treat residents. In California, only 28% of the 1,400 California nursing homes had 10 percent or less of residents in physical restraints, while many facilities had 25-90 percent or more of residents in restraints in 1997.[3] The information system will show these differences in resident conditions across facilities.

By the Year 2001, HCFA plans to replace the OSCAR resident information with information from the Quality Indicators (QIs) developed by the University of Wisconsin.[4] The 24 QIs are based upon individual resident information collected from the resident assessments that use the Minimum Data Set form. Validation studies were conducted on the QI's and they were found to be reliable and stable. These 24 QI's cover 11 domains of care:

1. Accidents
2. Behavioral & Emotional Patterns
3. Clinical Management
4. Cognitive Functioning
5. Elimination & Continence
6. Infection Control
7. Nutrition & Eating
8. Physical Functioning
9. Psychotropic Drug Use
10. Quality of Life
11. Skin Care

The QI's for each facility will be reported to each state for use in the state survey process as of July 1,1999. State surveyors will evaluate those facilities that have poor quality indicators to determine whether the federal quality standards are being met. Software has recently been deployed, which will enable all survey agencies and nursing homes in the country to run Quality Indicators reports at both the facility and resident levels. The QI's are also being used in internal quality improvement efforts at more than 1000 facilities across the nation. All that remains is the incorporation of the QI's into a consumer information system, but HCFA officials report that they do not expect to finalize this step until the year 2001. **HCFA should speed up this process to provide the summary Quality Indicator information for each facility on its Web site to the public next year.**

Nurse Staffing Information

We believe that nurse staffing levels are a critical quality indicator and HCFA has agreed. HCFA plans to put the basic staffing information on the system by July 1999. The nurse staffing information on the Web will compare different types of nursing hours per resident day and total nursing hours. This will show that there are real differences across facilities and that this can translate into very different outcomes for residents. To help users maximize the use of the Internet information, specific questions have been developed that users can ask of nursing home staff, residents, and family members.

Our UCSF studies were the first to examine nurse staffing, using the national OSCAR data for all US nursing homes. The average RN time (including nurse administrators) was 42 minutes per resident day, LPN/LVN time was 42 minutes, and nursing assistant time was 126 minutes in 1997.[4,6] Total average nurse staffing time was 210 minutes or 3.5 hours per resident day in 1997. In other words, there is only 1 RN and 1 LVN for every 34 residents and 1 nursing assistant for every 12 residents per day in the US.[4,6] If you consider how long it takes to assist individuals with bathing, dressing, eating, toileting, walking, and taking medications, it becomes apparent that the average staff time may not be sufficient to provide good nursing care.

Wide disparities in nurse staffing levels have been found for different types of facilities. Hospital-based nursing homes and skilled nursing facilities that take only Medicare residents have twice as much nursing staff as other facilities. Smaller facilities, non-profit, governmental, and non-chain facilities have significantly higher staffing than their comparison groups.[4,6,7] Moreover, some facilities have dangerously low staffing. Twelve percent of US nursing homes had only 1 and 2.5 hours of nursing staff per resident day compared to the national average of 3.5 hours of staff.[8] These data are essential to a consumer information system.

Unfortunately, the OSCAR staffing data are only collected for a two-week time period during the annual survey by state surveyors. Facilities may increase their staffing during the survey, compared with other times of the year, in order to improve facility performance on the survey. **HCFA should require facilities to report staffing data on a quarterly basis at the same time the facilities report their resident assessment data on the Minimum Data Set. The staffing should be reported for each 24- hour period during the quarter.** The principal rationale is that Medicare is paying nursing facilities based on staff resource requirements to provide care to residents in 44 different categories based on resident characteristics. Since the payment rates are based on staffing, the staffing data are needed to ensure that the services are provided by facilities. Without staffing data, facilities can take advantage of the payment rates without paying for staff to provide the care that is needed. This is an urgent matter that should be addressed by HCFA to ensure that care is provided.

ACCURACY

Information systems must be monitored to ensure accuracy and to prevent errors or falsification of data. Currently, the OSCAR staffing data are not reviewed or audited by the state surveyors. **The staffing data should be audited as a part of the regular state surveys of facilities. Whenever there are reports of low staffing or poor quality of care, state surveyors should examine the payroll records of facilities for different time periods prior to the survey, with special attention to staffing on evenings, nights, and holidays.** This would allow surveyors to determine whether the facility had sufficient staffing to provide care to its residents and whether the staffing data were reported accurately. **HCFA should issue penalties for false and inaccurate OSCAR data to encourage greater accuracy.**

INFORMATION MANAGEMENT AND MONITORING

At the present time, HCFA does not have an effective system for information management and monitoring of the OSCAR data system. Having used the OSCAR data from 1991-1998, we have found many problems with the data set. The OSCAR data include duplicate facility records and many errors in the total number of beds, the total number of facilities, and the staffing data. Some of these errors can be attributed to facility staff confusion about the instructions for completing the data while other errors.may simply be reporting and data entry errors. These problems have been repeatedly pointed out to HCFA over the past five years by myself and other users of the data systems but corrections have not been made.

When facility reports are collected by the surveyors during the annual survey, the surveyors should review the information before entering the data into the OSCAR system, but obviously this does not happen consistently. Once information is entered into the OSCAR system, the state data managers should identify errors and ask facilities to make timely corrections but this is also apparently not done on a systematic basis. The OSCAR data are sent by the state licensing and certification program to the HCFA regional offices and to the HCFA central office. While HCFA staff ensure that the data are computerized, the editing process is not effective in identifying and correcting errors. HCFA has yet to invest in adequate data management and oversight of the OSCAR information system.

HCFA officials state that they plan to revamp and modernize the OSCAR information system in the next few years. Although this is an important step forward, immediate improvement in the day to day management of the data system is needed now that the information is being put on the HCFA Web site.

HCFA may have been unable to develop a system for managing and monitoring its OSCAR system because of lack of resources and because the information system has a low

priority. **HCFA should give the information system a top priority and that the appropriate resources and management should be allocated to ensure immediate improvement in the OSCAR system.**

NEW DATA ELEMENTS NEEDED

In order to make a better consumer information system, new data elements need to be added. In addition to the new staffing data discussed above, I recommend the collection of new data on staff turnover and stability rates, wages and benefits, facility cost data, and ownership data.

Staff Turnover and Stability Rates. Not surprisingly, the average annual turnover rates are 50 to over 100 percent in nursing homes across the US.[9] The 1996 Institute of Medicine report on nurse staffing reviewed the literature on labor shortages and the unstable labor pool for long-term care and the factors contributing to these problems.[10] In addition to overall staff turnover rates, the length of time of employment is also important. A very high turnover rate among a small percentage of employees is less likely to be a problem than moderately higher turnover rates for a large percentage of employees. High turnover rates of administrators and key supervisory personnel are worrisome given the concerns about the caregiving workforce and the vulnerability of many of those receiving long-term care. **HCFA should require facilities to report data on turnover rates for the different types of staff categories (i.e. administrators, registered nurses, and nursing assistants) as a part of the quarterly staffing reports.** Such information should then be included in a consumer information system.

Wages and Benefits. In the long run, the quality and stability of the nursing home workforce will not be resolved, however, until wages and benefits and working conditions are improved. Wages in nursing homes are 15 percent lower than those in acute care settings and many staff have no health care benefits. The average wages are $6.94 per hour, which is less than

the federal poverty level and less than workers make in the fast food industry and casinos.[9] High wages and benefits build morale and institutional loyalty, so a facility can have excellent staff that will remain for many years. **The average staff wages and benefits in each facility are important quality indicators and we recommend that wage and benefit data be added to the HCFA consumer information next year. Wage and benefit data should be obtained from Medicare and Medicaid cost reports.**

Facility Cost Information

One important question for consumers is how do facilities spend their resources. Only 36 percent of total US nursing home dollars are spent on nursing staff, 16 percent for indirect care (food and housekeeping) and 3 percent for therapy services.[11] Administrative costs account for a shocking 27 percent of operating expenses.[12] On top of these expenses, many nursing homes have been highly profitable. This explains why some corporate nursing homes are able to have their own jets, the best lobbyists, and the best lawyers available.

The public has a right to know the financial status of the nursing home where their loved ones live or are considering living. This information is available in the Medicare and Medicaid cost reports. **HCFA should require that the Medicaid cost reports be standardized and computerized and HCFA should make key elements from the Medicare and Medicaid cost reports available to the public on the HCFA Web site.**

Ownership

Finally, 66 percent of the US nursing homes are for-profit, and most of those are publicly-traded corporations.[3] Consumers need to know the owners of the nursing home corporations and if they are a part of a nursing home chain. Some chains have poor reputations while others have reputations for high quality of care. At the present time, the public does not have a source of information about the owners and operators of facilities. Moreover, HCFA

itself is unable to track nursing home chains within or across states. If each facility were require to report the name of its parent corporation(s) and its major owners, this would be a big step forward to making companies more accountable for meeting the federal standards of care. **The names of all nursing home owners should be collected and made available on the HCFA Web site.**

SUMMARY

In closing, the nation's elderly and those with disabilities deserve our respect and honor. They deserve to lead happy and peaceful lives. And they deserve to die touched by kind hands and compassionate words. Information is needed about the quality of nursing home care. This work must continue so that we can ensure that good nursing home care is not a myth. Information is a first step in the quality improvement process. All those individuals in our nation's nursing homes have the right to a high quality of care and a high quality of life and human dignity.

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The CHAIRMAN. Senator Kohl has to go. I thank him very much for being a very active member of this committee and appreciate the fact that he was able to stay to hear the testimony.

I have quite a few questions. We may not get to all of them, but before I start what I had prepared as a result of your submitted testimony, Dr. Harrington, next year you said they are going to start having staffing information on these sites, right?

Ms. HARRINGTON. Yes, this summer, hopefully.

The CHAIRMAN. This summer. In regard to that, I hope that includes what I refer to in my statement as certified nursing assistants. Would it be that level?

Ms. HARRINGTON. Yes. It would include the number of minutes for RNs, LVNs, and nursing assistants.

The CHAIRMAN. The reason I stress that is because it is at the certified nurse assistant level, or what it might be called in other States something else, that quality of care problems arise. I think this was shown as a result of our hearing last summer. And it seemed like the elementary-type care of making sure that people get enough water not to dehydrate, enough food not to die of malnutrition, not the quality of food, but getting probably very good food into the body, and also the turning, is where we want to place attention. At least I as Chair of this committee want to place some attention and consideration by inspectors, by HCFA, and by the nursing home industry, to place emphasis on this, it seems to me, if we are going to get the horror stories of last summer corrected.

So I think, then, that this sort of information is probably as far as I am concerned—and I am looking at it as a political leader and not as an expert in the area, but where essential information to know that elementary-type care to eliminate the horror stories is going to be available to compare one nursing home with another. Is that the result?

Ms. HARRINGTON. Yes.

The CHAIRMAN. Or that is the result you hope for?

Ms. HARRINGTON. Yes, it is.

The CHAIRMAN. I would like to start with Dr. Zimmerman, if I could. You testified that successful deployment of new practices like quality indicators require considerable effort in the area of training and constant effectiveness monitoring. Could you give us some examples of what should be looked for in HCFA's implementation plan in these areas?

Mr. ZIMMERMAN. Certainly, Senator. I think that, first of all, one of the things that we should be looking for is a continuation of the commitment that HCFA has already made to the training that will be provided to surveyors. I believe that Rachel Block had talked about the increase in training funds and the increase in training resources and activity with respect to the new survey process changes, and those include the quality indicators.

There has been training of individuals in the State survey agencies who will, in turn, train those specific surveyors in those agencies. And there has been some training of some individuals in facilities through a cooperative effort of HCFA and the two major nursing home associations.

What we don't know yet and I think we need to make sure happens is how well or if this training that has been provided to the

trainers, if you will, will be translated into more specific training and detailed training to the actual surveyors who are going to be on the front line. This is something that each State will have to be responsible for. Certainly, it will be important for us to monitor the extent to which this occurs and to be, I believe, very quick to move in if, in fact, it looks like an inadequate job is being done in that area.

After the training, when the quality indicators are actually being used in the survey process, it will be important to monitor how that process is taking place, whether or not the specific use of the indicators is being undertaken as planned and whether or not the indicators are being used onsite and whether they are, in fact, helping to perform their stated function, which is to identify, going in, whether there are problems in particular areas of care, whether there are residents that might be good candidates for the investigation process in order to look at this at the resident level, as well as to document care problems when they are found.

So I think that the two most important areas will be in the provision of the next step of training, the first step already having been provided, and second that we make sure that we monitor diligently and carefully that the implementation process is occurring as we planned it to occur.

The CHAIRMAN. You testified that the litmus test of HCFA's commitment to follow through on implementing the use of quality indicators would be revealed by continued training, adequate monitoring efforts, ensuring that all relevant constituencies are integrally involved in the effort, and making necessary refinements in the process. Has anyone at HCFA shown you how this support will be provided over time?

Mr. ZIMMERMAN. Well, we have talked probably in most detail with our two project officers on the project that Dr. Kramer has discussed, and the two project officers, Karen Schoeneman and Susan Nannemaker, have had conversations with us. We have talked about what we think is necessary as the next step.

The relationship between the project activities and the program effort is something that we believe needs to be worked out in more detail. I do think that one encouraging sign is that unlike the situation that occurred in the demonstration to which I referred previously, there is a closer relationship now structurally in HCFA between the project staff who is actually undertaking some of these initiatives and the program staff who is responsible for carrying them out ultimately.

So we have had general conversations about what will be needed in each one of these areas—the next steps in training, diligent monitoring, and making sure that the constituencies are integrally involved in the effort. The specific details, I believe, still have to be worked out, and we certainly are prepared to talk with them in detail about doing that.

The CHAIRMAN. Dr. Kramer, as you indicated, you testified here last July, and you have been involved in this survey development for a long period of time. You testified about the quality problems at the California nursing homes last year. In that testimony, you based your statement on the results developed by a more thorough survey process.

Today, you are testifying about the same survey process, except now it is part of the Nursing Home Initiative. And you need to be congratulated for that, producing a survey system that delivers what you depicted here on Chart 3 would solve many problems that have plagued us. What are the benefits of the new system?

Dr. KRAMER. I would say there are really four major benefits. First is in terms of comprehensiveness. The system would assure that all quality indicators and all quality of care domains are included in the survey, no matter who is conducting the survey.

The second benefit is that it would standardize the process. The approach among surveyors and across facilities in terms of sampling and all of the things listed in that chart would be standardized.

Third would be accuracy. You would have greater ability to detect problems, or sensitivity, and more accurate detection. And fourth, I would hope with that you would have more successful enforcement because you would have a more uniform and accurate profile of the facility.

The CHAIRMAN. We always hear from nursing home operators complaints that surveyors exercise too much discretion and can be too subjective when they look for non-compliance. And we have heard complaints also from residents, and we probably hear from their relatives more often, that surveys miss even serious problems.

If properly used, your system is intended to ensure consistent application of the right criteria by surveyors which would reduce, if not eliminate, the problems that I have described here. How does your survey accomplish that?

Dr. KRAMER. Well, frankly, surveyors have a very tough job. There are large amounts of information that must be collected and synthesized onsite, and you can only provide so much information to them offsite in preparation for that. Changing surveyor's behavior by giving them more information the MPS to incorporate in the process will to not get surveyors approach it differently and conduct things in a more systematic, comprehensive way.

I can't promise that we would eliminate all those complaints and inconsistencies, but through standardizing all aspects of the process, providing, more directives as to how the sample will be drawn and structuring the process using automation and a very clear system of steps, you can minimize the subjective portion of the survey. And that is really what the goal is.

Just as in medical practice where the routine things that a physician can readily decide based on and simple decision rules, you want to systemitizey so that they can focus on the issues that require subjectivity. That is what would happen in this kind of a process.

The CHAIRMAN. Dr. Kramer, do you know who at HCFA is the central manager for this survey redesign effort and what his or her title is?

Dr. KRAMER. Well, the answer is two-fold, I guess. I certainly know who our project officers are. Dr. Zimmerman mentioned their names, Karen Schoeneman and Sue Nannemaker. So we know who our contract officers and project officers are. I am afraid I don't know who in HCFA is overseeing this major effort to make this long-term change. There seem to be a lot of players involved and

it is unclear who sees it as their responsibility to make the longer-term change.

The CHAIRMAN. And you see that as a weakness for the success of the change?

Dr. KRAMER. Yes, I do. I think that this requires a major concerted effort, with long-term planning. Again, as Ms. Morris mentioned in relation to the States being informed about what is going on, this kind of a change has to take place over a couple years. And somebody at a very high level within HCFA has to say, OK, I am going to see this as my responsibility and develop a strategic plan, be pushing this more concerted effort and this major change throughout the organization. Currently, there are so many different initiatives going on, I am afraid that in the short-term fray, the longer-term objectives may be getting lost.

The CHAIRMAN. This is probably a very important point that I should take a personal interest in, maybe, because one of the keys to getting things done is to make sure that responsibility is pinpointed. And I don't have the power to make sure that that happens, but I think congressional oversight is very important in this area so that we know who is responsible for success or failure.

If I could continue, this new survey system which you and Dr. Zimmerman are helping HCFA with is in the early stages of development, but is supposed to be ready for implementation by the end of 2000. That sounds like a very aggressive schedule for a large project.

You also show in chart number 4 what is necessary for reaching the objectives successfully. Are you saying that these items on your chart have not yet happened? Do you think the redesign of the survey system will succeed if these steps are not taken?

Dr. KRAMER. Let me first say that, yes, it is very aggressive when you consider the magnitude of the change. And I don't believe that these items on chart 4 have really taken place yet. Again, what I had mentioned before—what that means is there hasn't been a longer-range plan for getting this process implemented.

I am not sure Ms. Morris, who seemed very well-informed, even knows much about the longer-term plans. And she pointed out how much they are lacking in terms of a 2-year plan and a 3-year plan and a 5-year plan. The purchasing of laptops—the States have to be prepared to do that. There is a lot that could be moving that will require time to unfold. I don't think it will succeed if such a strategic approach is not taken.

The CHAIRMAN. You stated that strategic planning must begin now for the individuals, groups and resources that are needed to pull off this very great change in the system. Are you saying that such a plan does not exist or that it has not been shared with you?

Dr. KRAMER. Again, on this point we have had informal discussions about the kinds or things that need to be done. Helene Fredeking has been very involved in those discussions. Yet, I have not seen a strategic plan that says these are the methodical steps that we need to go through to make sure we get there. I would presume if there was such a plan, I would be involved in it, given my role.

The CHAIRMAN. I would like to go to Dr. Harrington, if I could. HCFA's initiative to place more consumer information about nurs-

ing homes on the Internet is very useful, as I have already indicated today, and as I have even complimented you for your involvement in it.

You said in your testimony HCFA plans to replace the current OSCAR resident information set with the comprehensive quality indicators, but not until 2001. First, would a consumer be able to understand the quality indicators, as you understand these? Second, what reasons has HCFA given for the 2001 target for incorporating the quality indicators into the consumer information system? And, third, will the quality indicators have been in wide enough use for them to generate consumer information?

Ms. HARRINGTON. Well, we hope that HCFA will put the quality indicators on the Web site, but that is not entirely clear. But it seems that they would be able to be understood because they would be a summary of the resident indicators for a facility as a whole. And I think guidelines can be developed that would help explain the quality indicators to a consumer.

And in the long run, these quality indicators are probably the most important way to measure the quality outcomes so that we could really tell if the quality of care is improving. As you asked earlier, how will we know if quality is improving? And I think having the quality indicators available to the public will help us know that. So I do think it will work and it would be a very important step forward.

The CHAIRMAN. You said you don't know whether they will be on the Web. You mean——

Ms. HARRINGTON. Well, we are hoping that they would put them on the HCFA Web site for each facility.

The CHAIRMAN. In other words, is it a policy dispute, do you think, at this point whether they will be, or you just don't know whether they are going to be?

Ms. HARRINGTON. I don't know that they have decided if it is going to be on the Web, and I don't know if it is part of the long-range plan.

The CHAIRMAN. What would be a potential reason they shouldn't be on the Web?

Ms. HARRINGTON. Well, I think the main reason they have given is the resource question, whether they have sufficient resources to get it done.

The CHAIRMAN. Well, then that is something for Congress to consider if it is important enough that they ought to have the resources to get it on, or that they ought to redistribute resources if it is important enough.

Ms. HARRINGTON. Yes.

The CHAIRMAN. Your judgment is that they ought to have the resources to put the information there, I assume.

Ms. HARRINGTON. Yes, I think it should be a top priority.

The CHAIRMAN. You testified that HCFA has agreed to put basic nursing home staffing information on the consumer Web site. Many experts believe that staffing is a critical factor contributing to quality of care, and I have indicated before in questioning you today that this is a very good idea.

But would you explain further the point you raised in your testimony about why using OSCAR staffing data may not present an

accurate staffing picture in nursing homes, because I think comparative information is very important?

Ms. HARRINGTON. Yes. The OSCAR staffing data are collected for a 2-week period at the time of the survey, and so there is a lot of concern that facilities increase their staff when they know they are being inspected. So that 2-week time period may not be representative of the rest of the year. So that is why we are asking that HCFA change its requirements and require facilities to report their staffing each quarter for the entire quarter and to impose penalties if the staffing data are not accurate, because right now if they are not accurate, nothing happens to the facility.

The other thing is we think that most facilities probably report fairly accurately, but we know there are errors. And we want a strong commitment from HCFA to immediately concentrate on improving the accuracy of the nurse staffing data. So that would require the surveyors when they receive the staffing information during the survey process to check these reports.

So if a facility reports that they have no nurses or one nurse, either they should be investigating this problem immediately or it is inaccurate data. Or if they report that they have ten times the amount of nurses that you would expect, then the surveyors need to make sure the facilities correct the data. So if there is no audit process, we can't be assured of the accuracy. So that needs to be a priority.

The CHAIRMAN. Maybe along this same line, I wanted to ask you about the management information system that is supposed to be in place by 2002 that is going to link nursing homes with other quality-related data bases. You stated in your testimony that at present HCFA does not have an effective system of information management and monitoring. Does this mean that the consumer information that will be available between now and that date will be of dubious value?

Ms. HARRINGTON. Well, I think that it is good that HCFA is committed to improving their management information system, but we think in the meantime HCFA needs to give immediate attention to improving the quality of the current data because if the current data is not accurate, what is to make you think a new system would be more accurate?

So the issues around accuracy are not rocket science; they just require special attention by the surveyors and then people all the way up the line and then to have someone that is in charge that is responsible for this system and making sure that it is an accurate and reliable system.

The CHAIRMAN. Now, I have asked all the questions that I am going to ask orally. I may ask some in writing. Senator Breaux I don't think will be able to come back because he was called by his floor leader to go over and have a meeting on an issue that he is involved with.

So I am going to just say since I asked each one of you separate questions, but I didn't take the time to get comment from every one of you, if there is any one question that I asked of a specific individual that anybody else was waiting to comment on, I would invite your comment now and ask that you refer to the question that you wanted to give your side of.

Mr. ZIMMERMAN. Well, the only comment that I would add would be to the response that Dr. Harrington just gave on the information that will be going on the Web site. I think that with respect to the quality indicators, there are two things that are important here. First of all, the consumers should be able to understand the quality indicators because I presume that if they are going to be put on the Web site that we would be doing the same thing with those that we are trying to do with respect to the OSCAR information, and that is to provide some background and context so they can understand what the indicators are and how they should be viewed.

Second, I think it is important to remember that we are not just talking about the MDS indicators that exist right now. As Dr. Kramer has discussed, in terms of our work to provide more structure and more information to the survey process in general, we will be generating onsite indicators as part of the survey process. And presumably those indicators will also find their way into either the quality indicator system or the OSCAR system, and ultimately they can be put on the Web site as well. So I think that as we expand the amount of information, we are going to be able to provide better information to people, to consumers making the selection.

Last, I think the issue is not simply providing information that individuals can use to make the selection of a nursing facility. In some cases, they are very constrained in that choice. But I believe that it will be important to continue to show information about the facility so that they will be able to monitor the care on their own in that facility once their loved one is there.

The CHAIRMAN. Yes, and because maybe they made a misjudgment in the first place as well.

Yes, Dr. Kramer.

Dr. KRAMER. If I might add, on this discussion of the quality indicators and putting them on the Web site, one of the dilemmas is the way the quality indicators are currently developed is they are based on the MDS information that facilities report. So this is information that providers report on residents, and the system by which the accuracy of this information is then assured not yet in place.

Now, when the University of Wisconsin team goes in and does a survey, they verify the information and they use it in the survey process. They therefore are able to validate to some extent whether, in fact, quality problems are reported. If what you do is you just make quality indicator data available on the Web site, and what you are making available is information reported by facilities, frankly you don't know what you are getting until you have examined its accuracy.

We have been to sites where people have called pressure sores "abrasions," and they don't show up as pressure sores. They get a low pressure sore rate. They have rampant pressure sores, but they call them abrasions. I mean, those kinds of problems can exist, and until you have validation you can't detect them. Now, I should mention HCFA has a contract that we are involved in that is going to develop systems for assuring the quality of the MDS information. But the implementation of such system is at least a year away.

As David just referred to as well, when you use those indicators in the survey process, you have the opportunity to verify them and maybe the verified indicators may go on there. But you have to be a little careful putting provider-reported information on quality on there as the basis for people to make decisions, and I think we need to be cautious about that.

The CHAIRMAN. Dr. Harrington.

Ms. HARRINGTON. Yes. I just want to thank you for your support and for having the hearings and considering that information is a very important and valuable thing to have developed.

The CHAIRMAN. Well, obviously you deserve a thank you from me and the committee for not only participating today, but being involved in this over a long period of time. And I suppose in each instance it is probably your life's work and we don't even appreciate the amount of time you put into it.

I would say just in kind of summation I think as a result of today's hearing, obviously it begs that we continue to monitor this as a committee and continue to be involved in encouraging HCFA. And I suppose that it is difficult to draw definitive views, even though it is 1 year away from the scary story we had presented to us last July, because today we had both good news and bad news, and I suppose you folks and your testimony is an example of the good news.

The quality indicators are going to be, we hope, a real asset in making high-quality care the norm in nursing homes. The redesigned survey system, we hope, will allow an accurate assessment of care quality so that all facilities are measured constantly and consistently with the same quality yardstick. Better consumer information coming online is good news, and still greater improvement can be made so that people can make better-informed decisions about which nursing home is best for them, and as Dr. Zimmerman said, whether you want to continue to keep your friend or relative there.

HCFA is to be congratulated for mounting the initiatives. I urge them to continue forward with them until they are successfully completed, and particularly, as I exchanged with Dr. Kramer, to have a point of responsibility and a focal point higher up the chain of who is responsible.

The news from panel one is not as good. HCFA staff have worked hard to complete a number of initiatives. They continue to develop others. So far, the initiatives that HCFA designates as complete and on which the GAO reported today seem to me to be, as I indicated, a mixed bag.

Some States are implementing the requirement to investigate complaints within 10 days. Others aren't, and they plead that the reason that they aren't is they have resource constraints. Ten States that the GAO looked at are implementing the requirement to initiate surveys evenings and on weekends, but the General Accounting Office still argues that this requirement does not lead to the surprise inspections that their recommendation was designed to achieve. Apparently, little has been achieved by the initiative designed to increase the scrutiny of the "bad apple" facilities.

Throughout the hearing, GAO tells us that HCFA is not consistently monitoring State implementation. Many other initiatives are

underway, and we hope that many will succeed, but the initiatives reviewed today indicate that some of the old habits die hard. The old habits of not clearly defining what you want to achieve, following through to attain your goals, taking steps to find out whether those goals are achieved or not, and then making needed corrections so that the results that we actually get are the results that we want—all these seem to be in evidence in the initiatives that GAO reviewed for us today.

If these old habits are not broken, then it seems to me that the Nursing Home Initiative could join the ranks of other failed efforts to make all nursing homes an environment appropriate for elderly Americans. I reviewed this history of that in my opening statement and I don't want this committee to be responsible for that same environment as we might look back on the year 1999 10 years from now, for instance.

I believe that the HCFA leadership and HCFA are completely committed to the Nursing Home Initiative. I sense that not only in testimony today, but over a year of conversation with their top directors including their administrative. I applaud them for the progress that they have made to date, but I believe that the General Accounting Office report, the statement of our representative of the State surveyor organizations, and the statements of our other three witnesses should indicate to that same HCFA leadership and staff that they cannot flag in their efforts.

A year after the Nursing Home Initiative began, we cannot say that it has yet led to improvements in the quality of care in nursing homes. Perhaps a year is required for these initiatives to be put in place, after all, the United States being the big country it is and we are 50 very diverse States. But the Initiative to date, although much has been achieved, seems to display a certain lack of traction at the regional office and at the State level.

I had some questions on this that I didn't have time to bring out, but neither I nor HCFA leadership and staff want HCFA representatives to go back before this committee next year hearing from the General Accounting Office that these initiatives have not had a positive effect on the quality of care in nursing facilities.

For my part, as Chairman, I intend to have the General Accounting Office maintain its careful, watchful eye over the Nursing Home Initiative. I will also be discussing with the General Accounting Office a number of other efforts which would focus on some of the most important remaining work of the Nursing Home Initiative.

I intend to talk to the HCFA Administrator about these implementation problems and find out what she intends to do about them. I believe that she and all those working on the Nursing Home Initiative want this effort to succeed. I believe that sincerely. They are very serious about making it work.

It has been a year since this effort to address quality of care issues began. When you are very busy, as the people involved with the Nursing Home Initiative are, maybe a year does not seem like a very long time at all to them. However, if you are a nursing home resident suffering from neglect—and we had some of that neglect described by the General Accounting Office—and in physical pain and torment, a day is an eternity, without thinking of a year. So

we should remember that fact. In 6 months' time, we want to see concrete proof that quality of care problems are being solved.

I thank you all for your interest, and we will keep in touch with you. The meeting is adjourned.

[Whereupon, at 12:37 p.m., the committee was adjourned.]

APPENDIX

RACHEL BLOCKS RESPONSES TO SENATOR GRASSLEY QUESTIONS

Question. HCFA has directed the states to start 10 percent of their surveys on evenings or weekends in order to make the surveys less predictable. What measures are you using to determine if this action is actually making the surveys less predictable and surprise is being achieved?

Answer. Our plan is two fold. First we will analyze the first year's data to see if at least 10 percent of all nursing home surveys have been started off hours. Second, we will poll ombudsman and others on their experience with the predictability of nursing home surveys. We will do both steps after we've had at least a year's worth of data and expect to report on this next Spring.

Question. HCFA has issued interim and optional guidance to the states to refer nursing homes with actual harm deficiencies for sanctions if the nursing home is part of a chain that has other homes with poor performance records. However, identifying corporate ownership is something HCFA estimates will take several years to track. How will this initiative be meaningful if identifying corporate affiliation is years away?

Answer. We are letting a contract to track chain ownership. We expect that we will receive a quarterly report on chain ownership/affiliation of individual facilities that we will or can share with the States, beginning in December 1999.

Question. Targeting poor performing homes for greater scrutiny is an effort supported by three initiatives: (1) identifying two special focus facilities in each state, (2) redefining poor performing facilities (for now at the two consecutive H-level citations but moving in September to two consecutive G-level citations), and (3) focusing on poor performing chains. However, the GAO finds that these efforts, currently, are not subjecting problem nursing homes to scrutiny. Is this effort truly addressing the need for reviews of a larger number of more substandard facilities?

Answer. Once fully implemented, we do expect that these initiatives will focus more attention on the facilities rendering the poorest care and provide us with more data to demonstrate their impact. The Special Focus Facilities, designated in January, have had one survey conducted under the more frequent survey and visit protocol. The second effort, redefining facilities where remedies would be imposed immediately, will be implemented in September. The third effort, focusing on poor performing chains, is in development.

Question. The GAO found that state compliance with the directives HCFA has issued to implement the Nursing Home Initiatives has been spotty. How is HCFA ensuring that states comply with the directives? Will HCFA rank the states according to their successful implementation?

Answer. We are working with our regional offices to increase the accountability of each State. We are developing State performance measures which will correlate with the requirements in our contract with States (the 1864 Agreement). We will determine how well States meet these performance measures through the Federal Oversight and Surveillance Survey (FOSS). If States fail to meet these performance measures, we will take a variety of actions ranging from technical assistance to terminating the agreement with the State in part or in total. States will be evaluated against the performance measures and not in comparison to other States.

Question. The Committee heard testimony that resource constraints in the states have impeded the timely implementation of the Nursing Home Initiatives. Can we infer from this that the states capacity to implement an initiative were not accounted for by HCFA before the implementation order was given? What action is HCFA taking to determine if resource constraints are in fact a problem, and how will HCFA address the resource barriers to implementation?

Answer. We estimated the costs and resources required to implement the nursing home initiative and quickly allocated the necessary resources. But, the allocation of dollars is the first step in the implementation process. We understood there would

be some constraints and problems in getting the needed resources into place at the State level and doing the work. For example, States need considerable lead time to hire and train quality professionals. Many States had personnel ceilings that could not be surpassed unless approved by a convened State legislature or the governor. Many State legislatures had adjourned (some meet every 2 years) or the budgets for FY 1999 (State fiscal year calendars often differ from the U.S. fiscal year) has been established by the time the Nursing Home Initiative was approved so that additional Medicaid State matching funds could not be requested, or Federal Medicare funds appropriated by some States.

We also have faced additional challenges in allocating new survey and certification monies in the middle of a fiscal year. It takes time for States to get matching funds approved and to recruit, hire, and train staff.

Despite these obstacles, HCFA and the States have made progress in implementing the nursing home initiative. We have addressed out-year Federal budgets with the hope that Federal resources requested are adequate to the tasks at hand and can thus be viewed by the State Legislatures as a strong and continuous funding stream for these initiatives at both State and Federal levels. In our budget call letters, we have asked the States to report FY 2000 and 2001 resource requirements to address each provision of the nursing home initiative.

We also appreciate the efforts made by you, Senator Breaux and the Committee in securing additional funds to perform various functions within the nursing home initiative.

Question. The GAO received information from states that some Nursing Home Initiatives will require an increase in surveyor activity. Given that this increased workload will have to be accommodated by the existing surveyor workforce, how will states be guided by HCFA in making the "trade-off" between the existing survey requirements and the new requirements of the Nursing Home Initiatives?

Answer. We are working with the States to identify the balance between existing nursing home survey requirements and the new nursing home initiatives in a way that does not jeopardize the health and safety of the nursing home resident or violate statutory mandates.

However, many, if not most of the initiatives, do not lend themselves to "trade-offs" with other survey and certification processes and protocols. Some, like the redefinition (and eventual elimination) of the term "poor performer" streamline the process. Major resource savings are not contained in these changes.

We have formed a workgroup with State Agencies to identify ways to streamline the enforcement process. The workgroup has already identified several ways in which to do so. For example, we eliminated several non essential requirements related to developing and approving plans of corrections.

We are continuing to work together to identify other ways to do the work required with current staffing and resource constraints.

Question. The GAO described HCFA regional offices monitoring of the Nursing Home Initiatives as uneven. Has HCFA given guidance to its regional offices to ensure their timely and accurate review of state implementation? What reports from the regional offices are required to be submitted to the HCFA central office so you can develop an overall assessment of the status of the implementation efforts?

Answer. We have provided guidance to our regional offices through our regularly scheduled meetings and the workgroups. We are also establishing baseline data from each regional office on States compliance with individual initiative provisions. We will conduct cross-regional Federal Monitoring Surveys to identify areas where there may be some misunderstandings or miscommunication about what is required. We are also conducting an all-Federal surveyor training course in September which will include Federal surveyors, supervisors and program staff charged with the responsibility of implementing the nursing home enforcement process.

Question. Several Nursing Home Initiatives will require several years to complete specifically the redesign of the survey system and the development of a new information management system. Both of these projects are critical to improving the accuracy of our understanding of the quality of care in nursing homes and address serious shortcomings in the current system. However, given that many of the Nursing Home Initiatives are being implemented today, a question arises about when we will be able to tell if the quality of care has actually improved. How does HCFA propose to measure the benefit of the Nursing Home Initiatives between now and the time the new survey system and information management systems are operational?

Answer. We will assess the effectiveness of the implementation of the various initiative provisions, such as determining if there has been an increase in the surveys that have been initiated off hours. We also will develop and use selected key indicators of outcome based minimum data set (MDS) information. These indicators will

be compared for various time periods to determine how they affect residents and whether there are changes in outcomes of care. We are currently developing a more detailed evaluation plan which we will share with the Committee in out September report.

Question. The consumer information HCFA has placed on its web site has been a popular addition and is widely used. How is HCFA "getting the word out" so that additional individuals who can use the information on the web site are aware of its existence? Does HCFA have a system to determine user satisfaction with the web site, and how is this information used to enhance the utility of the web site?

Answer. The Nursing Home Compare database was announced in two HCFA press releases and has been written about in several news organizations, including the Associated Press and the January 1999 issue of the Contemporary Long Term Care Magazine. In addition, we recently participated in a video news release sent to local TV stations across the country by AARP which told consumers how to access the web site. The database is also described in the Medicare brochure which is disseminated at conferences and available for outreach by the Regional Offices and other partner organizations.

We are very interested in making the site as useful as possible. We continue to make adjustments to the web site based on comments received from advocates and consumers. We have designed a guestbook on the web site that consumers can use to submit comments and feedback for improving the database. In addition, we also will begin focus group testing with consumers and use that feedback to improve the overall effectiveness of the web site.

Question. Witnesses from the second panel of the hearing, including Dr. Andrew Kramer and Dr. David Zimmerman, were asked to state for the record who at HCFA is the central manager for the survey redesign efforts underway at HCFA. They answered similarly by identifying the two project managers, Karen Schoeneman, and Sue Nannemaker, but indicated that they did not know who, if anyone, is responsible for overseeing this project.

I have several questions related to this matter. First, who is the most senior level HCFA representative responsible for overseeing HCFA's survey redesign initiative? If this representative is anyone other than the HCFA Administrator or Deputy Administrator, would HCFA be willing to redesignate this responsibility to the highest level of leadership? HCFA's monthly report indicates that the lead individuals for initiative GAO–2 (Increase sample size for nutrition, dehydration & pressure sores), which includes the development of protocol using quality indicators, is Cindy Graunke and John Thomas. Can HCFA confirm that these two individuals are indeed the lead on this initiative? And if so, can HCFA comment on why the lead HCFA representatives have not made their leadership role apparent to Dr. Kramer or Dr. Zimmerman?

Answer. The most senior HCFA representative responsible for overseeing HCFA's survey redesign initiative is Rachel Block, Deputy Director for the Center for Medicaid and State Operations. In addition, both the Administrator and Deputy Administrator are actively involved in the direction and oversight of these initiatives. Cindy Graunke and John Thomas are responsible for managing the day-to-day operations for the divisions where these initiatives are performed. The staff routinely keep the senior management apprised of developments, as well as carrying out decisions made that that level.

The contractors are not involved in HCFA's internal decision-making processes, but are given the information necessary for performing their agreed contracted functions. It is important for the contractors to have a strong working relationship with their contract officers than with the top senior official responsible for the overall initiative. We will make sure the contractors know the lead person responsible for the initiative.

RACHEL BLOCKS RESPONSES TO SENATOR KOHL'S QUESTIONS

Question. I have heard from officials in Wisconsin that the State survey agency is making great progress in addressing serious complaints within 10 days. However, there is real concern that this is happening at the expense of inspections and other Survey activities. Last year, I worked hard to increase funding for the inspection and enforcement process to $171 million, and I am pushing for another increase this year. What level of funding is necessary to pay for all Survey activities? Is it a question of cash, or a question of using these resources more efficiently? Are even more resources needed to fully implement HCFA's nursing home initiative?

Answer. The President's fiscal 2000 budget includes $14.5 million specifically for the Nursing Home Initiative. We asked States to explicitly include resource needs related to the 10-day complaint initiative in their fiscal 2000 budget requests. We

are exploring options for obtaining additional funds that may be needed. We clearly have benefited from the additional funding you helped provide. And we want to continue working with you and States to ensure adequate funding.

Improving resource management and budget coordination between us and the States is equally important. We are working with States to determine how to improve the effectiveness of the available resources. We have formed a workgroup with State Agencies to identify ways to streamline the enforcement process. The workgroup has already identified several ways in which to do so. For example, we eliminated several non essential requirements related to developing and approving plans of corrections.

We are continuing to work together to identify other ways to do the work required with current staffing and resource constraints, as some States may simply have not yet been able to make use of the increased Federal allocation for fiscal 1999, including an additional $4 million in HCFA funds because they have not yet been able to secure supplemental State Medicaid matching funds or additional State staffing allocations.

Question. Last year, Wisconsin's largest nursing home was notified by HCFA of termination after inspectors found repeated, systematic care problems. Fortunately, rather than having to relocate all of the residents, the State found a new owner for the facility. I agree that HCFA must take action against facilities that jeopardize the health and safety of patients. However, residents' families and advocates have raised concerns that relocation can be equally damaging to residents—causing disruption, trauma, and even further medical problems. Is there any benefit to placing poor-performing facilities into receivership or appointing temporary management, rather than closure? What steps have you taken to make sure that termination is the option of last resort?

Answer. Termination from the program must be used only as a remedy of last resort. It was used only 18 times in the last year (between July 1, 1998 and June 30, 1999), which is about the same rate as for the past several years. Because termination is so disruptive to residents, we work diligently with States to encourage facilities to fix problems so termination will not be necessary. This is usually accomplished through alternative remedies such as temporary managers, denial of payment for new admissions or for all admissions, state monitoring, and fines. However, by statute, a facility in continuous noncompliance with health and safety regulations for 180 days must be terminated from the program, regardless of their previous compliance history.

Question. Wisconsin officials have raised the issue that it is getting more difficult to track facilities that are members of large chains. Many of them operate under different names or subsidiaries—making it harder to track chains with care and safety problems. How widespread is this problem and is there a way of better tracking chains?

Answer. Nursing home chains operate under arrangements with individual nursing homes that often involve management agreements, leasebacks, subsidiary corporations, and other complex arrangements. These arrangements also change frequently. As a result, it is difficult, particularly in the case of privately-held chains, to obtain up-to-date and accurate information about them and their membership. We are letting a contract to track chain ownership. We expect that we will receive a quarterly report on chain ownership/affiliation of individual facilities that we can share with the States, beginning in December 1999.

Question. I have heard that in some cases, survey results reported on the Internet are outdated? How often is the website updated?

Answer. There sometimes are delays in reporting survey results to us. Such delays are often caused by the existence of ongoing appeals or negotiations by the nursing home with the State and that slows the release of the final statement of deficiencies. We are working with all State survey agencies to streamline this process so that the results on the Nursing Home Compare website are up-to-date.

BILL SCANLONS RESPONSE TO SENATOR KOHL'S QUESTION

Question. I have heard from officials in Wisconsin that the State survey agency is making great progress in addressing serious complaints within 10 days. However, there is real concern that this is happening at the expense of inspections and other Survey activities. Last year, I worked hard to increase funding for the inspection and enforcement process to $171 million, and I am pushing for another increase this year. What level of funding is necessary to pay for all Survey activities? Is it a question of cash, or a question of using these resources more efficiently? Are even more resources needed to fully implement HCFA's nursing home initiative?

Answer. Our contacts with 10 states indicated that several other states are expressing similar concerns as Wisconsin about their ability to meet the new HCFA requirement for investigating complaints alleging actual harm within 10 days given current resources and other necessary survey activities. For states that did not already have similar practices, the new complaints requirement and other HCFA initiatives, such as more revisits to ensure that serious deficiencies are corrected, will require a more frequent state surveyor presence in homes where either the state has previously identified serious deficiencies or complainants allege serious care concerns.

We have not assessed the resource requirements for an effective state survey and certification process. Nonetheless, our work indicates that states that commit more resources to their complaint process have a more effective system for responding to complaints. In many regards, Washington may be considered a good example for effective complaint investigation practices. Compared to other states we reviewed, Washington received a much greater volume of complaints, conducted more complaint investigations per home, prioritized most complaints within its two highest categories, and was more timely in conducting investigations. But, to achieve this system, Washington spent nearly 2½ times the national average on complaint investigations per certified bed in fiscal year 1998. In contrast, Maryland spent less than one-fourth the national average and Michigan spent about 70 percent of the national average in fiscal year 1998. In their comments on a draft of our report, both states highlighted resource constraints as contributing to their problems with complaint investigations.

Congress and HCFA have recognized the need for additional funding to improve oversight of nursing home quality in support of HCFA's initiatives. In fiscal year 1999, Congress appropriated an additional $4 million, and HCFA reallocated another $4 million from other sources, for nursing home survey and certification. The Administration has requested a $33 million increase in the fiscal year 2000 budget, and HCFA has requested another $33 million from other sources, for survey and certification funding. States, too, have financial responsibility both for ensuring that homes meet their licensing requirements as well as to share in the Medicaid certification costs. Some states, including Maryland, have increased their funding for nursing home survey activities. We believe that HCFA and the states should conduct a careful assessment of what, if any, additional resources are required for the nursing home initiatives, taking into account the existing wide variations in Federal and State funding as well as survey and certification practices among the states. HCFA reports that it has begun such an assessment in relation to its new complaint investigation policy.

AHFSA RESPONSE TO SENATOR KOHL'S QUESTION

Question. I have heard from officials in Wisconsin that the State survey agency is making great progress in addressing serious complaints within 10 days. However, there is a real concern that this is happening at the expense of inspections and other Survey activities. Last year, I worked hard to increase funding for the inspection and enforcement process to $171 million, and I am pushing for another increase this year. What level of funding is necessary to pay for all Survey activities? Is it a question of cash, or a question of using these resources more efficiently? Are even more resources needed to fully implement HCFA's nursing home initiative?

Answer. The Association of Health Facility Survey Agencies is most appreciative of efforts to increase funding for the survey and certification process.

The issue is one of needing more resources to pay for all of the survey activities excepted of state agencies for nursing homes and other federally certified health care providers. It is also an issue of using the available resources more effectively until full funding is made available and until states are able to utilize the additional funding.

In this regard, and specifically related to its complaint initiative, HCFA has been unwilling to accept the states' recommendations to modify its spending priorities in order to allow states to use current allocations to conduct more timely complaint investigations in lieu of meeting the 12 month average timeframe for standard surveys. We had believed that such a change in priorities would result in a more effective and efficient use of our limited survey resources. As a result, and unlike what you have heard about Wisconsin, most states have not made much progress in implementing the HCFA mandate to investigate complaints alleging actual harm within 10 days. As we had advised HCFA immediately after the Administrator announced this initiative, the states simply could not implement the initiative within the restraints of existing resources and HCFA's national priorities for use of those

funds. Although HCFA has advised us that they are requesting additional funding for this initiative for the FY2000 budget, HCFA has yet to do anything to enhance the states' ability to investigate complaint allegations of actual harm in a more timely manner.

In our testimony of June 30, 1999, AHFSA included a comparison of the increase of certified providers and beds to the increase in funding for the survey and certification agencies. In any given recent year, Federal funding for oversight of the quality of care has never approached 1 percent of the amount spent to pay for care. Additionally, implementation of OBRA 87 added significantly to states' workloads for supervisory review of survey documentation and enforcement recommendation notification letters, informal dispute resolution, multiple revisits to providers, automation of the MDS and significant surveyor and provider training activities. Federal focus, through OBRA 87, on long term care has resulted in continual declines in funding for non-long term care provider survey activities. There is no question from the perspective of state survey agencies that funding is insufficient to meet all of the expectations established through the Federal regulatory process for the effective monitoring of quality of care in federally certified providers.

The fragmented way in which the presidential initiatives and the recommendations of the GAO are being implemented has resulted in fragmented estimates of the funding needed. For example, states have estimated the resources required in order to investigate complaints within 10 days in isolation from other resource needs. The same is true of the additional time required to implement the enhancements to the survey process that became effective July 1, 1999. In both cases, and consistent with HCFA's past practice, discussion of resource needs followed the effective date by which states were expected to implement changes.

Your question to us about adequate funding levels for survey activities is certainly timely and welcomed by the states. We are currently in the process of responding to HCFA's annual budget call letter for FY 2000 and, for the first time, HCFA has asked us to submit budget requests that reflect our actual projections of what it will take to meet HCFA's program priorities—rather than the traditional approach wherein states had to "back into" predetermined allocation amounts. This approach should give us a much better baseline of staffing and funding needs for survey and certification activities. As an association, we look forward to working with the Committee and all interested parties to then secure the level of funding necessary to carry out these vital functions.

Once established, the ability of states to count on steady levels of funding in subsequent budget periods would also greatly improve the ability for long range planning, recruitment and development of staff. Steady funding levels would also greatly assist those states with multi-year budget cycles, which require advance notice to obtain legislative authority to establish new positions and to use allocated funds.

Thank you for your interest in the funding issue and for the opportunity to provide input into the discussion.

DR. KRAMERS RESPONSE TO SENATOR KOHL'S QUESTION

Question. I have heard from officials in Wisconsin that the State survey agency is making great progress in addressing serious complaints within 10 days. However, there is a real concern that this is happening at the expense of inspections and other Survey activities. Last year, I worked hard to increase funding for the inspection and enforcement process to $171 million, and I am pushing for another increase this year. What level of funding is necessary to pay for all Survey activities? Is it a question of cash, or a question of using these resources more efficiently? Are even more resources needed to fully implement HCFA's nursing home initiative?

Answer. Resources could definitely be used more efficiently by focusing on poorer performing facilities very intensively, and less on better performing facilities. Furthermore, automated collection of data and synthesis of information will help. However, we need to improve the process of quality problem detection and improving quality of care problems are identified. That will take more resources both for development and over the long run. But when you look at the number of nursing homes (about 17,500) and the quality of care problems that exist, its necessary.

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THE NURSING HOME INITIATIVE: RESULTS AT YEAR ONE

HEARING BEFORE THE SENATE SPECIAL COMMITTEE ON AGING
JUNE 30, 1999

COMMENTS FOR THE RECORD SUBMITTED BY THE NATIONAL SENIOR CITIZENS LAW CENTER

The National Senior Citizens Law Center thanks and commends the Senate Special Committee on Aging for its sustained commitment to improving quality of care and quality of life for nursing home residents. For the past year, Senator Grassley and the Committee have devoted significant time to addressing the continuing problems in nursing home quality. We also thank and commend the Health Care Financing Administration (HCFA) for its work over the past year. With resources that are far too inadequate, HCFA staff have worked extraordinarily hard to develop and implement the President's Nursing Home Initiative and the recommendations of the General Accounting Office.

We now have a unique opportunity to make significant and lasting changes for nursing home residents. We encourage the Committee and HCFA to continue their efforts together.

We would like to submit the following specific comments on the topic of the hearing: President Clinton's nursing home initiative after its first year.

1. There is an urgent need for the federal and state survey and enforcement budgets to be increased substantially.

> ***A. The survey budget is relatively small and stagnant and reflects only a trivial percentage of the federal money that is spent on nursing home care under the Medicare and Medicaid programs.***

The federally-mandated survey and certification process is seriously underfinanced.

In 1998, the federal government gave states only $147 million to conduct certification

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surveys; receive, investigate, and resolve complaints; and take appropriate enforcement action against facilities that have deficiencies. Six years earlier, in 1992, the federal survey budget was $145 million. The federal survey budget was reduced to $136 million in 1994 and gradually increased to the $147 million figure by 1998.[1] The budget has been virtually stagnant during this entire decade.[2]

At the same time as the federal budget for state surveys has remained essentially stable, federal spending for nursing facility care has increased dramatically. HCFA data indicate that Medicare and Medicaid payments for nursing home care increased from $24.8 billion in 1990 to $33.1 billion in 1992 and $49.5 billion in 1997.[3]

Between 1992 and 1997, the federal survey budget increased by 1% while the amount of money spent on care increased by 66%.

Using the HCFA data and overstating the federal contribution for survey, certification, and enforcement activities for nursing homes (by attributing *all* federal survey money to nursing home surveys), we calculate that federal dollars spent on surveys to determine compliance with federal standards now reflect less than one-third of one percentage point.

In 1992, the survey budget reflected .0043% of the amount spent on care; by 1998, the survey budget had declined to less than .003%.[4] In other words, the amount of money

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[1] Association of Health Facility Survey Agencies, *HCFA Survey and Certification Budget Fact Sheet* (undated). The federal survey budget is not restricted to nursing home activities. State survey agencies must also inspect non-accredited providers, including home health agencies, end-stage renal disease (ESRD) facilities, acute care hospitals, psychiatric hospitals, hospices, ambulatory surgical centers, rural health clinics, outpatient therapies, comprehensive outpatient rehabilitation facilities, portable x-ray providers, and other facilities serving Medicare and Medicaid beneficiaries. In addition, survey agencies must conduct validation surveys of accredited providers and investigate allegations of patient dumping by acute care hospitals.

[2] The percentage of funds allocated for the survey process that is paid by the federal government has also declined substantially. When the nursing home reform law was enacted in December 1987, it included a provision for increased federal funding under the Medicaid program on a sliding, decreasing rate, beginning in fiscal year 1991. The federal match in 1991 was 90%; in fiscal year 1992, 85 %; in fiscal year 1993, 80%; in fiscal year 1994 and thereafter, 75%. Pub.L. 95-142, §1903(a)(2)(D). The percentage for the Medicare program was and remains 50%.

[3] HCFA, *Table 7: Nursing Home Care Expenditures Aggregate and Per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-97*, http://www.hcfa.gov/stats/nhe-oact/tables/t15.htm (site visited Jul. 6, 1999).

[4] While public oversight of facilities, reflected in the survey budget, declined, instances of fraud and abuse by nursing facilities led the federal government in May 1995 to initiate a program called Operation Restore Trust (ORT) to focus on fraud and abuse by three categories of health care providers, including nursing facilities, in the five states with the highest Medicare expenditures, California, Florida, Illinois, New York, and Texas. ORT was a two-year collaborative effort by the Department of Justice and

spent by the federal government to assure that the care it paid for was properly provided to residents is considerably less than half of one percent of the federal cost of care -- an inadequate sum to determine whether appropriate care is provided to some of the most vulnerable members of our society.

There is clearly not enough money for states to do their jobs.

The budget for HCFA is equally inadequate. There are far too few staff people available in HCFA's Central Office to do all the work that is needed to develop the survey and enforcement systems, to train state and federal surveyors, to set policy, and to answer questions.

The lack of appropriate enforcement allows poor care to continue.[5]

B. States and the federal government cannot do more to implement the initiative without additional funding.

Testimony from various witnesses at the June 30 hearing made clear that lack of adequate funding has led to parts of the Initiative remaining unimplemented. For example, Catherine G. Morris, President-Elect of the Association of Health Facility Survey Agencies, testified that while states support HCFA's directive to investigate complaints within 10 days, many states lack the staff and money to conduct investigations in such a timely way. While states support the policy of investigating complaints promptly, they do not have sufficient resources to implement the policy.

C. The Medicare and Medicaid statutes should be amended to require

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three agencies within the Department of Health and Human Services -- the Inspector General, the Health Care Financing Administration (survey agencies), and the Administration on Aging (long-term care ombudsmen).

In recognition of the continuing problems of fraud and abuse, documented in numerous reports by the Inspector General and the General Accounting Office, funding for fraud and abuse activities was made permanent and national by the Health Insurance Portability and Accountability Act (Kassebaum-Kennedy bill). Pub.L. 104-191 (Aug. 21, 1996).

[5] The correlation between inadequate enforcement and poor care outcomes is not limited to nursing homes. A GAO report on the certification and enforcement systems for home health agencies also found that pervasive noncompliance with standards was allowed to thrive when the public regulatory system did not work. GAO, *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies*, GAO/HEHS-98-29 (Dec. 1997). The GAO reported that home health agencies can easily achieve initial certification and that once certified, "serious deficiencies in the [recertification] process allow problems to go undetected." *Id.* 3. The survey evaluates compliance with only five of 12 conditions of participation, and even when a survey agency identifies deficiencies, it imposes no remedies. The GAO concluded that public regulation of home health agencies is essentially a "self-policing" system that does not work. *Id.* 19. "[T]he threat of termination has little, if any, deterrent value, and problem HHAs seem to operate with impunity." *Id.* 20.

> ***facilities to pay for the full costs of surveys beyond the annual standard survey, when revisits are required to determine whether facilities have corrected their deficiencies and have achieved full compliance with federal standards of care.***

In order to develop additional sources of funding for survey and enforcement activities, Congress can look to state experience. Legislation enacted last year in Delaware permits the state to charge nursing facilities for the costs of revisits that are made necessary because of the facilities' noncompliance with quality standards. The legislation makes facilities financially responsible for their noncompliance with federal standards of care and provides additional funding for the federally-mandated survey process.

Section 1107(b) of Senate Bill No. 322 states in its entirety:

> The Department shall have the authority to assess additional fees to recover the actual costs and expenses of the Department for any monitoring or inspections needed beyond the standard inspection in those cases in which substantiated violations are found.

Federal legislation should mandate the assessment of the costs of resurveys, rather than just give the Secretary authority to assess the costs. An additional provision should prohibit facilities from being reimbursed for these costs; that is, facilities should not be allowed to submit these costs on their Medicare or Medicaid cost reports.

The Delaware approach, along with an additional provision explicitly prohibiting facilities from seeking reimbursement for the costs of revisits, would create a new financial consequence, and, in effect, a new remedy, for facilities' noncompliance. It would also help fund the survey process in a way that is preferable to user fees.

While states and the federal government have an obligation to conduct annual surveys, they should not have to bear the extensive additional costs of revisits that are caused by facilities' noncompliance. As the General Accounting Office (GAO) reported to the Committee in July 1998,[6] the federal survey protocol in place since July 1995 has generally permitted remedies to be imposed only if deficiencies continue to be found at the time of a revisit. Consequently, the protocol encourages facilities to demand repeated revisits to demonstrate their compliance. The Delaware model would create different incentives and would establish a financial deterrence to noncompliance.

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[6] General Accounting Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 23-26, GAO/HEHS-98-202 (Jul. 1998) (describing how HCFA's "forgiving enforcement stance" allows most facilities cited with deficiencies an opportunity to correct, avoiding remedies for noncompliance) [hereafter GAO, *Care Problems Persist*].

2. Use of quality indicators in the survey reflects an important improvement in the federal survey process, but better use needs to be made of the quality indicators.

One of the most important innovations in the new federal survey process that went into effect on July 1, 1999 is the introduction of quality indicators to help surveyors identify potential concerns about care and to select the sample of residents whose care they will review during the survey. Despite the importance of quality indicators and their potential to improve the survey process, the limited resources available to federal and state survey agencies have led HCFA to make only partial use of the extensive information that quality indicators actually provide.

A. Quality indicators are not being used to determine compliance with the requirements of the reform law; they are being used to compare a facility's performance with the performance of other facilities in the state.

The new forms generated from the minimum data set (MDS) data will flag quality indicators (QIs) for any of three sentinel health events and for QIs in which the facility scores in the 90th percentile (as compared with other facilities in the state). Trainers told surveyors at the training meeting in May to review QIs at the 75th percentile and also suggested that surveyors consider QIs that are identified for a large number of residents, even if the percentile ranking on that indicator is lower than 75%.

These instructions do not use the information available from the QIs as fully as possible to determine facilities' compliance with federal Requirements of Participation. A considerable amount of potentially valuable information will be overlooked by survey teams if a QI does not reach the designated thresholds.

With time pressures and limited survey funds, surveyors will look at QIs that are officially flagged, i.e., sentinel events and QIs at the 90th percentile. But surveyors will probably not consider QIs at the 75th percentile and almost certainly will never look at deficiencies in lower percentiles, even with large numbers of residents affected. What this means is that only the top 10% (or 25%) of facilities in a state whose MDS data suggest concerns about potentially bad care outcomes will have those care issues reviewed by survey teams. Other possible deficiencies will be overlooked.

This result is insufficient to determine facilities' compliance with the requirements of the reform law. Surveyors need to make better and fuller use of the information presented by the QIs. Whenever any resident is flagged for a QI, there is the possibility of a deficiency. Consequently, both the resident who is flagged and the QI need to be reviewed. Although the survey protocol generally reviews the care received by a sample of residents, surveyors cannot ignore potential problems for individual residents

or for small numbers of residents. Isolated and pattern deficiencies[7] matter and need to be identified and cited in the survey process. At the very least, HCFA must expand the size of the sample, as the GAO recognized was necessary last summer,[8] in order to review the care of a larger number of residents.

B. At their best, quality indicators identify the presence of bad outcomes. They cannot, and are not intended to, identify the absence of good outcomes. Consequently, quality indicators cannot by themselves fully identify potential problems related to a facility's compliance with the comprehensive requirements of the reform law.

Quality indicators do not purport to determine the absence of good outcomes. Whether residents are achieving their highest possible functional level, as mandated by the reform law,[9] will not be evaluated by the use of quality indicators, regardless of how low the percentile rankings are set. For example, if a resident is admitted to a nursing home following a hip fracture and is unable to walk, the care plan requires that she receive physical therapy, and the expectation is that she will regain her ability to ambulate and return home, the QIs will not highlight her failure to get the therapy and improve. The QI process will not identify the absence of anticipated improvement.

While quality indicators can provide a wealth of information to surveyors, HCFA needs to supplement the information they provide with additional protocols that more comprehensively evaluate facilities' compliance with all the requirements of the nursing home reform law.

C. The survey protocol inappropriately excludes resident assessment information submitted under the Medicare prospective payment system.

Medicare's new prospective payment system (PPS) requires facilities to conduct more frequent assessments than the nursing home reform law requires. Despite the availability of this additional assessment information, trainers told surveyors in May that PPS assessment information will not be reflected in the assessment information compiled for survey purposes. This decision is a mistake.

A common complaint about survey and enforcement is that they are totally separate from reimbursement decisions. The new PPS system provides an opportunity to unite the two systems.

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[7] These are terms of art in the federal nursing home survey protocol.

[8] GAO, *Care Problems Persist, supra* note 5, 17-21.

[9] 42 U.S.C. §§1395i-3(b)(2), 1396r(b)(2), Medicare and Medicaid, respectively (facilities must provide services "to attain or maintain the highest practicable physical, mental, and psychosocial well-being of *each* resident . . . ." [emphasis supplied].

The survey protocol should use any assessment information that facilities are required to develop, whether for reimbursement or care planning purposes. The incentives for facilities under PPS system are, of course, to identify as many care needs and problems as possible in order to increase reimbursement. The incentives for facilities under the survey process are the opposite -- to downcode problems so that residents are not identified as having potential care problems.

Using all assessment information completed by a facility for a resident for any purpose is more likely to give surveyors a true picture of that resident's actual condition.

D. HCFA needs to evaluate the accuracy of MDS information and to take strong enforcement actions when facilities misrepresent or intentionally falsify assessment information.

Although HCFA has developed a new task for the survey process to evaluate the accuracy of MDS information, that task may need to be strengthened. In any event, the tool certainly needs to be combined with strong enforcement responses when the assessment information is misrepresented or falsified, whether intentionally or negligently.

Since the entire QI process is based solely on MDS data and relies on the accuracy of those data, misrepresentations and falsifications must be treated seriously. Mandatory remedies are appropriate under these circumstances and should be imposed.

E. Information learned from quality indicators should not only help focus the survey process and identify residents to be included in the resident sample; information should also be used to determine the composition of the multidisciplinary survey team.

When the survey agency reviews the quality indicators to prepare for a survey, it should use the information to help determine which professional disciplines are necessary and appropriate for the survey team. For example, if the quality indicators reflect a potential problem in medication issues, the survey agency should assure that a pharmacist is a team member, or, at least, is readily available to consult with the survey team in order to assure the accuracy and credibility of the survey team's findings, a potentially important issue if these findings are later challenged by the provider in informal dispute resolution or in a hearing.

3. HCFA should direct states to use specialized survey teams in "special focus" facilities.

One part of the initiative calls for 100 "special focus" facilities – two in each state – to receive at least one additional survey per year. While increased attention to these facilities may be useful, it is not sufficient.

As a general matter, many surveys are already conducted in facilities that have significant deficiencies.[10] A more important need is for facilities with significant care concerns to be subject to be more focused surveys and to stronger enforcement activity when deficiencies are first identified.

The 1987 reform law authorizes states

> . . . to maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard [facilities].[11]

With additional funding, and/or using the civil money penalty money that they have collected,[12] states should establish and use specialized teams to identify deficiencies in "special focus" facilities and to pursue appropriate enforcement actions.

4. Off-hour surveys are effective in identifying care problems.

One measure in the President's Initiative requires states to conduct 10% of surveys in

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[10] Two cases in which facilities challenged their terminations illustrate this point. In *Libbie Rehabilitation Center, Inc. v. Shalala*, 1998 WL 774178 (D.D.C. Oct. 30, 1998) (temporary restraining order), the state survey agency identified immediate jeopardy and substandard quality of care in a complaint survey conducted in February 1998. In revisits conducted in May and August, the state found that while some deficiencies identified in February had been corrected, the survey teams identified some new deficiencies and some previously-cited deficiencies remained uncorrected.

Similarly, in the Greenbelt cases, *United States of America v. Northern Health Facilities, Inc.*, C.A. No. AW 98-3113 (D.Md. Sep. 14, 1998) (consent decree in False Claims Act case filed by U.S. Attorney), *Northern Health Facilities, Inc. v. United States of America*, C.A. No. AW 98-4006 (D.Md. Dec. 7, 1998) (complaint filed to enjoin termination), repeated noncompliance was identified over the course of several months in repeated resurveys. A January 1998 survey first identified noncompliance and substandard quality of care. The state survey agency conducted revisits in the facility in April, June, and July, all of which continued to find that the facility had not achieved substantial compliance.

[11] 42 U.S.C. §§1395i-3(g)(4), 1396r(g)(4), Medicare and Medicaid, respectively.

[12] The reform law requires that money collected as civil money penalties be kept separate from general revenues and be

> . . . applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

42 U.S.C. §1396r(h)(2)(A)(ii).

"off-hours," by extending the survey to nights and weekends.[13] NSCLC recently learned of a state agency's midnight survey (on a Saturday night) that found three staff members on duty to provide care for 245 residents. The extraordinarily inadequate staffing ratios that residents and their advocates have long complained about, especially for nights and weekends, were witnessed directly by the state survey team.

Off-hour surveys are an important improvement in the federal survey process.

5. The nursing home industry opposes various parts of the nursing home initiative.

The nursing home industry has publicly expressed its opposition to various parts of President Clinton's nursing home initiative.

A. Per instance civil money penalty rule

On March 18, 1999, HCFA published a final rule with comment period establishing per instance civil money penalties (CMPs) as an additional enforcement remedy.[14] On behalf of its state affiliates and member facilities and in order "to advance its own organizational goals," the American Health Care Association (AHCA) challenged the rule in court.[15] AHCA argues that HCFA did not have statutory authority to promulgate rules authorizing per instance CMPs and that the agency did not provide the public with advance notice and an opportunity to comment, in violation of the Administrative Procedures Act.

B. Education campaign on abuse and neglect

On June 30, 1999, HCFA announced a new education campaign to help nursing home residents and their families "identify and report incidents of abuse and neglect."[16] HCFA developed a poster and information cards about abuse and neglect, which it sent to more than 3,000 facilities in 10 states.[17] HCFA asked the facilities to display the

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[13] Transmittal No. 5, amending §7207 of the State Operations Manual (Jan. 1999).

[14] 64 Fed. Reg. 13354 (Mar. 18, 1999).

[15] *American Health Care Association v. Shalala*, No. 1:99 CVO 127 (D.D.C. May 18, 1999). AHCA has now filed a motion for summary judgment; the National Citizens' Coalition for Nursing Home Reform, the national advocacy organization for residents, has moved to intervene as defendant; and defendants have filed a motion to dismiss.

[16] "HCFA Asks Nursing Homes to Join Education Campaign to Reduce Abuse and Neglect of Residents," (News Release, Jun. 30, 1999), http://www.hcfa.gov.news/pr1999/pr990630.htm.

[17] These states are Arizona, Colorado, Georgia, Idaho, Louisiana, Massachusetts, Missouri, New Jersey, West Virginia, and Wisconsin.

posters and intends to evaluate the effectiveness of the campaign before distributing the posters nationwide.

As "an alternative to a . . . HCFA poster campaign, which AHCA believes is inappropriate and will demoralize staff rather than educate them," AHCA unveiled its own "Dignity Initiative."[18] AHCA's educational initiative for nursing home staff is a two-hour training program developed by the Massachusetts Extended Care Federation and the Massachusetts Attorney General's Office. NSCLC understands that AHCA is advising facilities not to display HCFA's posters.

The American Association of Homes and Services for the Aging (AAHSA), representing not-for-profit providers, calls the poster "controversial" and "depressing" and says it "perpetuates a negative image of nursing homes and their residents."[19] AAHSA says that staff and residents will have to decide whether to display the posters.

6. Discussion about enforcement has focused on imposition of immediate remedies for deficiencies causing harm in two consecutive years. Remedies should be imposed, at the very least, in the first instance when harm occurs.

The President's Initiative announced last July included a measure to impose remedies immediately whenever deficiencies cause harm in two consecutive years. HCFA implemented this measure for deficiencies that were "pattern" or "widespread" in scope.[20] It has not yet implemented the measure for deficiencies that are "isolated" in scope that affect only a single resident or a small number of residents. The proposal to impose immediate remedies for isolated level G deficiencies has been strongly opposed by the provider industry.

At the Committee's request, the GAO evaluated deficiencies cited by state survey agencies at box G on the federal enforcement grid – deficiencies reflecting isolated

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[18] "AHCA Unveils Dignity Initiative As Alternative to HCFA Poster Campaign: Educational Program to Stress Abuse Awareness, Prevention," (Jun. 28, 1999), http://www.ahca.org/brief/nr990628c.htm.

"AHCA Calls for Collaboration, Not Confrontation with Administration: AHCA Pushes for a 'Better Way' of Improving Health Care for Seniors," (Jun. 30, 1999), http://www.ahca.org/brief/nr990630.htm.

[19] "AAHSA Views New Quality Indicators As a Positive Step in the Survey Process" (Jul. 2, 1999), http://www.aahsa.org/public/pr111.htm.

[20] Memorandum fro Richard P. Brummel, Acting Director, Disabled and Elderly Health Programs, Center for Medicaid and State Operations, to Associate Regional Administrators and State Agency Directors, "Change in Mandatory Criteria Used to Make 'Poor Performing Facility' Determination" (Sep. 22, 1998).

harm to a resident or residents.[21] Dr. William Scanlon testified that the GAO agreed with 98% of the states' determinations that harm to residents had occurred (105 of 107 facilities) and supported the level-G deficiency citations.[22] These citations involved pressure sores, nutrition, accidents, and other serious quality of care and quality of life concerns. Dr. Scanlon testified that the other 2% reflected deficiencies where the GAO believed not enough documentation had been provided for full analysis.

This extraordinary testimony offered strong support for HCFA's implementation of the policy to impose remedies against facilities with "double Gs" without first giving them an opportunity to correct the deficiency, a policy which HCFA has now promised to implement in September 1999.

While this new policy strengthens states' and HCFA's enforcement authority, remedies must be imposed sooner. The so-called double Gs reflect deficiencies causing harm to residents, but only if harm has occurred *twice*, in two subsequent survey years. There is no reason to allow nursing facilities to avoid imposition of a remedy the first time they cause harm to residents.

Facilities are bound by federal standards of care, and the federal survey and enforcement systems to determine compliance with those standards, only if they choose to participate in the Medicare and/or Medicaid programs. For all but a small number of facilities, the decision to participate is voluntary.

Federal law should impose remedies swiftly against facilities with deficiencies when those facilities have voluntarily chosen to subject themselves to those standards and that enforcement system. Having chosen to be reimbursed by the Medicare and Medicaid programs, facilities must meet the standards of care or be sanctioned.

A. Enforcement remedies must be imposed in a manner that deters or prevents facilities' noncompliance.

Even if remedies were imposed whenever facilities' noncompliance with standards of care caused harm to residents, that practice would still be a limited response to deficiencies. A regulatory system should attempt to *prevent* noncompliance, not simply respond to noncompliance that occurs. The California Supreme Court so held in a unanimous 1997 decision.

In *California Association of Health Facilities v. Department of Health Services*, 940 P.2d 323, 65 Cal.Rptr. 872 (1997), the California Supreme Court held that the "reasonable

[21] General Accounting Office, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, GAO-HEHS-99-157 (Jun. 1999).

[22] *Id.* 5.

licensee defense" authorized by state law does not relieve nursing facility licensees of vicarious liability for the acts of their employees. The Court rejected the nursing home industry's argument that residents could protect their own interests through litigation under the state's elder abuse statute. Quoting an earlier decision, *Kizer v. County of San Mateo*, 53 Cal.3d 139, 150 (1991), the Supreme Court said that suggesting that residents assume responsibility for enforcing state law

> "... is to abrogate the most basic and traditional police power of the state – the oversight of public health and safety.... Relying on the threat of a personal injury lawsuit to impose compliance with health and safety regulations defeats the very purpose of the statutory scheme, i.e., *preventing* injury from occurring." [emphasis in original]

65 Cal.Rptr., 885. If the purpose of a regulatory scheme is to prevent avoidable harm or injury to residents, limiting enforcement to instances where harm has already occurred misses the point and is inadequate. Other legal responses exist when harm occurs: tort litigation, criminal prosecution, litigation under the federal False Claims Act, and so on. The regulatory system is intended to prevent avoidable harm. Enforcement of standards of care set by the regulatory agency should occur sooner -- before, rather than after -- avoidable harm to residents has already occurred.

7. Conclusion

The President's Initiative holds substantial promise for improving quality of care and quality of life for residents. The Initiative is making the survey process increasingly effective in identifying care issues through use of quality indicators and off-hour surveys, among other changes.

The area of greatest concern to residents and their advocates in the federal regulatory system remains enforcement. While the Initiative calls for some improvement in the federal enforcement system, it remains overly tolerant of noncompliance. Additional changes to the enforcement system are necessary to assure that facilities attain and sustain compliance with all federal requirements of participation.

Finding ways to improve and strengthen the regulatory system to protect residents is not easy and the resistance of the nursing home industry cannot be ignored. Nevertheless, the combined efforts of HCFA and the Senate Aging Committee, along with state survey agencies, can make a difference in quality of care and quality of life for residents.

Toby S. Edelman
July 30, 1999

STATEMENT FOR THE RECORD
Senate Select Committee on Aging
For the hearing on
Improvements in Nursing Homes Care
June 30, 1999

Contact:
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301-652-6611 x 2012

The American Occupational Therapy Association (AOTA) submits this statement for the record of the hearing on June 30, 1999. AOTA thanks the Select Committee on Aging for its continuing and aggressive attention to quality in nursing facilities. While today's hearing may bring forward evidence of improvement in care, AOTA calls your attention to two issues that are critical to the health, well being and quality of life of Medicare beneficiaries and that are having negative consequences for patients in nursing facilities.

The two issues are the prospective payment system for skilled nursing care under Medicare and the cap on outpatient occupational therapy and other rehabilitation services.

Prospective Payment: Forcing Choices, No Monitoring

The change in the payment under Medicare for services in skilled nursing facilities (SNFs) from a cost-based system (with routine limits) to a fully prospective system (PPS) is causing tremendous upheaval in the occupational therapy profession. For the first three years of implementation, only a portion of the payment is based on patient characteristics. This results in discrepancies between what is needed for caring for a particular patient and the amount that facilities receive. **For instance, for one facility whose rates we have reviewed, the first year transitional rate for the ultra high rehabilitation category is $294.59 per day while the full federal rate is $409.29, for a difference of more than $110 per day.**

HCFA developed the federal RUGs rates based on resource requirements to meet the service needs identified for these categories. Yet the discrepancy is so significant, we question whether a facility would even choose to place a patient in this category, denying them access to needed therapeutic interventions and other services. Several categories of a lesser intensity have full federal rates and transitional rates that are more closely aligned providing an incentive to downgrade patients, providing fewer services.

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Fiscal pressures created by inadequate payments for expensive chemotherapy drugs or high-cost prosthetics are forcing facilities to either refuse high-cost patients or cut costs in other areas. Because therapy services appears to be one area where facilities can cut (and are doing so), practitioners are experiencing changes in their employment status, in their economic status, challenges to their professional standards and ethics, and, most importantly, **limitations in their ability to provide adequate, appropriate, and required services to Medicare beneficiaries in these settings.**

AOTA is recommending several strategies to the Committees of jurisdiction to address these funding problems:

> **Allow facilities that are negatively affected by the three-year transition period to move immediately to the full federal rate which is based on patient characteristics and includes a more adequate level of resources to address special needs.**
>
> **Design an outlier or other system to assure reimbursement for specialized medications, equipment, interventions or services for those patients who need them.**
>
> **Address needed modifications to the patient categories, or "Resource Utilization Groups," to assure that patient needs for therapy are adequately identified and met.**

In testimony on February 10, 1999 before the House Ways and Means Committee, the General Accounting Office (GAO) also raised some concerns about the system. First, GAO stated that "the SNF PPS has design flaws" and that this is "coupled with a lack of adequate planned oversight" by HCFA. While GAO merely raises the specter of less than expected savings from the combination of these two problems, **AOTA is deeply concerned for patient welfare under a system that is "flawed" and, as GAO admitted, the implementation of which is unfettered by appropriate oversight.**

GAO went on to state that "the new SNF PPS' design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services, since the amounts paid still depend heavily on the number of therapy and other services patients receive." This statement has no connection to the reality our therapists and their patients are experiencing in SNFs and belies the experience and common sense understanding of capitated payment systems. GAO appears not to understand the other major problems with the PPS system: **the incentives to under provide, under identify, and provide minimal care for patients.**

For instance, rules for using qualified professionals to provide therapy services are being skirted. Standards of supervision of aides and assistants, though covered by law in most states and reaffirmed in Medicare regulation, are a particular area of concern. If standards of care, including use of qualified personnel, are not upheld, patients will suffer loss of function and reduced health status and the purposes of the Medicare program will not be achieved.

<u>HCFA Oversight Is Weak</u>

AOTA is concerned that the Health Care Financing Administration (HCFA) is not adequately or effectively monitoring the implementation of this massive change. To our knowledge, HCFA has provided no guidance to fiscal intermediaries about medical review or quality assurance criteria to assure patients are receiving the care that nursing facilities are being paid for. We are not aware of any information transmitted to fiscal intermediaries on how to monitor the provision of care in relation to the payment received. Nor are we aware of any efforts by HCFA to empower the intermediaries with methods to determine the accuracy of the SNF categorization of individuals into appropriate RUG categories. **AOTA urges that efforts be undertaken to assure nursing homes are not minimizing care, either intentionally or because of inadequate payment levels.**

When Medicare payment to hospitals was changed to the prospective payment system in the 1980's, based on diagnosis-related groups (DRGs), hospitals used many ways to adjust to the new payment system. Not all were sensitive to patient needs and desired outcomes. In that post-DRG environment, many changes were observed and reported and beneficiaries felt the consequences. Increased use of outpatient pre-admission services billed to Part B, decreases in length of stay, and movement to non-hospital post-acute care settings were common. Also common were problems for patients and beneficiaries: transfer to nursing facilities unable to treat the acute conditions patients had, discharges to home with subsequent readmissions for exacerbations of conditions, and shifting provision of care to other, perhaps less appropriate, sites.

AOTA is concerned that similar negative consequences will accrue as the PPS is implemented by SNFs and that HCFA is neglecting critical oversight issues. This neglect may jeopardize patient health and safety.

AOTA urges the Committee to address these issues of Medicare implementation as they affect patient care and to use your interest in and obligation for quality to hold HCFA accountable for instituting the proper guidelines and procedures to prevent problems that are likely to occur and to monitor changes in patient care and outcomes that may result from the change in the payment system. **Patients in skilled nursing facilities are too vulnerable to be left to suffer the**

vagaries of funding changes without some protection from the agency charged with that duty.

__Specific Requests__

In addition we would like the Special Committee to be aware that AOTA has urged the Committees of jurisdiction to address particular questions to HCFA to determine if indeed its oversight is lax.

Specifically:

> **When will HCFA issue medical review guidelines for fiscal intermediaries to assess correct and appropriate categorization of patients?**
>
> **When will HCFA put in place quality assurance mechanisms to assess any decreases in patient access to care and subsequent deterioration in patient status due to the move to PPS?**
>
> **When will HCFA institute guidelines and procedures to assure that nursing homes are not minimizing care, either intentionally or because of inadequate payment levels under PPS?**
>
> **What plans and timetable does HCFA have to develop the medical review process required in the Balanced Budget Act, now Sec. 1888 (d)(1) of the Social Security Act?**
>
> **What immediate steps will HCFA undertake to assure quality services are adequately and appropriately provided with no negative impact on patients until such medical review criteria and processes are established?**
>
> **What steps will HCFA take to assure that patients, once classified into a Resource Utilization Group (RUG) will receive services appropriate to each individual's condition and not simply the minimum for classification into a category?**
>
> **What steps will HCFA take to monitor access to the appropriate clinical professionals to meet the full spectrum of patient needs as assessed by the Minimum Data Set process?**

Maintain Intent of OBRA; Conduct Studies of PPS Impact

The protection of the health and quality of life of nursing home patients has been frequently addressed by Congress. Congressional intent and expectations are clearly stated in the protections included in the 1987 Omnibus Budget Reconciliation Act which assure the public interest in patients maintaining highest possible function, being free of inappropriate restraints, and achieving optimum physical and mental health. AOTA believes that it is Congress' duty to assure that the changes it made in the Balanced Budget Act are not implemented in a way that is contrary to the important safeguards established in OBRA.

Because our members are being laid off, are spending less time with patients because of cutbacks in hours, and are being asked to adhere only minimally to standards of appropriate practice, AOTA is concerned that there will be increases in health and other problems in nursing facilities. We believe the Congress should ask GAO to act on its concerns about SNFs under PPS and immediately undertake a monitoring effort to look at questions such as the following:

Comparing charts of similar patients one or two years ago with post-PPS charts, are there changes in patient routines? (E.g., are patients in bed more and moving to activities less?)

Is use of pharmaceutical or other restraints increasing because reduced hours of receiving therapy are causing cognitive or behavioral problems?

Is there an increase in problems such as decubiti ulcers (bed sores), incontinence, pneumonia, and circulatory problems which can be linked to fewer hours spent receiving therapy, and loss of function and slower recovery due to receipt of less therapy?

Are there more feeding and hydration problems because occupational therapy or speech-language pathology services are not provided to address feeding or swallowing problems?

Is nursing staff following different routines with patients because of increased burdens of care due to less access to therapy?

AOTA is aware that there are concerns about some therapy services provided to SNF patients in the past. Even if some therapy was improperly documented or not appropriately authorized, the reductions in the amount of therapy patients are and will be receiving based on the staff and contract cuts observed in the SNF sector are, in our view, disproportionate to reductions in payment and to any amount of possible overutilization. AOTA is very concerned for patient well being and protection under Medicare standards and the OBRA requirements. Cost control can be achieved without sacrificing patient health, safety and well-being.

Impact of the $1500 Cap on Nursing Home Patients

The Balanced Budget Act of 1997 also imposed a payment limitation on outpatient rehabilitation services under Medicare Part B. The limit affects providers including private practitioners, clinics, rehabilitation agencies, skilled nursing facilities and home health agencies (for services for non-homebound individuals). The limit established is $1500 for occupational therapy and a combined cap of $1500 for physical therapy and speech-language-hearing services. Implementation in 1999 is incomplete; the Health Care Financing Administration (HCFA) has determined that the cap will apply per provider as there is no way at this time to track individual beneficiary use.

Patients in skilled nursing facilities who are eligible for Part B outpatient rehabilitiation (because they are no longer in a covered Part A stay and have moved to private pay or Medicaid coverage) are particularly hard hit by this implementation approach because they cannot seek services from another provider or a hospital outpatient department. This cap will be imposed without regard to patient need for continued therapy and without regard to whether the patient has more than one episode of need for therapy during a year. It will harm the most in need patients in nursing facilities—those with conditions such as stroke which have multiple consequences or chronic debilitating diseases like Parkinson's. These patients could be helped by therapy interventions but will not have access to them in nursing facilities under the cap.

In addition, this provision puts the government squarely between the patient and his or her medical caregiver. Such interference in medical decision making is inappropriate for the Medicare program and potentially harmful to beneficiaries.

AOTA supports legislation to address the cap and restore patient access to appropriate Medicare rehabilitation. We urge the Special Committee to consider this issue as it affects quality care and greatly appreciates the interest of the Committee's chair and members in support of legislation in this area.

Conclusion

AOTA is in full support of the Special Committee's continuing role as the champion for our country's most vulnerable citizens. AOTA stands ready to assist you and these patients to assure they have a high quality of life, free from abuse, and that they achieve a maximum level of functioning.

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Submitted Testimony

of the

AMERICAN HEALTH CARE ASSOCIATION

for the

SENATE SPECIAL COMMITTEE ON AGING

June 30, 1999

Introduction

Mr. Chairman and members of the Senate Special Committee on Aging, thank you for this opportunity to submit written testimony for today's hearing on the Health Care Financing Administration's Nursing Home Initiatives.

This committee has assumed a leadership role in pushing for quality improvements. Your diligent work has already improved caregiving throughout America.

You have also made it clear that you will not rest until further significant improvements in quality are made. The American Health Care Association, as the nation's largest organization of care providers, is ready to work with you to make your passionate commitment to higher quality a reality.

We share your commitment because it is only through our hands that quality can be improved. It is ultimately upon our shoulders that the responsibility rests for our most frail and vulnerable citizens.

Providing humane and dignified care to our nation's elderly and disabled citizens is not one goal among many. It is our purpose. It is why we have chosen this profession.

Regulators also, undoubtedly, share this commitment. There is no other industry in which regulators are more influential than in long-term care. Yet it is equally critical to regulate the regulators, and it is for that reason that we address the committee today.

The HCFA nursing home initiatives affect care providers deeply and personally on a daily basis. All too often HCFA's enforcement initiatives, though well-intentioned, have tended to put process before results, and the completion of checklists before meaningful improvements for vulnerable people.

Punishment—including the ultimate sanction of closure—is appropriate for bad actors that consistently act in bad faith. We believe that such outfits are the vast exception to the rule. Most long-term caregivers that need to improve are also striving to improve. Punishing a troubled enterprise with paperwork and fines can be like punching fresh holes in the hull of a ship that has taken on a little water. The ultimate victims will not be the caregivers. It will be the passengers.

We suggest the emphasis should be on progress, not punishment. The bottom line should not be the fulfillment of arbitrary standards, but the improvement of care. Facilities that need the most improvement should be given the resources, training and benchmarks to do so.

In short, we propose a new relationship, one based on constructive cooperation. We suggest the committee look to the State of Florida, where the legislature enacted a "Gold Seal" that highlights facilities that provide superior care, creating a benchmark for all to strive to meet. Florida has also created pilot programs for teaching nursing home care, authorized consumer satisfaction surveys, allowed staff to assist residents in eating and drinking, and funded teams of Registered Nurse -Nursing Home Monitors who consult with facilities to raise the quality of care.

The American Health Care Association believes we can and must do better for the elderly who rely on us by building a system which defines, measures, improves and communicates quality of care.

Threats and punishment make for good headlines. Cooperation and collaborative assistance make for better facilities, greater dignity and more humane treatment.

HCFA's Nursing Home Initiatives

Since the landmark Institute of Medicine study in 1986, and the Nursing Home Reform Act of 1987, nursing home care has been strictly monitored and critically investigated through statute, regulation, guidance to states, and surveyors.

At this time of crisis, this committee should examine the complex regulatory system in place and its shortcomings. Has it worked as intended? Has it worked well at all?

The provider community shares the responsibility of working with consumers, policymakers and regulators toward improving the system and ensuring better outcomes and quality of life for those whose care is entrusted to us. The following comments are intended to help move us toward that goal.

Almost one year has passed since this committee announced hearings and a GAO report that investigated care problems in some of California's nursing facilities. In the days between your announcement and the date of the hearing, the Administration announced a list of "Nursing Home Quality Initiatives." We believed the seriousness of the issue warranted the investment of more time in the development of this policy. Our statements at your hearings last year still stand.

We support the goals of these initiatives.

If anything, we believe these proposals are not ambitious enough. They settle for harsher punishment, and do not go far enough in taking meaningful steps that will lead to better care.

The American Health Care Association would like to comment briefly on each of the initiatives that GAO evaluated, and recommend substantive solutions that will result in better care.

1. **Mandatory visits for complaints alleging actual harm** – Most of the complaints received by regulators are self-reported by the caregivers. Still, we believe every complaint must taken seriously. Each complaint alleging harm to residents should be investigated promptly, and providers and regulators should work together to make sure it never happens again.

2. **Special Focus Facilities** – This initiative entails the arbitrary selection of two homes in each state to what was known as the "100 worst facilities." This means that two facilities out of the 1,400 in California made the list, and so did two out of the 14 facilities in Alaska.
   Another problem is that the reality of "special focus" has proven much different than anticipated. For instance, Arbors at Gallipolis, in Ohio, was chosen as one of the 100 worst. This facility did have care problems. Yet these problems were prior to its takeover by Extendicare, with was followed by significant improvements in care delivery. Over the past several months, the staff has spent great time and caregiving dollars hosting a government inspection team every month. In each of these inspections, regulators have been unable to find any substantial deficiencies. Nevertheless scarce long-term care resources are being spent on repeated inspections. We can see no evidence that this policy improves caregiving in any way. To make matters worse, HCFA has yet to develop criteria for removal from this list. For providers willing to take a chance and turnaround facilities with care problems, this policy serves as a disincentive. It punishes those who go out of their way to improve care.

3. **Evening and weekend surveys** – Quality does not depend on what time or day of the week a regulatory snapshot is taken. There should be no appreciable difference in quality in nursing facilities whether they are inspected during weekends or evenings. In fact, AHCA believes that a true quality measurement system will measure quality continuously, not just once a year. The current policy of alternating inspection times adds costs in the form of regulators' overtime. It does not foster better care delivery.

4. **Mandatory Revisits** – It must be noted that nursing facilities begin correcting problems as soon as facilities are made aware of them. By regulation, a plan of correction is immediately drawn up and implemented as soon as regulators approve it. The revisit policy encourages inspectors to make a higher priority of coming back and reevaluating the improvements. In the case where a per day fine is levied against a provider, each day the surveyors delay in revisiting can cost thousands of caregiving dollars.

5. **Poor Performing Facilities** – It is flatly unfair for any facility that receives a citation for an isolated incident at the "G-level" on two consecutive surveys to be labeled a "poor performing facility. This one policy embraces a multitude of flaws. For instance:
   - G-level violations are sometimes very serious, sometimes not at all. They can be written up over trivial, even nonsensical incidents. All G-level violations are by their very nature not systemic problems. They are isolated incidents.
   - For the reason above, two consecutive G violations are usually completely unrelated.
   - Labeling providers "poor performers" demoralizes staff, scares residents and their families, and does nothing to encourage quality improvement.
   - All problems are actually corrected as soon as providers are made aware of them. The denial of "opportunity to correct" simply means that a fine or other sanction will be imposed in addition to correction.
   - This is a strictly punitive remedy, yet it is seldom possible to deter isolated and unrelated incidents through threat of fine.
   - The increasing of the level of citation to G level would increase the number of "poor performers" by over 2400% according to HCFA's OSCAR data.
   - Even state surveyors themselves believe that: "It would be most appropriate for the level H to continue to be the level where there is no 'opportunity to correct' prior to implementation of a remedy." [1]
6. **Poor Performing Chains** – AHCA firmly believes that government should not label a nursing home with a good record of caregiving a "poor performer" simply because the facility is part of a chain that owns another facility that has had a problem. This policy will mislead residents and families about the care they are receiving, will demoralize staff, and ultimately hurts the quality of care.
7. **Civil Monetary Penalties** – HCFA issued a final rule with comment in March which changed the guidelines for imposing fines on facilities from per-day fines to per-instance. It is clear that HCFA does not have the statutory authority to do this nor did it comply with the procedures for public input prior to issuance of the policy. This is one more step toward making the survey system more punitive and away from quality improvement.

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[1] Letter from Washington State Survey Agency to HCFA Region Chief

Steps toward quality improvement

When AHCA testified at last year's hearing, we stated that the initiatives "did not go far enough toward improving quality of care." Following is a list of improvements we propose that would lead to improved oversight, and more importantly, to higher quality of care for residents.

These improvements should not be taken as a substitute for establishment of an outcome-oriented, data-driven continuous quality measurement system.

However, in the absence of comprehensive reform, there are several steps that if taken today, would lead toward improved quality of care and quality of life in nursing homes.

1. **Allow regulators to give comment and suggestion to caregivers** – Currently professional nursing home inspectors are forbidden by HCFA from commenting on care practices that they find in facilities. We would like to free regulators to make suggestions to improve procedures and care in a situation. There is no reason why the experience and knowledge of regulators should be off limits. This federal gag policy should be rescinded.
2. **Allow new owners to start with a clean slate** – Under current law when a new owner purchases a troubled nursing home and plans to improve quality, that owner is held responsible for the mistakes of the previous owner. This discourages quality improvement. It discourages takeovers by good operators. And it often jeopardizes residents, who can find themselves thrown out of a home that has been closed by the government, despite the new owner's improvements.
3. **Prevent mandatory closure of nursing homes and transfer of residents** – Under current policy, a facility that is cited with a substantial deficiency must subsequently be found perfect (deficiency-free) within six months or face mandatory closure. This can cause many resident transfers and cases of transfer trauma. In most cases, the initial serious citation is immediately corrected, but the facility can still be closed for very minor violations that were found later in the process.
4. **Allow fine money to be spent in facilities on improving care** – Currently over $20 million in state fines and significant federal funds collected from nursing homes sit unused in state and federal coffers. These funds could be used to provide in-service training to caregivers in problem facilities. They could be invested in an abuse prevention initiative, to disseminate best practices, or hundreds of other laudable goals. Instead they sit in an account while providers struggle to find the resources to improve caregiving.

A Better Quality Measurement and Improvement System

The people who make it their life's work to care for our elderly understand that care problems do not exist because providers lack the will or intent to provide the highest quality care. Problems sometimes occur because they lack the tools, knowledge, or resources to define, measure, communicate, and improve the quality of care in the most difficult of clinical circumstances. AHCA members know that true quality improvement must take place internally. That only the caregivers themselves can improve the quality of the care that they give. External regulatory measures can only peripherally effect quality of care.

Therefore, if policymakers and regulators want to improve nursing home quality, it can be done most effectively by working with providers to give them the tools, knowledge, and resources they need. This is a new way of looking at the public-private sector relationship, one that puts achieving high results before blame.

The quality indicators (QIs) being developed and tested are solely intended by HCFA as tools for surveyors to achieve more efficient enforcement. We have no objection to this use, but feel that QIs could be far more valuable for use by providers to measure their care against benchmarks and determine where they excel and where they have opportunities for improvement.

Use of the minimum data set (MDS) data for this purpose would enable facilities to track their performance month to month instead of once per year, and thus would enable them to find possible care problems before serious harm takes place. However, HCFA does not contemplate making MDS data available for this purpose.

In fact, AHCA has been working with Dr. Zimmerman at University of Wisconsin-Madison (UWM) since 1994 to develop a quality measurement system based upon the MDS data. The resultant system is known as *Facilitator®*, and is currently in use in over 1,500 nursing facilities nationwide.

Facilitator® goes even further than just the QIs to incorporate measures of resident and family satisfaction that have been developed with UWM and the Gallup Organization called Quality of Life Indicators (QoL). Through this tool, care providers can measure their performance against similar facilities locally, statewide, or nationally in clinical care performance and satisfaction. This is the way to give caregivers information that will allow them to monitor, communicate, and improve their care continuously over time.

Recently, AHCA's Board of Governors approved a plan that aims to put the *Facilitator®* tool in the hands of every one of our members. Access to the national MDS data would make the benchmarking more accurate and would lead to more rapid improvements in care. The response from HCFA has not been encouraging. South Dakota state surveyors have applied for a waiver to use *Facilitator®* with their survey teams to evaluate care in the homes in their states. HCFA has denied the request. It is critical that HCFA not stand in the way of improvement requests from those regulators and providers closest to the residents.

Consumer Information

Another extremely valuable use of the QIs is as a consumer information tool. If properly translated, QIs and satisfaction scores could be an indispensable tool in helping consumers choose a home that meets their clinical care needs and satisfaction expectations.

The current HCFA web site dedicated to consumer information called "Nursing Home Compare" gives only negative information. It is based on the deficiencies in compliance with the subjective and mostly process-driven requirements found at each facility during the once per year inspection. In many cases the data is outdated. AHCA believes this is not a guide to choosing a nursing home, but a guide to not choose one. Consumers will find no information on where a particular home excels, what types of care they specialize in (i.e. Alzheimers), and how they compare to other homes with regard to outcomes or satisfaction.

AHCA believes consumers deserve better. Currently several state provider associations have deployed web sites that give a much better range of information to consumers in the form of satisfaction scores, report cards, areas of specialty, and other comparative information. For example, the Health Care Association of Michigan (HCAM) publishes a "Consumer guide to Michigan Nursing Homes" that includes scores for facility's resident and family satisfaction surveys as well as a regulatory score, services offered, payments accepted, and facility comments. A good example of public benchmarking is Florida's "Gold Seal" program. This is a designation that consumers will look for, and one of the first examples of any government entity using a positive incentive to encourage quality improvement.

Dignity Campaign

HCFA is expected to begin an abuse awareness campaign in 10 states next month. This campaign consists of a poster and attached information cards that nursing homes will be asked to post in a public area of the facility. AHCA participated in the early development of this campaign. From the outset, we have expressed concern that we can do more to foster abuse awareness than distribute posters.

Accordingly, AHCA has developed an abuse awareness campaign we call the "Dignity Initiative – Keeping Nursing Facility Residents Safe." This is a two hour training program that consists of a training notebook and accompanying educational video that includes: role playing, group discussion topics, intervention strategies, information on stress, and ideas for testing participants. This campaign was originally developed by the Massachusetts Extended Care Federation in cooperation with the Massachusetts Attorney General's Office. Though it may have been more difficult to develop and more costly to implement, the AHCA feels it is far superior to a poster campaign that communicates little and trains no one.

Conclusion

America's providers of long term care to our nation's vulnerable elderly are the front lines of caregiving. They work long hours at physically and emotionally difficult jobs. They do everything in their power to give the best care all the time, but they need your cooperation. They need further leadership from the policymakers in the Senate and House. They need help from the regulators at HCFA and in the states.

We are once again appealing to you to work with the provider community to design and implement a system of collaborative assistance with the shared goal of improved care for all nursing home residents.

Our nations' seniors have given their lives working to make this country great. Please help us make their lives great in return. We owe them at least this much.

Thank you.

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