WRITTEN TESTIMONY
OF

Mary K. Ousley
Chairman
American Health Care Association

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Good morning Senator Grassley, and members of the Committee. I appreciate the opportunity to be with you here today -- and to provide you with perspective on the progress we are making in regard to improving the quality of long term care we provide to more than 1.5 million elderly and disabled Americans annually.

My name is Mary Ousley -- and I am the Chairman of the American Health Care Association. I speak today on behalf of all members of the American Health Care Association (AHCA). We are a national organization representing some 12,000 providers of long term care that employ more than 1.5 million caregivers.

I have been in the care giving profession for nearly three decades. I am a senior executive with a multifacility corporation, a registered nurse and a licensed nursing home administrator. I am intimately familiar with the challenges of being on the front lines of care giving -- and acutely aware that providing quality care to our seniors, necessarily, is a collective and collaborative effort.

I have worked formally and informally with the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), over several decades, in various capacities, and on many issues representing the long term care profession -- a profession that is facing economic uncertainties. We are struggling in an environment of Medicare cuts, critical reductions to Medicaid programs in many states and skyrocketing liability costs. Despite the fact that the profession is under severe financial pressures, skilled nursing facilities are dedicated to maintaining the highest quality of care and services for the frail elderly and disabled of America.

I'd like to thank you Mr. Chairman for calling this important hearing. You are providing stakeholders a valuable opportunity to discuss in detail our commitment to the quality of long term care services, and you are fostering an environment in which we can continue to work successfully together.

In addition to you, Chairman Grassley, it is also important to recognize President Bush, HHS Secretary Tommy Thompson and CMS Administrator Tom Scully for their commitment to ensuring America's seniors receive the highest quality health care our great nation has to offer.

Measuring, Communicating and Improving Care Quality: Charting a New Course

We feel nothing but compassion for those who appeared first before this Committee -- their stories and unfortunate experiences will remain with us all long after today's hearing. It is, however, critically important to emphasize these incidents are the exception, and the efforts of all of us here today are dedicated toward eliminating such occurrences. Mr. Chairman, we must understand that bad outcomes are not the norm and we are committed to working with the government to improve substandard providers or get them out of our profession. The positive long term care

experiences of millions of America's seniors do not garner headlines, nor, really should they – because quality care is expected, and must be the norm.

But I'm not here today to say the state of affairs regarding quality is optimal –- the process of health care delivery is dynamic and must never remain static—we must always seek to improve the norm of performance -- we can never feel complacent or satisfied with incremental progress; achieving progressively higher levels of care quality is an ongoing effort – as is the progressive effort to measure, assess and evaluate quality care itself.

We understand that the GAO report that is the subject of today's hearing finds an almost 30% reduction in actual harm deficiencies over an 18 month period that ended in 2002. Perhaps this is an indication of actual quality improvement, or as the GAO concludes, this is due to an understatement of deficiencies. This points to the central problem in today's survey process – that it cannot distinguish between an oversight problem and quality improvement.

In fact, Mr. Chairman, you addressed this very issue in the September 2000 hearing when you asked GAO Inspector General Scanlon, and I quote, whether "the quality of the surveys and the information in the OSCAR data base is reliable enough to make judgments about the level of quality provided in the nation's nursing homes."

Mr. Scanlon's answer was, "Mr. Chairman, I am afraid it is not."

This, of course, does not mean we view the survey process as defunct and irrelevant by any means. We do not. The survey procedure for long term care facilities' is a necessary and important process that Congress has directed CMS to use to determine facilities' compliance with regulations and certify facilities as Medicare and Medicaid providers. The statistical information (OSCAR data) that the process generates is used by many to define quality. However, this information forms only one part of the picture of quality.

Yes, Mr. Chairman, it is but one tool – and we believe the true barometer of quality is not deficiency rates but patient outcomes. The clinical outcomes achieved by residents receiving care in our nation's nursing facilities -- and the satisfaction of the patients, their families and staff -- hold the most reliable information on the quality of care provided by facilities.

We have, Mr. Chairman, set upon a new course with quality as our guide and compass. We view quality improvement as essentially an internal process – not an external process. Regulatory efforts are important, but they will not necessarily lead to sustained improvements in quality because changes in care giving and patient outcomes must come from internal processes. Yet, improving the accuracy and consistency of the survey process, and encouraging facilities to adopt quality

assessment and improvement systems are not mutually exclusive – they are compatible.

Internal quality improvement and quality management systems must be customer centered. These systems must be based on solid, well-understood policies and procedures and resident care protocols. The policies, procedures and protocols then will enable the facility interdisciplinary team to monitor not only the multiple clinical conditions but also the processes of care that lead to improved outcomes for residents. It is in this way that quality is measured, communicated, and improved. It is only through these systems that sustained and system wide improvements in quality of care and patient outcomes can be maintained. Logically, these results will lead to fewer deficiencies and overall improved compliance with federal and state regulatory expectations.

I have had this experience first hand—when I became part of the new management team that assumed the leadership of my current company in mid-2001. The company was in Chapter 11 and was very challenged in its ability to achieve and sustain regulatory compliance with the requirements of participation. In addition to a comprehensive set of policies and procedures, we developed and implemented an array of quality management tools including the Resident Care Management Systems ("RCMS"). RCMS presents "best practice" procedures for significant clinical areas within specialized modules. The modules outline procedures, responsibilities, and documentation requirements specific to respective patient conditions. These systems provide for quality and consistency in care and outcomes as reflected in the RCMS Quarterly Audit and our company's Standards Report. This unique approach is just one of many 'Foundations for Improvement' initiatives within our company, which fosters a patient-centered focus in contrast to the facility survey focus of the past.

Since that implementation of these initiatives, the company has realized steady improvement in the areas detailed in the following list:

- Quality Indicators Profile percentiles have improved, which are indicative of improved resident outcomes.
- Average number of deficiencies has decreased.
- Average number of facilities found to be deficiency free on annual survey has increased.
- Average level of severity of deficiencies have decreased.
- Facilities meeting regulatory care standards have increased.

- Imposition of remedies including denial of payment and monetary penalties has decreased.

While our company needs to continue its ongoing quality management and quality improvement efforts -- the emphasis on understanding the importance of the regulatory framework for long term care facilities—complemented by the resident-centered quality improvement efforts of our management teams at all levels of the corporation have demonstrated that change can occur and reap rewards for both residents and staff.

While there are some nursing homes that need closer regulatory oversight, there also needs to be an emphasis on working with facilities to address their systems of care and culture that involves the facility staff. Creating an environment that promotes sharing of best practices between nursing homes -- and that focuses on systems of care – are critically important to complement the current regulatory approach.

The total number of deficiencies as a proxy for quality is a false choice, and it is our common sense contention that there is no single measure of quality – there are multiple measures. The multiplicity and confluence of indices represents the new course of quality evaluation that benefits patients, policymakers, caregivers and consumers alike.

Just as competition spurs choice, productivity and product innovation in the economic marketplace, competing of quality assessment outcomes will provide similar benefits in the health care marketplace.

The many innovations and improvements in healthcare we've seen just in the past two decades has been extraordinary, and we fully expect and hope additional means to measure quality will emerge. We are excited about the pace of changes we see occurring in long term care, and we look forward to working collaboratively with all stakeholders to determine, on an ongoing basis, what constitutes quality, and how we can best measure it.

In regard to the GAO report that is one of the focal points of today's hearing, there are obviously some aspects of the report that trouble us – they cannot be discounted. Yet there is also evidence that improvements have been made, at least from the standpoint of the existing survey process, which, as we indicated, is just one way to go about evaluating quality.

One time progress, though, is not good enough. We need to keep working together to improve care quality across the board. The joint HHS/CMS Nursing Home Quality Initiative (NHQI) and our own Quality First initiative are the ways we are working to do so.

The NHQI: More Accountability, Increased Disclosure, More Competition

The NHQI, like our Quality First initiative, has helped place us on the course necessary to ensure care quality improves and evolves in a manner that best serves patient needs. It focuses upon:

- Resident centered care;
- Care outcomes;
- Public Disclosure;
- Increased collaboration; and
- Accountability and dissemination of best practices models of care delivery.

The Nursing Home Quality Initiative -- introduced by HHS and CMS in 2002 -- requires all nursing facilities in all states to participate in the program. It was implemented nationally last year, and our profession endorsed it from its introduction, and committed to the government to help make it succeed. The goal of this initiative is to identify care areas that may need improvement within a facility, publicly report nursing facility quality measures to assist consumers in making nursing home choices, and to improve patient care outcomes.

The public reporting of nursing home quality measures is done via the CMS Nursing Home Compare web site. Eight standardized measures that are intended to capture meaningful aspects of nursing care outcomes are reported. The measures are posted and updated quarterly on the CMS Web site. An additional component of the NHQI is the reporting of "statewide averages" for the measures so consumers can compare results to other facilities in the state where the facility is located.

Preliminary results of the NHQI indicate that it has been successful in promoting quality improvement activities among nursing homes. The initiative is only 8 months into its national implementation, but we are already witnessing change. According to CMS, analysis has shown that over three-quarters of nursing homes (78%) reported making quality improvement changes during the NHQI pilot and 77% indicated that the NHQI was, in part, responsible for their decision to undertake these activities. Other evaluations have confirmed that within the first five months of the NHQI, more than half of the nursing homes (52%) in the six pilot states requested quality improvement technical assistance from the Quality Improvement Organizations (QIO).

In an effort to inform consumers about the NHQI and the availability of the quality measures, CMS placed one-time-only newspaper ads in many news markets to

promote consumer awareness of its web site. CMS' studies also indicate that consumers are using the information available to them at the Nursing Home Compare website. In fact, 70% of the web users rated the information as "clear, easy to understand, easy to search and valuable."

Even in this system there are limitations that are related to inadequacies in the clinical data assessment tool and clinical information system currently used in long term care and from which the quality measures are derived. However, we are excited about the recent announcement by the Secretary of HHS, Tommy Thompson, concerning the department's efforts to standardize medical/clinical terminology. The new and recommended terminology and classification system, called SNOMED (Standardized Nomenclature of Medical Diagnoses), is far more advanced than what is currently used in long term care and supports clinical decision-making needed to achieve quality care and outcome measures.

An extremely important component of the NHQI is that it uses a collaboration and partnership model to leverage knowledge and resources. The NHQI introduced the involvement of state Quality Improvement Organizations (QIOs) to assist nursing home providers in implementing continual, community-based quality improvement programs designed for nursing homes to improve their quality of care.

A nursing home in Florida, which was one of the six pilot states, discovered that 21% of its patients were reported as suffering from chronic, unresolved pain. They did not know this fact prior to the reporting effort and they began working with Florida Medical Quality Assurance, Inc. (the QIO). FMQAI helped them analyze the system they were using to assess and manage residents' pain. They reviewed some patient charts and worked with staff to analyze where their current system was breaking down. Rather than trying to invent an entirely new system -- the FMQAI was able to identify and fix weak spots in the facility system and teach the staff how to continuously monitor their own improvement.

By November of last year, when the Quality Initiative was launched nationally, this facility's reported number for chronic pain was down to 6.6%. As of the latest round of reports (last month), their number is down to 3.25%.

In Iowa, the partnership between the individual nursing facilities and the state's QIO, the Iowa Foundation for Medical Care, has already delivered impressive results. The percentage of residents with pain dropped from 12.5% in the second quarter of 2002, to 9.1% in the fourth quarter for those facilities working with the QIO. Other quality measures, including rates of infection and residents with a loss of ability in basic daily tasks have been reported by the QIO to have significantly improved. One important reason for the improvement is the partnership between the facility and the QIO – both parties acknowledge there are problems and work together to improve the situation. In fact, a nursing facility nurse involved in the Iowa NHQI project

stated that, "the NHQI process, while it is just the beginning, has brought a collaborative effort of sharing ideas for quality improvements among the health care profession which is only improving the quality of care we provide to our residents."

A further affirmative example is a facility in the Salt Lake City area that prior to NHQI did not have any programs or processes in place regarding the assessment of residents with pain. After working with Utah's QIO, *HealthInsight*, the facility has learned best practices and implemented a process where the nurses assess residents for pain every shift when they are giving medications. The changes have been easy to implement, have decreased the amount of time it takes for documenting pain on the required assessments, and have led to better patient pain management.

Another example of how the NHQI has fostered positive relationships is evident in Mississippi. The Mississippi Health Care Association representing 190 nursing homes and long term care facilities is working in concert with the state QIO and the long term care ombudsman to educate consumers on what to look for in a nursing home through a series of statewide forums.

CMS, stakeholders, members of Congress, researchers and consumers recognize the value of quality assessment and improvement methods and their effectiveness in measuring, promoting and rewarding quality outcomes in nursing facilities. The increasing complexity of the long term care environment in recent years and the growing demands and expectations on the regulatory process offer both an opportunity and a need to creatively incorporate methods into the equation of providing and regulating long term care.

Patient, family and staff satisfaction should, officially, be a key measurement of quality. We recommend that Congress allow CMS to use measures in addition to the survey process to assess patient outcomes and their satisfaction. CMS will then have the requisite legal latitude and authority to develop better measures of quality of care in skilled nursing facilities so the process can begin to design appropriate payment incentives.

Quality First Initiative: Proactive, Profession-Wide Partnership to Advance Quality Care

Providers have also learned that we must lead in the area of improving public trust and customer satisfaction. Like quality, these areas can best be improved by providers themselves rather than by regulators, Congress or others. So we in the long term care profession have made this one of our primary missions. In July of 2002, the American Health Care Association, the Alliance for Quality Nursing Home Care, and the American Association of Homes and Services of the Aging, joined together to establish a proactive, profession-wide partnership to advance the quality of care and services for older persons and persons with disabilities.

This signifies a turning point in the empowerment and shared mission of providing quality long term care to today's and tomorrow's seniors. We are proud that long term care providers have taken this step to improve quality through increasing accountability and disclosure – a voluntary initiative that no other health care provider group has taken.

The Quality First Covenant, as it is known, is based upon seven principles that cultivate and nourish an environment of continuous quality improvement, openness and leadership. These include:

- Continuous Quality Assurance and Quality Improvement;
- Public Disclosure and Accountability;
- Patient / Resident and Family Rights;
- Workforce Excellence;
- Public Input and Community Involvement;
- Ethical Practices; and
- Financial Stewardship.

Quality First supports and builds upon CMS's Nursing Home Quality Initiative -- and is based on the concept that reliably measuring nursing home quality and making the results available to the public is in the best interest of consumer and caregiver alike.

Within Quality First there are six expected outcomes for assessing the quality in the profession. By 2006, we are working to achieve the following benchmarks:

- Continued improvement in compliance with federal regulations;
- Demonstrable progress in promoting financial integrity and preventing occurrences of fraud;
- Demonstrable progress in the quality of clinical outcomes and prevention of confirmed abuse and neglect;
- Measurable improvements in all Centers for Medicare and Medicaid Services Continuous Quality Improvement measures;
- High rates on consumer satisfaction surveys that will indicate improved consumer satisfaction with services; and
- Demonstrable improvement in employee retention and turnover rates.

It is noteworthy, Mr. Chairman, these outcomes incorporate measures from key regulatory bodies, as well as incorporating the voices of staff, residents and families. Our research demonstrates that staff and residents are important arbiters of quality. This provides the impetus for targeted systems improvement, which, as I previously noted, is an important mechanism for boosting quality. Since Quality First has been announced, providers who have made this pledge are beginning to work to catalogue their progress, identify shortfalls, and make necessary improvements.

Quality First is born from the profession and the implementation of Quality First must reside inside the profession. But of equal, if not greater importance, Quality First must be supported by those outside of the profession who are able to provide unbiased analysis. Therefore Quality First will provide for the establishment of a National Commission to advise and monitor performance and the need for improvement. While the profession supports the establishment of this Commission, it also recognizes that to be effective and credible the Commission must be independent of the profession.

The National Commission will be a private sector, non-partisan panel composed of nationally respected health care and quality improvement experts, consumer representatives, former government officials, and business leaders.

As part of its work, the Commission will evaluate the current state of long term care performance, identify key factors influencing the ability of providers to achieve meaningful quality improvement, and make recommendations on national initiatives that will lead to sustainable quality improvement.

An area of great progress has been the evolution of quality programs at the state level.

Supplementing CMS's introduction of QIOs, AHCA affiliates are collaborating within their states to implement activities and programs that foster performance improvement. Models of particular note are those in Georgia, Ohio, Minnesota and Florida.

Working in concert, the Georgia Nursing Home Association, the Department of Community Health, the Alzheimer's Association and InnerView consultants developed *The Evidence-based Quality Improvement Program for Georgia Nursing Homes* to improve the quality of life for patients in nursing homes. The program provides long term care facility managers with the knowledge and skills necessary to implement an effective continuous quality improvement program, and consumers with informational resources including nursing home quality profiles and family and employee satisfaction surveys.

In Ohio, our state affiliate was instrumental in securing legislation that funds ongoing customer satisfaction surveys of nursing facility patients and families. The most recent results indicate an average satisfaction score of 89.1 out of 100 for families and 91.8 for patients. Because Ohio nursing facility providers recognize the importance of weighing customer satisfaction when measuring quality, the Ohio Health Care Association currently is urging the legislature to continue to fund the surveys.

In addition to these state programs, AHCA has committed significant resources to the tools and programs that will support providers in quality improvement. Efforts have included development of the *How to Be A Nurse Assistant* curriculum that effectively trains nurse assistants to deliver top-quality care, and the creation of *Radiating Excellence: The Senior Nurse Leader Self-Assessment* -- a unique program that delivers leadership and management education. Additionally, we have produced the AHCA Model Consumers Guide, which promotes the value of providing customer focused information and provides resources for long term care providers to assess customer satisfaction.

Mr. Chairman, I'd like to thank you again for providing us the opportunity to share our views about how we can continue to work together to improve the quality of long term care, and to do so in a manner that helps us best measure both progress as well as shortcomings. To be effective, our profession needs economic and workforce stability that the government has a role in providing. We saw the devastating result of BBA cuts and the impact of BBRA relief. We must modulate this seesaw with adequate funding.

As I noted, improving care quality is a continuous, dynamic, ongoing enterprise – and I can say from all my years in long term care that there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it keeps improving.

Let us all commit today to ensure the systems and methods used in the 20th century to help assess and measure care quality are improved upon by new, evolving systems and methods that, in the 21st century, we are just now beginning to explore. We are committed to achieving demonstrable, measurable quality improvements on every front, and we look forward to maintaining a successful working partnership with you, Mr. Chairman, and with everyone here today.