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NURSING HOME TRANSPARENCY AND IMPROVEMENT

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UNITED STATES SENATE

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NURSING HOME TRANSPARENCY AND IMPROVEMENT

THURSDAY, NOVEMBER 15, 2007

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

The Committee met, pursuant to notice, at 1:30 p.m., in room G–50, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl, Wyden, Lincoln, Nelson, Salazar, Casey, Smith, and Craig.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. We will get started right now. We are awaiting our first witness, Senator Grassley, who will be here momentarily. So we call this hearing to order. We welcome our witnesses today.

In May this Committee held a hearing to examine the legacy of the 1987 Nursing Home Reform Act. We heard from various experts on how far nursing homes have come in the past 20 years. While our previous hearing was about looking back, today's hearing is about moving forward and taking the next big step in improving our nation's nursing homes.

To do so, we have been working—I have been with my colleague, Senator Grassley, on our proposal to improve nursing home quality by increasing transparency as well as strengthening enforcement. We are very pleased to have Senator Grassley here today to make a statement.

We believe that Americans should have access to as much information about a nursing home as possible, including the results of government inspections, the number of staff employed at a home, as well as information about the home's ownership. The government should ensure that consumers can obtain this information in a clear, timely, and accurate manner so that they can make the right decision about where to place a loved one.

Our bill will strengthen the government system of enforcement. Under the current system, nursing homes that are not providing good care or even worse, are putting their residents in harm's way, can escape penalty from the government while they slip in and out of compliance with Federal regulations. If course, that is not acceptable.

We need the threat of sanctions to mean something. Under the bill that I am working on with Senator Grassley, they will mean something. We also need to make sure that regulators are able to intervene quickly in order to protect the safety of residents.

Today we will also hear from CMS Acting Administrator Kerry Weems. While working on our bill with CMS, we have discovered that many of our goals are aligned. Administrator Weems will testify shortly about the special focus facility program created by CMS to deal with those nursing homes exhibiting a consistent history of providing poor care to residents.

We will be asking him about a significant move toward transparency that CMS is planning to undertake in the near future. In fact, in just over 2 weeks, CMS will be disclosing the names of the facilities taking part in this special focus facility program.

I am pleased to say that CMS is beating us to the punch. Disclosing this list is a provision in our forthcoming bill. CMS does understand what we understand, that it is in everyone's best interest to let consumers know which nursing homes are repeatedly demonstrating deficiencies and violating government standards. Those homes are obviously not doing their jobs.

Often the only way to ensure the improvement of any entity is to bring its failings to light. Senator Grassley feels that way. CMS feels that way. I feel that way, too.

I do honestly believe that more nursing homes will come back into compliance for good if they have the court of public opinion and the power of market forces as encouragement. At the same time, we acknowledge that our goal is not to close a home, but to fix the home because that is often what is best for the residents. As you will hear, the special focus facility program is helping these facilities make the changes that are needed to improve.

Our hearing today also features a third panel of distinguished witnesses. In a rare stroke of good fortune, three of them come to us from my own home state.

We will hear recommendations from national experts, organized labor, and representatives of the nursing home industry on the topics of transparency and enforcement. As always, I find it very important to state that while we are shining a light on poor performing homes, we believe that a vast majority of nursing homes in our country are doing a good job. Most homes provide exemplary care, the type of care that you would be happy to have a member of your own family receive.

We will hear from one such home today, the Marquardt Memorial Manor in Watertown, WI. I can personally vouch for this home, as I have had the opportunity to visit it many times.

So we thank everybody for being here today. We look forward to working with you all. I look forward also to hearing from the Ranking Member on this Committee, as well as Senator Craig. But I would ask them to defer for just a few minutes because Senator Grassley, whose statement we very much would like to hear, has only a limited time to be with us today.

So, Senator Grassley, we recognize you.

STATEMENT OF SENATOR CHARLES GRASSLEY, RANKING MEMBER, SENATE FINANCE COMMITTEE

Senator GRASSLEY. I thank you and my colleagues who are deferring to me. I thank you very much for not only that, but, of course, your very important role as leaders on this Committee.

First of all, thank Chairman Kohl for his holding this very important hearing. When I had the privilege of serving as Chairman of this Committee, many of our efforts were focused on abuse and substandard care in America's nursing homes. I am glad to see that under the leadership of Chairman Kohl this critical issue remains at a top priority. I applaud the Committee's efforts.

In America today there are nearly 1.7 million elderly and disabled individuals in approximately 17,000 nursing homes. This includes the men and women of the World War II generation. Our duty to ensure that these Americans receive high-quality care couldn't be higher.

But in addition to the people currently living in nursing home facilities, another issue lies on the horizon. That is the baby boom generation getting older. The number of Americans in nursing homes will go up dramatically. Therefore, it is critical that we confront the issue of safe and high-quality nursing homes today to be ready for tomorrow.

As the Ranking Member of the Senate Finance Committee, I have a special interest in nursing home care. The industry is often the subject of both my investigative and legislative work, and today I would share some thoughts with you.

I want to emphasize four areas: the problem of repeat offender homes; the issue of fire safety; the need for greater transparency in quality at these homes; and recent concern over reports that the rise of private equity firm ownership of nursing homes is resulting in poorer quality of care. In the nursing home industry, the vast majority of homes provide quality care on a consistent basis. They provide an invaluable service to our older and disabled. We applaud them for that service.

But as in many sectors, this industry is given a bad name by a few bad apples that spoil the barrel. A critical tool in confronting these bad actors is the sanctions that CMS can place on homes for failure to meet certain standards of care. Yet too often, nursing homes are able to yo-yo in and out of compliance, temporarily correcting deficiencies and having the sanctions rescinded, only then to fall back into noncompliance.

When sanctions are put in place, nursing homes currently have the incentive to file appeal after appeal after appeal, delaying the imposition of penalties and adding costs to the taxpayers. A recent Government Accountability Office report examined 63 nursing homes that had been identified as having serious quality problems.

Of these, nearly half continued to cycle in and out of compliance between years 2000 and 2005. Twenty-seven of the 63 homes were cited 69 times for deficiencies warranting immediate sanctions. Yet in 15 of these cases sanctions were not even imposed.

Eight of the homes reviewed cycled in and out of compliance seven or more times each period. This is unacceptable.

But the real meaning of substandard care isn't about numbers. It isn't about statistics. It is about real people-our mothers, fathers,

grandparents and loved ones. Every day there are stories reported across the Nation about residents suffering or even dying from preventable situations.

Imagine, just recently I read about a nursing home resident in Florida who was taken to a hospital with bed sores, a partially inserted catheter, an infected breathing tube, and maggots in one of his eyes.

Each and every one of you will agree with me. This is unacceptable. It is not humanitarian. It is an outrage.

The current system provides incentives to correct problems only temporarily and allows homes to avoid regulatory sanctions, while continuing to deliver substandard care to residents. This system must be fixed.

In ongoing correspondence that I have had with Kerry Weems, who is here and is Acting Administrator of CMS, and you will be hearing from him, that agency has requested the statutory authority to collect civil monetary penalties sooner and hold them in escrow pending appeal. I think that is a good start.

Penalties should also be meaningful. Too often, they are assessed at the lowest possible amount, if at all. Penalties should be more than merely the cost of doing business. They should be collected in a reasonable timeframe and should not be rescinded so easily. These changes will help prod the industry and particularly, the bad actors to get their act together or get out of business.

Another pressing issue is that of fire safety. As we saw in 2003, this is an issue of life or death importance.

Sixteen people died in a nursing home fire in Hartford, CT, and 15 died-in a home in Nashville in 2003. Neither home had installed automatic sprinkler systems.

Despite the fact that a multiple-death fire has never occurred in a sprinklered home, there are approximately 2,773 homes still without full sprinkle systems. Following these terrible events, I requested the Government Accountability Office to look into this matter and have held an ongoing conversation with CMS on how we can better protect America's nursing home residents from preventable fires.

In October 2006, CMS began to move in this direction and expects to issue a final rule in the summer of 2008. This is much-needed improvement that will surely save lives.

While a better penalty system and better fire safety will do much to increase nursing home safety, we have also got to give nursing home residents and their families better access to information about these homes. To do that we obviously have to have more transparency than we presently have.

The public does currently have access to some information on nursing homes through the Web site Nursing Home Compare, located on Medicare's Web site. Yet for all the valuable information this Web site provides, it could be improved through the inclusion of information on sanctions, as well as an identification of the worst offending homes, often called special focus facilities. By listing these homes and the implemented enforcement action online, information the government already has, you don't have to go out and get more information. The public then would have better ac-

cess to nursing home information, and nursing homes would have an extra incentive to meet quality standards.

The process of choosing a nursing home is a very important and personal one for thousands of American families every year. We owe it to them to give them complete information when they are making a decision of where to put a loved one. Acting Administrator Weems in a recent letter to me, gave his assurance that CMS would begin posting some of this information online. I thank him for his commitment and look forward to seeing that carried out.

So for me, the key is to ensure that nursing homes provide quality care to residents consistently day in and day out. If they don't, the public should be aware of that fact. In this area, as in others, a little sunshine will go a long way.

Finally, I want to touch on an issue that has garnered a lot of attention lately, that of the purchase of nursing homes by private equity groups. Recent news reports have highlighted concerns over decreasing quality of care, decreasing staffing, and decreased budgets at nursing homes purchased by private equity groups. At one home, it is alleged that 15 residents died in 3 years due to negligent care at a home purchased by one of these groups.

In response to these concerns, Senator Baucus and I have launched an inquiry into private equity firms and their ownership of nursing homes. Last month, we sent letters to five private equity firms asking for detailed information about their purchases and impending purchases of nursing facilities.

In private equity ownership of nursing homes if that ownership is, in fact, having the effect of decreasing staffing, decreased budgets, and, in turn, decreased care, then something must be done about it. I plan to continue my inquiry and look forward to working with Senator Baucus to take whatever measures are appropriate to address the issue.

Those four issues that are presented to you: ineffective enforcement; nursing home fire safety; the need for greater transparency; and concerns over private equity ownership affect millions of vulnerable Americans. The U.S. Senate has a great responsibility in addressing them.

Again, I thank Chairman Kohl and the members of this Committee for holding this hearing and look forward to working with you all on these matters. I also want to acknowledge the efforts of the group that is entitled Advancing Excellence in America's Nursing Homes. This group is a broad coalition of organizations dedicated to improving the quality of care and quality of life of nursing home residents.

Coalitions such as this are vital to our efforts. All of us-and I mean private organizations. I mean families. I mean residents. I mean caregivers, nursing home advocates, the government, all of the above and maybe more that I haven't mentioned, have a role to play in this important work if we want to be successful in our efforts to continue improving nursing home care.

Indeed, much work needs to be done. So, I thank you for taking my testimony and wish you well. You are doing good work in this area. Because where we were 10 years ago the job is still not done. Thank you very much.

The CHAIRMAN. That was a great statement, Senator Grassley. We appreciate your stopping by and making it. As a former Chairman of the Committee, what you have to say is valued, appreciated. We will take into consideration everything you have said with the greatest seriousness.

Senator GRASSLEY. Thank you.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR GRASSLEY

Good morning. I want to begin by thanking Chairman Kohl and the members of the Senate Special Committee on Aging for holding this important hearing. When I had the privilege of serving as chairman of this committee, many of our efforts were focused on abuse and substandard care in America's nursing homes. I'm glad to see that under the leadership of Chairman Kohl, this critical issue is remains a top priority and I applaud the committee's efforts.

In America today, there are nearly 1.7 million elderly and disabled individuals in approximately 17,000 nursing home facilities. This includes the men and women of the world war two generation—and our duty to ensure that they receive the quality care they deserve couldn't be higher.

But in addition to the Americans currently living in nursing home facilities, another issue lies on the horizon. As the baby boom generation gets older, the number of Americans in nursing home facilities is going to rise dramatically. Therefore, it's critical that we confront the issue of safe and high quality nursing home care today.

As the Ranking Member of the Senate Finance Committee, I have a special interest in nursing home care. The industry is often the subject of both my investigative and legislative work, and today I'd like to share some of my thoughts. In particular, I want to emphasize four area that are of concern in the nursing home industry from my perspective: 1) the problem of repeat offender homes, 2) the issue of fire safety, 3) the need for greater transparency in nursing home quality, and 4) recent concern over reports that the rise of private equity firm ownership of nursing homes is resulting in poorer quality of care.

In the nursing home industry, the vast majority of homes provide quality care on a consistent basis. They provide an invaluable service to those who can no longer care for themselves, and we applaud them for this service. But as in many sectors—this industry is given a bad name by a few bad apples that spoil the barrel. A critical tool in confronting these bad actors are the sanctions CMS can place on homes for failure to meet certain standards of care. Yet too often, nursing homes are able to "yo-yo" in and out of compliance, temporarily correcting deficiencies and having the sanctions rescinded, only to fall back into noncompliance. When sanctions are put in place, nursing homes currently have the incentive to file appeal after appeal, delaying the imposition of penalties and adding costs to the taxpayer. So for me the key is to ensure that nursing homes provide quality care to residents consistently—day in and day out—and if they don't, the public should be aware of that fact.

A recent GAO report examined 63 nursing homes that had been identified as having serious quality problems. Of these, nearly half continued to cycle in and out of compliance between fiscal years 2000 and 2005. Twenty seven of the 63 homes were cited 69 times for deficiencies warranting immediate sanctions, yet in 15 of these cases sanctions were not imposed. Eight of the homes reviewed cycled in and out of compliance seven or more times each period. This is unacceptable.

But the real meaning of substandard care isn't about numbers and statistics—it's about real people—our mothers, fathers, grandparents and other loved ones. Every day there are stories reported across this nation about residents suffering or even dying from preventable situations. Imagine, just recently I read about a nursing home resident in Florida who was taken to a hospital with bed sores, a partially inserted catheter, an infected breathing tube, and maggots in one of his eyes. Each and every one of you will agree with me—this is unacceptable. It is an outrage.

The current system provides incentives to correct problems only temporarily and allows homes to avoid regulatory sanctions while continuing to deliver substandard care to residents. This system must be fixed. In ongoing correspondence I've had with Kerry Weems, the acting administrator of CMS, that agency has requested the statutory authority to collect civil monetary penalties sooner, to be held in escrow pending the decision on appeal. I think this is a good start. Penalties should also be meaningful—too often, they are assessed at the lowest possible amount, if at all. Penalties should be more than merely the cost of doing business; they should be collected in a reasonable timeframe; and should not be rescinded so easily. These

changes will help prod the industry's bad actors to get their act together or get out of the business.

Another pressing issue is that of fire safety, and as we saw in 2003, this is an issue of life-or-death importance. That year, 16 people died in a nursing home fire in Hartford, Connecticut, and 15 died at a home in Nashville, Tennessee. Neither home had installed automatic sprinkler systems. Despite the fact that a multiple-death fire has never occurred in a sprinklered home, there are approximately 2,773 homes still without full sprinkle systems.

Following these terrible events, I requested that GAO look into the matter, and have held an ongoing conversation with CMS on how we can better protect America's nursing home residents from preventable fires. In October 2006, CMS began to move in this direction, and expects to issue a final rule in the summer of 2008. This is a much needed improvement that will surely save lives.

While a better penalty system and better fire safety will do much to increase nursing home safety, we've also got to give nursing home residents and their families better access to information about these homes. And to do that you need more transparency.

The public currently has access to some information on nursing homes through the website "Nursing Home Compare," located on Medicare's website. Yet for all the valuable information this website provides, it could be improved through the inclusion of information on sactions, as well as an identification of the worst offending nursing homes, often called "Special Focus Facilities." By listing these homes and the implemented enforcement actions online—information the government already has—the public would have better access to nursing home information and nursing homes would have an extra incentive to meet quality standards.

The process of choosing a nursing home is a very important and personal one for thousands of American families every year—we owe it to them to give them complete information when making this decision. Acting Administrator Weems, in a recent letter to me, gave his assurance that CMS would begin posting this information online. I thank him for his commitment and look forward to seeing this carried out. In this area, as in others, a little sunshine will go a long way.

Finally, I want to touch on an issue that has garnered a lot of attention lately—that of the purchase of nursing homes by private equity groups. Recent news reports have highlighted concerns over decreasing quality of care, decreased staffing, and decreased budgets at nursing homes purchased by private equity groups. At one home, it is alleged that 15 residents died in three years due to negligent care at a home purchased by one of these groups.

In response to these concerns, Senator Baucus and I have launched an inquiry into private equity firms and their ownership of nursing homes. Last month, we sent letters to five private firms asking for detailed information about their purchases and impending purchases of nursing facilities. If private equity ownership is in fact having the effect of decreased staffing, decreased budgets, and, in turn, decreased care, then something must be done about it. I plan to continue my inquiry and look forward to working with Senator Baucus to take whatever measures are appropriate in addressing this issue.

Those four issues—ineffective enforcement mechanisms, nursing home fire safety, the need for greater transparency, and concerns over private equity ownership—affect millions of vulnerable Americans and the United States Senate has a great responsibility in addressing them. Again, I thank Chairman Kohl and the members of this committee for holding this hearing, and look forward to working with you all on these matters. I also want to acknowledge the efforts of the group "Advancing Excellence in America's Nursing Homes." This group is a broad coalition of organizations dedicated to improving the quality of care and quality of life of nursing home residents. Coalitions such as this are vital to our efforts. In closing, all of us—and I mean private organizations, families, residents, caregivers, nursing home advocates, and the government—have a role to play in this important work if we want to be successful in our efforts to continue improving nursing home care. Indeed, much work remains to be done. Thank you.

The CHAIRMAN. Thank you.

Now, I would like to turn to our Ranking Member, Senator Smith, for his statement.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, RANKING MEMBER

Senator SMITH. Thank you, Mr. Chairman. I appreciate this important hearing and this continuing discussion we are having on nursing home quality.

These discussions are necessary to ensure that those in need of long-term care get the quality care that they deserve. The issue of nursing home quality and safety is of particular interest to me and all members of this Committee. I thank our panelists today for being here.

I, like Senator Kohl, appreciate Senator Grassley. As a former Chair of this Committee and having served as both Chairman and Ranking Member of the Senate Finance Committee, the interest of our citizens in nursing homes has long been a priority for him.

We know that the need for long-term care is expected to grow significantly in the coming decades. Almost two-thirds of the people currently receiving long-term care are over the age 65. This number is expected to double by 2030.

We also know that the population over age 85, those are the ones most likely to need long-term services and supports. They are expected to increase by more than 250 percent by the year 2040 from 4.3 million to 15.4 million.

Today, millions of Americans are receiving or are in need of long-term care services and support. We don't have to wait that long. It is already here.

Surprisingly, more than 40 percent of the persons receiving long-term care are between the ages of 18 and 64. The past decade has revealed a shift in the provision of long-term care.

A great example of this is in my home State of Oregon, where much of the care is provided in community settings and in recipients' homes. We also have seen that long-term care providers are offering services that put the patient at the center of care, encouraging inclusion of families in decisionmaking, and giving more choices in the location of care, such as community-based and home care settings.

As I have said in this Committee before, ensuring patient safety is a responsibility that rests with no one party or entity. It is shared by care providers, by Federal and State governments, law enforcement agents, local agencies, and community advocates. It is a responsibility that I and my colleagues take very seriously.

We must all work together more collaboratively to curb the incidence of elder abuse. We owe that to the millions of seniors who have placed their trust in our nation's long-term care system and to those who remain in their homes and in their communities.

With the passage of the Elder Justice Act, this would be a wonderful and much-needed step toward this goal. Apart from improving communication and cooperation of enforcement activities, there would be new stronger policies in place to ensure that seniors receive the safest long-term care possibily.

To that end, I have introduced the Long-Term Care Quality and Modernization Act with Senator Blanche Lincoln. This bill encourages a number of important improvements to nursing homes and the long-term care system that aim to enhance the quality and safety of care provided to our seniors. I look forward to continuing

to work with the many advocates, industry representatives, and regulators here today to ultimately pass this important legislation.

I would like to applaud the work that Senator Kohl has done in this area as well, and especially in regard to helping nursing homes and other facilities better identify potential bad actors in the workforce and to ensure families are informed of facility quality. It is essential that we find more effective ways to help poor performing facilities operate at a much higher level or to consider ways that they can be phased out of the system. We cannot let the inappropriate actions of a few continue to destroy the trust our nation's seniors have placed in the long-term care system.

I am confident this fine panel of experts will be able to provide a fresh light, some fresh insight into the work that is being done at the Federal, State, and local levels to reduce elder abuse and provide the safest, highest quality care that is possible. Thank you.

The CHAIRMAN. Thank you, Senator Smith.

In order of arrival, we have Senator Craig first and then Senator Casey.

Senator Craig.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG

Senator CRAIG. Mr. Chairman, thank you very much. A special thanks to you and our Ranking Member, Senator Smith.

Before Senator Grassley left the room, there were either four former or currently serving chairmen. I think once you have served on this Committee a time, your passion for its mission never leaves you because we have always viewed our aging community as one of our more vulnerable communities. Thank you for the work you are doing and for the work Senator Smith has done.

The challenge of nursing home improvement is a prime example of the Aging Committee's importance of putting a spotlight on issues that are of vital significance to our senior population and their families. This Committee also plays a valuable role in crafting solutions to challenges facing our aging population.

During my tenure as Chairman of this Committee, I spent some time examining long-term care and issues relating to the well-being of our vulnerable seniors. While our aging population is moving more toward home and community-based services, as Senator Smith has mentioned, there still is going to be a need for nursing home care.

Now, I look forward to the hearing and to our witnesses today, and to all of your comments. Transparency is an important factor in ensuring that our nursing homes are safe places. It is important for families to have the necessary background information when choosing a nursing home. Most people are not going to choose a poor performing facility for their loved ones.

So making inspection information readily available to the public is also a great incentive for nursing homes to meet their standards. Unfortunately, like all good ideas, the devil is in the details.

CMS' nursing home compare is a great step for those who want more information about nursing homes. However, more can be done to make information on the Web site easier to understand so that families know what the deficiencies that a facility receives actually mean and how this actually impacts a senior in these facilities.

Families who are looking for a nursing home are often overwhelmed by this tremendous lifestyle change that is about to hit their family. They do not have the time to become the expert in nursing home oversight and inspection.

I also want to stress the importance of information on nursing home compare being kept as up to date as possible. It is unfair to both the nursing home provider and seniors when only outdated information about the problem at a particular facility is available online.

With that said, I look forward to our hearing today.

Mr. Chairman, it is an important one as legislation moves forward on this issue. I thank you.

The CHAIRMAN. Thank you, Senator Craig.

Senator Casey.

OPENING STATEMENT OF SENATOR BOB CASEY

Senator CASEY. Mr. Chairman, thank you very much for chairing this hearing and for your work as the Chairman of our Committee. This is an incredibly important hearing, for a lot of reasons. I was going to tell some personal stories that I think demonstrate to me how critical this hearing is and the subject matter of the hearing.

I also want to thank Senator Grassley for his testimony. I missed part of it, but I know his commitment and so many others who are here.

This issue for me is probably more personal than most because it affected both the work that I did before I got to the Senate, as well as has had an impact on my own family background. My work as a State official, the auditor general, allowed us to audit the oversight by the Pennsylvania Department of Health of nursing homes. We put out a report, which was very critical. I hit that agency very hard in 1998. That led to a lot of work down the road.

I don't want to spend a lot of time on that, but suffice it to say that some of the problems that we will talk about today, some of the questions that we will ask, some of the priorities that we enunciate from this platform, but also at the witness table, remind me of what we were doing in 1998 and 1999. So there is still much work to be done.

But two personal insights, Mr. Chairman. One is a meeting I had across the street from a nursing home. When we got into this work pretty deeply, a lot of families were contacting us. We know from the work in long-term care that this is an issue that isn't just about older citizens in the twilight of their lives. It is about the whole family.

Younger members of the family worry about where a loved one is placed. They worry about the care. They worry about the expertise and the professionalism that will be brought to bear on their loved one.

So we set up a meeting with a woman whose husband was in a nursing home. We wanted to meet her across the street first to talk to her, and then we went for a visit. As soon as she sat down across from me in—I think it was a deli or a coffee shop. As soon as she sat down, I shook her hand. She looked at me. Before she could talk, she started to cry.

Now, she wasn't crying because he was getting terrible care. There was no crisis necessarily. But she was crying because, like a lot of Americans, it is a traumatic decision, as others have said today, to place a loved one in a nursing home. Once they are there, you worry about them.

I think the basic worry that most people have, especially a spouse or a close family member, is will that person get the same kind of care in this facility, as good as it might be, as they would get in the home or they would receive from a husband or a wife or a family member. That is the principle worry that people have.

Our obligation in the Senate is to do everything possible to understand that fear and that worry and that sometimes the failure to have the kind of peace of mind that people deserve and to bring about policies that will do our best to meet that obligation so that someone who makes that decision, a family decision, can have that kind of peace of mind.

The second example in my own life is my father. He suffered from an incurable disease in the later part of his life. He was a big, tough, powerful person in his day. But at the end of his life, he had no power. His mind was fine, but he had no power to move.

So when he was in a long-term care setting, moving from here to here, I mean, literally inches, he couldn't do on his own. So he relied upon the skill and the expertise of long-term care workers, nurses, nurses aids, the whole gamut of expertise.

I learned a lot about that. He got great care. But I remember distinctly being in the hospital one night when he was getting very bad care from one particular nurse.

She just happened to be an agency nurse who was there temporarily. She didn't know him, didn't know much about his medications. She made a terrible error.

So, I had a glimpse, a fleeting glimpse into what bad care can result in. Fortunately, he wasn't permanently impacted by that poor care.

So all these personal and human memories come back when I think about this issue. It is particularly disturbing in light of this new phenomenon with regard to private equity firms purchasing, acquiring long-term care facilities.

It is bad enough when the government is not doing its job in terms of oversight. I saw that at the State level. Fortunately, it is better today, at least in terms of what we were identifying.

That was bad enough. But when you have the added problem of private entities that stand to make a lot of money on the initial purchase, but also stand to make a lot of money in the long run, sometimes at the expense of good care, that makes the problem all the worse.

I was just citing a report that I know from the back of the room by the Service Employees International Union, "Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents." What is in this report is not just disturbing to me, it reminds me what I was working on almost a decade ago in Pennsylvania. I am sure the same was true in a lot of other states.

What is identified in this report is disturbing. It is troubling, to say the least. It cries out for action by this Committee, by the U.S. Senate, and, frankly, by the administration. Frankly, the adminis-

tration doesn't always need a new law or a new regulation to move forward. The administration should focus more acutely on this.

So we have a lot of work to do. This is a very personal issue for a lot of Americans. I feel that obligation very deeply.

I know, Mr. Chairman, you do, and the members of this Committee. I look forward to the testimony today. Thank you.

The CHAIRMAN. Thank you, Senator Casey.

Senator Wyden.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I want to commend you and Senator Smith and so appreciate the bipartisan approach that you all take to this issue.

I just make three points very quickly. First is something is out of whack in this country when it is a lot easier to find information about the quality of a washing machine than it is to get information about the quality of long-term care facilities. That is a fact.

All over this country you can easily get access to information about home appliances and a variety of other retail purchases you make. But you can't get information about the essential health care services that are available.

I think that is why it is so good that you are going forward in your leadership, Senator Kohl and Senator Smith.

Second, on this trend toward the large chains and private equity firms getting into the field. I think it is worth noting Senator Smith and I see it as we have a great many long-term care facilities in our State that are essentially small, family owned facilities. I think it is pretty clear that those kinds of health care facilities do a lot more to make information available to families, share information with respect to long-term care choices than some of these big chains.

So this notion that you can't be straight with the public and with the consumer and the families, as Senator Casey speaks so eloquently about, that is not correct, No. 1. and No. 2, we have some concrete examples of how to have more transparency in long-term care.

That is particularly in a lot of our small towns where you have family owned long-term care facilities. They are showing how to get information out to families, work with families, and make sure they know more about their choices.

One last point, Mr. Chairman. As you and I have talked about, in the Healthy Americans Act, the legislation I have, we now have 11 United States senators. It is the first bipartisan universal coverage bill in more than 13 years here in the U.S. Senate. We have a significant long-term care section in that legislation, both on the public side and on the private side.

One of the reasons I think your hearings are so helpful, Mr. Chairman, it is my intent to take the information that you all get through the leadership in this Committee and to add to that legislation some of what you have found about how to promote transparency. Frankly, we have taken some baby steps in the legislation to get more information out.

But as a result of your good work and these important hearings, it is my intent to take the information that comes out of these

hearings on long-term care facilities and transparency, take that information and put it into our legislation. I think that is one additional way the Senate can work in a bipartisan way to promote better long-term care choices for our people.

Mr. Chairman, I thank you. I look forward to working with you.

The CHAIRMAN. Thank you very much, Senator Wyden.

At this time, we will call Kerry Weems to make a statement to us. Kerry Weems is the CMS Acting Administrator.

Mr. Weems was tapped in September 2007 to take over the helm of the agency that administers Medicare and Medicaid, as well as the State children's health insurance program, which does provide health care services to more than 100 million Americans. We are very pleased to have Administrator Weems here today to provide us with an account of CMS initiatives to enforce existing standards as well as to address the problem of poor performing nursing homes to which we have referred already today several times.

So, Mr. Weems, welcome, and thank you for coming. We would be delighted to hear your statement.

STATEMENT OF KERRY WEEMS, ACTING ADMINISTRATOR, CENTER FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. WEEMS. Mr. Chairman, good afternoon. Thank you for holding this hearing. Senator Smith, other distinguished members of the panel, it is my pleasure to be here today to discuss the Centers for Medicare and Medicaid Services' initiatives to promote and improve nursing home quality.

Roughly 1.5 million Americans reside in the nation's 16,400 nursing homes on any given day. More than 3 million rely on services provided by a nursing home during any point in the year. These individuals and an even larger number of their family members and friends must be able to count on nursing homes to provide reliable care and consistently high quality.

Charged with overseeing the Medicare and Medicaid programs, whose enrolled populations comprise the vast majority of nursing homes, CMS takes nursing home quality very seriously. Our efforts in this area are broad, including initiatives to enhance consumer awareness and transparency as well as rigorous surveying and enforcement processes focused on safety and quality.

As Acting Administrator of CMS, nursing home quality is a professional priority, but also a personal cause. My mother-in-law was a nursing home resident who suffered from Alzheimer's disease and was bedridden. During the time that my nomination to this position was under consideration in my household, my wife, Jean, went to this nursing home to visit her mother and noticed a large bruise over her mother's eye.

If this wasn't upsetting enough, the staff wasn't able to tell her what happened. This is exactly the kind of situation that CMS' safety and quality initiatives are intended to prevent.

When Jean returned from the visit with her mother, she told me that I could accept the nomination to be the next CMS administrator, that if I was going to do that, I needed to make quality nursing home care a priority. So advancing nursing home quality

is not only a condition of my employment, you see, it is also the condition of a harmonious marriage.

Now, if I could bring your attention to the chart on display-and you also have the materials in front of you-I am prepared to lay out a set of milestones for further improvement in nursing home care. We talk about accountability in government. This is our plan.

The only caveat that I would add is as CMS administrator, I am not the sole decisionmaker on these. These are our aspirational goals. This is where we would like to find ourselves over the next year.

Senator Grassley mentioned our participation in Advancing Excellence in America's Nursing Homes campaign. That will continue.

The next item. By December 1 of this year, we will post on the CMS nursing home compare Web site the names of the special focus facilities. I will discuss that in greater detail in a moment.

In early 2008, we plan to expand the quality indicator survey pilot to a sixth-State. The program is currently testing ways to improve the traditional survey process in Florida, Connecticut, Kansas, Louisiana and Ohio. We are seeing promising results.

The survey employs methodological data analysis and technology to better focus surveyors on probable areas of concern. Data collected from a particular facility are used to derive quality of care indicators, which can be then compared to national norms that will help guide our surveyors' assessments.

In spring of 2008 CMS hopes to issue a solicitation to begin the process of inviting states and nursing homes to participate in a value-based purchasing demonstration. The program would adjust payment in a manner that recognizes the quality improvement in nursing home quality, thus stepping up incentives for high-quality care, which is, in the end, what we care about, high-quality care.

In April CMS plans to co-sponsor a national symposium to examine and support culture change in the nursing home community. This culture change will move nursing homes to a more person-centered approach, an environment that respects individuals, and inspects nursing home quality at all levels, staff management and ownership. Some of this is very simple things such as teaching the aids to knock on the door before they enter, to ask simple permissions, to move the care to a very patient-centered form of care.

CMS is working on the final evaluation of a 3-year pilot demonstrating the comprehensive system of criminal and other background checks for prospective new hires.

I know this is a particular concern of yours, Mr. Chairman.

Our goal is to issue this final report in May 2008. In June we expect to report on the progress of an ongoing national campaign to reduce the incidents of pressure ulcers in nursing homes and reduce the use of restraints. In that same month we hope to issue guidance to surveyors on infection control and nutrition in nursing homes. These new guidelines will be the latest of an ongoing set of CMS efforts to improve consistency and effectiveness of the survey process.

Senator Grassley mentioned a final CMS regulation on fire safety protection, which would require all nursing homes to be fully sprinkled by a defined phase-in period. It is currently expected to be released in August 2008.

Also, in August, a new CMS contract for quality improvement organizations will take effect. CMS hopes to build into that a 3-year agenda for the QIOs to begin working with nursing homes who have poor quality, including the special focus facilities.

In September 2008, CMS will issue a report describing feasible methodologies for improving the accuracy of staffing information submitted by nursing homes for posting on the CMS nursing home compare site. Finally, CMS has stated on the record previously before this Committee-Senator Grassley mentioned that as well-that we would envision supporting legislative efforts to permit the collection and escrow of deposit for civil monetary penalties as soon as the penalties are imposed. Our expectation is that such legislation might be reasonably enacted by the Congress by 2008.

I will now turn to a particular CMS effort that I understand is of interest to the Committee, the special focus facility initiative. Facilities we target for special focus consistently provide poor quality care. Yet oftentimes they pass isolated surveys by just fixing the number of problems to enable them to satisfy the survey. They then fail the next survey, often for many problems that they had ostensibly fixed.

Of course, this in and out or yo-yo compliance does not address the homes' underlying systematic problems. The special focus facility program is designed to put an end to fluctuating compliance. Once a facility is placed on the special focus program, CMS applies a progressive enforcement until the nursing home takes one of three paths: graduates from the program because it has made significant long-lasting improvements; is terminated from participation in the Medicare or Medicaid programs; or is given more time because we see potential for improvement such as the sale of the nursing home to a new owner with a better track record of providing quality care.

We are finding that the special focus initiative really works. Here is one example.

A nursing home in rural South Carolina was a special focus nursing home that failed to improve during its first 18 months after selection. As a result, in April 2007 CMS issued a Medicare notice of termination to the facility. We were prepared to see the 132 residents located to another facility that provided better care. We all know the trauma that that brings with it.

At that point, however, the nursing home operators evidenced a willingness to implement serious reforms with clear potential to transform their quality of care. CMS agreed to extend the termination date on the condition that the nursing home would enter into a legally binding agreement to adopt specific quality focus programs. We required a root cause analysis of their underlying system of care deficiencies, which was conducted by a QIO selected by CMS but paid for by the nursing home.

We required an action plan based on the root cause analysis and also an $850,000 escrow deposit to finance the needed reforms. Our interventions were successful. The nursing home passed its subsequent survey, was purchased by another owner, and is now on track to graduate from the special focus facility. The nursing home operator is now seeking to replicate this approach in the other nursing homes that it operates.

In closing, I would stress that CMS' quality and safety assurance mandates extend to every nursing home in the Nation, large, small, public or private. Regardless of setting or ownership, quality care for Medicare and Medicaid beneficiaries is of utmost importance to CMS.

To that end, I hope the milestones I have shared with you demonstrate our tireless work to quality at CMS. Thank you. I would be pleased to answer any questions you might have.

The CHAIRMAN. Thank you, Mr. Weems. The special focus facility program-you have, I understand, compiled the list of facilities that will likely appear on that program?

Mr. WEEMS. We currently have 62 facilities, the names of which we will be prepared to put on the Web site on or before December the 1st.

The CHAIRMAN. That interim period is for what reason?

Mr. WEEMS. Senator, we want to make sure that we have notified the facilities and the facilities have had an opportunity to talk to their staff, talk to the residents, talk to the family of the residents so they understand the nature of the action being taken. One of the things that we want to make sure that we do is make clear the three possible paths, that by being in a special focus facility it is possible to improve. But termination is also possible. We don't want to induce panic among the residents or among the staff.

The CHAIRMAN. In terms of improving the quality of these facilities, are you optimistic that this kind of a program will be serious enough to really make a marked difference in a relatively short period of time? Because of the nature of the sanctions and the awareness that children will have about their parents being in a facility that is not performing up to standard, are you optimistic that this over a reasonable period of time will result in a marked improvement as well as a big-time reduction in the number of facilities on this program?

Mr. WEEMS. Well, Senator, it certainly will produce a result for those facilities that are in the program. They are going to go down one of those three paths that we have mentioned. Also disclosing these facilities and giving people a good understanding about what they mean, I think, also provides the right kind of incentives to improve quality system-wide.

The CHAIRMAN. Thank you.

Senator Smith.

Senator SMITH. Mr. Chairman, thank you.

Mr. Kerry, thank you for being here.

Mr. WEEMS. Good to see you, sir.

Senator SMITH. I recognize that this is probably your last appearance before this Committee for the balance of this year. With the chairman's indulgence, I need to ask you to answer a couple of questions about two topics that we have had hearings on in this Committee, in no way to take away from the importance of the questions being asked or this topic. But they affect seniors, and they affect people in nursing homes.

I need some answers from CMS that I fear I am not getting. It first relates to the 1-800-Medicare call centers.

Mr. WEEMS. Yes, sir.

Senator SMITH. In anticipation of your appearance here today, I had my staff make 15 calls to these centers this past week. They asked very basic questions that should have a quality control so that there are very easy and accurate answers given.

Like what is the difference between Medicare Part D and Medicare Advantage. Pretty basic. What are the enrollment periods for these plans? Pretty important. Can a beneficiary switch plans after enrollment if they aren't satisfied with their plan? They were given false information repeatedly.

Under what circumstances is the late enrollment penalty assessed? Again, very divergent kinds of answers.

I guess my point in raising this is I think you need some quality control at 1-800-Medicare. I am hoping that you can tell me what you are going to do about it.

Mr. WEEMS. Well, Senator, I certainly will look into it. Those are basic questions that——

Senator SMITH. Ought to have real scripted answers.

Mr. WEEMS. We audit answers given. We do have quality control processes in place. Obviously if you and your staff are getting these kinds of answers, those aren't adequate. So let me try to make them so.

Senator SMITH. There were 15 calls in the past week, and the answers were all over the board. They were often inaccurate.

Mr. WEEMS. Well, that is not acceptable, Senator.

Senator SMITH. Second, another hearing we had was on the validity of genetic testing. Here is a Wall Street Journal article last week talking about genetic testing. Is there a heart attack in your future? Genetic tests promise to map your personal health risks. But some question usefulness.

CMS has spent 6 years trying to write guidelines for this. They have just abandoned it. This field is proliferating.

It's usefulness is clearly in question. So I would like to know what you will do since CMS is apparently walking away from a felt need—I mean, an obvious need if the Wall Street Journal is questioning it and other publications as well—what CMS is going to do to re-pick up the ball and try to put forward some guidelines so that the questions as to validity can be assured. Because a lot of seniors are getting this stuff, often scaring them to death and often without any medical validity at all.

Mr. WEEMS. Well, Senator, first of all, this was brought to my attention just before this hearing so I will respond in writing and with clarity as to what our plans are. The FDA, of course, has responsibility for the initial approval of such tests. Then CMS would work with them under the Clinical Laboratory Improvements Act. But exactly what actions we have taken in the past and our current trajectory I will provide you in writing.

Senator SMITH. Well, I appreciate it. It is a national issue. It is a legitimate concern of this Committee and I think many of the Senators on this panel.

I don't think we are meeting our public responsibility if this field is growing. Whether it is snake oil or not, it is attracting a lot of money.

I am not saying it is, but I am saying it may be. To make sure it isn't, there ought to be some Federal standard at which people

can have confidence that it is being met so that people aren't just being scammed.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you so much.

Senator Craig, then Senator Casey, then Senator Wyden, and then Senator Salazar.

Senator CRAIG. Mr. Chairman, again thank you.

Mr. Weems, thank you for being with us. Your testimony is appreciated.

In my opening comments I talked about information and its value. How much of the information on nursing home compare is-I should say much of it-is vague about what deficiencies actually mean for the patient. At least that is certainly my interpretation of it. Are there any initiatives underway to make the language easier for the average individual to read and actually understand what the practical affects of the information are on the patient?

Mr. WEEMS. The Web site itself has been run through several focus groups to make sure that that information is more understandable. We work with focus groups to continue to improve to try and make it as understandable as possible.

There is a lot of information on the Web site. For each quality indicator that there is given, there is an explanation of what that means. We do strive to make it as user-friendly as possible.

Senator CRAIG. Do you have any idea how many people utilize nursing home compare?

Mr. WEEMS. Senator, we measure it in page reads. Last year we had about 12 million page reads, which is a significant number. Actually, up until the Part D program, it was our most visited Web site.

Senator CRAIG. That is good. What kind of outreach have you done or are you continuing to do as it relates to making more people aware of nursing home compare?

Mr. WEEMS. Well, we work with a number of partners at the local level as somebody is being essentially moved into a nursing home so that they know that that potential exists. We push it at the-you know, through our national site. There are also education efforts that go with physicians and discharge nurses who can help in education efforts.

Senator CRAIG. In your testimony you talked about improvements in a nursing home in South Carolina that was about to be shut down. Could some of these tough measures that were implemented in that situation, such as a root cause analysis of the problem at the facility, been tried earlier in the process when the facility was failing?

Mr. WEEMS. Senator, the method that we take with the special focus facilities is progressive enforcement. So when they first enter, we begin with some enforcement efforts. Those enforcement efforts get more progressive as the facility fails to improve.

This "last chance" systems change that we announced really is sort of the end of the road. Either the facility is going to improve, or they are going to be terminated.

The thing about the special focus facilities and this sort of "last chance" program is it is highly resource-intensive. So working out individual agreements with the nursing home the way that that

one was worked out is very, very resource-intensive. So we try and spread our resources through progressive enforcement.

Senator CRAIG. OK. Thank you very much, Mr. Weems.

Mr. WEEMS. Certainly.

Senator CRAIG. Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Craig.

Senator Casey.

Senator CASEY. Thank you, Mr. Chairman.

Mr. Weems, we appreciate your testimony, but, of course, even more so your service. It is important work you are doing. I appreciate you sharing your own personal story.

I have a couple of questions that center on staffing. But I wanted to first of all talk about the issue that a number of us have mentioned and I think is on the minds of a lot of people because of the public coverage of this, the New York Times. I cited the SEIU report.

Mr. Chairman, I guess I would ask unanimous consent that this SEIU report, "Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents," be made part of the record of the hearing.

The CHAIRMAN. Without objection.

[The information referred to follows:]

NCCNHR The national consumer voice for quality long-term care

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November 15, 2007

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It's Time for Congress to Require Accountability From Nursing Home Owners and Operators

Decades of congressional hearings on poor care, neglect and abuse in nursing homes have demonstrated that Congress must do more to ensure quality in an industry that receives $75 billion a year from taxpayers but is not sufficiently accountable to them. The Nursing Home Reform Law, enacted 20 years ago next month, is one of the strongest laws Congress has ever enacted to protect a vulnerable population; yet repeated studies show that nursing home residents are still neglected in understaffed facilities depleted of resources by owners and investors.

NCCNHR welcomes today's hearing by the Senate Special Committee on Aging on nursing home transparency and improvement. The September 23 New York Times article, "At Many Homes, More Profit and Less Nursing," exposed worsening conditions in many chain-operated nursing homes and reflected the experiences of many of our members who live in nursing homes or who advocate for residents.

Congress should immediately enact common-sense proposals to make nursing home operations more transparent and owners more accountable to consumers, taxpayers, and government. In the attached letter, NCCNHR and eight other national organizations recommend steps that we believe Congress should take now to address corporate accountability. These include disclosures about ownership, expenditures, inspection findings and enforcement actions, and nurse staffing.

In addition, NCCNHR urges the committee to consider the urgent need, in addition to improving the survey and enforcement process, to increase nurse staffing to levels recommended in the 2002 HHS report to Congress, *Appropriateness of Minimum Nursing Staffing Ratios in Nursing Homes*. Our organization has been working for more than 30 years to improve quality in nursing homes, and we are convinced that we will never have the quality of care we need for our loved ones or ourselves unless this critical issue is addressed and resolved.

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November 9, 2007

The Honorable Herb Kohl
Chair
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Gordon Smith
Ranking Member
Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Kohl and Ranking Member Smith:

Twenty years after Congress passed landmark nursing home reform legislation, progress ensuring resident quality of care is threatened by the takeover of nursing home chains by private equity investors who are maximizing profits while isolating themselves from accountability to residents, workers, or regulators. A *New York Times* investigation, "At Many Homes, More Profits and Less Nursing," September 23, 2007, found that the typical private investor-owned facility scores worse on most quality indicators than other types of facilities; has 19 percent more serious health deficiencies than the national average; and ranks 35 percent below the national average in registered nurses. Unfortunately, staffing levels and quality of care at many for-profit, chain-operated facilities are already below acceptable standards.

The nursing home industry receives approximately $75 billion a year in federal Medicare and Medicaid funding. As organizations that represent nursing home residents, their families, and nursing home workers, we urge you to use the Medicare legislation currently under consideration to take initial steps to improve transparency, accountability and staffing throughout the entire nursing home industry. These include the following recommendations, which can be implemented at minimal cost:

Increasing the transparency and accountability of corporate ownership

- Require full disclosure to the Centers for Medicare & Medicaid Services (CMS) of all affiliated entities with a direct or indirect financial interest in the facility and their parent companies, and the owners (including owners of the real estate), operators, and management of each facility; and require that all these entities be parties to the Medicare provider agreement and listed on Nursing Home Compare. CMS should maintain an ownership database and monitor the quality of care provided by the companies. Severe penalties, including exclusion from Medicare, should be established for hiding ownership or affiliated relationships.
- Many nursing home chains have created complex corporate structures that make compensating residents who have been harmed and recovering penalties from entities that actually have assets very difficult. As early as 1979, a GAO report, *Problems in Auditing Medicaid Nursing Home Chains*, HRD-78-158 (Jan. 9, 1979), http://archive.gao.gov/f0302/108331.pdf, identified complex transactions and relationships in chains and recommended better auditing practices. CMS should address this lack of transparency and the related problem of "judgment proof" or bankrupt entities that commit wrongdoing, such as violations of regulations or fraud, by requiring a surety bond. The provider agreement should be amended to require that providers including purchasers of an existing facility or company, deposit assets in a surety bond with the amount (to be determined) proportional to the number of beds in the facility. The bond would cover

fines, civil monetary penalties, expenses associated with receiverships and temporary management arrangements imposed by state agencies, operational costs where residents are abandoned or workers are not paid, and attorneys' fees, litigation costs and damages awarded to plaintiffs in civil damage actions.
- Require CMS to certify the provider agreements annually to ensure that they are consistent with the current ownership structure and affiliated entities.
- Require CMS to post enforcement actions against facilities and maintain actual CMS Form 2567 survey reports on Nursing Home Compare.

Promoting improved staffing

- Require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis, including data on turnover and retention; and require CMS to report that information on Nursing Home Compare as quality measures that include a ratio of direct care nursing staff (RNs, LPNs, and CNAs) to residents and turnover and retention rates. CMS should monitor the reported staffing levels on a quarterly basis and direct that a survey be conducted at facilities where staffing appears to be low and/or declining. CMS has already developed a system to collect and report this staffing information. The National Quality Forum has also recommended that CMS establish a nurse staffing quality measure.
- Require that information on cost reports for Medicare be reported based on five cost centers: (1) direct care nursing services; (2) other direct care services (e.g., activities, therapies); (3) indirect care (e.g., housekeeping, dietary); (4) capital costs (e.g., building, equipment and land costs); and (5) administrative costs. The cost reports should be reported electronically to CMS and summary data should be made available on Nursing Home Compare. In 2004, MedPAC recommended requiring nursing facilities and skilled nursing facilities to publish nursing costs separately from other costs on cost reports. This recommendation was reiterated in a June 2007 MedPAC report (www.medpac.gov/Chapters/Jun07_Ch08.pdf).
- Require CMS to conduct audits of nurse staffing data reports and cost reports at least every three years to ensure the accuracy of the data reported and to prevent fraud. Severe penalties should be established for filing false reports or failing to file timely cost reports.

It is imperative that Congress take immediate action to prevent the further deterioration of care.

Please contact Janet Wells, NCCNHR Director of Public Policy, 202/332-2275, or Michelle Nawar, SEIU Assistant Director of Legislation, 202-730-7232, if you have questions.

Sincerely,
NCCNHR: The National Consumer Voice for Quality Long-Term Care
Alliance for Retired Americans
American Federation of State, County, and Municipal Employees
B'nai B'rith International
Center for Medicare Advocacy
Consumers Union
National Senior Citizens Law Center
OWL – The Voice of Midlife and Older Women
Service Employees International Union

cc: All Members, Senate Special Committee on Aging

Senator CASEY. Just, I guess, on two levels. One is how you would compare what you set forth in your testimony where you say that, starting on page five under the heading of nursing home ownership-and then on page six, you say, "CMS has developed a new system called the provider enrollment chain and ownership system, known by the acronym PECOS. This new system is designed to track and maintain information regarding entities that own 5 percent or more of a nursing home to ensure only eligible providers and suppliers are enrolled and maintain enrollment in the Medicare program." Then it goes on from there. Your testimony talks about the function of this application process, gathering information about the provider, whether that provider meets State licensing qualifications, where it practices or renders its services, the identity of the owner, going on from there.

The concern that I think a lot of us have is that this initiative, your initiative might be just getting up and running. That is one concern I have. I would like to have you address that.

Second, whether or not the concerns that have been expressed already about the impact of this kind of ownership, whether those concerns about the ownership and how it has led to some really questionable ownership practices that lead to a diminution in the quality of care. So if you could just do a comparison here. Then if you can amplify that in a written record after the hearing, we would appreciate that as part of the record.

Mr. WEEMS. I would be happy to do that, Senator. The system that you mentioned, the PECOS system, is gathering information about ownership and fractional ownership of nursing homes. That data base right now is about 60 percent complete. We continue to gather that information.

Once complete, we will be able to perform the kinds of analysis that you allude to as to whether or not type of ownership affects quality of care. But we are not in a position to reach that conclusion just yet, sir.

Senator CASEY. I would ask you as you are developing this system to keep in mind these reports. I am just reading from the summary of the SEIU report. But here is what it says in part talking about two different chains.

I quote—this is from the executive summary. "We see increases in the number of resident care deficiencies along with a trend toward restructuring that, in effect, No. 1, limits liability; No. 2, minimizes tax responsibilities; and No. 3, makes it difficult for the public," as Senator Wyden was alluding to, "to determine how effectively Medicare and Medicaid dollars are spent and the care that is a part of that."

I would ask you to take a look at this report and other reports that are on the public record and compare that to how you are gathering this information. I think that is going to be critically important.

I would also want to ask you about—one idea that has been floated is to have a surety bond requirement that is proportional to the number of beds in the facility. Do you consider that kind of requirement or anything else-any other hurdles or hoops through which a firm, an entity or a person has to go through before they would be allowed to make that kind of a purchase?

Mr. WEEMS. Let me begin with the comment on the first part. First of all, CMS has the ability to enforce civil monetary penalties, to not provide reimbursement for new admissions or to terminate somebody from the program, regardless of how they are owned. So that kind of ownership we still have the ability to enforce good quality in those areas.

So we will need to see if ownership affects quality. We have not reached that conclusion yet. But nonetheless, we believe that we still have the ability to take actions against bad quality.

Senator CASEY. I am out of time. But just a quick answer to the question on a surety bond.

Mr. WEEMS. With respect to surety bonds, we are looking at it. We think our survey techniques, especially a survey that happens when a sale happens, are probably sufficient. We do worry about surety bonds in this and other arenas where they might limit access.

Senator CASEY. Thank you.

The CHAIRMAN. Thank you, Senator Casey.

Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Weems, one, let me thank you for that kind note about the Wyden twins. It was gracious of you to acknowledge their arrival. Let me pick up just on one last question on the very good points that Senator Casey was making.

The issue with the change, of course, is about hidden ownership.

Mr. WEEMS. Yes.

Senator WYDEN. I am not clear. Can the government now identify all the nursing homes throughout the country owned by one corporate entity?

Mr. WEEMS. Probably not is the answer. We know nursing homes by the provider agreement that we have with them, especially as there is fractional ownership we have difficulty telling that. The PECOS system that Senator Casey alluded to that we are building will give us the ability to determine who owns a facility down to the fraction of 5 percent.

Senator WYDEN. So it is not possible to have the information today, but essentially information about hidden ownership is going to be made available and brought to light under your project essentially down to these small fractions?

Mr. WEEMS. Yes, sir.

Senator WYDEN. When will that be available?

Mr. WEEMS. At our current pace, that would be 2009 to have a completely populated database.

Senator WYDEN. OK. One question with respect to the information that is being made available to consumers. We have been trying to go through some of that. I am looking at a page involving a facility in Illinois, Hillcrest Home. There is a long section that has involved a variety of things.

I am looking at a category called vertical openings deficiencies. This says something about exit doors and the like. Have you all brought together consumers and families to have them involved in looking at whether this kind of information is useful to them?

Mr. WEEMS. We have brought together focus groups in that regard. We still need to improve the way that that information is

useful. We need to, first of all, make sure that the information that we are providing is useful in making a decision. Then second, we need to make sure that it is understandable.

But I would also tell the panel that there really is no substitution for visiting a nursing home when making that decision, that it is absolutely critical that a visit occur. On the CMS Web site you can get actually a fairly simple checklist of when you go to a nursing home what you should look for that might help ask the right questions in that visit.

Senator WYDEN. Let me ask just one last question. Again, it sort of speaks to the way decisions get made in the real world.

A lot of older adults and their families have to make quick decisions about nursing home placement typically while you have a senior in the hospital. At that point, the discharge planner plays a very important role with respect to getting out information about the quality of facilities. What are you all doing to get the discharge planners involved in this quality area?

Mr. WEEMS. We work with the discharge planners to make sure that they are aware of the choices in the area. But we also want to make sure that the families are involved in that decision as well.

Senator WYDEN. It just seems to me that if the families are going to get timely information-and I share your view about how important they are-it is the discharge planner who, in a lot of instances-is going to lay that information out. In other words, in a typical instance, you are not going to have a family in a position to run to a Web site and crank up their laptop and look at the information.

They are going to ask that discharge planner to help them with the choices. I hope you all will be more aggressive in reaching out to them because I think that, in the real world, is the way a lot of these decisions get made. I look forward to working with you and also on the Finance Committee as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Wyden.

Senator Salazar.

Senator SALAZAR. Thank you very much, Chairman Kohl. Hello? Thank you very much, Chairman Kohl.

I have to leave to go preside, but I wanted to just make a quick statement. First of all, I would ask unanimous consent that my full statement be made a part of the record.

The CHAIRMAN. Without objection.

Senator SALAZAR. Let me also say, Chairman Kohl and Senator Smith and the members of this Committee, I think that for all of us there is no doubt that we have been through the experiences of both the joys and the heartaches and the realities of nursing homes with loved ones as we have visited these places. I know I have often been in those places in my State of Colorado.

At the end of the day, what concerns us, what concerns me, what concerns all of us is that the consumer of the service at the nursing home is getting the best quality care possible. Certainly, during my days as attorney general there were times when we had to prosecute those who were in charge of nursing homes because of the abatament which had occurred in those nursing homes with patients where we actually had to go in in several occasions and file criminal charges against nursing homes.

We hope that that is, in fact, the exception and not the rule and that indeed the enforcement powers of both the Federal Government shared with State Government as well as the self-regulation that occurs with some parts of the nursing home industry results in the desired end, the desired end being that our loved ones, our elderly population in this Nation are taken care of in these facilities.

So I very much appreciate the fact that you decided to hold a hearing on this very important issue. I do believe that in a major way, just like the issues of Social Security and Medicare will continue to be huge issues for us here in Washington, here in the Congress, that the aspect that deals with nursing homes and long-term care will continue to be a huge issue. I appreciate your interest and your leadership on this issue.

I will make just a comment about the private equity issue and the ownership matter, which has been discussed already, I am sure, in this Committee. I think Mr. Weems can respond to some of the questions from other members of the panel.

You know, it is an issue that has been raised with legitimate concerns. I do think that we need to take a look at it from the point of view that in the context of trying to create wealth within a private equity firm that we are not somehow displacing the quality of service that ought to be provided to seniors who are being served in these homes. So I think it is a very important inquiry that has been raised here.

So I thank you very much, Chairman Kohl. I look forward to working with you on this issue.

The CHAIRMAN. Thank you very much, Senator Salazar.

Before we let you go, Mr. Weems, I would like to ask Senator Lincoln if she would like to say a word or two to CMS Director Weems, make a statement, ask a couple of questions, whatever you wish.

Senator LINCOLN. Thank you, Senator Casey.

I don't, Mr. Chairman. I just want to thank you so much. I think this is such a critical issue. As always, you have come right to the mark in terms of bringing us to the awareness and bringing up the appropriate individuals in here for us to visit with.

We appreciate you, Mr. Weems. Thank you.

The CHAIRMAN. Mr. Weems, we thank you very much for being here with us today. I had the opportunity to visit with you myself. I am very impressed with you as a person of great capability and ambition and focus.

Obviously you know I am particularly interested in your special facilities program. I agree with you that making it transparent and bringing a bright light to shine on those relatively few, very few facilities who are not getting the job done will do an awful lot to eliminate the problem or vastly reduce the problem, if not to eliminate it.

My sense is that it is pretty difficult for a facility to continue to function if it is on this list. I think you feel the same way. So, that having this list and being, as I am sure you will be, very judicious in its use, will tend to vastly improve the performance of those facilities that are on the very lowest end of our nursing homes.

So, you know, I think that is really important. I appreciate your responsiveness to this issue. I wish you well. I am sure we will be dealing with each other frequently. Thank you for being with us.

Mr. WEEMS. Thank you for your comments, sir.

[The prepared statement of Mr. Weems follows:]

STATEMENT OF

KERRY WEEMS

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

CMS' OVERSIGHT OF NURSING HOMES:
THE SPECIAL FOCUS FACILITY & OTHER PROGRAMS
TO ADDRESS TROUBLED NURSING HOMES

BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

November 15, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

Before the
Senate Special Committee on Aging
On
CMS' Oversight of Nursing Homes: The Special Focus Facility and Other Programs to Address Troubled Nursing Homes

Good afternoon Chairman Kohl, Senator Smith and distinguished members of the Committee. It is my pleasure to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) initiatives undertaken in the past few years to improve the quality of care for nursing home residents. Our quality efforts in this area are broad, including initiatives to enhance consumer awareness and transparency, as well as rigorous survey and enforcement processes to ensure nursing facilities provide quality care to their residents.

Background

Americans are growing older and living longer – many with complex, chronic medical conditions. As increasing numbers of our nation's baby boom generation retire, the need for high-quality long term care, both in the community and in nursing homes will grow commensurately. About 1.5 million Americans reside in the nation's 16,400 nursing homes on any given day.[1] More than 3 million Americans rely on services provided by a nursing home at some point during the year.[2] Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable care of consistently high quality.

In 2006, approximately 2.8 million (7.4 percent) of the 37.3 million persons aged 65 and over in the United States had a nursing home stay.[3] By contrast, 22 percent of the 5.3 million persons

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[1] Centers for Medicare & Medicaid Services. *2007 Action Plan for (Further Improvement of) Nursing Home Quality* (www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/2007ActionPlan.pdf) at i.
[2] *Ibid.*
[3] Centers for Medicare & Medicaid Services. *Nursing Home Data Compendium* (http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage).

aged 85 and older had a nursing home stay in 2006. Some of these were long-term nursing home residents, while some had shorter stays for skilled nursing care following an acute hospitalization.[4]

Roughly 1.8 million persons received Medicare-covered care in skilled nursing facilities in 2005.[5] Medicare skilled nursing facility benefit payments increased from $17.6 billion in 2005 to nearly $21.0 billion in Fiscal Year (FY) 2007.[6] Approximately 1.7 million persons received Medicaid-covered care in nursing facilities during 2004.[7] Medical assistance payments for Medicaid-covered nursing facility services topped $47 billion in FY 2005, representing nearly 16 percent of overall medical assistance payments that year.[8]

Action Plan for Nursing Home Quality

Congress has authorized a variety of tools that enable CMS to promote – in the words of the statute – "...the highest practicable physical, mental, and psychosocial well-being of each resident..."[9] The most effective approach to ensure quality is one that mobilizes all available tools and aligns them in a comprehensive strategy. An internal CMS Long Term Care Task Force helps shape and guide the Agency's comprehensive strategy for nursing home quality. Each year, CMS publishes a comprehensive *Nursing Home Action Plan*[10] on our web site, which reflects the vision and priorities of the Task Force and the Agency. The current *Action Plan* outlines five inter-related and coordinated approaches -- or principles of action – for nursing home quality, as described in detail below.

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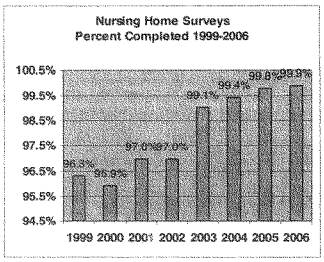
[4] *Ibid.*
[5] U.S. Department of Health and Human Services. *2007 CMS Statistics* at 4 and 34. Washington D.C.: U.S. Government Printing Office.
[6] *2007 CMS Statistics* at 3 and 28.
[7] *2007 CMS Statistics* at 4 and 39. "Nursing facility" in this context includes SNFs and all other nursing facilities other than intermediate care facilities (ICF/MR).
[8] *2007 CMS Statistics* at 29. Note these figures exclude payments under SCHIP.
[9] Section 1819(b)(2) of the Social Security Act.
[10] See http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage

Consumer Awareness and Assistance. The first principle of action is consumer awareness and assistance. Aged individuals, people who have a disability, their families, friends, and neighbors are all essential participants in achieving high quality care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. This information also can increase the ability of such individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information that can be readily accessed by the public.

With regard to nursing home care specifically, the CMS web site "Nursing Home Compare" at www.Medicare.gov features key information on each nursing home; the results of their three most recent quality of care inspections; and other important information for consumers, families, and friends. The web site contains the results of 19 different quality of care measures for each nursing home, such as the percent of residents who have pressure ulcers or are subject to physical restraints. Recently CMS added information to help consumers know the extent of sprinklers and other fire-safety features in each nursing home. CMS also added information about the percent of residents who were vaccinated for flu and pneumonia.

Survey, Standards, and Enforcement Processes. The second principle is to have clear expectations for quality of care that are properly enforced. CMS establishes both quality of care and safety requirements for providers and suppliers that participate in the Medicare and Medicaid programs. Such requirements are carefully crafted to highlight key areas of quality and convey basic, enforceable expectations that nursing homes must meet. More than 4,000 Federal and State surveyors conduct on-site reviews of every nursing home at least once every 15 months (and about once a year on average). CMS also contracts with quality improvement organizations (QIOs) to assist nursing homes to make vital improvements in an increasingly large number of priority areas.

We take our responsibilities for on-site surveys of nursing homes seriously. In 2006, the most recent year for which complete data are available, the percent of nursing homes that were surveyed at least every fifteen months reached 99.9 percent – the highest rate ever recorded. In addition to about 16,000 comprehensive surveys that year, CMS and States conducted more than 45,000 complaint investigations in nursing homes. Our strengthened fire-safety inspections led to the identification of 67.8 percent more deficiencies in 2006 compared to 2002 (to 66,470 from 39,618). Nursing homes are responding to these findings by improving their fire-safety capability as never before.



Quality Improvement: The third *Nursing Home Action Plan* principle is to have effective quality improvement strategies. CMS is promoting a program of quality improvement in a number of key areas. These areas include reduction in the extent to which restraints are used in nursing homes; reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents; and the Agency's participation in a larger national movement known as "culture change." Culture change principles echo Omnibus Budget Reconciliation Act (OBRA) of 1987 principles of knowing and respecting each nursing home resident in order to provide individualized care that best enhances each person's quality of life. The concept of culture change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs.

Quality Through Partnerships: The fourth *Nursing Home Action Plan* principle is to promote quality through enthusiastic partnerships with any and all organizations that will join with us. No single approach or actor can fully assure quality. CMS must mobilize and coordinate many actors and many techniques through a partnership approach. State survey agencies and the QIOs under contract with CMS are more than ever coordinating their distinct roles so as to achieve

better results than could be achieved by any one actor alone. CMS is also a founding member of the "Advancing Excellence in America's Nursing Homes" campaign. This campaign is an exceptional collaboration among government agencies, advocacy organizations, nursing home associations, foundations, and many others to improve the quality of nursing homes across the country.[11] The campaign voluntarily enlists nursing homes to measure and make improvements in eight key quality of care areas. More than 6,000 nursing homes have signed up to make quality improvements such as the consistent assignment of staff to individual nursing home residents; the assessment of satisfaction on the part of residents and families; or the reduction of pressure ulcers.

Value-Based Purchasing: The fifth principle of the *Nursing Home Action Plan* is to use purchasing power to promote quality. As the largest third-party purchasers of nursing home services in the country, States and CMS exert leverage to insist on basic levels of quality. CMS is working collaboratively with private and public organizations to stimulate high quality care and improve efficiency. Payment reforms could show promise in helping providers deliver care that prevents complications, avoids unnecessary medical services, and achieves better outcomes at a lower overall cost.

With these five principles in mind, the testimony will now turn to two topics that we understand may be of special interest to the Committee. The first is the issue of nursing home ownership, and the second is the CMS "Special Focus Facility" initiative.

Nursing Home Ownership

CMS is aware of recent media reports about the relationship between quality nursing home care and nursing home ownership, particularly investor-owned facilities. We understand the importance of responsible ownership of nursing facilities serving the Medicare and Medicaid population. To that end, in response to these recent concerns CMS is actively engaged in improving the transparency of facility ownership by working collaboratively with nursing home providers.

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[11] Information about the campaign for *Advancing Excellence in America's Nursing Homes* may be found at: http://www.nhqualitycampaign.org

CMS has developed a new system called the Provider Enrollment Chain and Ownership System (PECOS). This new system is designed to track and maintain improved information regarding entities that own five percent or more of a nursing home and to ensure only eligible providers and suppliers are enrolled and maintain enrollment in the Medicare program. The primary function of the provider enrollment application is to gather information from a provider or supplier that tells CMS who it is; whether it meets State licensing qualifications and federal quality of care and safety requirements to participate in Medicare; where it practices or renders its services; the identity of the owner of the enrolling entity; and information necessary to establish the correct claim payment. The PECOS database is being populated now and is expected to be 70 percent populated by the second quarter of FY 2008. Supported by this new system, CMS will be able to better track ownership, potentially beginning in the Spring of 2008. CMS also is exploring a web-based application for 2008 to allow providers and suppliers to enter contact information and other updates directly. This will facilitate the ability of nursing homes to maintain up-to-date enrollment information.

In terms of quality, CMS focuses on the quality of care experienced by residents regardless of who owns the facility. Our focus on actual outcomes ensures that Medicare's quality assurance system does not depend on any theory of quality or theory of ownership. Instead, the federal survey and certification system is grounded in what CMS and State nursing home surveyors actually find through on-site inspection; through in-person interviews with residents and staff; through the eyewitness observation of care processes; and through the review of records of care. CMS continuously seeks to improve the effectiveness of both the survey process and the enforcement of quality of care requirements. An example of such continuous improvement is our Special Focus Facility initiative that addresses the issue of nursing homes that persist in providing poor quality.

Special Focus Facility Program

The Special Focus Facility program was initiated because a number of facilities consistently provided poor quality care, yet periodically fixed a sufficient number of the presenting problems

to enable them to pass one survey, only to fail the next survey. Moreover, they often failed the next survey for many of the same problems as before. Such facilities with an "in and out" or "yo-yo" compliance history rarely addressed the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

Nursing homes on the Special Focus list represent those with the worst survey findings in the country, based on the most recent three years of survey history. The selection methodology takes into account for the severity of deficiencies and the number of deficiencies. Deficiencies identified during complaint investigations are also included in the computation. Each State selects its Special Focus nursing homes from a CMS candidate list of approximately 15 eligible nursing homes in their own State, using additional information available to the State regarding the nursing homes' quality of care in order to make the final selection.

States conduct twice the number of standard surveys for Special Focus nursing homes compared to other nursing homes. If serious problems continue then CMS applies progressive enforcement until the nursing home either (a) graduates from the Special Focus program because it makes significant improvements that last; or (b) is terminated from participation in the Medicare and Medicaid programs; or (c) is given more time due to a trendline of improvement and promising developments, such as sale of the nursing home to a new owner with a better track record of providing quality care.

To analyze the impact of the Special Focus Facility initiative CMS compared the 128 nursing homes selected in 2005 with alternate nursing homes on the candidate list that were not selected. The Special Focus nursing homes had more deficiencies than others: 11 deficiencies on average in the Special Focus Facilities compared with 9 deficiencies for the alternates and 7 for nursing homes on average. However, over the course of the next two years approximately 42 percent of the Special Focus nursing homes had significantly improved to the point of meeting the Special Focus Facility graduation criteria, whereas only 29 percent of the alternates had so improved. At the same time, change of ownership or closure of poorly performing nursing homes was greater in the Special Focus nursing homes. Approximately 15 percent of the Special Focus nursing

homes were terminated from participation in Medicare compared with less than 8 percent in the alternates and 2 percent for all other nursing homes. The better response of the Special Focus nursing homes in addressing deficiencies has been a function of the greater attention that CMS paid to those nursing homes on the Special Focus Facility list, and the imperative for action that is built into the Special Focus Facility program design.

The Special Focus initiative can pay great quality-of-care dividends for nursing home residents. For example, a nursing home in rural Monck's Corner, South Carolina, was a Special Focus nursing home that failed to improve significantly over the 18 months after it was first selected. As a result, in April 2007 CMS issued a Medicare notice of termination to the facility. We were prepared to see the 132 nursing home residents relocated to other facilities that provided better care. At that point, however, the nursing home operators evidenced a willingness to implement the type of serious reforms that had clear potential to transform their quality of care. CMS agreed to extend the termination date provided the nursing home would enter into a legally-binding agreement to institute certain quality-focused reforms. We required that they undergo a root cause analysis of their underlying systems-of-care deficiencies, to be conducted by a QIO selected by CMS. We required that the nursing home then develop an action plan based on the root cause analysis, and also place $850,000 in escrow to pay for the reforms indicated by the action plan and root cause analysis. These interventions were successful. The nursing home passed the subsequent survey, was purchased by another owner, and is on track to graduate from the Special Focus Facility initiative provided it can sustain the improvements over time. The corporation that operated the nursing home is now seeking to replicate this approach with other nursing homes that it operates

Conclusion

Mr. Chairman, thank you for the opportunity to testify here today. Regardless of setting or ownership, quality health and long-term care for Medicare and Medicaid beneficiaries is of the utmost importance to CMS. To that end, I plan to work to ensure high quality medical care for all nursing home residents. I would be pleased to address any questions or hear any comments you may have.

The CHAIRMAN. I will call our third and final panel. Our first witness will be professor David Zimmerman, who is a distinguished professor of health systems engineering. He is also the head of the Long-Term Care Institute at the University of Wisconsin, Madison.

In this capacity, Dr. Zimmerman leads pioneering work to improve nursing homes that operate under corporate integrity agreements with the HHS Office of Inspector General. Dr. Zimmerman has worked with more than 900 nursing homes to improve the care that they provide.

Next we will hear from Arvid Muller, who is the assistant director of research for the Service Employees International Union. For the last 14 years, Mr. Muller has conducted much of the analytic work underpinning SEIU's positions on nursing home ownership, reimbursement, and quality issues.

Next we will hear from Steve Biondi, who is vice president for clinical services at Extendicare Health Services in Milwaukee. Mr. Biondi is a registered nurse, licensed nursing home administrator, and has been certified by CMS as a nursing home surveyor.

He co-chairs the American Health Care Associations Survey and Regulatory Committee. He also serves on the quality improvement Committee, which seeks to advance quality improvements in the use of evidence-based practices.

The fourth witness will be Bonnie Zabel, also a registered nurse and a nursing home administrator for the last 15 years. Ms. Zabel runs an exemplary operation at the Marquardt Memorial Manor facility in Watertown, WI. She is also a member of an advisory group sponsored by the Wisconsin Association of Homes and Services for the Aging charged with developing training materials for facilities throughout the State of Wisconsin.

Our final witness will be Sarah Slocum. For the past four years, Ms. Slocum has served as Michigan's long-term care ombudsman. She is the lead advocate on behalf of residents living in licensed long-term care facilities. As the State ombudsman, Ms. Slocum oversees a network of paid staff and volunteers working in every region of Michigan to improve the quality of life and the quality of care for that State's most vulnerable citizens.

So we welcome you all here today.

Mr. Zimmerman, we will start with you.

STATEMENT OF DAVID ZIMMERMAN, PROFESSOR AND ACADEMIC DIRECTOR OF THE COLLEGE OF ENGINEERING, UNIVERSITY OF WISCONSIN, MADISON, WI

Mr. ZIMMERMAN. Thank you very much, Mr. Chairman and the other members of the Committee. My name is David Zimmerman. As the Chairman has said, I am a professor of health systems engineering and the director of a research center at the University of Wisconsin, Madison. I am also the president of a nonprofit organization that was created to assist in the monitoring of quality of nursing home care in organizations with Corporate Integrity Agreements with the DHHS Office of the Inspector General. I have been conducting research in nursing home quality of care and performance measurement for 25 years.

Our researchers developed the original set of quality indicators used by all 17,000 nursing homes and 50 State survey agencies.

More recently, the Long Term Care Institute has been involved in 13 monitoring engagements with national and regional corporations under OIG corporate integrity agreements covering more than 1,000 nursing homes and 100,000 nursing home residents.

Our researchers and monitors have conducted visits to more than 900 nursing homes in the past 6 years. We have observed or participated in more than 100 quality improvement meetings, including more than 30 such sessions at the corporate level of organizations. I have spoken to at least 15 corporate boards or board committees and met with individual board members about quality of care issues.

These activities have given us important insights into the world of nursing home quality assurance, and they provide the background for my remarks this afternoon.

There has been increasing attention focused on the quality of nursing home care, most recently because of the rise in the number of ownership transactions between nursing home corporations, and the tendency for these transactions to involve a transfer of ownership from a public corporation to entities commonly referred to as private equity firms. At the heart of this debate and scrutiny over this particular phenomenon, I believe that the single most important issue that we need to face, and soon, is the issue of transparency.

I have five suggestions for how we should proceed with respect to progress on that problem. My first suggestion is that there should complete transparency on full ownership of every nursing home, including both the operating entity and the landlord.

The Federal Government, which spends billions of dollars on nursing home care every year, should have the right to know the complete ownership structure of every nursing home participating in the Medicare and Medicaid program no matter which or what type of entity owns them.

The complete ownership structure of all entities involved in the provision and administration of resident care should be fully reported to CMS as a matter and a condition of participation in the Medicare and Medicaid program.

The ownership reporting responsibility should be that of the provider organization. That is, it should not be the function or the responsibility of the Federal Government to ferret out the information on who owns what and which entity is providing what part of the care to residents.

The principle of transparency should apply no matter what level of complexity in the labyrinth of organizational structures exists. In fact, the more complex the web, the greater the need for the more detailed transparency that I am calling for. The greater the complexity, the more reasonable it is that those who have created the complexity should have the responsibility for explaining it in very detailed terms to the Federal Government.

My second suggestion is that staffing information for every nursing home should be reported in a standardized format to the Federal Government. In other words, there should be transparency on the staffing in nursing homes so the purchaser of care can know the labor resources that are being devoted to this task. Nursing

home care is what we call a high-touch industry. The labor resources need to be known.

This information should be based on payroll data, which exists in accessible form for virtually every nursing home in this country. The technological means exist to achieve this goal. We have been in enough nursing homes that I can make that statement with absolute confidence.

Reasonable people representing all stakeholders can make sound decisions about how to structure the definitions into a common taxonomy for the purpose of reporting. Acuity-based staffing in this industry, frankly, is far more crowed about than practiced; but to the extent that it is necessary to make adjustments for acuity of residents, this can be done.

My third suggestion is that there needs to be greater ability to expand the scope of observation and analysis from individual facilities to nursing home corporations and networks. In many situations, it is the corporate entity's policies and procedures that govern the system of resident care in the facility. In some cases, these corporate policies and procedures are not adequate to provide proper governance to the delivery of that care. Yet in many other cases, the problem at the facility and resident care levels is that reasonable corporate policies and procedures are not being executed consistently across facilities in their own networks. A stronger focus on this level of management would be a very efficient way to improve care systematically across an organization, as opposed to one facility at a time.

Yet currently there is virtually no way that a State regulatory agency can expand its scope across State lines. CMS does have greater authority to expand the scope to a more systematic examination of multi-facility networks, even to some extent across State lines, but much more could be done to utilize the available information in an aggregated fashion to focus on regional and even national nursing home networks.

Our center produces monthly reports on survey deficiencies comparing the largest national corporations and provides them to the OIG and to each specific corporation that is covered by a corporate integrity agreement. I have provided de-identified examples of these types of reports with this testimony.

We provide similar information on the MDS quality indicators and quality measures to the same parties on a quarterly basis. This information can and should be provided on all national and regional corporations on a routine basis.

My fourth suggestion is that there needs to be greater use of intermediate corrective measures, as several speakers have talked about earlier. There have been calls for broader and more innovative ways to incentivize, exhort, and pressure providers into taking better and more systematic corrective actions to improve care and sustain that higher care level. Care problems need to be identified earlier and addressed in meaningful ways more promptly and with more ingenuity and commitment.

There needs to be increased scrutiny on providers at both the facility and corporate network level who have not demonstrated the ability to adequately self-identify a problem and fix it and then keep it fixed.

One measure that has demonstrated success in both process and outcomes is the use of monitors to provide additional scrutiny on the care provided in problematic facilities, as well as the systems put in place to correctly identify problems and sustain that fix, including systems that actually have their origin in the corporation itself as opposed to just the facility.

Our previously mentioned work with several national corporations has provided a number of insights into barriers to and facilitators of quality improvement efforts. Monitoring can correctly place the focus on the systems of care that need to be implemented consistently across every facility, every shift, and every bedside. It is the systems more than it is the leaders that, in fact, really deliver good quality care.

Providers sometimes place too much reliance on finding leaders and then do not provide those individuals with the kind of support they need to be able to do their jobs. When there is a failure of care, there leaders are the ones who typically are the scapegoats. I call that concept the "awesome goat" phenomenon.

The monitoring process can also promote and expand the concept of transparency described earlier. Facilities and organizations that have demonstrated problems in providing quality care should be the focus of additional scruting with the transparency that monitors can provide to determine the providers capability to improve their systems.

My final solution is that I think we absolutely have to increase the focus on the landlord as well as the licensed operator in nursing homes. Currently, the entity owning the actual physical asset of the nursing home, what is typically referred to as the bricks and mortar, has virtually no responsibility or accountability for the adequacy of the care provided at that facility. Yet we have seen cases, many of them in our monitoring work, in which actions or inactions of the landlord have had deleterious and sometimes direct effects on the quality of care in the facility.

There are sometimes restrictive clauses in the lease agreements that effectively prohibit the licensed operator from making needed upgrades or renovations consistent with evidence-based care practices. Other restrictive lease practices might make the implementation of physical or structural changes so onerous financially that it becomes prohibitive for the licensed operator to even consider such changes, especially under some of the new lease agreements that we see. Frankly, those lease agreements in some cases are the most important single document in the practice of care in the facility and create major constraints on the ability to adequately deliver care.

Holding the landlord to the identical certification and licensing requirements as the operator may not be feasible. But consideration should be given to making sure that these lease provisions are transparent, along with other aspects of ownership, and we should find a way to ensure that if lease agreements stand in the way of corrective actions there is a way to deal with these situations.

All the solutions that I have proposed have to do, in some way, with increasing the transparency of information about who provides care and who owns whatever entity or entities responsible for the decisions pertaining to that care. Transparency is essential to

the continued delivery of nursing home care through existing private and public markets.

With full transparency, of ownership so we know who is and should be accountable, and transparency on staffing, so we will know who is providing care, we can examine the outcomes as they are produced through the survey process and resident level status measures. Facilities and organizations demonstrating their ability to deliver adequate care can continue on with this critical task, and with our appreciation. Facilities and organizations that have demonstrated an inability to deliver adequate care should expect to see additional scrutiny and even greater transparency requirements, including outside monitors to assure that they can earn our trust to provide care and protect the health and safety of our most vulnerable population. Thank you very much.

[The prepared statement of Professor Zimmerman follows:]

Testimony of David R. Zimmerman, Ph.D.

Department of Industrial and Systems Engineering
University of Wisconsin–Madison

Senate Select Committee on Aging

November 15, 2007

Good Afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion:

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

Exhibit Table 1:
Deficiency Trend Profile by Selected Corporation and Ownership

Most Recent Survey as of June 30, 2007

		Corporation A		Nation		All Selected Corporations		For Profit		Non Profit		Government	
		Current Survey	Prior Survey	Current Survey	Prior Survey	Current Survey	Prior Survey	Current Survey	Prior Survey	Current Survey	Prior Survey	Current Survey	Prior Survey
	Number of Facilities			15878	15699	2164	2163	10578	10459	4340	4293	960	947
A.	Total Health Deficiencies - Average	7.82	6.82	6.90	6.56	7.53	6.89	7.51	7.12	5.58	5.37	6.12	5.81
B.	Health Deficiency Index	1.15	1.09	1.00	1.00	1.11	1.06	1.07	1.07	0.84	0.85	0.89	0.88
C.	Percent Severe Deficiencies	15.9%	14.6%	21.7%	21.7%	21.4%	20.4%	23.3%	22.4%	17.7%	18.5%	22.0%	23.9%
D.	Severe Deficiency Index	0.95	0.88	1.00	1.00	0.99	0.95	1.06	1.02	0.87	0.91	0.93	1.03
E.	Percent Zero Deficiencies	8.0%	7.1%	8.4%	8.3%	6.3%	6.4%	7.0%	6.5%	11.7%	11.8%	9.5%	10.3%

A. Average number of Health Deficiencies: Health deficiencies include any deficiency that has an F-Tag. It does not include Life Safety Code deficiencies. Scope and Severity is above level A.

B. Index is computed by dividing facility health deficiencies by average health deficiencies for the state. Indices greater than 1 indicate more deficiencies than the state average.

C. Percent severe deficiencies: The proportion of facilities whose last survey included at least one health deficiency that was at a level of "F" or higher (excluding "G") on the severity grid. It includes all health deficiencies, not just those that

D. Index is computed by dividing the percent of facilities with a severe deficiency by the percent of facilities for the state. Indices greater than 1 indicate a higher percentage of severe deficiencies.

E. Percent zero deficiencies: The proportion of facilities who on their last survey had no health deficiencies cited by surveyors. In contrast to the other measures, a higher number is better in this field.

Note: 1. If a state did not cite any severe deficiencies the index computed for the group was a 1.
2. A 0.0% for zero deficiencies indicates there were no deficiency free surveys.

Source: Online Survey, Certification and Reporting (OSCAR) data network, Centers for Medicare and Medicaid (CMS).

Exhibit Table 1a:
Deficiency Trend Profile by Selected Corporation and Ownership
All Surveys, 2007 Surveys, Surveys Entered into OSCAR System in Last 3 Months

Most Recent Survey as of June 30, 2007

		Corporation A			Nation			All Selected Corporations**			For Profit			Non Profit			Government		
		All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.*	All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.	All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.	All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.	All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.	All Surveys	2007 Surveys	Entered into OSCAR - last 3 mos.
	Number of Facilities				15878	5813	4093	2164	747	536	10578	3833	2707	4340	1625	1136	960	355	250
A.	Total Health Deficiencies - Average	7.82	8.15	7.73	6.90	6.73	6.99	7.53	7.31	7.54	7.51	7.32	7.66	5.58	5.51	5.62	6.12	5.96	6.04
B.	Health Deficiency Index	1.15	1.27	1.16	1.00	1.00	1.00	1.11	1.10	1.12	1.07	1.08	1.12	0.84	0.84	0.86	0.89	0.91	0.89
C.	Percent Severe Deficiencies	15.9%	13.9%	15.3%	21.7%	21.1%	21.7%	21.4%	19.5%	19.8%	23.3%	22.9%	23.5%	17.7%	17.2%	17.7%	22.0%	20.0%	21.2%
D.	Severe Deficiency Index	0.95	0.87	0.91	1.00	1.00	1.00	0.99	0.93	0.94	1.06	1.02	1.07	0.87	0.84	0.87	0.93	0.87	0.92
E.	Percent Zero Deficiencies	8.0%	8.9%	8.5%	8.4%	8.9%	7.6%	6.3%	7.4%	6.7%	7.0%	7.6%	6.4%	11.7%	11.9%	9.9%	9.5%	10.1%	10.4%

* Includes new surveys entered into the OSCAR CMS system within the last 3 months (regardless of the date of the survey).

** The averages presented are the weighted averages of all of the facilities in the Selected Corporations. The averages are therefore weighted by the size (number of facilities) of the corporation.

A. Average number of Health Deficiencies: Health deficiencies include any deficiency that has an F-Tag. It does not include Life Safety Code deficiencies. Scope and Severity is above level A.

B. Index is computed by dividing facility health deficiencies by average health deficiencies for the state. Indices greater than 1 indicate more deficiencies than the state average.

C. Percent severe deficiencies: The proportion of facilities whose last survey included at least one health deficiency that was at a level of "F" or higher (excluding "G") on the severity grid. It includes all health deficiencies, not just those that are in the substandard care category in the CMS definition of substandard care.

D. Index is computed by dividing the percent of facilities with a severe deficiency by the percent of facilities for the state.Indices greater than 1 indicate a higher percentage of severe deficiencies.

E. Percent zero deficiencies: The proportion of facilities who on their last survey had no health deficiencies cited by surveyors. In contrast to the other measures, a higher number is better in this field.

Note: 1. If a state did not cite any severe deficiencies the index computed for the group was a 1.00.
2. A 0.0% for zero deficiencies indicates there were no deficiency free surveys.

Exhibit Table 2:
Deficiency Profile by Selected Corporations

Most Recent Survey as of June 30, 2007

		Nation	Corporation A		1		2		3		4		5		6	
			Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank
	Number of Facilities	15878														
A.	Total Health Deficiencies - Average	6.90	7.82	7	6.76	4	7.93	9	7.47	6	8.55	12	6.78	5	6.40	2
B.	Health Deficiency Index	1.00	1.15	7	0.90	2	1.29	13	1.29	12	1.24	11	0.99	4	1.01	5
C.	Percent Severe Deficiencies	21.7%	15.9%	3	16.2%	4	28.6%	12	19.7%	6	19.5%	5	20.0%	7	14.6%	2
D.	Severe Deficiency Index	1.00	0.95	6	0.94	5	1.52	13	1.14	11	0.86	3	0.96	7	0.69	2
E.	Percent Zero Deficiencies	8.4%	8.0%	4	12.2%	2	2.9%	13	4.9%	8	4.9%	9	5.3%	6	10.7%	3

		7		8		9		10		11		12	
		Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank
	Number of Facilities												
A.	Total Health Deficiencies - Average	6.54	3	7.84	8	8.92	13	8.14	10	4.54	1	8.48	11
B.	Health Deficiency Index	0.93	3	1.12	6	1.18	8	1.22	10	0.73	1	1.18	9
C.	Percent Severe Deficiencies	23.3%	10	22.8%	9	22.7%	8	28.8%	13	11.1%	1	28.4%	11
D.	Severe Deficiency Index	1.07	9	0.98	8	0.90	4	1.24	12	0.51	1	1.13	10
G.	Percent Zero Deficiencies	6.3%	5	5.3%	7	4.4%	10	3.6%	11	15.3%	1	3.3%	12

A. Average number of Health Deficiencies: Health deficiencies include any deficiency that has an F-Tag. It does not include Life Safety Code deficiencies. Scope and Severity is above level A.

B. Index is computed by dividing facility health deficiencies by average health deficiencies for the state. Indices greater than 1 indicate more deficiencies than the state average.

C. Percent severe deficiencies: The proportion of facilities whose last survey included at least one health deficiency that was at a level of "F" or higher (excluding "G") on the severity grid. It includes all health deficiencies, not just those that are in the substandard care category in the CMS definition of substandard care.

D. Index is computed by dividing the percent of facilities with a severe deficiency by the percent of facilities for the state.Indices greater than 1 indicate a higher percentage of severe deficiencies.

E. Percent zero deficiencies: The proportion of facilities who on their last survey had no health deficiencies cited by surveyors. In contrast to the other measures, a higher number is better in this field.

Note: 1. If a state did not cite any severe deficiencies the index computed for the group was a 1.00.
2. A 0.0% for zero deficiencies indicates there were no deficiency free surveys.

Exhibit Table 2a:
Deficiency Profile by Corporation
All Surveys, 2007 Surveys, Surveys Entered into OSCAR System in Last 3 Months

Most Recent Survey as of June 30, 2007

		Nation	Corporation A		Selected Corporations All Surveys**			Corporation A 2007		Selected Corporations 2007 Surveys			Corporation A Entered into OSCAR - last 3 mos.*		Selected Corporations Entered into OSCAR - last 3 mos.*		
			Mean	Rank	Min	Avg	Max	Mean	Rank	Min	Avg	Max	Mean	Rank	Min	Avg.	Max
	Number of Facilities	15878															
A.	Total Health Deficiencies - Average	6.90	7.82	7	4.54	7.40	8.92	8.15	9	3.21	7.31	9.86	7.73	8	3.06	7.44	9.57
B.	Health Deficiency Index	1.00	1.15	7	0.73	1.10	1.29	1.27	10	0.56	1.10	1.41	1.16	8	0.58	1.11	1.44
C.	Percent Severe Deficiencies	21.7%	15.9%	3	11.1%	20.9%	28.8%	13.9%	4	6.9%	19.9%	37.9%	15.3%	5	5.9%	19.3%	33.3%
D.	Severe Deficiency Index	1.00	0.95	6	0.51	0.99	1.52	0.87	7	0.34	0.98	2.09	0.91	7	0.29	0.94	1.83
G.	Percent Zero Deficiencies	8.4%	8.0%	4	2.9%	6.7%	15.3%	8.9%	4	0.0%	8.0%	24.1%	8.5%	4	0.0%	8.1%	29.4%

* Includes new surveys entered into the OSCAR CMS system within the last 3 months (regardless of the date of the survey).

** The averages presented are an unweighted average of the corporation averages presented in Table 2.

A. Average number of Health Deficiencies: Health deficiencies include any deficiency that has an F-Tag. It does not include Life Safety Code deficiencies. Scope and Severity is above level A.

B. Index is computed by dividing facility health deficiencies by average health deficiencies for the state. Indices greater than 1 indicate more deficiencies than the state average.

C. Percent severe deficiencies: The proportion of facilities whose last survey included at least one health deficiency that was at a level of "F" or higher (excluding "G") on the severity grid. It includes all health deficiencies, not just those that are in the substandard care category in the CMS definition of substandard care.

D. Index is computed by dividing the percent of facilities with a severe deficiency by the percent of facilities for the state. Indices greater than 1 indicate a higher percentage of severe deficiencies.

E. Percent zero deficiencies: The proportion of facilities who on their last survey had no health deficiencies cited by surveyors. In contrast to the other measures, a higher number is better in this field.

Note: 1. If a state did not cite any severe deficiencies the index computed for the group was a 1.00.
2. A 0.0% for zero deficiencies indicates there were no deficiency free surveys.

Source: Online Survey, Certification and Reporting (OSCAR) data network, Centers for Medicare and Medicaid (CMS).

The CHAIRMAN. Thank you very much, Professor Zimmerman.

Mr. Muller I would like to request that you all hold your statements to the 5 minutes when the red button appears.

Mr. MULLER. OK.

The CHAIRMAN. Go ahead.

STATEMENT OF ARVID MULLER, DIRECTOR OF RESEARCH, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, DC

Mr. MULLER. Chairman Kohl and other distinguished members of the Committee, thank you for giving me the opportunity to appear before you today. I am the assistant director of research for SEIU, which represents almost 1 million health care workers, including more than 150,000 nursing home workers.

SEIU appreciates Chairman Kohl's commitment to improving the quality of care in nursing homes. We also want to acknowledge Senator Grassley's long-time leadership on these issues. We look forward to continuing our work with both senators on this issue.

Twenty years after Congress passed landmark nursing home reform legislation, SEIU remains concerned that there are serious problems with quality of care across the industry. We fear the current enforcement system is simply not working. It is also difficult for families and residents to get the information they need because the industry still lacks transparency.

SEIU analyzed OSCAR deficiency data from CMS. It is unfortunate that any way you cut the data the analysis shows that nursing homes have far too many quality problems. In fact, our research indicates care appears to be getting even worse.

In our analysis we do not include life safety code violations, nor do we include complaint violations. So the total number of problems found by State inspectors in any given year was actually worse than our numbers indicate.

By compiling all the deficiencies from annual inspections for the years 2004 through 2006, we were able to determine if the number of violations per inspection increased or decreased from year to year. Unfortunately the trends we found were quite disturbing. Overall the number of violations per inspection increased each year for a total increase of 13.8 percent from 2004 to 2006.

The next analysis we did was to look at the severity of the violations. Violations of resident care, otherwise known as deficiencies, have four levels of severity: deficiencies with potential for minimal harm, deficiencies with potential for actual harm, deficiencies that cause actual harm, and finally, the most serious deficiencies, those that cause immediate jeopardy.

When we looked at the same data sets and broke down the violations by severity, we found that while the least serious violations decreased during this time, the more serious violations increased. Violations that had only potential for minimal harm decreased from 2004 to 2006 by almost 10 percent. However, violations that had potential for actual harm increased by 17.8 percent. Violations that were found to have caused actual harm increased by an even greater 19.5 percent.

Since the average number of violations per facility is between six and seven during this period, we also looked to see whether there

was an increase in the number of facilities that had significantly more violations. For this analysis, we looked at all the facilities that had 10 or more violations during a single inspection in any given year.

We discovered an increase in the number of facilities that got cited by State inspectors for at least 10 violations from 20.9 percent in 2004 to 26 percent in 2006. This means that more than one out of every four facilities inspected in 2006 had 10 or more violations of minimum Federal resident care standards.

In addition, as has been mentioned here today, a new breed of nursing home operator, private equity, has entered the nursing home markets;. and for the companies we analyzed, this had a clearly negative effect on care.

Private equity firms take on a lot of debt, have ownership structures that are particularly complex and a business model that is based on buying and selling businesses within a relatively short period of time. This private equity model lacks transparency and accountability and may be exacerbating the care problems we find in the overall industry.

In our analysis of deficiency data, we released a new report today in which we compared the number of violations per inspection from just before they got bought by private equity to their most recent inspection. In the case of the private equity buyout of Mariner Health Care in December 2004, we found that since the buyout the total number of Mariner Home violations increased by 29.4 percent, more than double the increase of the non-Mariner facilities in those same states.

Moreover, actual harm violations for the Mariner Home increased by an incredible 66.7 percent, while the other homes in these states saw an increase of just 1.5 percent. During their most recent inspections, over 43 percent of Mariner facilities were cited by State inspectors for 10 or more violations compared to only 25 percent before the sale.

Most importantly, we must remember that each of these statistics reflect a fragile nursing home resident whose needs are not met or who is or who could be injured because of the nursing home's poor performance. We owe it to our seniors to do better.

The bottom line is that reform is needed to improve transparency and enforcement throughout the industry. CMS must improve the efficiency of the enforcement system in ways that will catch the homes that need to make improvements. They need to do so earlier in the process than many do now before fragile nursing home residents are injured. Furthermore, given the increase in the number of homes cited for 10 or more violations, it is imperative to focus more attention on homes that are chronic poor performers.

We are encouraged that the Chairman and Senator Grassley are considering legislation to address these concerns, and we urge you to consider the following policy changes: increase the transparency and accountability of corporate ownership, require full disclosure to the CMS of all affiliated entities with a direct or indirect financial interest in the facility and their parent company, amend the provider agreement to require that providers deposit assets in a bond, require CMS to certify the provider agreements annually, and, require CMS to post enforcement actions against facilities.

In order to promote improved staffing, we urge you to require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis. We would ask you to require that information on cost reports for Medicare be reported based on five cost centers: direct care nursing services, other direct care services, indirect care, capital costs, and administrative costs. Finally, we ask that you require CMS to conduct audits of nursing staff data reports and cost reports at least every 3 years.

Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors and the disabled with the quality care they deserve. I thank you for inviting me here today to testify about SEIU's concerns about the quality of care in nursing homes today.

The CHAIRMAN. Thank you, Mr. Muller.

[The prepared statement of Mr. Muller follows:]

Testimony of Arvid Muller

Assistant Director of Research
Service Employees International Union
1800 Massachusetts Ave NW
Washington, DC 20036

on Nursing Home Transparency and Improvement
Before the Special Committee on Aging
United States Senate
November 15, 2007

Chairman Kohl, Ranking Member Smith, and other distinguished Members of the Committee,

Thank you for giving me the opportunity to appear before you today. I am the Assistant Director of Research for the Service Employees International Union (SEIU). SEIU represents almost one million health care workers, including more than 150,000 nursing home workers. SEIU respects Chairman Kohl's commitment to improving the quality of care in nursing homes. We must also acknowledge Senator Grassley's long-time leadership on theses issues. And we look forward to continuing our work with both Senators on this issue. Twenty years after Congress passed landmark nursing home reform legislation, SEIU remains concerned that there are serious problems with quality of care across the industry and we fear the current enforcement system is simply not working. And it's difficult for families and residents to get the information they need to make an informed choice about their loved ones' care because the industry lacks transparency.

SEIU analyzes deficiency data from the Online Survey, Certification, and Reporting (OSCAR) data available from the Centers for Medicare and Medicaid Services (CMS). It's unfortunate that any way you cut the data, OSCAR shows that nursing homes have far too many quality problems. In fact, our research indicates that nursing home care overall appears to be getting even worse. In our analysis, we do not include life safety code violations, nor did we include complaint violations. So, the total number of problems found by state inspectors in any given year was actually worse than our numbers indicate.

By compiling all the deficiencies from annual inspections for the years 2004 through 2006 we were able to determine if the number of violations per inspection increased or decreased from year to year. Unfortunately the trends we found were quite disturbing. Overall the number of violations per inspection increased each year for a total increase of 13.8% from 2004 to 2006 [i].

What do these deficiencies mean?

The next analysis we did was to look at the severity of the violations. Violations of resident care, (aka deficiencies) have four levels of severity.

The first, deficiencies with "potential for minimal harm" are those that have the potential for causing no more than a minor negative impact on a resident.[ii]

Next are deficiencies with "potential for actual harm" which reflect non-compliance on the part of the nursing home in a way that causes, or has the potential to cause, no more than minimal physical, mental, or psycho-social harm to a resident.[iii]

Then there are deficiencies that "cause actual harm" causing real injury to fragile nursing home residents.[iv] Examples of actual harm citations include:

- Failure to give each resident enough fluids to keep them healthy and prevent dehydration.
- Failure to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

- Failure to make sure that residents who cannot care for themselves receive help with eating/drinking, grooming and hygiene.[v]

Finally we have deficiencies that "cause immediate jeopardy" meaning that something the nursing home did or failed to do put residents' health, safety, and lives directly in harm's way. These deficiencies require immediate correction.[vi]
Examples of immediate jeopardy citations include:

- 1) Failure to hire only people who have no legal history of abusing, neglecting or mistreating residents; or 2) failure to report and investigate any acts or reports of abuse, neglect or mistreatment of residents.
- Failure to protect each resident from all abuse, physical punishment, and being separated from others.[vii]

When looked at the same data set and broke down the violations by severity we found that while the least serious violations decreased during this time, the more serious violations increased. Violations that had only potential for minimal harm decreased from 2004 to 2006 by almost 10% However, violations that had potential for actual harm increased by 17.8% and violations that were found to have caused actual harm increased by an even greater 19.5%. Even the most serious violations, those that put the resident in immediate jeopardy increased by 3.3% per inspection.

Increase from 2004	Potential for Minimal harm	Potential for Actual Harm	Actual harm	Immediate Jeopardy
2005	-4.3%	9.1%	8.2%	10.7%
2006	-9.6%	17.8%	19.5%	3.3%

The data for 2007 is of course still incomplete but based on about 60% of the projected inspections, the decrease in the least serious violations continues while violations that put residents in immediate jeopardy increased by over 20% from 2004.

Since the average number of violations per facilities is between six and seven during this period, we also looked at to see whether the number of facilities that had significantly more violations increased. For this analysis we looked at all the facilities that had ten or more violations during a single inspection in any given year.[viii] We discovered an increase in the number of facilities that got cited by state inspectors for at least ten violations from 20.9% in 2004 to 26% in 2006. This means that more than one out of every four facilities inspected in 2006 had 10 or more violations of minimal federal resident care standards.

10 or more deficiencies	# of facilities surveyed	# of facilities with 10 or more	% of facilities surveyed
2004	15190	3168	20.9%
2005	14981	3603	24.1%
2006	14816	3845	26.0%

In addition, a new breed of nursing home operator--private equity firms—has entered the nursing home market and, for the companies we analyzed, had a clear effect on care. The private equity business model lacks transparency and accountability and may be exacerbating the problems. On September 23, *The New York Times* published an investigative story on the impact on care when nursing homes are bought by private equity firms. *The New York Times* found that among other concerns with private equity ownership of nursing homes, there are serious quality of care deficiencies. In our analysis of the deficiency data, we also looked at some of the facilities that had been bought by private equity firms, whose ownership structures are particularly complex and whose business model is based on buying and selling business within a relatively short period of time. Our analysis compared the number of violations per inspection at the nursing homes for annual inspection just before they got bought by private equity to their most recent inspection. In the case of the private equity buyout of Mariner Health Care involving over 200 nursing homes and almost 30,000 beds at the end of 2004, we found that since that buy out the total number of violations increased by 29.4%, more than double the increase of the other facilities in the same states where those homes operate.

Actual harm violations increased for these same facilities increased by an incredible 66.7%, while the other homes in these states saw an increase in these types of violations of 1.5%.

Deficiency Type	**Mariner % Increase Post Buyout**	**Non-Mariner % Increase**
All Deficiencies	29.4%	11.9
Potential for Minimal Harm	-8.0%	-13.3%
Potential for Actual Harm	33.6%	18.0%
Actual Harm	66.7%	1.5%
Immediate Jeopardy	87.5%	13.3%

And during their most recent inspection over 43% of this company's facilities were cited by state inspectors for ten or more violations compared to 25% before the sale.

Facilities Cited for 10 or More Violations		
	% of Facilities Before Sale	**% of Facilities After Sale**
Mariner Homes	25.1%	43.8%
Non Mariner Homes	21.6%	26.2%

Most importantly, we must remember that each of these statistics reflect a fragile nursing home resident whose needs are not met or who is or could be injured because of a nursing home's poor performance. We owe it to our seniors to do better.

The bottom line is that reform is needed to improve transparency and enforcement throughout the industry. CMS must improve the efficiency of the enforcement system in ways that will catch the homes that need to make improvements, and they need to do so earlier in the process than many do now, before fragile nursing

home residents are injured. Furthermore, given the increase in the number of homes cited for ten or more violations, it is imperative to focus more attention on homes that are chronic poor performers. We are encouraged that the Chairman and Senator Grassley are considering legislation to address these concerns, and we urge you to consider the following policy changes:

Increase the transparency and accountability of corporate ownership

- Require full disclosure to the Centers for Medicare & Medicaid Services (CMS) of all affiliated entities with a direct or indirect financial interest in the facility and their parent companies, and the owners (including owners of the real estate), operators, and management of each facility; and require that all these entities be parties to the Medicare provider agreement and listed on Nursing Home Compare. CMS should maintain an ownership database and monitor the quality of care provided by the companies. Severe penalties, including exclusion from Medicare, should be established for hiding ownership or affiliated relationships.
- CMS should address the lack of transparency by amending the provider agreement to require that providers, including purchasers of an existing facility or company, deposit assets in a surety bond with the amount (to be determined) proportional to the number of beds in the facility.
- Require CMS to certify the provider agreements annually to ensure that they are consistent with the current ownership structure and affiliated entities.
- Require CMS to post enforcement actions against facilities and maintain actual CMS form 2567 survey reports on Nursing Home Compare.

Promote improved staffing

- Require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis, including data on turnover and retention; and require CMS to report that information on Nursing Home Compare as quality measures that include a ratio of direct care nursing staff (RNs, LPNs, and CNAs) to residents and turnover and retention rates.
- Require that information on cost reports for Medicare be reported based on five cost centers: (1) direct care nursing services; (2) other direct care services (e.g., activities, therapies); (3) indirect care (e.g., housekeeping, dietary); (4) capital costs (e.g., building, equipment and land costs); and (5) administrative costs. The cost reports should be reported electronically to CMS and summary data should be made available on Nursing Home Compare. In 2004, MedPAC recommended requiring nursing facilities and skilled nursing facilities to publish nursing costs separately from other costs on cost reports. This recommendation was reiterated in a June 2007 MedPAC report (www.medpac.gov/Chapters/Jun07_Ch08.pdf)
- Require CMS to conduct audits of nurse staffing data reports and cost reports at least every three years to ensure the accuracy of the data reported and to prevent fraud. Severe penalties should be established for filing false reports or failing to file timely cost reports.

Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors and the disabled with the quality care they deserve. I thank you for inviting me here to testify about SEIU's concerns about the quality of care in nursing homes today.

[1] The deficiency data for each year was compiled from the CMS archives of quarterly inspection data from the Online Survey Certification and Reporting System (OSCAR). Since it sometimes takes a while for data to be

submitted to CMS we combined information from multiple quarterly downloads to capture all the inspections for a particular year. We then eliminated any duplicate inspections (e.g. due to changes in provider number) and duplicate deficiencies in a single survey. Data for 2007 included deficiencies as recent as September 26th 2007. Deficiencies per inspection increased from 6.07 in 2004 to 6.90 in 2006

[ii] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P – Survey Protocol for Long Term Care Facilities – Part I – (Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.

[iii] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P – Survey Protocol for Long Term Care Facilities – Part I – (Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.

[iv] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P – Survey Protocol for Long Term Care Facilities – Part I – (Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.

[v] Based on information from "About the Nursing Home – Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.

[vi] Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P – Survey Protocol for Long Term Care Facilities – Part I – (Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.

[vii] Based on information from "About the Nursing Home – Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.

[viii] Even if a facility had more than one inspection that resulted in 10 violations the facility was only counted once.

Mr. Biondi.

STATEMENT OF STEVE BIONDI, VICE PRESIDENT OF EXTENDICARE, MILWAUKEE, WI; ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. BIONDI. Thank you, Chairman Kohl and members of the Committee. I am pleased to be here representing the American Health Care Association and the nursing home profession. My name is Steve Biondi. I have been an ombudsman, a State regulator of health care, a health facility operator, and a consumer who has had a family member cared for in a nursing home. By profession I am a licensed nursing home administrator and a registered nurse and have worked in acute care, long-term care, and home care.

First I want to thank you, Chairman Kohl, for your leadership in this important Committee and for introducing the Patient Safety and Abuse Prevention Act, which the AHCA supports. I also want to acknowledge Senator Grassley's longstanding commitment to issues of aging and the millions of Americans our profession cares for each and every day. I also commend the other members of this Committee, especially Senators Smith, Lincoln, and Collins who have put forth some of the most important regulatory reform concepts of the past 20 years.

Their Long-Term Care Quality and Modernization Act takes an important step toward broadening the culture of cooperation among long-term care stakeholders and benefits the patients and families we all serve. My comments build on testimony of my colleague, Mary Ousley offered to this Committee about the refinements of OBRA 1987 that are still needed to support the vision of patient-centered care.

What was undeniable 20 years ago, is undeniable today and will be undeniable 20 years from now is the unbreakable link between stable funding and quality and the critical need for well-qualified staff who deliver quality care each and every day. We are proud of the progress we have made and the transparency we have around improving quality.

Our latest initiative is advancing excellence in America's nursing homes. It is a voluntary program co-founded by the American Health Care Association and a coalition of providers, caregivers, researchers, government agencies, workers, and consumers. Advancing excellence focuses on specific measurable clinical quality and organizational goals. The resources for providers include best practices and are all evidence-based.

Perhaps the most unique feature of this campaign is how it encourages greater partnership among the stakeholders, both nationally and at the State level to improve care and services. Our profession is also focusing on consumer satisfaction. Consumers, including patients and families, are being asked how they judge our services and whether they would recommend them to a friend.

A very high percentage are truly pleased. Providers use these independent satisfaction surveys to improve the patient quality, quality of care and quality of life. My own company uses these consumer feedback mechanisms to make changes within our facility operations.

These kinds of focused efforts have improved quality and clinical outcomes. CMS OSCAR data shows a positive trend in the quality measures posting on nursing home compare with improvements in key areas for short-term and long-term stay patients and residents in pain, restraints and pressure ulcers.

I think it is important to expand the concept of transparency beyond just facilities to include the survey and enforcement process itself. We have been working with CMS for more than a year with some success trying to better understand its special focus facility program. We still need clarity around the formula that CMS uses to identify those facilities and the successful strategies that more than 60 facilities thus far have used to achieve sustained compliance.

Clearly, all of us share a commitment to quality. Transparency around this program would improve regulatory compliance and reduce the number of poor performing facilities.

From our perspective the quality improvement organizations are a valuable external resource for all facilities, even those that are already doing well in terms of quality. The commonwealth fund study looking at residents' quality of life found that QIOs work with nursing homes "a sound investment for health care dollars."

However, when we look at internal resources, our greatest challenge is attracting, training, and retaining quality long-term care staff. Today we have nearly 100,000 vacant nursing positions. We could use your help in addressing the critical shortage of nurses, which is driven as well by the nurse educator shortage.

For the consumer, AHCA has an easy to understand Web site to educate consumers about long-term care. Since beneficiaries generally look to CMS for guidance in this arena, we have a number of recommendations on improving nursing home compare in my written testimony. The main point we want to make is that nursing home compare does not currently give consumers understandable information that they can use in truly choosing a nursing home.

Last, as we look at our survey and enforcement system, what most people haven't considered is how the survey process impacts caregivers and nursing homes. The system focuses solely on operational shortcomings with rare positive acknowledgement for the quality of services provided. It is important that we begin to recognize our most valuable resource, the human capital that work within our facilities and within our profession.

We personally appreciate your focus on long-term care, Senator Kohl. AHCA looks forward to working with this Committee toward our mutual interest of continuing the progress we are making in improving nursing home quality. Thank you.

[The prepared statement of Mr. Biondi follows:]

ahca
American Health Care Association

Statement
of

Steve Biondi, RN, LNHA

On behalf of the

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

November 15, 2007

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

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

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

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

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

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

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

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

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

Commitment to Quality

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

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

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

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

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

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

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

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

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

Measuring Quality Improvement

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

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

Specifically, the data shows:

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

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

Assessing Patient & Family Satisfaction

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

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

Long Term Care Workforce

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

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

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

Special Focus Facilities

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

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

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

Expanding the Role of the Quality Improvement Organizations

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

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

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

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

Stakeholder Collaboration to Address Poor Performing Facilities

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

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

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

Consumer-Friendly Resources

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

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

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

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

Transparency, Empowering Consumers & Nursing Home Compare

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

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

AHCA Reform Recommendations

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

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

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

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

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

Encourage Joint Training of Surveyors & Providers

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

Greater Transparency in the QIS Pilot

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

Eliminate the Loss of Critical Nurse Aide Training

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

suspension of a facility's nurse aide training program.

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

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

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

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

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

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

Alleviating the Workforce Shortage

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

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

Improving Nursing Home Compare

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

Transparency In Reporting – Protecting the Process

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

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

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

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

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

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

Conclusion

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

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

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

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

Thank you.

The CHAIRMAN. We thank you, Mr. Biondi.
Ms. Zabel.

STATEMENT OF BONNIE ZABEL, ADMINISTRATOR FOR MARQUARDT MEMORIAL MANOR, INC., WATERTOWN, WI; ON BEHALF OF THE AMERICAN ASSOCIATION OF HOME SERVICES FOR THE AGING

Ms. ZABEL. Thank you. My name is Bonnie Zabel. I am pleased to be here representing Marquardt Memorial Manor in Watertown, WI and the American Association of Homes and Services for the Aging. I am grateful for this opportunity to fulfill my personal desire to tell you from my heart what I feel is needed for quality long-term care. This is based upon my 20 plus years in long-term care.

True quality of care has to include all providers at all levels of service from acute care to long-term care to assisted care in the home setting. We all need to provide the same quality.

Consistency in care is especially important at the time of admission to the nursing home. Currently hospital discharge decisions are made with little if any family input or time to visit or check out a nursing home. Consumers often are stressed and don't know that they can challenge the hospital's decision.

Often they have neither the time nor the knowledge to make a good decision. No one says, "When I grow up, I want to live in the home," and decides in advance where they want to go. People are in crisis when the decision must be made.

I recently experienced such a crisis with my own father. He had a joint infection in his knee which required urgent surgery and I.V. antibiotics. He hasn't gotten out of bed in his first 24 hours in the hospital, even though there were orders to do so. He happens to be 86 years old.

I informed them that he couldn't urinate without standing. They put a catheter into his bladder three times that first 24 hours. He urinated blood for 2 days after that.

On his first post-op day, the discharge planner came in and told us that he needed to go to a nursing home the next day because he wasn't walking well enough. I told her that he wasn't going to a nursing home the next day. Her response was she would be back at 8 a.m. the next day and, yes, he would be going to a nursing home.

The next day his drain was out, his dressing changed, he was dressed and ready to go home. Her response, "What a difference a day can make."

In reality if I were not a nurse and administrator, my father most likely would have been discharged to a nursing home. I could challenge the hospital decision in a way that most consumers cannot. Discharge planners too often take the path of least resistance, which is calling a facility and getting the resident admitted within an hour or two.

Marquardt Manor was actually reprimanded by our local hospital for wanting to assess a resident prior to admission and requiring doctor orders the afternoon before admission so we could be sure that the resident's needs could be met. Their rationale, given by a physician and the vice president of patient services, was, "People

get infections and die and there are multiple medication errors that can kill in hospitals. We need to get them out as soon as possible."

How should the hospital discharge and nursing home admissions system work? We make sure that our staff knows about the resident and family and their needs prior to admission. All supplies and equipment are available.

For the past 10 years, all of our residents have had private rooms with private baths. A one-day admission process improves quality and allows the family to personalize the room. This is not an additional cost to Medicare. Poor transitions have cost, too.

Families are in crisis when they hear that admission to a nursing home is needed. If they have time to choose, they don't know what to look for. Nursing home compare is written in industry language and only tells consumers about problems in facilities, not about what to look for in quality.

For example, the site tells you if the home has a separate dementia unit, but the availability of dementia units doesn't necessarily mean that the residents receive specialized care. Questions need to be asked.

How does staffing differ from regular units? How many hours of activities are provided beyond the regular units? How long will my mother stay on this unit, until the end of her life, only while ambulatory, only while continent?

Wisconsin's consumer information report does a much better job of explaining the survey results for consumers. But it, too, is limited by its focus on deficiencies and compliance. However, the CIR also reports on nurse staffing and retention, which is a very good piece of information.

Consumers should be looking for places that provide person-directed care. But nursing home compare doesn't give you the tools to do this or even say that this is an important element of quality.

Person-directed care is a philosophy, not a building design, animals, plants or buffet dining. It is about individuals as people, people who are someone's mother, father, brother, sister or spouse, people who were teachers, butchers, farmers, factory workers, business people. Their lives made a difference in America, and they deserve to be treated with dignity, caring, and respect.

Finally, I would like to emphasize the importance of adequate funding, especially for Medicaid. Funding has declined and continues to decline. There was no Medicaid Title 19 increase in Wisconsin this year, zero. My facility loses $65 per day per Title 19 resident. Sixty-five to 70 percent of my residents are on Title 19.

Facilities are limiting Title 19 admissions or eliminating them altogether. I fear the return of the "poor farm" of the 1950's. Not funding Title 19 will certainly get us there.

Without adequate financing there cannot be quality. We are a service industry that requires good staff. I identified that 20 years ago.

I have been proactive and innovative in creating programs to attain and maintain good staff. Adequate wages and benefits are a necessity. High standards for performance and adequate training, equipment, and supplies run a close second. That does not mean an increase in the time of training. It means adequate training.

Consistent, caring hands-on managers cannot be overlooked. Eight years ago I created a gratitude attitude program in my facility. It has made a big difference in staff quality and retention. Our workers compensation costs are minimal due to adequate training, equipment, and oversight. Our staff retention surpasses most. Our customer relations and satisfaction are excellent.

We need your help to change our current system of educating consumers. Consumers need adequate time to make decisions and good information to base those decisions upon. The system already has lots of regulations and the means to enforce them. It is time to focus on getting the word out on quality.

I thank you for this opportunity of a lifetime.

[The prepared statement of Ms. Zabel follows:]

Statement by Bonnie Zabel

Administrator

Marquardt Memorial Manor, Inc.

1020 Hill Street

Watertown, WI 53098

Before the

Senate Special Committee on Aging

Hearing on

Nursing Home Transparency and Improvement

November 15, 2007

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creating the future of aging services

Statement by Bonnie Zabel
Administrator
Marquardt Memorial Manor, Inc.
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Introduction

Chairman Kohl, Ranking Member Smith and members of the Committee, I am pleased to have the opportunity to testify today on behalf of Marquardt Memorial Manor (Marquardt Manor) and the American Association of Homes and Services for the Aging (AAHSA), of which we are a member. Marquardt Manor is also a member of the Wisconsin Association of Homes and Services for the Aging (WAHSA), where I serve on the Board of Directors.

The members of the American Association of Homes and Services for the Aging *(www.aahsa.org)* serve as many as two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Our 5,700 members offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services through quality people can trust.

Marquardt Manor is a certified Medicare and Medicaid skilled nursing facility. Founded in 1969, Marquardt Manor is a part of Marquardt Village, a retirement community sponsored by the Western District of the Moravian Church. Our mission is to care for the elderly and the handicapped in a Christian environment, although we are open to all faiths. The Marquardt retirement complex began as the nursing home but now consists of all levels of services and housing – low-income and market rate senior housing; assisted living; skilled nursing; supportive home care services; home health; therapy; hospice; and a senior center.

I joined Marquardt Manor 20 years ago as a nurse and was appointed administrator in 1994. Our residents receive a wide range of medical and social services, but we are more than medical services, we are home for our residents. Quality of care and quality of life merge in three specific ways:

- We care about our resident's transition to Marquardt and quality of care. We are fully prepared before we accept a resident – we tell hospital discharge planners that we require a full and complete medical history so that we are prepared with the correct medication, correct immediate care plan, and correct immediate treatment when a new resident arrives. Care happens immediately – a personalized care plan needs to be in place upon admission.

- We care about our residents' comfort. Although we are almost 70% Medicaid funded, each of our rooms is private and carpeted, with its own bath. Residents are encouraged and able to bring their personal furnishings so that they can say, especially if they will be with

us for a long time, "I am home". While the overhead for private rooms is higher than shared rooms, the benefits far outweigh the costs: residents are more content and relate better to each other; families and kids visit more often and have much better visits. On the care side, infections have been reduced; nurses have more time to spend with each resident; rooms stay much cleaner; and everyone is much happier. Creating a good atmosphere is not a frivolous activity, it is central to a good and caring environment.

- We care about our workforce. We have almost no turnover and we are an employer of choice in our community. Our staffing levels are higher than average (3.9 hours per resident) as is our pay (starting salary for CNAs is $13.95 per hour plus benefits, compared with $9.00 in Milwaukee and Madison), and we have excellent in-house education and training programs. We created an educational program with our local high school which has funneled interested and well-trained young people into our field as CNAs. They get their on-the-job training at Marquardt Manor as they are completing their high school education. Our turnover really is related to graduates who decide to move on, often to get advanced degrees – we are proud that we have educated generations of young people to join our field and provide quality care throughout Wisconsin and the country.

  In addition we have and enforce fair and reasonable work rules – good work is recognized and poor quality not tolerated. We recognize the value of our workforce through a program we developed called "Gratitude, Attitude", which is now being promoted state-wide by WAHSA, where staff and residents share appreciations for each other. Staff feel that their work is recognized, and residents can express what really matters to them in their every day life (taking a walk, having their hand held, morning bath – the "little" things that aren't medical but are essential and personal) which in turn helps us provide better service.

  Finally, we care about our employees as people – we recognize that balancing work and family is not easy and have created informal and formal programs to help our staff. We provide in-service programs for staff in such areas as coping skills and balancing work and family. Personally, I have an open door – staff knows that they can come to me with concerns and that we will work together for solutions.

In my testimony today, I will focus on our field's efforts to improve nursing home transparency and quality, and address certain improvements to the overall system that could improve the consumer's ability to make informed decisions regarding the decision to enter a nursing home.

Transparency

It is difficult for consumers to obtain adequate and useful information on nursing homes so that they can make an informed decision for themselves or a loved one. The information that is available is not written for the lay person and does not contain critical information to assess the quality of life and care provided by the home. This lack of good information is particularly disturbing because consumers seldom have the time or capacity to research homes.

The primary source of information is Nursing Home Compare, the website established and maintained by CMS. Nursing Home Compare contains the results of the latest surveys for each Medicare and Medicaid-certified nursing home, quality measures based on the information collected for the Minimum Data Set (MDS) Repository, and some general information regarding each nursing home. Although an effort has been made to explain each reported measure and deficiency citation, the site never actually explains the process and the meaning of the results, how surveys are conducted, what they mean and don't mean. How should the consumer assess the meaning of a deficiency that ranks as a "2" and affects a "few" residents? Consumers cannot even determine if cited deficiencies relate to many incidents or one incident. Nor is there any lay explanation of the facts underlying the deficiency so that a consumer can understand the meaning of the deficiency. What is the actual impact on "quality"? How should the consumer use this data? Other issues that have been raised about the information provided on Nursing Home Compare relate to the reliability of the data[1], as well as understanding that compliance with regulations is not the same thing as quality.

None of these questions is answered, even though understanding how to interpret survey data and integrate this data into one's analysis of any particular nursing home seems like fairly basic information.

In Wisconsin, the state has developed its own website, (http://dhfs.wisconsin.gov/bqaconsumer/NursingHomes/CIRindex.htm), using the same data, but presented in a more consumer-friendly manner. The reports are re-titled "Consumer Information Reports" (CIR) and contain explanations of the information reported in plain English. In addition, the CIR contains useful information on staffing retention and turnover rates. Staffing is one of the key indicators for quality. A home with a low turnover and high retention of staff is more likely to have higher quality and greater satisfaction of staff and residents, and so this information can be very useful to consumers.

The survey is only one tool for evaluating a nursing home, indeed it may be the least useful in the end because it only reports on deficiencies and does not provide information on all the other elements of care and services that are critical for evaluating quality of care. Unfortunately, there really is no other data source for identifying which nursing homes have high quality.[2] As a result, everyone from CMS to consumer groups to nursing homes ourselves urge prospective residents or their decision makers to visit the nursing homes they are considering if at all possible. . The time to visit prospective homes and the tools to analyze the information obtained from NH Compare and their visits, are critical to the ability of consumers to make thoughtful and intelligent decisions.

There are several variations of tools for consumers. CMS has developed a "Guide to Choosing a Nursing Home" (which unfortunately is buried deep in its website but which can be found on the home page of the Wisconsin site). AAHSA has also developed a publication for consumers,

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[1] See, e.g., Lee, Gajewski & Thompson, "Reliability of the Nursing Home Survey Process: A Simultaneous Survey Approach," 46 THE GERONTOLOGIST 772-780 (2006) (copy attached to testimony).

[2] There is extensive literature on quality but it is not easily accessible to consumers. "Aging Services: The Not-For-Profit Difference", an AAHSA publication, cites many of these independent studies as identifying higher quality provided by NFPs.

"How to Choose a Nursing Home",
http://www.aahsa.org/consumer_info/how_to_choose/tour_nursing_home.asp.[3] Each of these guides tries to provide the consumer with questions that will hopefully elicit sufficient information to identify the quality of the care and services provided.

In addition, AAHSA developed and recommends that our members distribute two checklists to prospective residents and their families, The Consumers Guide to Quality Aging Services (http://www.aahsa.org/qualityfirst/assessment/documents/consumers_guide.pdf) and a checklist called "First Impressions" which is designed to provide feedback to the provider but also serves as a good one-page checklist for consumers themselves. (http://www.aahsa.org/qualityfirst/resources/public_trust/documents/FirstImpression.pdf)

The Consumers Guide to Quality Aging Services is considerably different than the standard guides because it tracks the elements of AAHSA's Quality First initiative.[4] The AAHSA Guide recommends that the prospective consumer ask the nursing home questions such as: "Does your organization participate in a quality improvement or accreditation program (and if so, explain which one and why)"; "Who serves on your Board of Directors?"; "How does your organization identify and adopt new care and services practices?"; "What kinds of community programs or services do you bring into the facility, and how do you involved residents in programs, activities and events in the neighboring community?"; "Is your staff encouraged to give feedback? For example, do you conduct staff satisfaction surveys and if so, how do you use the results?", and "What is the average length of employment for your staff members and what reasons do employees cite for leaving your organization?"

AAHSA linked several questions in the Consumers Guide to "Governance and Accountability", one of the elements of AAHSA Quality First, because good governance and corporate accountability are critical to quality. Not-for-profits are not only obligated to report to the public on their finances, they are also legally and morally obligated to reinvest their earnings in their community, whether by providing more and better services, higher pay for staff, improving the physical environment or serving more people, to name just a few possibilities.[5]

Consumers and Choice: The Challenge of Transition

One of the most pressing problems for consumers is having the time to use the various tools available. Nursing home admissions through Medicare by definition have to be preceded by a 3-day hospital stay and it is has been our experience that most nursing home admissions in fact come directly from hospitals. Thus, the gatekeeper tends to be the hospital discharge planner. A number of commentators have examined the transition process from hospital to nursing home and

[3] Other organizations that have developed consumer guides include the American Health Care Association (AHCA) and NCCNHR, the nursing home consumer advocacy organization.
[4] Quality First is the industry-wide voluntary quality improvement initiative initiated in 2001 by AAHSA, AHCA and the Alliance (which represents publicly-traded nursing home companies). The associations implement Quality First independently.
[5] Not-for-profits are obligated to report their finances to the IRS on the I-990 form, make the form publicly available, and meet specific governance and charitable requirements to maintain their tax exempt status. It should be noted that publicly traded companies are also required to report their finances and major business activities; it is the financial obligations that are significantly different.

identified a considerable number of concerns, including failure to provide x-rays and other studies, failure to include end of life documents (do not resuscitate orders), dietary information and the like when patients are transferred to nursing homes.[6]

The ability of the consumer/caregiver/patient to make careful choices is likewise compromised. As hospital stays have shortened, the time between admission and discharge planning has likewise shortened, thus reducing the ability of the caregiver to make careful choices. The National Alliance for Caregiving has published a pamphlet for caregivers explaining the process and providing advice on how to manage and challenge decisions,[7] but it is unlikely that many consumers have access to this document. Family and patient may feel they have no choice but to take the recommendation/order of the hospital – and no meaningful time to determine alternatives much less search for information on quality of care and life and then seek out the best facilities.

These transitions, we firmly believe, need to be addressed if we are serious about wanting consumers to exercise choice based on meaningful information and if we want the people we care for to move through the system smoothly. AAHSA has joined with 26 other organizations to form The National Transitions of Care Coalition (NTOCC), which brings together thought leaders, health care providers and consumers from various care settings to address improving the quality of care coordination and communication when individuals are transferred from one level of care to another.

Quality Initiatives from the Field

AAHSA and many of our members have developed and implemented initiatives to improve both the quality of care and the quality of life of people living in nursing homes. AAHSA's own "five big ideas for the future of aging services" include cultural transformation: the creation of a healthy nursing home workplace based on respect for caregivers, team building and management, continuous quality improvement, and resident centered care.

A few examples of quality initiatives in which our members have taken a leading role[8]:

Pioneer Network

Ten years ago, nursing home leaders who wanted to change the dynamics of our field to reflect life and growth began meeting together to find common areas for research and reform. The Pioneer Network was established in 2000 as the umbrella organization for the culture change movement. Its members work with long-term care professional organizations, facilities and their staffs in implementing fundamental changes in the operations of nursing facilities. Several

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[6] Lee, et al., "If at First You Don't Succeed: Efforts to Improve Collaboration Between Nursing Homes and a Health System", Topics in Advanced Nursing eJournal, www.medscape.com (posted 09/01/94).
[7] Hunt, *A Family Caregiver's Guide to Hospital Discharge Planning* is available at www.strengthforcaring.com.
[8] Marquardt Memorial adapted many of the elements of the various culture transformation models to meet our community's needs. It is not necessary to adopt an entire program; what is necessary is the will to create a healthy nursing home workplace and to maintain that healthy workplace over the years.

AAHSA conferences have included educational sessions led by Pioneer Network members. Nursing homes that have implemented Pioneer principles are reporting improved staff retention and resident outcomes. Nine states have formed culture change coalitions. The Network has now expanded to include providers of home- and community-based services.

Wellspring

Wellspring, an initiative begun by a group of AAHSA members in Wisconsin in 1994, integrates federal quality indicators, best practices and a new management paradigm to dramatically improve resident outcomes and cost efficiency. Fundamental to the Wellspring program is the concept that the definition of quality care is created by top management, but that the best decisions about how the care is delivered to each resident are made by the front-line staff who knows the residents best. This empowerment is achieved through extensive line staff education in the form of "care resource teams", shared decision-making and enhancing critical thinking skills of all staff. The program is lead by a geriatric nurse consultant who utilizes other clinical experts for teaching best practices.

Group process is central to Wellspring. The shift from traditional autocratic management structure to staff empowerment where frontline staff has equal responsibility for resident outcomes is what has made Wellspring unique. Key components are establishing permanent staff assignments to groups of residents and allowing staff to do their own scheduling.

Because of the initial success Wellspring achieved (98% resident/family satisfaction, a cut in the CNA turnover rate from 105% to less than 30%, a waiting list of CNA applicants, high staff retention, and good survey results) the program now is being replicated in nursing homes in several states.

Eden Alternative

Several years ago, Dr. Bill Thomas began a program to combat the loneliness, helplessness and boredom that many nursing home residents experienced. His program has now been replicated across the country, and participating nursing homes commit to creating human habitats, with residents at the center, surrounded by plants, animals and children. Elders in these communities have the opportunity to both give and receive care, to engage in meaningful activity, and to experience variety and spontaneity.

A vital part of the Eden Alternative is the de-emphasis on top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the elders or into the hands of those closest to them.

Green Houses

Green Houses, also the brainchild of Dr. Thomas, build on the concepts of the Eden Alternative. These projects emphasize small communities for elders and staff where necessary medical care is provided, but is not the focus of activity. The Green House is intended to replace large institutions with small, social settings for six to ten elders. Elders have private rooms and baths,

situated around a common kitchen and dining area. Elders have access to outdoor gardens and patios and can choose their own activities throughout the day without the imposition of any kind of sleeping or eating schedule. Green House projects now are being planned or operated in eighteen states.

Advancing Excellence in America's Nursing Homes

Advancing Excellence in America's Nursing Homes is a two year, coalition-based campaign concerned with how we care for elderly and disabled citizens. This voluntary campaign:

- Monitors key indicators of nursing home care quality
- Promotes excellence in caregiving for nursing home residents
- Acknowledges the critical role nursing home staff have in providing care

The campaign builds on the success of other quality initiatives like Quality First, the Nursing Home Quality Initiative (NHQI), and the culture change movement. Campaign goals include creating a culture of person-centered, individualized care and an empowered workforce in nursing homes. The campaign has brought together all long-term care stakeholders, including consumer advocates, medical and quality improvement experts, and enforcement agency officials.

Several thousand nursing homes already have enrolled and committed to working on three out of eight quality indicators: reducing high risk pressure ulcers, reducing the use of daily physical restraints, improving pain management for short-stay, post-acute patients and for longer term nursing home residents, establishing individual targets for improving quality, assessing resident and family satisfaction with the quality of care, increasing staff retention; and improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Quality First

The Quality First initiative, begun in 2002, is a philosophy of quality and a framework for earning public trust in aging services. More important, it is a renewal of our commitment as aging-services providers to help older adults and their loved ones live their lives to their fullest potential. Through Quality First, we work in partnership with all stakeholders - government, consumers and the people we serve and their families - to create quality of care and quality of life in aging services.

AAHSA Quality First provides all AAHSA members with opportunities to reaffirm their public commitment to quality; assess their strengths and opportunities for improvement; pursue continuous quality improvement based on the belief that improvement is always possible; and earn the public's trust and the confidence of consumers. A majority of our members have signed the Quality First covenant, and we encourage all of our members to use the tools provided for assessment of areas in which services may be improved.

Center for Aging Services Technology (CAST)

The application of technology to aging services is one of AAHSA's "five big ideas" for the future of aging services. A few years ago, we established the Center for Aging Services Technologies, which has brought together researchers, technology companies, and long-term care providers to develop and apply technological solutions to aging services issues. These initiatives promise greater efficiency and quality in service delivery at the same time that they will give consumers more choices in the services they may obtain and the settings in which they receive them.

Responses to the challenges related to the workforce crisis

Adequate staffing is a challenge that will not go away for the foreseeable future. The nursing home reform provisions of OBRA '87 contain no set levels of staffing, and the statute's general prescription that staffing must be sufficient for residents to attain and maintain their highest practicable level of functioning has been criticized as inadequate. However, the most recent staffing study by the Centers for Medicare and Medicaid Services concluded that there was insufficient data on which to base and recommend specific staffing levels for nursing facilities. In addition, nursing homes face the same nursing shortage that prevails throughout the healthcare field, and are at a competitive disadvantage as compared to other health care providers in recruiting and retaining the staff they and their residents need.

A recent report to the National Commission for Quality Long-Term Care by the Institute for the Future of Aging Services describes the workforce crisis in the long-term care field and makes a number of recommendations for meeting this challenge. The report lists the need to bring more people into the long-term care field, to provide more competitive wages and benefits, to improve working conditions and job quality, to make larger and smarter investments in education and workforce development, to develop new models of service delivery and to moderate the demand for hands-on care through the application of technology.

AAHSA is working on all of these fronts. We encourage our nursing home members to open their doors to nursing schools and to offer opportunities for rotation through their facilities. We have also supported the concept of career ladders for nursing assistants to enter the field of professional nursing. Since 1989, under a grant from the Patient Care Division of Proctor and Gamble, we have sponsored an annual scholarship program for nursing assistants to become RNs or LPNs. In addition, we have many nursing facility members who have independently developed scholarship or tuition assistance programs to enable nurse aides under their employ to become registered (RNs) or licensed practical nurses (LPNs). Marquardt Manor partnered with the local high school in Watertown to train students to become CNAs, using our home for on the job training.

To address the issue of job quality, the Institute for the Future of Aging Services has undertaken the national Better Jobs Better Care campaign and several other initiatives to research and demonstrate organizational changes that make nursing homes attractive places to work.

Congress also has a role to play in growing staffing resources in our field. The Nursing Workforce Development programs under Title VIII of the Public Health Service Act educate

nurses, enable them to remain current with developments in their field and enhance their ability to supervise other staff. The programs also include loans to increase the number of qualified faculty at nursing schools, which have had to turn away thousands of applicants for nursing education due to faculty shortages. These programs have been flat-funded for the last several years as the nursing shortage continues to grow. Additional resources are essential to meet the rising need for nursing care, and we urge an increase in funding to $200 million for these programs in fiscal 2008.

Furthermore, the IFAS report noted the need for more parity in wages and benefits between acute and long-term care settings. Because approximately seventy percent of the cost of nursing home care is paid under Medicare and Medicaid, governmental payment policies disproportionately influence the amount of resources that nursing homes have available to compensate their staff. The Long-Term Care Quality Improvement Act, H.R. 1166, introduced in the House during the last Congress, would have required the Department of Health and Human Services to study the adequacy of the entire package of funding for long-term care, Medicaid as well as Medicare.

This legislation, reintroduced in the 110th Congress as H.R. 3784, calls for nursing homes to report separately on their Medicare cost reports the amounts they spend on wages and benefits for nursing staff, by staff level, breaking out the figures for registered nurses, licensed professional nurses, and certified nurse assistants. Since staffing is so integral to quality of care, AAHSA felt that this requirement would be a strong first step toward aligning payment incentives with quality. Under current policies, Medicare pays for skilled nursing at the same rate whatever the quality of care provided. We understand that CMS is beginning to develop policies to tie payment incentives to quality and we welcome this initiative.

In addition, the IFAS report noted that the negative public perception that is fostered through the media and sensational reports that focus only on the harmful incidents and occurrences in nursing facilities is demoralizing to front-line workers. We recognize and concur that incidents of bad care are intolerable. However, the kind and compassionate care that is provided on a daily basis by the vast majority of nursing home staff members goes without notice. Portraying the entire nursing home profession in a negative light is unfair to the many dedicated staff who work continuously to assure quality care to the residents they serve. Not only does this do a disservice to these individuals, but it results in a chilling effect on our ability to recruit and retain competent, caring individuals. The long-range impact of "negative-only publicity" on our organizations is inestimable.

Recommendations

We believe the nursing home reform provisions of OBRA '87 have led to significant improvements in the quality of nursing home care. However, as implemented the federal survey and certification system fails to give consumers a reliable means of choosing the best nursing home care for themselves or their loved ones. Inconsistency in survey results and the imposition of remedies with a limited right of appeal may cause consumers to avoid facilities that in fact are providing good care. In addition, CMS's efforts to improve state inspections and enforcement and crack down on poor performers still fail to target bad providers, as noted in a recent GAO

report (GAO-07-241). Oversight authorities must expend the same amount of time and resources on facilities with exemplary records as they do on those demonstrating chronic or serious quality of care problems, and facilities that consistently fail to provide appropriate quality of care remain in business.

Specifically, we recommend:

Nursing Home Compare should be revamped to ensure that the information provided is accurate, reliable and understandable to consumers. The site should contain clear explanations of the survey process, what deficiencies mean in plain English and an explanation of the rating system. Information that shows the provider corrected the deficiency would be helpful. In addition, the site should explain the difference between compliance, i.e., that the facility has met the minimum standards at the time of the inspection, and quality. Finally, the "Guide to Choosing a Nursing Home" should be clearly linked on the home page. CMS could consider linking to other organizations' publications as the Wisconsin website does.

The importance of transitions – in particular from hospital to nursing home – needs to be addressed in a constructive fashion. Ensuring that patients and their families have sufficient information and time to make a decision is critical, as well as ensuring that nursing facilities receive all the information they need from the hospital in a timely fashion.

Part of transparency and accountability is to understand where Medicare dollars are going. H.R. 3784 mandates reporting of expenditure broken out by type of staff, and AAHSA urges support for this measure.

We believe that while OBRA '87 has led to significant improvements in the quality of nursing home care, some provisions of the statute no longer meet the needs of today's nursing home consumer.

The nursing assistant shortage has compounded the counter-productivity of OBRA's two-year disqualification of nurse-aide training programs for facilities found to be out of compliance with certain standards. An inability to train nurse aides, once compliance has been achieved and demonstrated, results in a potential compromise to quality of care that is inappropriate and unnecessary, and is addressed in S. 1980, introduced by Sen. Smith.

Barriers to the takeover of poor performers by new owners with good records of compliance should be removed. Under the current system, a facility's compliance record and any enforcement remedies sustained by a previous owner are required to be transferred to the new owner. This forces competition between the new owner's resources to restore quality of care and services to the residents, and the previous owners' liabilities related to compliance and financial penalties. Faced with carryover liability for heavy fines by a consistently poor performer, healthier facilities are unlikely to step in to try to turn a problem facility around. In areas where long-term care services are limited, residents may have few or no alternatives to remaining in a poor facility, and facilitating new management would be in the residents' best interests.

The existing mandate that states use civil monetary penalty funds to improve resident care must be better enforced; many states have not adopted programs to implement this requirement and the monies collected are being used for other purposes. To fulfill the mandate, CMP funds should be used for surveyor training, consultation and technical assistance to facilities in developing and implementing quality improvement or resident care protocols.

America's seniors and their families need a quality assurance system that enables them to choose facilities that provide excellent quality of care and quality of life. An approach must be developed that allows surveyors and care-giving staff to work not only on promoting and achieving sustained compliance, but on meeting individual care needs and expectations to improve care. Nursing home care is evolving, and we need a resident-focused system that fosters continuous quality improvement. The focus of the survey and enforcement process should be on fixing problems and offering expert guidance rather than on punishment.[9]

Conclusion

It is appropriate for all stakeholders to take stock of the progress that has been achieved in improving care and services provided by our nursing homes and the ways in which the highest quality nursing home care can be ensured and achieved for the oldest and most vulnerable Americans. It is incumbent upon all of us – government, providers, community – to make sure that consumers have reliable information to select the best nursing homes, and the time and ability to use that information.

AAHSA commits itself and its members to continuous improvement in the quality of care and services we provide, and we look forward to working with the Senate Special Committee on Aging to ensure continued progress in our field.

[9] The "Patient Safety" movement, building on the seminal Institute of Medicine studies of hospital errors, provides a good starting point for shifting from a "blame" mode to a "fix the problem" mode – in many respects the culture change movement in nursing homes, described above, addresses the recommendations made by IOM and safety experts. AAHSA staff would be happy to discuss this in greater depth with the Committee.

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Reliability of the Nursing Home Survey Process: A Simultaneous Survey Approach

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Purpose: We designed this study to examine the reliability of the nursing home survey process in the state of Kansas using regular and simultaneous survey teams. In particular, the study examined how two survey teams exposed to the same information at the same time differed in their interpretations. ***Design and Methods:*** The protocol for simultaneous surveys consists of having one in-region and one out-of-region team survey a facility together. ***Results:*** The regular and simultaneous survey teams generally agreed about the number of deficiencies. The intraclass correlation coefficient was 0.87 for total deficiencies and 0.76 for deficiencies with scores of G or higher. But in a substantial number of instances the teams did not agree about the scope and severity of the deficiency or about what regulation the nursing home had breached. ***Implications:*** The survey process is reliable when assessing aggregate results, but it is only moderately reliable when examining individual citations. Stakeholders (i.e., consumers, policy makers, nursing home administrators) should be aware of the limitations of the survey process. It needs to be modified to reduce variability.

Key Words: Federal citations, F tags, Quality of care, Deficiencies

In order to participate in Medicare and Medicaid, nursing facilities must meet conditions of participation set by the Centers for Medicare and Medicaid Services (CMS; for a review, see Mullan & Harrington, 2001). In order to ensure compliance with 189 federal regulations, state survey agencies must inspect each nursing facility every 9 to 15 months (CMS, 2005). These regulations fall into several categories: resident rights, quality of life, quality of care, resident assessment, services, dietary, pharmacy, rehabilitation, dental and physician, physical environment, and administration. Surveyors cite deficiencies when a facility does not substantially comply with a regulation. Although the regulations and survey process are federally mandated, state agencies carry out the survey process.

Dissatisfaction with the survey process is widespread. Resident advocacy groups stress that state survey teams often miss important problems with care and fail to respond to complaints quickly. A Government Accountability Office (GAO; 2004) study identified several reasons for these shortcomings: insufficient and inexperienced survey staff, confusion about the regulations, inadequate state oversight of the survey process, and the predictable timing of surveys. Surveyors question the integrity of the inspection, political pressures to water down inspection findings, and the effectiveness of the enforcement process (Grassley, 2004). Industry representatives argue that the current survey and enforcement system "is an entirely subjective, process-oriented snapshot inspection system that focuses on punishment—not quality improvement" (Ousley, 2001 p. 1).

An ongoing concern for all of these stakeholders is that the number of deficiencies varies substantially between states (GAO, 2003). For example, in 2001 the proportion of deficiency-free nursing homes ranged from 33.5% in Virginia to 0% in Nevada, and the mean number of deficiencies ranged from a high of 14.2 per facility in Nevada to a low of 1.9 per facility in New Jersey (Office of the Inspector General, 2003).

Variation also exists within states. For example, the state of Kansas is composed of 6 survey regions. In 2001 facilities in the Northeast Region averaged 11.64 deficiencies, nearly three times as many as facilities in the West Region (3.69 deficiencies). Furthermore, deficiencies in the Northeast Region tended to be assigned higher scope and severity. Administrators and directors of nursing tended to think this heterogeneity reflected differences in the survey process; surveyors thought it reflected differences in facility characteristics. Although they did

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Table 1. Scope and Severity Matrix

Severity of the Deficiency	Scope of the Deficiency, Rating (State Share)		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J (0.2%)	K (0.0%)	L (0.0%)
Actual harm that is not immediate jeopardy	G (5.8%)	H (0.0%)	I (0.0%)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D (45.0%)	E (34.0%)	F (9.7%)
No actual harm with potential for minimal harm	A (0.0%)	B (0.9%)	C (4.3%)

Notes: The State Share is the percentage of deficiency citations with this scope and seerity cited in surveys of freestanding Kansas nursing homes in 2003. F, H, I, J, K and L deficiencies may constitute substandard quality of care. Fines may be levied or restrictions on participation in Medicare and Medicaid may be imposed.

not resolve this question, our earlier analyses found statistically significant regional differences ($p < .001$) even after controlling for size, case mix, nursing hours per resident day, and ownership (Forbes-Thompson et al., 2003). The reliability of the survey process appears to be worthy of careful study.

The purpose of this study was to evaluate in some depth how and why Kansas survey teams varied in their assessments. More specifically, our aim was to compare the findings of two survey teams exposed to the same information at the same point in time. We addressed this aim using a mixture of quantitative and qualitative methods.

An overview of the survey process provides a context for our study. Surveys entail standard procedures plus flexibility once a team enters a nursing facility. The process begins with presurvey preparation that includes a review of the facility's quality indicators (Arling, Kane, Lewis, & Mueller, 2005), history of complaints, and previous survey results. The team then proceeds to an entrance conference with the administrator and an initial tour. After this the team selects a group of residents, based on presurvey information and the initial tour, for a more in-depth review. Using protocols established by CMS, the survey team gathers information in a number of ways, including medical record reviews, observations of direct resident care, resident interviews, family interviews, and observations of events such as activities and meals. Each phase of the survey process has detailed written guidelines, and as information is gathered, the team reviews it and sharpens the focus of the survey on potential problem areas.

This structure allows teams to react to and explore problems identified during data collection. It also allows for prioritization of problems while on site. However, this flexibility may also increase the variability of the survey process, because surveys of apparently similar facilities may focus on quite different aspects of care. How detailed a survey becomes also may depend on the observational skills of the surveyors, the clinical and management skills of the surveyors, or the number of problems found.

On the last day of the survey, surveyors meet to interpret their findings and to identify the number, scope, and severity of deficiencies that they found. The survey team then meets with the administrative staff and shares its preliminary findings. In Kansas, a quality improvement coordinator reviews these findings before the team submits the final survey report to the Department on Aging.

We should note that the final survey report may not be "final." Nursing homes can appeal any deficiencies or penalties through an informal dispute resolution process. Reductions in the number, scope, and severity of citations are common (GAO, 2003a).

Some deficiencies identify more serious problems than others, and some deficiencies allow for the imposition of more serious penalties. Table 1 outlines the scope and severity of deficiencies that surveyors may cite. Ratings A through C indicate substantial compliance with recommendations, so only Category 1 remedies are permitted (Office of the Inspector General, 2005). These remedies include development of a plan to correct the problem, enhanced monitoring by the survey agency, or mandatory training. Teams often do not cite such deficiencies. There were 0 A citations in Kansas in 2003, 21 B citations, and 96 C citations.

Citations that are rated D, E, or G permit imposition of Category Two remedies. These remedies include fines, denials of payment for new admissions, or denials of payment for all residents. These are the most common types of citations. More than 1,700 D and E deficiencies were cited in Kansas in 2003. G deficiencies are far less frequent; only 129 were issued in 2003.

Deficiencies that are rated F, H, I, J, K, or L can result in Category Three remedies. These include fines, termination from Medicare and Medicaid, and temporary management by an individual chosen by the state agency. F deficiencies are fairly common; more than 200 were cited in 2003. In contrast, H–L deficiencies are uncommon. A total of 5 J deficiencies were cited in 2003.

In most instances, the Department on Aging imposes Category Two or Three penalties only when a nursing home has failed to make corrections by the time of its resurvey. As a result, Category Two or Three penalties are not common. During the second and third quarters of 2003, the Kansas Department on Aging imposed fines on 11 nursing homes and admission bans on 18 (Kansas Department on Aging, 2004). The Department did not terminate any nursing homes from Medicaid or install temporary management in any nursing homes.

Table 2. Simultaneous Survey Protocol

Protocol
1. The RST guided all aspects of the survey process and followed normal policies and procedures.
2. RST assignments (e.g., who would conduct the closed record review) were shared with the SST so that the respective team members would be informed of their responsibilities.
3. All team meetings to discuss findings were held in separate locations and tape recorded for evaluation by the research team.
4. Preliminary off-site preparation was conducted in separate locations. The SST received the same presurvey documents to review as the RST.
5. The RST and SST were matched teams and respective SST members followed respective RST members one on one.
6. Team members were not allowed to discuss assessments or interpretations with members of the other team.
7. If the RST did not raise a concern, the SST was not allowed to pursue that issue. The SST was to document the issue in field notes.
8. Members of the SST followed respective RST members continuously (e.g., into residents' rooms to observe care and into meetings to interview staff).
9. All survey-related information (e.g., policies and procedures) were requested by and directed to the RST. Copies were made for the SST.
10. Teams and facilities were informed that the findings of the SST were not related to the facility's certification and state licensure.

Notes: RST = regular survey team; SST = simultaneous survey team.

The Department also recommended additional federal penalties to CMS.

Methods

Setting and Sample

Kansas has six geographical survey regions. Each region has at least two trained survey teams, a quality improvement coordinator, and a regional manager.

During the summer of 2003, we randomly selected two nursing homes from each region from a list of facilities scheduled for resurvey. We excluded from consideration nursing homes with fewer than 50 beds in order to reduce the burden on small facilities of having two survey teams in their home. Twelve homes comprised the sample for what we labeled "simultaneous surveys."

The simultaneous survey teams consisted of one in-region team (the regular survey team or RST) and one randomly selected out-of-region team (the simultaneous survey team or SST). The regional manager overseeing the annual survey selected the RST. The manager from another randomly selected region selected the SST. In order to ensure that survey differences were not due to their composition, we matched teams in size and expertise. For example, if the RST included their quality improvement coordinator, the SST also sent their quality improvement coordinator.

This design reflected two considerations. First, as we noted above, there were indications that the survey process varied by region. In order to examine this, the SST needed to come from a different survey region than the RST. Second, in order to ensure that the regular survey would be seen as valid by all interested parties, the RST needed to be assigned by the usual practice in that region. Otherwise a simultaneous survey might place a nursing home at a competitive advantage or disadvantage. Clearly, other designs might be preferable in other circumstances.

Procedures

Table 2 outlines the simultaneous survey protocol. The RST entered facilities following the normal protocol as prescribed by CMS. A member of the research team immediately informed the administrator that the SST would be following them as part of a quality improvement evaluation. A member of the research team also informed the administrator that the SST would not be interviewing staff, looking at or requesting additional records, or evaluating residents on their own. The SST would be shadowing the RST and reviewing its information. The RST directed the survey in accordance with policies and procedures. Members of the SST followed their RST counterparts to observe the same environmental dynamics; however, we did not allow the two team members to discuss interpretations or assessments with each other.

Survey teams usually meet several times during a survey to review what information they have collected to that point. These meetings then guide the remainder of the survey. For example, teams can use these meetings to decide which resident problems should be emphasized or which additional staff interviews are needed. The RST and SST conducted their meetings at the same time in different locations and tape recorded them. We had instructed SST members to document the problem areas and interviews they would follow up on if they were conducting a regular survey; we used the information obtained from both teams in order to evaluate consistency and provide insights into decision-making processes that influenced survey results. A member of the research team was onsite to ensure that the RST and SST

Table 3. Deficiencies Cited by the RST and the SST

Facility	Total Deficiencies		G+ Deficiencies[a]		Same F Tag, Different Scope or Severity	Same F Tag, Distinctly Different F Tags
	RST	SST	RST	SST		
1	22	23	2	2	5	14
2	3	3	0	0	1	0
3	30	31	3	5	6	14
4	9	19	0	1	4	11
5	16	24	0	1	9	11
6	17	17	2	1	7	6
7	19	15	0	1	4	5
8	18	23	1	2	6	15
9	8	9	1	1	1	7
10	13	16	0	0	6	7
11	0	1	0	0	0	1
12	6	3	0	0	0	5
Total	161	187	9	14	49	96
Intraclass correlation coefficient		0.87		0.76		
95% confidence interval		0.64–0.96		0.38–0.92		

Notes: RST = regular survey team; SST = simultaneous survey team.
[a]G+ deficiencies include G, H, I, J, K, and L, but none higher than H were cited.

members followed the protocol and did not share information with one another.

Protocol Rationale

We took several issues into consideration when designing this protocol. One was to avoid compromising the quality of resident care. Survey teams tend to disrupt normal routines, and we were concerned that repeated inspections would lead to repeated disruptions. In addition, our primary goal was to evaluate the performance of two teams exposed to the same information. Because nursing homes must address violations that teams observe during the course of an inspection, having back-to-back surveys would not have guaranteed that a follow-up survey team would have been exposed to the same problems. Conducting simultaneous surveys minimized disruption and ensured that both teams analyzed the same information.

Data Analysis

Our aim was to describe how and why the conclusions of the RST and SST differed. We used a triangulated design using both quantitative and qualitative methods (Fielding & Fielding, 1986; Jick, 1979). Our analysis of how the conclusions differed was largely quantitative. We designed the qualitative analyses to add depth to the analyses and to help answer why the reports of the teams differed.

Our approach examined the data at two very different levels of aggregation. First, treating each nursing home facility as a random effect, we calculated the intraclass correlation coefficient (ICC). The ICC equals the between-facility variance divided by the sum of the within-facility variance (from RST and SST) plus the between-facilities variance. Perfect agreement between the two survey teams would result in an ICC of 1.0, and complete randomness would result in an ICC of 0.0. Recognizing that differences in the scope and severity of deficiencies matter as well as the number of deficiencies, we cross-tabulated the deficiencies by the levels of harm cited by the RST and SST and calculated a Kappa statistic. Kappa measures how much the agreement between the teams exceeds the amount expected by chance. Complete agreement would give a Kappa of 1.0, and agreement that is no better than chance would give a Kappa of 0.0.

In order to assess why the conclusions differed, we performed a content analysis (Weber, 1990). Two registered nurse researchers, one with formal training in the survey process, independently reviewed the content of all of the written documentation for each team (researcher field notes, team notes, and meeting transcripts). They then met to resolve any differences in their reviews. In order to ensure confidentiality, we substituted numbers for resident names in these materials, and we restricted access to the materials to the research team.

In order to explore what prompted differences between the teams, the content analysis examined the data that the RST and SST used to reach their conclusions. At issue was whether the teams described different problems or characterized the same problems in different ways. For the same infraction, for example, one team could cite F-tag F221 "no unnecessary physical restraints" and another team could cite F-tag F223 "free from abuse." If both registered nurse researchers agreed that the RST and SST had cited the facility for separate shortcomings, they categorized the F tag as "distinctly different."

Results

ICCs

Table 3 shows that the RST and SST cited similar numbers of deficiencies. The ICC for total deficiencies cited by the two teams was 0.87 with a 95% confidence interval of 0.64 to 0.96. Given that values greater than 0.70 indicate good reliability, this is quite high (Kramer & Feinstein, 1981). The RST and SST also cited similar numbers of G+ deficiencies. The ICC was 0.76 with a 95% confidence interval of 0.38 to 0.92. The SST cited more deficiencies than the RST for 8 of the 12 nursing homes, but a paired t test failed to reject the hypothesis that the means were the same.

Counts do not fully describe the decisions of the RST and SST. Table 3 also shows that in 49 instances the RST and SST agreed about which regulation was being breached but differed on the

scope and severity. In another 96 instances, the two teams cited distinctly different deficiencies, meaning that they identified different failures to comply with the regulations. The number of distinctly different deficiencies rose with the number of citations. The correlation with RST citations was 0.76 and the correlation with SST citations was 0.89. Both correlations were significantly different from 0 at the 0.01 level.

Kappa Statistics

Table 4 cross-tabulates the findings of the RST and SST, focusing on the levels of harm identified. With 12 facilities and 189 regulations, 2,268 violations were possible. Overall, the level of agreement was moderate, as we estimated a Kappa of 0.57 (Landis & Koch, 1977). Kappa estimates the degree of consensus while controlling for the amount of chance agreement to be expected based on the marginal distributions (Stemler, 2004). Because the RST and SST found no deficiencies most of the time, we needed this control in order to avoid overstating reliability.

In most instances neither team found a violation. The RST found no violations 92.9% of the time, and the SST found no violations 91.8% of the time. The SST agreed with the RST 96.5% of the time.

The teams seldom cited deficiencies entailing no actual harm with potential for minimal harm. The RST gave 11 A, B, or C citations, and the SST gave 9. The similar totals masked considerable disagreement. The SST found no deficiency for 55% of the A–C deficiencies cited by the RST and found a D–F deficiency for 18%. The RST found no deficiency for 11% of the A–C deficiencies cited by the SST and found a D–F deficiency for 56%.

Deficiencies with D–F scope and severity levels, which entail a finding of no actual harm with the potential for more than minimal harm, were the most common citations. Most disagreements also involved these deficiencies. Of the 141 cited by the RST, the SST cited no deficiency for 29%, an A–C deficiency for 4%, a D–F for 63%, and a G–I for 4%. Of the 164 D–F deficiencies cited by the SST, the RST cited no deficiency for 42%, an A–C deficiency for 1%, a D–F deficiency for 54%, and a G–I for 2%. In short, both teams cited no deficiency in a substantial number of the cases in which the other team issued a D–F deficiency.

Deficiencies involving actual harm were uncommon. Even so, the teams differed in their conclusions. The SST cited a D–F deficiency for 4 of the 9 G–I deficiencies cited by the RST and found no breach of the remaining regulation. The RST cited a D–F deficiency for 6 of the 14 G–I deficiencies cited by the SST and found no breach in four instances.

Neither team cited J, K, or L deficiencies, which involve immediate jeopardy for residents.

Table 4. Cross-Tabulations of Deficiencies by Level of Harm

Deficiency	No Deficiency	A–C	D–F	G–I	J–L	RST Totals
No deficiency	2,033	1	69	4	0	2,107
A–C	6	3	2	0	0	11
D–F	41	5	89	6	0	141
G–I	1	0	4	4	0	9
J–L	0	0	0	0	0	0
SST totals	2,081	9	164	14	0	2,268

Notes: RST = regular survey team; SST = simultaneous survey team.

A–C deficiencies find no actual harm with potential for minimal harm. D–F deficiencies find no actual harm with potential for more than minimal harm. G–I deficiencies find actual harm for residents. J–L deficiencies find immediate jeopardy for residents.

Kappa = 0.57.

Content Analysis

As noted above, ICC and Kappa calculations do not fully take into account the differences between the RST and SST. A closer examination of Facility 6 illustrates this. The RST and SST cited the same number of deficiencies, yet there were important differences in their findings. In seven instances the teams disagreed on the scope and severity of the deficiencies, and in six instances the teams cited distinctly different deficiencies. Most of the scope and severity differences were minor, but not all. The RST and SST both identified quality of care deficiencies in the management of pain. The RST assigned an E deficiency, and the SST assigned a G, implying actual harm to residents. The RST and SST both identified deficiencies in the treatment of residents with pressure ulcers. The RST assigned a G deficiency, and the SST assigned a D. In addition, the RST cited three deficiencies that the SST did not: not having an adequate activities program, improperly ordering medications, and not having a backup power supply system. The SST cited four deficiencies that the RST did not: failing to reassess a resident whose condition had changed, not taking adequate care to prevent urinary tract infections, having an overly high medication error rate, and failing to investigate a bruise of unknown origin.

Some disagreements reflected different interpretations of the facts, even though the RST shaped the information that both teams had. For example, in Facility 4 the RST issued a D quality of care citation because the facility failed to follow its own protocol in caring for a resident with a pressure ulcer. The SST identified additional problems with the care provided to this resident and saw similar problems in the care of another resident. The SST issued a G quality of care citation. In another instance, both the RST and SST cited Facility 3 for failures to provide an appropriate accounting of resident funds. The initial citations were both Es, but the SST ultimately assigned an H. The difference appeared to spring

from the conclusion of the SST that at least three items that had been purchased with residents' funds could not be found anywhere in the facility, an issue that the RST did not address. The SST issued an additional H citation for staff treatment of residents and revised its citation for improper accounting of resident funds citation to an H.

Overall, SSTs cited 26 more deficiencies than RSTs, with 18 of these coming from Facilities 4 and 5. For Facility 4, the SST final report identified 10 more deficiencies than the RST final report. The SST issued seven D citations for problems that the RST did not identify or discuss. The SST also issued two citations for problems that the RST combined into one deficiency. After consultation with the regional office, the RST chose not to cite two problems that both teams had identified. In one instance the RST discussed a problem that the SST cited, but decided not to cite the facility. (The RST also cited one deficiency that the SST did not.) For Facility, 5 the SST identified eight more deficiencies than the RST. Five of these deficiencies were due to inconsistencies between the care plan and the care provided that the SST examined and the RST did not. The missing care included activities for one resident, assistance with eating for another resident, protective booties for a resident at risk for pressure ulcers, a contracture boot for another resident, and range of motion therapy for yet another resident.

Our observers noted a striking difference in how the teams tracked medication administration. In Facility 4 the RST focused on one of the medications given to a resident, but the SST made notes on all of the resident's medications. The two teams found similar numbers of errors, but the SST calculated a much lower error rate because the denominator was much larger. The RST gave an E deficiency to Facility 4 for medication administration; the SST did not.

In their discussions, SST members critiqued the RST fairly regularly. For example, the SST notes for Facility 6 included comments that, "I would have followed up more on [the] broken thermostat," and "I would have knocked and checked" to see if a resident scheduled for an interview was in her room with the door closed. The SST notes for Facility 11 noted that there were unasked questions about a "resident being left alone on toilet and orthostatic hypotension" and "fall investigation." Additionally, some teams identified deficiencies by "running through the regulations." Other teams identified deficiencies by running through the leader's concerns.

Yet attributing these differences to the teams obscures the important roles of other staff.

Teams discuss concerns with their regional managers and quality improvement coordinators several times during a survey. Furthermore, teams discuss their findings with these administrative staff following their decision-making meeting. Again, this process has both strengths and weaknesses. On the one hand, the experience of regional managers and quality improvement coordinators allows them to assist more junior surveyors by providing guidance and putting information into perspective. On the other hand, most regional managers and quality improvement coordinators are not on site and so provide guidance without seeing the evidence firsthand. Analyses of meeting and field notes indicated that the number of changes between the initial and final reports ranged from 0 to 14 per team.

Several comments indicated that regional managers had a significant influence on the survey process. For example, some regional managers did not encourage surveyors to write deficiencies for paperwork violations unless there were concomitant care problems. In addition, some surveyors noted that their regional managers instructed them that hand washing had to be a huge issue before they should cite it. One team commented that their regional manager would never let them go into an extended survey for a particular F tag. Some teams made a point of staying for the first meal after entering the facility, and others did not. Some teams were very methodical in their decision-making style, going in order through the regulations, whereas others discussed concerns according to their priority or in top-of-mind order. In short, different teams used different processes.

An important finding was that teams differed in assessments of scope and severity for the same resident care issue. Our content analysis identified several instances in which there were no clear right or wrong assessments of scope and severity. When teams disagreed on the scope and severity, we could trace these differences to differences in interpretations of the regulations and of the interventions provided by the facility.

An example dealing with pressure ulcer prevention and healing illustrates the difficulty with scope and severity determinations. The *Facility Guide to OBRA Regulations, and Interpretive Guidelines and the LTC Survey Process* offers the following guidance:

> A determination that development of a pressure sore was unavoidable may be made only if routine preventive and daily care was provided. Routine preventive care means turning and proper positioning, application of pressure reduction or relief devices, providing good skin care, (i.e., keeping the skin clean, instituting measures to reduce excessive moisture), providing clean and dry bed linens, and maintaining adequate nutrition and hydration as possible. (p. 22)

Their notes indicated that surveyors seldom had difficulty in determining whether the facility identified the resident as being at risk. But surveyors looking at the same evidence disagreed on whether the facility interventions were aggressive enough or

whether the facility tried enough different interventions. Surveyors scrutinized the data collected and took their decisions very seriously but had differing perceptions of when a facility had done enough.

Discussion

Even though the teams examined the same data, they often differed in the number, scope, and severity of deficiencies cited. The teams also routinely assigned different F tags when they cited facilities. In short, the teams generated substantially different surveys from the same facts. Yet abstracting from the details of the surveys, the teams painted very similar pictures of facilities' overall compliance with federal regulations.

These data support two very different interpretations. One stresses the variability of the survey process; the other stresses its global consistency. The variability interpretation notes that the two survey teams often reached different conclusions about whether a deficiency existed, what regulation had been breached, the scope of the deficiency, or the severity of the deficiency. These differences, furthermore, might well have consequences. The penalties imposed by the survey agency, the career prospects of facility managers, and the responses of consumers are likely to be different for a nursing home that gets 7 D deficiencies than for a nursing home that gets 12 D deficiencies and 1 G.

The variability of the survey process reduces its value to nursing home managers, who should be the primary users of its detailed findings. The same process can draw no deficiencies from one survey team and multiple deficiencies from another. As a result, nursing home administrators and directors of nursing cannot be confident that a good survey means that a process works well. Nor can administrators and directors of nursing be confident that genuine improvements in care will result in a better survey if the next team relies on different interpretations of the regulations and what constitutes having done enough. Speaking for a number of her peers, one director of nursing described the survey process as "demoralizing." Improvement efforts are inhibited by a survey process that falls short of systematic, replicable data gathering and analysis (Schnelle, Osterweil, & Simmons, 2005).

The variability of the survey also reduces its value to regulators and policy makers. The inspection is supposed to provide assurance that a nursing home is in substantial compliance with federal and state regulations, either at the time of the inspection or after completion of a plan to correct problems. An unreliable survey process may mean that nursing homes that do not actually meet federal or state standards will be eligible for Medicare and Medicaid payments. The many disagreements of these two teams about whether a regulation had been breached, which regulation had been breached, and how serious the breach was cannot make federal or state officials comfortable.

The variability perspective would also note that we had designed the structure of this study in order to exclude some forms of variation. Had they not been constrained to look at the data assembled by the RST, the members of the SST might well have gathered different facts and identified different problems. Indeed, comments to this effect by members of the SST were routine. It is likely that this study understates the variability of the survey process.

Yet these data also highlight the overall consistency of the survey results. The total numbers of deficiencies and the number of G+ deficiencies cited by the RST and SST were quite similar. If consumers rely on the total number of deficiencies or the number of high-level deficiencies as measures of quality, our results suggest that consumers should view surveys as highly reliable. We do not know how consumers use nursing home survey results, but their structure suggests that consumers should use them as part of a broader assessment process. Surveys may not reflect current conditions in a nursing home and should be used with care, just like any other measure.

Viewed at a macro level, this study suggests that, given the same data, the two teams reached very similar conclusions. Viewed at a micro level, this study suggests just the opposite. Although state survey agencies and consumers may feel comfortable focusing on macro results, managers must make decisions at the micro level, and their concerns about reliability weaken the credibility of the survey process. In order to reduce the variability of survey results, changes in the survey process and in the training of surveyors warrant consideration. The CMS trial of the Quality Indicator Survey appears to be a promising initiative (CMS, 2004). This five-state experiment enhances training, sampling, and decision support software to make surveys more structured.

This article suggests that surveyors need more specific criteria, in the form of decision-making algorithms, to reduce the influence of individual perceptions. These findings concur with other evaluations of survey consistency (GAO, 2003b; Office of the Inspector General, 2003, 2004). CMS has begun a process of developing and evaluating clearer guidelines for surveyors. Our findings support that effort.

These results also suggest that continued efforts to standardize training and decision rules are important. Especially at the state level, common understandings of what constitutes a breach of the regulations should reduce the angst of the industry and increase the confidence of regulators and the public. In assigning the number, scope, and severity of deficiencies, consistency is of primary importance.

One should not overlook the limitations of this study. It applies to one state with a specific administrative structure. Moreover, the sample used in this study was not large. And, although they were

randomly selected and generated data comparable to statewide averages, we cannot guarantee that the facilities or survey teams were representative of Kansas. The results should not be generalized to other states. Furthermore, this study eliminated differences in the information collected. As a result, the differences reported here were entirely due to differences in interpretation. As we noted above, these results seem likely to understate the variability of survey results in the wild.

It is important to remember that the survey process is designed to measure compliance with federal regulations. It is tempting to infer that a survey with few deficiencies identifies a good facility and a survey with many deficiencies identifies a bad one. Indeed, numerous research studies and consumer guides do exactly that (e.g., Castle, 2000; Castle & Mor, 1998; Harrington, O'Meara, Kitchener, Simon, & Schnelle, 2003). Yet, as one surveyor noted, "The number of deficiencies is not a good quality indicator for whether I would put my mom somewhere or not. You know it relates back to what was the scope and severity of those deficiencies and what were those deficiencies really about" Our results suggest that the survey process is only moderately reliable in describing the scope and severity of nursing home deficiencies. Given that compliance with federal regulations may well have changed since the survey was completed, consumers should use the survey results with care.

Many states and CMS rely on public reporting of survey results as a spur to better nursing home care. Indeed, this appears to represent an important de facto shift from a policy of pure deterrence to a policy of deterrence plus transparency (Chou, 2002). Consumers evidently seek this information. Yahoo! reports that "Nursing Home Compare" is the nation's second most popular nursing home care site and is one of the most frequently visited sections of the Medicare Web site (Office of the Inspector General, 2004; Yahoo! Health Directory, 2005). As a result, the reliability of nursing home surveys becomes an even more visible public policy issue. Survey results will have the greatest impact on nursing home quality if consumers and the industry believe that deficiencies are valid, reliable measures of quality. This belief will be undercut by variations in the number, scope, and severity of deficiencies when the facts are held constant. The appropriate policy response is to acknowledge these variations and address them by clarifying definitions and interpretations, by improving training, and by providing feedback to surveyors. Simultaneous surveys like the ones reported here should become standard features of survey agencies. Using simultaneous surveys as a calibration tool is clearly feasible.

References

Arling, G., Kane, R. L., Lewis, T., & Mueller, C. (2005). Future development of nursing home quality indicators. *The Gerontologist, 45,* 147–156.

Castle, N. (2000). Nursing homes increasing and decreasing restraint use. *Medical Care, 38,* 1154–1163.

Castle, N., & Mor, V. (1998). The use of physical restraints in nursing homes. A review of the literature since the Nursing Home Reform Act. *Medical Care Research and Review, 55,* 139–170.

Centers for Medicare and Medicaid Services (2004). *Action plan for nursing home quality.* Retrieved August 25, 2005, from http //www.cms.hhs gov/quality/nhqi/NHActionPlan.pdf

Centers for Medicare and Medicaid Services. (2005). *The official U.S. government site for people with Medicare.* Retrieved June 15, 2005, from http://www.medicare.gov

Chou, S. (2002). Asymmetric information, ownership and quality of care: An empirical analysis of nursing homes. *Journal of Health Economics, 21,* 293–311.

Fielding, N. G., & Fielding, J. L. (1986). *Linking data: The articulation of qualitative and quantitative methods in social research.* Beverly Hills: Sage.

Forbes-Thompson, S., Dunton, N., Gajewski, B., Wrona, M., Becker, A., Chapin, R., et al. (2003). *Kansas nursing facility project evaluation.* Kansas City: Kansas Department of Aging.

Government Accountability Office. (2003a). *Nursing home deficiency trends and survey and certification process consistency.* Retrieved October 11, 2006, from http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Government Accountability Office. (2003b). *Nursing home quality: Prevalence of serious problems, while declining, reinforces importance of enhanced oversight* (Report No. GAO-03-561). Retrieved June 15, 2005, from http://www.gao.gov/new.items/d031016t.pdf

Government Accountability Office. (2004). *Prevalence of serious quality problems remains unacceptably high, despite some decline* (Report No. GAO-03-1016T). Retrieved June 15, 2005, from http://www.gao.gov/new.items/d031016t.pdf

Grassley, C. R. & Letter to Mark McClellan. (July 7, 2004). Retrieved October 11, 2006 from http://www.canhr.org/news/GrassleyLetter html#LetterToCMS.

Harrington, C., O'Meara, J., Kitchener, M., Simon, L. P., & Schnelle, J. F. (2003). Designing a report card for nursing facilities: What information is needed and why. *The Gerontologist, 43*(Special Issue II), 47–57.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly, 24,* 602–611.

Kansas Department on Aging. (2004). *Sunflower connection.* Retrieved May 8, 2006, from http://www.agingkansas.org/kdoa/lce/facts_newsltr/jan_2004_final.pdf

Kramer, M., & Feinstein, A. (1981). The biostatistics of concordance. *Clinical Pharmacology and Therapeutics, 29,* 111–123.

Landis, J., & Koch, G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33,* 159–174.

Mullan, J. T., & Harrington, C. (2001). Nursing home deficiencies in the United States. *Research on Aging, 23,* 503–531.

Office of the Inspector General. (2003). *Nursing home deficiency trends and survey and certification process consistency.* Retrieved February 24, 2006, from http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Office of the Inspector General. (2004). *Inspection results on Nursing Home Compare: Completeness and accuracy.* Retrieved August 18, 2005, from http://www.canhr.org/pdfs/oei-01-03-00130 pdf

Office of the Inspector General. (2005). *Nursing home enforcement: The use of civil monetary penalties.* Retrieved February 24, 2006, from http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf

Ousley, M. K. (2001). *Testimony before the Subcommittee on Health of the House Committee on Ways and Means, March 15, 2001.* Retrieved June 15, 2005, from http://waysandmeans.house gov/legacy/health/107cong/3-15-01/3-15ous.htm

Pate, T. (2005). *The Facility Guide to OBRA Regulations and the Long-Term Care Survey Process.* Miamisburg, OH: Med-Pass.

Schnelle, J. F., Osterweil, D., & Simmons, S. F. (2005). Improving the quality of nursing home care and medical-record accuracy with direct observational technologies. *The Gerontologist, 45,* 576–582.

Stemler, S. E. (2004). A comparison of consensus, consistency, and measurement approaches to estimating interrater reliability. *Practical Assessment, Research & Evaluation, 9*(4). Retrieved March 9, 2006, from http://PAREonline.net/getvn.asp?v=9&n=4

Weber, R. P. (1990). *Basic content analysis* (2nd ed.). Newbury Park, CA: Sage.

Yahoo! Health Directory. (2005). *Site listings by popularity.* Retrieved August 17, 2005, from http://dir.yahoo.com/Health/Long_Term_Care/Nursing_Home_Care/

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The CHAIRMAN. Thank you, Ms. Zabel.
Ms. Slocum.

STATEMENT OF SARAH SLOCUM, STATE LONG TERM CARE OMBUDSMAN, OFFICE OF SERVICES TO THE AGING, LANSING, MI

Ms. SLOCUM. Thank you, Senator Kohl, Senator Smith, and members of the Committee. I deeply appreciate this important hearing that you are holding today. Chairman Kohl, the National Association of State Ombudsman Programs particularly wants to thank you for your years of work on behalf of nursing home residents.

Twenty years after the passage of OBRA we see too many instances of poor quality care and continuing poor performance by certain providers. Given the vulnerability of residents, we must ensure the public has access to meaningful information about ownership, enforcement actions, financial solvency, and staffing in all nursing facilities.

On ownership, Congress should require CMS to publish information on the nursing home compare Web site that shows ownership linkages. It should publish information about ownership also of other services such as pharmacy, laundry, and food services. Owners should be required to submit audit results and financial data to demonstrate fiscal solvency of all commonly owned entities.

Why is ownership important? Here is one example. During 2005, two nursing facilities in Michigan burned. One resulted in two resident deaths and partial facility evacuation during the Easter holiday. The other resulted in two resident deaths and 60 residents sent to the hospital along with a complete evacuation in mid-December.

There was no overt connection between these two facilities such as the same name. It took considerable effort by the ombudsmen to learn of their common management company. Neither facility had provided specific training and drills to ensure that staff knew how and when to use fire extinguishers and fire doors. Had a connection been apparent, regulators could have required a review of emergency procedures in all facilities operated by this management group prior to these terrible events.

Enforcement-all enforcement actions—should be published by facility name on the nursing home compare web site. Actions such as denial of payment for new admissions, civil money penalties, directed plans of correction, mandatory temporary management, monitors, terminations, and special focus facilities should all be clearly listed on the Web site. Plain English explanations of these terms must be included.

Residents of facilities, their loved ones, and the community at large should be notified of enforcement action. For too many residents and families, the termination action is their first notification of the facility's problem. Information on enforcement actions would help individuals make informed decisions in choosing a nursing home and would give residents and families information about areas that require vigilance in their home.

The complete text of the survey results, the 2567 form, should be published on nursing home compare. The descriptive text found in

these reports helps consumers get a better idea of what violations are cited and what is needed to correct these problems.

Another essential tool for residents, families, and friends is a standard complaint form. This type of form helps people by prompting them to identify and include all basic information needed to investigate a complaint. Survey and complaint units must also continue to provide for telephone complaints where staff assists consumers in reducing the complaint to writing.

On civil money penalties, Federal CMP funds should be collected without any discount for non-appealed violations. If the CMP is not correct or is too harsh and the facility appeals the decision, the appeal process will deal with any reductions or deletions that are merited. Federal CMP funds should be returned to the State survey and certification agency for, first, increased staffing for survey teams and ombudsmen programs; second, funding to carry out financial viability audits and reports; and, third, financial restitution to any individual resident who has suffered harm.

Staffing: Staffing shortages continue to plague residents and staff at many nursing facilities. A recent revisit survey at a Michigan facility resulted in a citation for pressure sores. In the narrative for the citation, there is an interview with a certified nursing assistant who had not turned a resident as stated in his care plan. The CNA said, "I have 14 residents to care for, and 11 residents are total care. It is very hard to turn people every 2 hours because sometimes we just can't." One resident at this facility was admitted in December 2006 with no pressure ulcers. By February 2007, he had a pressure ulcer on his left heel. By September 2007, he had a maggot infestation and infection that required surgery on his stage four pressure sore and removal of part of his heel.

Congress should enact safe and clearly enforceable staffing requirements to ensure no other residents suffer this fate. The amount and type of nursing staff, RNs, LPNs and CNAs serving residents in each nursing facility should be posted on nursing home compare. Substantiated complaints about staffing levels should also be listed.

Ombudsman access to information: All information about ownership, enforcement actions, civil money penalties, staffing, and special focus status must be shared immediately by State agencies with long-term care ombudsmen. Ombudsmen serve as a source of counseling and information for consumers and their families as they consider long-term care options. When ombudsmen know about sanctions and facility status, they can increase visits to safeguard residents, and they can help consumers through the trauma should there be a closure.

Ombudsmen should be consulted in the development of lists of potential and actual special focus facilities. Data from the ombudsman program about complaints and issues at facilities would add a consumer perspective to the decisionmaking process.

There are very serious effects on residents of the enforcement actions taken. For years ombudsmen in many states have expressed a need for CMS to hold poorly performing facilities accountable, to consistently use strong enforcement action when violations exist, and to enforce all requirements for quality of care and quality of life. At the same time, ombudsmen have expressed great concern

over the harm suffered by residents when these same enforcement actions bring about decertification and closure.

The special focus facilities program has brought these competing concerns into sharp relief as chronically poor performing facilities receive additional scrutiny in a shortened enforcement cycle. On average, five Michigan facilities, slightly more than one percent of our nursing home supply, close each year.

During fiscal year 2007, 445 nursing facility residents were forced to move from their homes because of these closures. We must take resident welfare very seriously and consider that at every point in the enforcement process.

Some recommendations about enforcement and closure that I would like to make in closing here. State survey and certification agencies must always take control of the relocation of residents. Voluntary closures result in chaos and in lack of resident choice too many times.

Specific timelines for each closure must be established by CMS and the State survey agency. Timelines may vary depending on the number of residents, the availability of acceptable options, and the risk of harm to residents who remain at the facility.

Medicare and Medicaid payments should not be limited to 30 days after the termination date. Thirty days is often not adequate to choose a better facility or transition to home and community-based services. A 30-day timeline pushes residents to move to far away homes or to substandard facilities.

Every day I hear from consumers who are thirsty for reliable and understandable information. The National Association of State Ombudsmen Programs stands ready to provide information on resident experiences and how information can be made accessible, transparent, and meaningful to consumers.

We are grateful for your determined efforts to inform, to protect, and to empower each long-term care resident. Thank you.

[The prepared statement of Ms. Slocum follows:]

Statement of Sarah Slocum

Michigan State Long Term Care Ombudsman and

Secretary of the National Association of State Long-Term Care

Ombudsman Programs

To the

U.S. Senate Special Committee on Aging

On Improving Nursing Home Transparency, Enforcement and

Quality of Services

November 15, 2007

Senator Kohl, Senator Smith and members of the Committee, thank you for the opportunity to speak with you today about nursing home transparency, enforcement and quality. Chairman Kohl, I especially want to express the appreciation of the National Association of State Ombudsman Programs for your years of work on nursing home issues and your support of the Ombudsman Program and State Survey and Certification efforts.

The landmark OBRA 1987 legislation and subsequent regulations and policies aimed at improving the quality of care and life of nursing home residents is to be celebrated. But as 20 years have passed and we still see too many instances of poor quality care and continuing poor performance by certain providers, your efforts to make improvements in this realm are much needed. Nursing homes are an awkward mix of private businesses and public funding attempting to provide care and a home-like environment for some of our most vulnerable citizens. Within this structure and given the level of vulnerability of residents, we must assure that the public has access to meaningful information about ownership, enforcement actions, financial solvency, and staffing in all certified nursing facilities.

Ownership

Congress should require the Centers for Medicare and Medicaid Services (CMS) to collect and publish information on Nursing Home Compare that shows any ownership linkages. The linkages would be determined by common ownership of the real estate, the license, or any management company operating the facility. Additionally, commonality of investors or stockholder with more than a 5% interest, and members of any board of directors or governing body should be available to Ombudsmen and consumers. CMS should also collect and publish information on ownership linkages to other businesses, such as pharmacies, laundry services, food services, etc.

Owners must be accountable to state and federal payment sources, Medicaid and Medicare, and must be required to submit audit results and financial data to demonstrate fiscal solvency of all commonly owned and related ownership entities. Further, accountability to residents should include a requirement for adequate liability insurance, so that residents who suffer wrongful death or other severe harm can pursue their private right of action in a meaningful way.

During 2005, two nursing facilities burned in Michigan. One resulted in 2 resident deaths and partial facility evacuation during the Easter holiday weekend. The other resulted in 2 resident deaths and 60 residents sent to the hospital along with complete evacuation in mid-December. There was no overt connection between these two facilities (such as the same name) and it took considerable effort by the Ombudsman to learn of their common management company. Despite different owners of the real estate, the management and operations of the two facilities were run by the same people. In both cases, inadequate staff training contributed to resident harm. Both facilities had not provided specific training and drills to assure that staff knew how and when to use fire extinguishers and fire doors. The common management company showed a pattern of inadequate training

on fire safety. This is an example of how important ownership linkage information is to consumers and regulators. Had a connection been apparent, regulators could have required a review of emergency procedures in all facilities operated by this management group.

Enforcement

All enforcement actions should be published by facility name on Nursing Home Compare. Actions such as Denial of Payment for New Admissions, Civil Money Penalties, Directed Plans of Corrections, Mandatory Temporary Management, Monitors, Terminations, and Special Focus Facility status should all be clearly listed on the website. Additionally, plain English explanations of these terms must be listed after each usage of the terms so that consumers can understand the sanctions.

Residents of facilities, their loved ones, and the community at large should be notified of enforcement actions taken at facilities. Too often, Ombudsmen hear from residents and families that the termination action is their first notification of the facilities problems. Residents and families at each decertification action where I have been involved say they had no idea the facility was in such trouble. Having this information would support people in making informed decisions during nursing home placement and would give consumers and families information about areas that require vigilance in a facility. If a facility has citations about wound care, and I need that service, I may be more watchful if I have that information. Residents deserve to know.

The complete text of the survey results (the 2567 form) should also be published on Nursing Home Compare. The descriptive text of these reports helps consumers to get a better idea of what violations are cited, and what is needed to correct problems. This narrative helps consumers get a real sense of the problems in a facility, rather than just the technical regulatory description. CMS should be required to post the complete 2567, then to add information about citations overturned or modified on appeal, so that consumers have complete access to facility information.

Another essential tool for residents, families and friends is a standard complaint form. This type of form helps people who have not filed complaints before by prompting them to identify and include all basic information needed to investigate the complaint. Survey and Certification Complaint Units must also continue to provide for telephone complaints, where staff assists consumers in reducing the complaint to writing.

Additionally, local hospitals, hospice agencies, home and community based waiver programs, Area Agencies on Aging, Centers for Independent Living, the Long Term Care Ombudsman, and the Protection and Advocacy Agencies should all be directly notified of state and federal enforcement actions. These entities make referrals to nursing facilities or have clients living in these facilities. They need current and accurate information about facility status to best assist consumers.

Civil Money Penalties (CMP)

Federal CMP funds should be collected without any discount for non-appealed violations. If the violation was severe enough to merit a Civil Money Penalty, there should not be any discount. If the CMP is not correct, or is too harsh and the facility appeals the decision, the appeal process will deal with any reductions or deletions that are merited.

Federal CMP funds should be returned to the State Survey and Certification Agency where the violation took place to be used for:

- Increased staffing for survey teams and Ombudsmen;
- Funding to carry out financial viability audits and reports;
- Financial restitution to any individual resident who was harmed;
- Other quality improvement projects selected by states that provide clear and immediate benefit to residents.

Staffing

The amount and type of nursing staff (R.N.s, L.P.N.s, and C.N.A.s) serving residents in each nursing facility should be posted on Nursing Home Compare. The information should be collected by states from payroll data on a quarterly basis and audited for accuracy, then submitted to CMS. CMS should include an analysis of staffing trends by facility, and whether the facility has increased or decreased its direct care staffing levels by category over the last three years. Additionally, any substantiated complaints about staffing levels should also be listed on Nursing Home Compare.

Staffing shortages continue to plague residents and staff at many nursing facilities. A recent revisit survey at a Michigan facility resulted in a citation for Pressure Sores (F 314 based on CFR 483.25(c)). In the narrative for this citation, an interview with a CNA, who had not turned a resident as stated in his care plan, said the following, "I have 14 residents to care for and 11 residents are total care. It's very hard to turn people every two hours because sometimes we just can't. He (Resident 56) is a two person transfer so we can't answer lights because he could fall. Nurses will turn off the light and then tell us what the resident needs which doesn't help us." Resident 56 was admitted to this facility in December 2006 with no pressure ulcers. By February 2007 he had a pressure sore on this left heel, and by September 2007 had a maggot infestation and infection that required surgery on his Stage IV pressure sore and removal of part of his heel.[1] Clearly this type of severe short staffing is unacceptable and Congress should enact safe and clearly enforceable staffing requirements to assure that no other residents suffer this fate.

Ombudsman Access to Information

All information about Ownership, Enforcement Actions, Civil Money Penalties, Staffing, and Special Focus Facilities must be shared immediately by all State Survey and Certification agencies with each State Long Term Care Ombudsman. Ombudsmen are a

[1] Metron of Bloomingdale, Revisit Number Three to the Annual Survey, 11/20/2007, pp.15, 16.

direct source of information for consumers, and serve as a source of counseling and information for consumers and their families and friends as they consider long term care options. Ombudsman are able to track this information, provide a sounding board for consumer questions, and help consumers understand the complex and multifaceted information they are bombarded with during what is usually a health crisis. I am deeply troubled that not all state Ombudsman have access to this information, and I urge Congress to require states and CMS to share all facility information with Ombudsmen. When Ombudsmen know about sanctions and facility status they can increase visits to safeguard resident safety and well-being. Ombudsmen also need information at the earliest possible time to be prepared to help consumers through the trauma of closure, should the facility become terminated from Medicare and Medicaid.

Ombudsmen should also be consulted in the development of the lists of potential and actual Special Focus Facilities. The data from the Ombudsman program about complaints and issues at facilities would add a consumer perspective to the decision making process around Special Focus Facilities. I urge CMS and State Survey and Certification agencies to establish and use input mechanisms to gather information from the Ombudsmen in each state.

Effect of Enforcement on Residents

For many years, the Michigan Long Term Care Ombudsman Program, and Ombudsmen in many other states, have expressed a need for CMS to hold poor performing facilities accountable, to consistently use strong enforcement action when violations exist, and to enforce all of the requirements for Quality of Care and Quality of Life found in the federal Nursing Home Reform Law of 1987. At the same time, Ombudsmen have expressed great concern over the harm suffered by residents when these same enforcement actions bring about the decertification and closure of facilities.

The Special Focus Facilities program has brought these competing concerns into sharp relief as chronically poor performing facilities receive additional scrutiny and a shortened enforcement cycle while on the Special Focus Facilities list. In Michigan, for the most part, Special Focus Facilities either improve or close. Approximately 5 facilities, slightly more than 1% of Michigan's nursing home supply, close each year in Michigan. During FY 2007, approximately 445 nursing facility residents were forced to move from their homes because of nursing home closures. The majority of these facilities were either in Special Focus status or were on the list of possible Special Focus Facilities.

Almost all of the nursing home closures in Michigan over the last 4 years have been at facilities with a high number of violations, financial problems, a higher than average percentage of their population reliant on Medicaid, and a higher than average percentage of their population made up of younger residents with largely unaddressed mental health needs. Whether the closure is labeled "Regulatory" or "Voluntary" seems largely to depend on the timing of the owner's taking action to surrender their certification, rather than on any substantive difference.

In two recent decertification actions in Michigan, the facilities have sought and received permission from CMS to voluntarily surrender their Medicare and Medicaid certification one day prior to their termination dates. The result in one case was a "Voluntary" closure. During this type of closure, the state has less control and authority over what happens to residents, the facility and corporate staff remains in charge of the building and the relocation of residents. State placement agents, ombudsmen, and community mental health agency staff are far less effective in ensuring residents' rights and choice when the facility or corporation is left in charge. These closure situations in Michigan have resulted in less resident choice about their next placement, much pressure on facility staff, residents and their families to move out quickly, and less effective state oversight during the closure. Congress should add closure provisions to federal law, so that:

- State Survey and Certification Agencies always take control of the relocation of residents during the closure;
- Special fines against owners are levied when residents are not provided meaningful choice in their next living arrangement;
- Specific timelines for each closure are established by CMS and the State Survey agency – these timelines may vary depending on the number of residents, the availability of other acceptable options and the level of risk of harm to residents remaining in the facility during the closure period;
- Federal Medicare and Medicaid payments should not be limited to thirty days after the termination date. Thirty days is often not adequate time to choose a better facility, or to transition to home and community based services. This timeline pushes residents to move to far away facilities, or to other substandard facilities in many cases.

In closing, I applaud this committee's efforts to shed light on nursing home ownership, enforcement, staffing and special focus status. Everyday I hear from consumers who are thirsty for reliable and understandable information about nursing homes. The National Association of State Ombudsman Programs stands ready to provide additional information on residents' experiences and on how information can be made accessible, transparent and meaningful to consumers. We are very grateful for your determined efforts to empower, inform and protect long term care residents.

The CHAIRMAN. Thank you, Ms. Slocum.

I would like to call now up Senator Bill Nelson who has not had an opportunity to speak yet.

We would be delighted to recognize you, Senator Nelson.

OPENING STATEMENT OF SENATOR BILL NELSON

Senator NELSON. Thank you, Mr. Chairman.

Thank all of you for your participation on what is an increasingly going to be an aspect of American life. Naturally you would expect from my State of Florida that we see a greater proportion of nursing homes per 1,000 of population. That is the good fortune that we have in Florida of having so many people decide to spend their twilight years in Florida, the land called paradise.

Now, I want to ask you, Mr. Muller. You have come up with this study here. It is about-well, it is entitled, "How Private Equity Buyouts Hurt Nursing Home Resident." I am curious what are the unique concerns with private equity owned chains? Why single out them as your concern with nursing homes?

Mr. MULLER. As I think I mentioned in my testimony, the private equity model sort of has a couple of things that are relatively unique about it, specifically that they take on a lot of debt. They need to make money quickly in order to sell the nursing home assets again quickly.

While it is true that all nursing homes need to do better, as our research and the New York Times article have pointed out, things seem to get even worse when private equity takes over. As I mentioned in the testimony, with Mariner Homes, actual harm deficiencies increased by 66.7 percent versus 1.5 percent for the overall industry.

We think Congress must take action to improve transparency and accountability enforcement for all nursing homes. But regulations must also keep up with industry trends. Private equity is one of those new trends that requires new regulation.

Senator NELSON. So what is it about private equity? Would you state that again?

Mr. MULLER. Sure.

Senator NELSON. Without reading it.

Mr. MULLER. OK.

Senator NELSON. I want you to just tell me.

Mr. MULLER. I think as I said before, with private equity what makes it different from other type of ownership situations is that private equity when they buy a nursing home company takes on a lot of debt. Right? They create a maze of operating structures. They need to make money very quickly because they have a relatively short time horizon in which to get in and get out. Right?

We are concerned that those business imperatives are incompatible with providing quality care, given what we have seen at Mariner. Right? Which is a company that was bought by a private equity firm. The number of increases in violations we saw there compared to the violations in peer group homes in those states.

Senator NELSON. How many private equity firms-let me put the question the other way. How many nursing homes are owned by private equity firms?

Mr. MULLER. That is a very good question and one to which I don't know the answer. I think it is very hard to figure that out in part given the maze of ownership and structures, the way private equity sets themselves up. It is very hard to figure that out.

I would certainly not want to contradict the gentleman from CMS who spoke earlier who said he doesn't know. So, I don't think we know, either.

Senator NELSON. Carlyle, a private equity firm, as you point out in this document, has announced its intention to buy Manor Care. What are your concerns about this?

Mr. MULLER. Well, Manor Care is one of the largest nursing home——

Senator NELSON. I don't want you to read your answer. I want you to talk your answer to me.

Mr. MULLER. OK. Manor Care is one of the largest nursing home companies in the country. So, that is a cause for concern right there. Second, when we have looked at the history of Manor Care violations over the last three inspection cycles, their care deficiencies have increased by about 23 percent compared to about 14.5 percent for the other homes in the states they operate.

We are concerned, given the history of private equity and the trends we have seen in other companies, that the care at Manor Care will get worse with Carlyle Group coming in.

Senator NELSON. Now, the other side says something different. In a recent Washington Post article, Manor Care's general counsel was quoted as saying that they will continue to control all their assets and it will be a transparent company. But in your review of the applications that Carlyle filed, can you tell us does that appear to be true?

Mr. MULLER. What we saw in the public filing was that there was a separation of the operating company from the property company and different layers of ownership set up between the ultimate parent corporation and the operating company, that is, the nursing home, the licensee.

Senator NELSON. Down in my State, the Florida Agency for Health Care Administration recommends that our State expand its definition of controlling interest to include all subsidiary operations. It recommends that this information be kept current with an online reporting mechanism and, of course, be available to the public. Do you think these recommendations are enough to make sure that we know of the transparent ownership of nursing homes?

Mr. MULLER. I have not had a chance to read those recommendations, so I wouldn't want to categorize them as being enough or not. But they certainly seem like a step in the right direction.

Senator NELSON. What would you say would be additional things that we must require to make sure that we have transparency?

Mr. MULLER. I think some of the things I mentioned in my testimony about requiring surety bonds to make sure that the assets of the entire company are available in case the Federal Government, State regulators or other parties need some form of redress.

Senator NELSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Nelson.

Senator Casey.

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

I wanted to thank all the witnesses for your testimony and the obvious expertise that you bring to these issues. Most of the focus that I wanted to bring to the discussion centers on staffing. Many of you have not just a lot of experience with this issue, but a whole list of recommendations, many of which could be the subject of many more hearings and certainly the subject of legislation.

But it has been my experience in State Government looking at this fairly closely as a public official that often in many places, many facilities it kind of begins and ends with staffing. You can make determinations very quickly about the quality of care based upon staffing.

I guess I would ask you to first of all outline-maybe I will start with you, Ms. Slocum, just to-and some of this is by way of reiteration of your testimony—but what you think is not happening now with regard to Federal initiatives, first of all, with regard to improving staffing in terms of the quality of the staff and second, with regard to what CMS is not doing in terms of providing information to consumers, to families before they make a determination about where to place a loved one. Because I will tell you, listening to CMS talk about the information they are providing, I think it is a heck of a lot better than it was 10 years ago.

But what you and others have outlined here today is we have still got a long, long, long way to go to provide the kind of information that people need and especially in the context of staffing. I guess I want you to comment on both what CMS needs to be doing better, but also what the Federal Government needs to do to ensure that we have quality staff.

Ms. SLOCUM. OK. Thank you for that question. First of all, I would say I-and I believe my ombudsman colleagues will applaud CMS continuing to add to and improve all of the data that is on nursing home compare.

Posting staffing data by particular job types and license types will actually help consumers have a more specific idea of how a particular facility is staffed. Using payroll data that facilities have to submit would also make it more specific.

So CMS is taking some steps. The ombudsmen will continue to comment to them and provide input about how we think that would be most useful to consumers. Part of the issue between State staffing requirements and Federal requirements—for example, in my State, we have staffing ratios and requirements that were enacted in 1978. They are extremely low.

It only requires 2.25 hours per day per resident of direct nursing time. That includes essentially everyone except the director of nursing—the CNAs, the LPNs and the RNs in the building. So that has become in Michigan essentially a meaningless staffing requirement. I have only in my four years, I think, seen one facility, which was in the process of closing, fall below that level.

The Federal requirements, despite all the great language and requirements that are in the OBRA 1987 law and the subsequent regulations, there is not a specific enforceable staffing level required. There have been well-respected studies that show just the average nursing facility needs to staff at about 4.1 hours of direct care per resident per day just in order to meet basic needs. That

is the average resident mix, not particularly a super-high acuity population in a facility.

In Michigan, we are running-I believe the current number is 3.8 hours per resident per day on average. So obviously some facilities are below that, and some are staffing above that.

But given that we have some data and studies about what is actually needed to provide adequate care, it seems like it is time, I think, to revisit some of the requirements and that Congress certainly could take an active role in looking at how to and what is a reasonable staffing requirement that is measurable so that we can know do all the facilities meet the requirement or not.

Senator CASEY. I want to ask you-I know I am a little low on time, but I wanted to ask others. But the focus really that I am trying to bring to this is the question of what can the Federal Government do in a strategic way, not just in terms of setting. As you said, various states do this with regard to the hours of care. That is obviously very important.

But what can the Federal Government do to better prepare that person who is the staffer? We heard stories all the time in Pennsylvania. They would train 10 people for a couple of weeks, and they would retain two. This whole recruitment and retention crisis is so central.

Ms. Zabel, if you wanted to comment on that.

Ms. ZABEL. I would love to. The only way that we can get good staff and keep good staff is to treat them like human beings. That means that we have to develop programs within our organizations. We have to pay them decent wages.

The starting wage in my facility right now is $13.95, which is probably the highest in Wisconsin. Believe it or not, we are in a rural wage scale as far as-a rural wage area as far as the Medicare program, which lost my facility over $100,000 a year. But I believe that the 3.8 hours is probably pretty high. That is not around the average.

In our State of Wisconsin, 2.8 hours are the amount of hours that our funding—Title 19 reimburses us that. So if you would make it 4.1, most of our facilities who run a high Title 19 census would not be able to survive. You certainly need to keep that in mind.

We have plenty of regulations and enforcement. But we have to look at enabling facilities to treat people well, provide adequate equipment, adequate supplies. CNAs shouldn't have to hide diapers in their ceiling for their favorite residents because the supply comes the first of the month and if it is gone by the 28th of the month, sorry, you can't have disposable, good diapers. We have to look at that sort of thing.

In Wisconsin, our reimbursement situation sets ceilings. There is a ceiling for administration, ceiling for direct care, ceiling for the supplementary care. Most of the facilities in Wisconsin exceed that ceiling as far as reimbursement. My facility is way over the top on that. But we still manage to survive.

We have to look at that. We can't have facilities that are just trying to meet that ceiling, the minimum amount of investment. We have to invest in these people. It doesn't require more regulation. It requires us to really be looking at how is the money being spent.

Indeed, our State association provides a financial report that tells you where your facility is in each of those areas compared to the national, compared to the State average, comparing for-profit, not-for-profit and governmental. That information is available. Perhaps that should be made available to the consumer.

But you have to remember the consumer is not involved in the admission process. It is the discharge planners. That has to change at that level, please.

Senator CASEY. I may want to come back to it. I know I am well over time.

Thank you, Mr. Chairman.

The CHAIRMAN. Members of the panel, in the range of all the problems that we are discussing here today, how many of them go back to financing and adequate financing in order to do the job? How much of it is basic competence of the people that are involved?

Who would like to take a crack? Is financing inadequate, financing of the nursing home industry the biggest problem we have?

Or what would you say, Ms. Zabel?

Ms. ZABEL. That is part of the problem. But I think as management——

The CHAIRMAN. Management?

Ms. ZABEL. That comes from management, whether it be from a corporate level or an individual facility level. You set the tone for what is going to happen in your facility. You have to be hands on management, not living in an ivory tower. You have to know what is happening in your building. You have to be available to the people that work in your building. You have to support them.

They have a life outside of your facility. That means that they can't just be giving in their work life. We have to support their home life as well and understand their needs. You can do that without really a very large investment in capital.

I have seen it happen from the day that I started 20 years ago. One of the things that you need to do is enforce your disciplinary policy. If you say she should be getting a warning, but I am not going to give it to her because we really need her to be here because we are short staffed today, then the good employees pack up and leave.

Why should I stay here when I work so hard, and all these other people do a mediocre job and they are still here? So you have to start at the basic founding of what is the mission of the organization and how can you care for these people. You establish that before you look at the money.

The CHAIRMAN. Good management and proper financing?

Ms. ZABEL. Correct.

The CHAIRMAN. Good management starts with the person at the top.

Ms. ZABEL. Yes.

The CHAIRMAN. It is you.

Ms. ZABEL. Well, it could be higher than me, but it is my ability to be a good manager——

The CHAIRMAN. At your facility that is you.

Ms. ZABEL. Yes, it is.

The CHAIRMAN. Anybody else?

Yes, Ms. Slocum?

Ms. SLOCUM. I agree with much of what Ms. Zabel has said. She has made some excellent points about staff need to be treated in a humane way so that they can treat residents in a humane way. I would say financing is certainly an area we need to look at. You can't have quality care without reasonable financing. But reasonable financing does not guarantee quality.

We have seen in Michigan because of large turnover rates in some of the issues that Ms. Zabel is bringing up, a lot of money, millions, over $100 million a year is one estimate, wasted on staff turnover. So there is money in the system, but we need to take a very careful look at how it is being spent, the oversight of that money, and making sure that the best system practices are in place so that it is well-used and we do actually achieve quality.

The CHAIRMAN. As an ombudsman, how much of an impact do you think this list that is going to be published by CMS on December 1st in terms of really highlighting those poorest performing facilities? Will that have a big impact on the industry in terms of lifting up the standards, at least at the bottom?

Ms. SLOCUM. I think it will be an excellent piece of information for consumers to have. I hope very much that it is viewed by the provider community as a very strong reason to make sure that nobody falls below that bottom line into the lowest rung and ends up on that list. I think it is an important step.

The CHAIRMAN. Anybody else want to comment?

Mr. Biondi.

Mr. BIONDI. Senator, if I could offer a few comments. I talked in my oral testimony about the survey process. One of the components that I think is important in our arena is when you think about what staff spends a lot of their day doing is difficult, difficult work. I think Ms. Zabel has made very excellent comments regarding many of the things I would have said in terms of treating people right.

We have got to find a way to reward and praise people, both in the survey process and find the good things that people are doing. Most people strive to do good things. Yet our survey process really doesn't identify any of that.

We all have to collectively every day find ways to make people feel proud about what they are doing, pay them decent wages, make sure we are getting paid in the Medicaid system for what we are doing. Clearly, from a staffing perspective, I have looked at it many a times where I think we have even been over-staffed or under-staffed in some of our facilities. Sometimes either way can cause a problem with delivering good quality care and services.

It really is dependent on the physical plant, the size of the facility, the way it is laid out, the type of residents you have there, and how stable that staff is, how educated, how trained they, whether they know the residents, know how to do the job correctly. There is a delicate balance, and we have to strive to find that delicate balance.

The CHAIRMAN. Thank you.

Mr. BIONDI. Thank you.

The CHAIRMAN. Anybody else want to make comment before I pass it on to Senator Casey for his last question or two? Anybody else?

Professor Zimmerman.

Mr. ZIMMERMAN. I think that it certainly is the case that we have states in which the Medicaid payment rate is probably not adequate to sustain a reasonable amount of care with a reasonable staff component. I also think that there are places in which the amount of each dollar of revenue that is spent on resident care varies substantially. That is, resident care relative to either a lease payment or some other form of a capital grab.

I think we have to be very attuned to how much of the expenses at a particular facility are retained at that facility and are used for facility improvements and facility care. That is not to say that any work is incapable of a system that gives sufficient money to the facility to do its job.

But I think we have to be very careful to make sure that the Federal Government, which deserves to know because it pays so much of the bill-how much of the expense sheet is going to resident care. That is a reasonable thing to know.

If somebody is more efficient and can get the job done more efficiently, that should be rewarded as well. But there are certain reasonable, intuitively compelling staff levels that are so low one would say you can't deliver care with this amount of staff. You have to have a greater staff component.

So that is why I am calling for transparency. It is reasonable to know what amount of staff is being used to provide care in a facility. That is not an unreasonable thing to know and to be reported.

The CHAIRMAN. Thank you.

Senator Casey.

Senator CASEY. Thank you.

I wanted to follow up, Professor Zimmerman, on your testimony as compared to what Mr. Weems presented. I asked him about the provider enrollment chain and ownership system, PECOS. Your testimony focused on the broad question of transparency.

Then you had, I guess, five-was it five-solutions. How would you compare what is in place now with regard to transparency as it relates to CMS, what CMS is doing or promising to do? How do you compare that with what you are recommending?

Mr. ZIMMERMAN. I think that as I understand the PECOS system-and I have not looked at it in detail-I think it has a lot of the elements that I think are going to be necessary in terms of ownership information. I think in some cases restricting it to only 5 percent may end up to be problematic because sometimes it is not the proportion of the ownership, but the way it is structured which may end up being the problem.

That is a segue into another point, which is that this issue of the landlord, as opposed to the operator, is something that we really have to investigate more and have more transparency about. I was deeply troubled by some of the statements made by individuals quoted in the New York Times article about the fact that, rather cavalierly, they were saying that the landlord simply has no responsibility.

Indeed, there are many cases in which the lease restrictions will provide major constraints for an operator who is the licensee to be able to make the changes sometimes that are going to be required by the State in order to fix things that come out of a survey. So

I think that there are really issues around the landlord and operator arrangement that are going to be necessary.

Frankly, I think we are starting to see some lease agreements that are so detailed and so constraining that they may end up putting major restraints on the ability of the operator to run the facility. Operators, frankly, can be replaced in days. That is a problem.

The operator is the licensee. So I think that actually the PECOS system starts the job, but what needs to happen is that they will need to go beyond that to be able to really ferret out who is it that is actually making decisions to control the care or direct the care in the facility. I think that is possible to do.

The OIG does it in the corporate integrity agreements. They basically say we want to know every part of this structure and who is making these decisions. I am not suggesting that we have to investigate it to that level of detail.

This should be based on permitting the people who are delivering decent care on the basis of the outcomes to continue doing so, as I said in my testimony. It is when they start to have problems that there should be the increased scrutiny immediately, that means that they will have to start answering questions about whether or not there may be some siphoning off of finances from the facility. The purchaser of care has the right to know that.

Senator CASEY. I know we are short on time. I would just ask you to consider an assignment, if you don't mind, for the record.

Mr. ZIMMERMAN. Thank you very much. I am very good at giving them.

Senator CASEY. I know it would help me, and I am sure it would help others if you could take a closer look at the so-called PECOS system as compared to the recommendations you make, kind of a side-by-side and see where you think the holes are. I don't want to sell it too short, but I am troubled by the fact that they could summarize it in a couple of lines and your testimony is more detailed than that.

That is probably not a fair way to assess it. But I think a more exhaustive look at it would help us.

Mr. ZIMMERMAN. It is likely that it probably will need at least some tweaking, given the increasing complexity of some of these Byzantine corporate structures.

Senator CASEY. I have got lots more questions, but I know we have to go.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Casey.

I would like to thank all the members of the panel that have journeyed here today to be with us to give us your expertise, your advice, your counsel. We, as you can tell, are determined to upgrade, along with you, the quality of performance of our nursing homes across the country. You have made a big contribution to that today.

I think we certainly should expect to see some measurable improvement in our nursing home operation across the United States in the months and in the year or two to come. So we thank you for your contributions. With that, the hearing is closed.

[Whereupon, at 3:53 p.m., the Committee was adjourned.]

APPENDIX

Testimony of Barbara Hengstebeck
To the Senate Special Committee on Aging
November 9, 2007

My name is Barbara Hengstebeck, and I am an advocate for nursing home residents and their families. Thirty-three years ago, my first job out of college was as an activities director in a Florida nursing home. Since then, I have worked in Florida's State Medicaid office as a nursing home policy specialist, served for 6 years as Florida's State Long-Term Care Ombudsman, and for the past 10 years, served as the Director of the Coalition to Protect America's Elders – a citizen advocacy group dedicated to raising public awareness about nursing homes. I have been a member of NCCNHR (formerly the National Citizen's Coalition for Nursing Home Reform) since 1989, served on NCCNHR's Board of Directors for the past 6 years and recently had the privilege of serving as NCCNHR's President. In 1999, I was appointed by the Governor to serve on Florida's "Panel on Excellence in Long-Term Care", also known as the "Gold Seal Panel" – a legislatively created panel that identifies exemplary nursing homes and recommends them to the Governor for his "Gold Seal Award"—and currently I serve as Chair of the Panel. In recent years, I have had two family members admitted to Florida nursing homes. My mother-in-law lived in three different Tallahassee facilities before her death in 2005.

I mention these things not only as a way of introducing myself to the Committee, but also because I believe I have a unique perspective on nursing homes. I have been a nursing home employee, a State

Ombudsman, a state level Medicaid employee, a family member of nursing home residents and a citizen advocate, all of which I believe gives me the ability to look at issues from several different viewpoints.

Nursing home care has definitely improved since I worked in them back in the 1970's. The passage of OBRA 87 had much to do with improving care. Strong regulations and consistent enforcement – including the imposition of sanctions - is critical to ensuring that residents get the quality care they need and deserve. It is not enough to impose CMP's -- the fines must also be collected! States should not continue to make Medicaid payments to facilities that have outstanding fines, and CMP funds should be used to fund projects that directly benefit residents such as family council development, not given back to providers as is being done in many states.

Nursing home owners have become increasingly more sophisticated. The mom and pop facilities of the seventies and eighties have all but disappeared, and we are now faced with a complex and confusing labyrinth of corporate structures that prevent consumers and even state agencies from knowing who owns and operates these facilities. These corporate structures seem to serve several purposes: protecting the corporate owners from accountability, preventing public and government scrutiny into their business practices and finances, and shifting funds intended for providing care into financing the debt incurred in purchasing the facilities as well as into profits for owners. Because nursing home care is highly subsidized by Medicare and Medicaid dollars, the government and the public have a right to know how these public dollars are being spent. Enacting legislation to

ensure transparency of these corporate structures is crucial, and your bill is a good start to doing this.

Consumers have also become more sophisticated and educated. The Internet has enabled consumers to obtain a vast array of information about facilities to assist them in making choices, but there is definitely a lack of information available about corporate ownership. Making this available to consumers would be very valuable. It is critical however to keep this information up to date, and to present it in a way that consumers can understand and use.

I have attached a sample copy of Florida's "Watchlist". This quarterly list was first published in 1997 by Florida's Agency for Health Care Administration, and lists, by region, each facility that received a conditional licensure rating during the previous quarter. It provided a concise summary of the deficiencies cited, the number of times a facility had previously been listed on the Watchlist (some as many as 20 times), and contained a list of facilities going through bankruptcy, along with other valuable information. At one glance, consumers could see the facilities in their area that were having compliance problems. In 2006, the Florida Legislature discontinued the Watchlist and directed the Agency to incorporate the information it contained into Florida's Nursing Home Guide, however I believe that the current presentation of the information is not as clear and consumer friendly as the separate Watchlist publication was. The information is still there, but now consumers have to look up each individual facility to find it, instead of having all the problematic facilities listed in one document. It would be useful for consumers to have a National

Watchlist contained on the Nursing Home Compare website, but kept separate in a listing format, and also to have a list of the Special Focus Facilities as is required in your proposed bill.

I have also attached some sample pages from Florida's Nursing Home Guide, which is available both in print format and on the internet at http://ahcaxnet.fdhc.state.fl.us/nhcguide/ I believe Florida's Guide is an excellent example of presenting information is a user-friendly format. Based on survey findings, each facility is rated in different categories using a system of stars. Five stars is the best. It means the facility is in the top 20 percent in that category compared to other facilities in the region where it is located. One star means they are in the bottom 20 percent. It is easy for consumers to tell at a glance, if a facility's inspection history for the past 30 months is good and which ones are not so good. The Guide also contains other information such as size, location, payments accepted, languages spoken, ownership etc.

I have mentioned that I am the Chair of the Florida's Panel on Excellence in Long-Term Care. This panel was created by the Florida legislature in 1999 because the nursing home industry felt that there was too much focus on the poor performing facilities and not enough recognition of facilities that are doing a good job. The Panel developed criteria to identify the "best of the best" facilities in Florida. This criterion includes financial stability, staff turnover and stability, quality of care based on survey findings, community involvement, in-service training, ombudsman complaints and consumer satisfaction. Since the program's inception in 1999, a total of 21 facilities have

received the Gold Seal designation, which is good for two years, and then the facility must re-apply. Currently, there are 14 Gold Seal facilities and two more under consideration. The majority of facilities that have received the award have been part of a Continuing Care Retirement Community – which are typically non-profit and faith based. There are approximately 675 nursing homes in Florida, so why is it that only 21 have received this award? Because the vast majority of Gold Seal facilities are part of CCRC's, this leads me to conclude that the free-standing corporately owned facilities either cannot meet the financial disclosure and soundness requirements, or the assets are being siphoned off to management companies and corporate owners, leaving the nursing home operation itself impoverished and without enough resources meet the quality of care requirements. Requiring facilities to identify direct-care and indirect-care spending in their Medicare and Medicaid cost reports as your bill suggests would go a long way towards identifying how facilities are spending government dollars.

Another thought that I would like to share pertains to STAFFING. The single most important thing that has been accomplished in Florida in recent years is the passage of a minimum staffing standard of 2.9 hours of Certified Nursing Assistant care per resident per day, which was done incrementally over several years. Facilities simply cannot provide good care unless they have adequate numbers of direct care staff. This has been substantiated in several studies, but has yet to be enacted at the federal level. I applaud your bill's provision to increase the required number of hours for CNA training,

because well-trained staff is vitally important. But what is ultimately needed is the passage of a national minimum staffing requirement. It should not be left up to the States to pass individual staffing requirements because of the political power of the nursing home industry to oppose such legislation and thwart its passage.

In conclusion, it would be difficult for me to choose which provisions of the bill would be most beneficial to consumers and residents. All of the issues that have been identified are important, and are interrelated. Improving transparency is vital. Improving the availability and accuracy of information to consumers in a user friendly format is also important. Collecting staffing information based on payroll information is extremely important and necessary to ensure accuracy and consistency. Strong and consistent enforcement of regulations including targeting problematic facilities, improved notification to residents, collection and use of CMP funds and simplified use of temporary managers would all be of great benefit to residents and consumers as well as increased nurse aid training requirements. I applaud you for an excellent bill.

Thank you for the opportunity to comment.

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Facility Display

AHCA Nursing Home Guid **Last Update: August, 2007**

Facility Display

EMERALD SHORES HEALTH AND REHABILITATION
626 NORTH TYNDALL PARKWAY
CALLAWAY
32404
BAY
Voice:
(850) 871-6363
Fax:
(850) 871-6367
Web:

Curr nt Lic nse :	EMERALD SHORES HEALTH CARE ASSOCIATES, L
License Since:	2001
Ownership Typ :	For-Profit
Affiliation:	
Bed :	77 Total: 66 Semi-Private / 11 Private
Occupancy Rate:	94.09%
Lowest Daily Charg :	$ 155.00
Paym nt Forms Accepted:	Medicaid, Medicare
Special Services:	24hr RN Onsite Coverage, HIV, Hospice, Pet Therapy, Respite Care, Tracheotomy Care
Languages Spok n:	Spanish
Prior Facility Name(Last Two Years):	

Overall Inspection	★★
Quality of Care	★
Quality of Life	★★
Administration	★

Components of Inspection	
Nutrition and Hydration	★
Restraints and Abuse	★★★★
Pressure Ulcers	★★
Decline	★
Dignity	★

Watch List Information

Conditional Timeframe	Number of Conditional Days	Percentage of Conditional Days
05/08/2005 to 11/08/2007	86	9.41%

Inspection Details for this Facility

AHCA Nursing Home Guide	Last Updat : August, 2007

Facility Display

APOLLO HEALTH & REHABILITATION CENTER
1000 24TH STREET N
SAINT PETERSBURG
33713
PINELLAS
Voic :
(727) 323-4711
Fax:
(727) 321-5963
Web:

Current Lic nsee:	GREENBROOK NH, LLC
Licensee Sinc :	2000
Own rship Typ :	For-Profit
Affiliation:	Greystone
B ds:	120 Total: 102 Semi-Private / 0 Private
Occupancy Rate:	88.89%
Lowest Daily Charg :	$ 171.00
Payment Forms Accept d:	CHAMPUS, Insurance or HMO, Medicaid, Medicare, VA, Worker's Compensation
Sp cial Services:	HIV, Hospice, Respite Care, Tracheotomy Care
Languages Spoken:	Spanish
Prior Facility Name(Last Two Years):	

Overall Inspection	★
Quality of Care	★
Quality of Life	★
Administration	★

Components of Inspection	
Nutrition and Hydration	★★★★★
Restraints and Abuse	★
Pressure Ulcers	★★
Decline	★
Dignity	★★★★★

Watch List Information

Conditional Timeframe	Number of Conditional Days	Percentage of Conditional Days
05/08/2005 to 11/08/2007	39	4.27%

Inspection Details for this Facility

Explanation of the **Glossary of**

AHCA Nursing Hom Guid **Last Updat : August, 2007**

Facility Display

HORIZON HEALTHCARE CENTER AT DAYTONA
1350 S. NOVA ROAD
DAYTONA BEACH
32114
VOLUSIA
Voice:
(386) 258-5544
Fax:
(386) 255-5623
W b:
www.encore-healthcare.com

Overall Inspection	★
Quality of Care	★
Quality of Life	★
Administration	★

Components of Inspection	
Nutrition and Hydration	★
Restraints and Abuse	★
Pressure Ulcers	★★★★★
Decline	★
Dignity	★

Current Licensee:	IHS ACQUISITION #103, INC.
Licens e Since:	1998
Ownership Type:	For-Profit
Affiliation:	
B ds:	84 Total: 18 Semi-Private / 21 Private
Occupancy Rate:	85.44%
Low st Daily Charge:	$ 165.00
Payment Forms Accepted:	Insurance or HMO, Medicaid, Medicare
Special Servic s:	24hr RN Onsite Coverage, Hospice, Pet Therapy, Respite Care, Tracheotomy Care
Languages Spoken:	Spanish
Prior Facility Name(Last	

Watch List Information

Conditional Timeframe	Number of Conditional Days	Percentage of Conditional Days
05/08/2005 to 11/08/2007	31	3.39%

Inspection Details for this Facility

Facility Display

AHCA Nursing Home Guide **Last Update: August, 2007**

Facility Display

BAY CENTER
1336 ST. ANDREWS BLVD.
PANAMA CITY
32405
BAY
Voic :
(850) 763-3911
Fax:
(850) 763-0242
W b:

Overall Inspection	★
Quality of Care	★
Quality of Life	★
Administration	★

Components of Inspection	
Nutrition and Hydration	★
Restraints and Abuse	★
Pressure Ulcers	★
Decline	★★
Dignity	★

Current Licensee:	HEARTHSTONE SENIOR COMMUNITIES, INC.
Lic nsee Since:	1996 or Earlier
Ownership Typ :	Non-Profit
Affiliation:	Age Institute of Florida
Beds:	160 Total: 92 Semi-Private / 28 Private
Occupancy Rat :	79.35%
Low st Daily Charg :	$ 165.46
Paym nt Forms Accepted:	CHAMPUS, Insurance or HMO, Medicaid, Medicare, Worker's Compensation
Special Servic s:	Alzheimer's Care, Eden Alternative, HIV, Hospice, Pet Therapy, Respite Care, Tracheotomy Care
Languages Spoken:	German, Sign Language, Spanish
Prior Facility Name(Last	

Watch List Information

Conditional Timeframe	**Number of Conditional Days**	**Percentage of Conditional Days**
05/08/2005 to 11/08/2007	55	6.02%

Inspection Details for this Facility

AHCA Nursing Home Guide **Last Update: August, 2007**

Facility Display

PAVILION FOR HEALTH CARE, THE

ONE PAVILION PLACE
PENNEY FARMS
32079
CLAY

Voic :
(904) 284-8578

Fax:
(904) 284-6259

Web:
www.penneyretirementcommunity.org

Gold Seal Awarded Nov/24/06 - Nov/23/08

Current Licensee:	PENNEY RETIREMENT COMMUNITY INC
Licensee Since:	1996 or Earlier
Ownership Type:	Non-Profit Retirement Center
Affiliation:	
Beds:	40 Total: 24 Semi-Private / 16 Private
Occupancy Rate:	89.5%
Lowest Daily Charge:	$ 164.00
Payment Forms Accepted:	Insurance or HMO
Special Services:	24hr RN Onsite Coverage, Alzheimer's Care, Hospice
Languages Spoken:	
Prior Facility Name	

Overall Inspection	★★★★★
Quality of Care	★★★★★
Quality of Life	★★★★★
Administration	★★★★★

Components of Inspection	
Nutrition and Hydration	★★★★★
Restraints and Abuse	★★★★★
Pressure Ulcers	★★★★★
Decline	★★★★★
Dignity	★★★★★

Inspection Details for this Facility

Facility Display

AHCA Nursing Home Guide **Last Update: August, 2007**

Facility Display

RIVER GARDEN HEBREW HOME FOR THE AGED

11401 OLD SAINT AUGUSTINE ROAD
JACKSONVILLE
32258
DUVAL

Voice:
(904) 260-1818

Fax:
(904) 260-9733

Web:
www.rivergarden.org

Gold Seal Awarded
Nov/24/06 - Nov/23/08

Overall Inspection	★★★★★
Quality of Care	★★★★★
Quality of Life	★★★★★
Administration	★★★★★

Components of Inspection	
Nutrition and Hydration	★★★★★
Restraints and Abuse	★★★★★
Pressure Ulcers	★★★★★
Decline	★★★★★
Dignity	★★★★★

Current Licensee:	RIVER GARDEN HEBREW HOME FOR AGED
Lic nsee Since:	1996 or Earlier
Ownership Type:	Non-Profit
Affiliation:	Jewish
Beds:	180 Total: 40 Semi-Private / 140 Private
Occupancy Rate:	95.63%
Low st Daily Charge:	$ 215.00
Payment Forms Acc pted:	Insurance or HMO, Medicaid, Medicare
Sp cial Services:	24hr RN Onsite Coverage, Adult Daycare, Alzheimer's Care, Hospice, Pet Therapy, Respite Care, Tracheotomy Care
Languages Spoken:	Filipino, French, German, Hebrew, Polish, Spanish, Yiddish
Prior Facility Name (Last Two Years):	

Inspection Details for this Facility

Explanation of the Performance Measur s **Glossary of Terms**

Gold Seal Facilities

The Governor's Panel on Excellence in Long Term Care recognizes these facilities, as meeting high standards and quality of care. The Gold Seal is awarded for a two-year period to those facilities that meet or exceed the Gold Seal standards, as mandated by Section 400 235 F S., and 59A-4 200-206, F A.C.

Facility	Effective Dates
Baldomero Lopez State Veterans' Nursing Home 6919 Parkway Blvd. Land O' Lakes, FL 34639 Contact: Rebecca Yackel (813) 558-5000	**Second Gold Seal Award** November 24, 2004 - November 23, 2008
Bay Village of Sarasota 8400 Vamo Road Sarasota, FL 34231- 7899 Contact: Jan Dalton (941) 966-5611	**Second Gold Seal Award** November 24, 2004 - November 23, 2008
Coral Gables Convalescent Center 7060 S.W. 8th Street Miami, Fl 33144 Contact: Jon Steinmeyer 305-261-1363	**First Gold Seal Award** August 1, 2007 - July 31, 2009
Florida Presbyterian Homes, Inc. 909 Lakeside Drive Lakeland, FL 33803 Contact: Kimberly Harris (863) 688-5521	**Second Gold Seal Award** May 1, 2006 - April 30, 2008
John Knox Village Med Center 4100 East Fletcher Avenue	**Third Gold Seal Award** July 24, 2002 - November 23, 2008

Tampa, FL 33613
Contact: Gary West
(813) 632-2455

John Knox Village Med Center - Orange City
901 Veterans Memorial Parkway
Orange City, Fl 32763
Contact: Cathy Holland

(386) 775-2008

First Gold Seal Award
November 1, 2006 - October 31, 2008

River Garden Hebrew Home for the Aged
11401 Old St. Augustine Road
Jacksonville, FL 32258
Contact: Martin A. Goetz
(904) 886-8409

Third Gold Seal Award
July 24, 2002 - November 23, 2008

Sunnyside Nursing Home
5201 Bahia Vista Street
Sarasota, FL 34232
Contact. Diane Marcello
(941) 371-27292

Second Gold Seal Award
November 24, 2004 - November 23, 2008

The Manor at Carpenters
1001 Carpenter's Way
Lakeland, Fl 33809
Contact: Brian Robare
(863) 858-3847

First Gold Seal Award
November 1, 2006 - October 31, 2008

The Mayflower Healthcare Center
1620 Mayflower Court
Winter Park, FL 32792
Contact: Yvonne Bell
(407) 672-1620

Second Gold Seal Award
November 24, 2004 - November 23, 2008

The Pavilion for Health Care
P.O. Box 555
Penney Farms, FL 32079
Contact: Janis M. Dyke
(904) 284-8582

Third Gold Seal Award
July 24, 2002 - November 23, 2008

Village on the Green
500 Village Place

Third Gold Seal Award

Longwood, FL 32779
Contact: Ansley Holt
(407) 682-0230

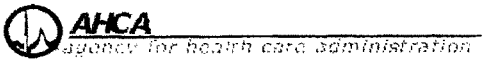
Octob r 14, 2002 - Nov mber 23, 2008

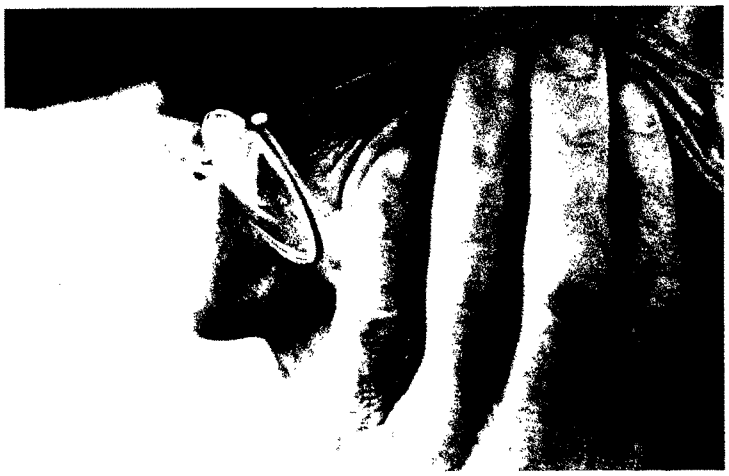
Water's Edge Extended Care
1500 SW Capri Street
Palm City, FL 34990
Contact: Jason Kohler
(772) 223-5863

Second Gold Seal Award
November 24, 2004 - November 23, 2008

Willowbrooke Court at St. Andrews
6152 V rde Trail North
Boca Raton, FL 33433
Contact: Ramon Flores
561-487-5200

Second Gold Seal Award
August 1, 2007 - July 31, 2009





Florida Nursing Home Guide

WATCH LIST

Agency for Health Care Administration
April to June 2006

Florida Nursing Home Guide Watch List is published by the state Agency for Health Care Administration to assist consumers in evaluating the quality of nursing home care in Florida. This *Watch List* reflects facilities that met the criteria for a c **nditional** status, on any day between **April 01, 2006 and June 30, 2006**. A conditional status indicates that a facility did not meet, or correct upon follow-up, minimum standards at the time of an annual or complaint inspection. Immediate action is taken if a facility poses a threat to resident health or safety. If the deficiencies that resulted in conditional status have been corrected, the current status as of November 20, 2006 is noted. Facilities appealing the state's inspection results are also noted. This document is subject to change as appeals are processed. Please refer to the Agency for Health Care Administration web site for the latest revisions: www.ahca.myflorida.com or www.floridahealthstat.com .

Due to a previously pending Informal Dispute Resolution (IDRs), the following conditionally licensed facility did not appear on a prior Watch List. However, since the conditional license was not overturned as a result of the IDR, the facility has now been added to a former Watch List.

January 2006 to March 2006 Watch List Addition:
Heartland Healthcare Center–Lauderhill
2599 NW 55th Avenue
Lauderhill, FL 33313

Kenilworth Care and Rehabilitation Center
3011 Kenilworth Blvd.
Sebring, FL 33870

Life Care Center at Inverrary
4251 Rock Island Road
Lauderhill, FL 33319

Manorcare Health Services
16200 Jog Road
Delray Beach, FL 33446

Miracle Hill Nursing and Convalescent Center
1329 Abraham Street
Tallahassee, FL 32304

Sinai Plaza Nursing and Rehabilitation Center
201 NE 112th Street
Miami, FL 33161

Southpoint Terrace
4325 Southpoint Blvd.
Jacksonville, FL 32216

Summer Brook Health Care Center
5377 Moncrief Road
Jacksonville, FL 32209

Tandem Healthcare of New Port Richey
8714 Old Country Road 54
New Port Richey, FL 34653

North Florida	
Facility Information	**Deficiencies**
DOCTORS LAKE OF ORANGE PARK 833 KINGSLEY AVENUE in ORANGE PARK **County:** CLAY **AO:** 4 **Number of Beds:** 120 **License Expires:** Mar-31-2007 **Owner:** SV/JUPITER PROPERTIES, INC. **Appealed**	**Facility corrected deficient practice and has a standard status as of Apr-20-2006. Beginning Feb-27-2006, survey inspectors determined that the nursing home did not:** Ensure the resident is free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from inappropriate physical and chemical restraints. (Class = I, Scope = Widespread, Cited on Feb-27-2006 and corrected on Apr-05-2006) **Number of times facility has appeared on the *Watch List*: 8**
LAKE PARK OF MADISON 259 SW CAPTAIN BROWN RD in MADISON **County:** MADISON **AO:** 2 **Number of Beds:** 120 **License Expires:** Aug-31-2007 **Owner:** MADISON HEALTH INVESTORS LC **Appealed**	**Facility corrected deficient practice and has a standard status as of Jun-9-2006. Beginning Apr-27-2006, survey inspectors determined that the nursing home did not:** Provide a safe, clean, comfortable and homelike environment, which allows residents to use their personal belongings to the extent possible. (Class = I, Scope = Pattern, Cited on Apr-27-2006 and corrected on Jun-09-2006) **Number of times facility has appeared on the *Watch List*: 1**
LEESBURG HEALTH AND REHAB, LLC 715 E. DIXIE AVENUE in LEESBURG **County:** LAKE **AO:** 3 **Number of Beds:** 120 **License Expires:** Dec-30-2006 **Owner:** LEESBURG HEALTH AND REHAB, LLC	**Facility corrected deficient practice and has a standard status as of Apr-7-2006. Beginning Feb-14-2006, survey inspectors determined that the nursing home did not:** Adopt procedures that assured accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. (Class = III, Scope = Isolated, Recited on Feb-14-2006 and corrected on Mar-10-2006) **Number of times facility has appeared on the *Watch List*: 4**
MIRACLE HILL NURSING & CONVALESCENT CENTER, INC. 1329 ABRAHAM STREET in TALLAHASSEE **County:** LEON **AO:** 2 **Number of Beds:** 120 **License Expires:** Aug-31-2007 **Owner:** MIRACLE HILL NURSING & CONVALESCENT CENTER, INC.	**Facility corrected deficient practice and has a standard status as of Apr-4-2006. Beginning Mar-2-2006, survey inspectors determined that the nursing home did not:** Make reasonable efforts to protect residents from abuse, neglect, or exploitation by others. (Class = II, Scope = Isolated, Cited on Mar-02-2006 and corrected on Apr-04-2006) **Number of times facility has appeared on the *Watch List*: 2**
PARK MEADOWS HEALTH AND REHABILITATION CENTER 3250 S.W. 41ST PLACE in GAINESVILLE **County:** ALACHUA **AO:** 3 **Number of Beds:** 154 **License Expires:** Sep-19-2007 **Owner:** THE OAKS NH, L.L.C.	**Facility corrected deficient practice and has a standard status as of Jun-22-2006. Beginning Apr-28-2006, survey inspectors determined that the nursing home did not:** Life Safety Code: Testing Of Fire Alarm (Class = III, Scope = Widespread, Recited on Jun-05-2006 and corrected on Jun-22-2006) Treat residents courteously, fairly, and with the fullest measure of dignity and to provide a written statement and an oral explanation of the services provided. (Class = II, Scope = Pattern, Cited on Apr-28-2006 and corrected on Jun-06-2006) Intentional or negligent act affecting the health or safety of the residents of the facility. (Class = II, Scope = Pattern, Cited on Apr-28-2006 and corrected on Jun-06-2006) **Number of times facility has appeared on the *Watch List*: 4**
SEA BREEZE HEALTH CARE 1937 JENKS AVENUE in PANAMA CITY **County:** BAY **AO:** 2 **Number of Beds:** 120 **License Expires:** Nov-30-2007 **Owner:** GULF COAST HEALTH CARE ASSOCIATES, LLC	**Facility corrected deficient practice and has a standard status as of Apr-25-2006. Beginning Feb-17-2006, survey inspectors determined that the nursing home did not:** Adopt, implement, and maintain written policies and procedures governing all services provided in the facility. (Class = II, Scope = Widespread, Cited on Feb-17-2006 and corrected on Mar-22-2006) Assure that all physician orders are followed as prescribed, and if not followed, the reason is recorded in the resident's medical record during that shift. (Class = III, Scope = Isolated, Recited on Mar-22-2006 and corrected on Apr-25-2006) **Number of times facility has appeared on the *Watch List*: 4**

Central Florida	
Facility Information	**Deficiencies**
APOLLO HEALTH & REHABILITATION CENTER 1000 24TH STREET N in SAINT PETERSBURG **County:** PINELLAS **AO:** 5 **Number of Beds:** 120 **License Expires:** Sep-19-2007 **Owner:** GREENBROOK NH, LLC **Appealed**	**Facility c rrected defici nt practic and has a standard status as of Apr-26-2006. Beginning Mar-30-2006, survey inspectors determined that the nursing home did not:** Provide adequate and appropriate health care and protective and support services to all residents. (Class = I, Scope = Isolated, Cited on Mar-30-2006 and corrected on Apr-26-2006) Intentional or negligent act affecting the health or safety of the residents of the facility. (Class = I, Scope = Isolated, Cited on Mar-30-2006 and corrected on Apr-26-2006) **Number of times facility has appeared on the *Watch List*: 4**
COMMONS AT ORLANDO LUTHERAN TOWERS 210 LAKE AVENUE in ORLANDO **County:** ORANGE **AO:** 7 **Number of Beds:** 126 **License Expires:** Apr-30-2007 **Owner:** ORLANDO LUTHERAN TOWERS, INC.	**Facility corrected deficient practice and has a standard status as of Jul-20-2006. Beginning Jun-15-2006, survey inspectors determined that the nursing home did not:** Adopt procedures that assured accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. (Class = III, Scope = Isolated, Recited on Jun-15-2006 and corrected on Jul-20-2006) **Number of times facility has appeared on the *Watch List*: 8**
KENILWORTH CARE & REHABILITATION CENTER 3011 KENILWORTH BLVD. in SEBRING **County:** HIGHLANDS **AO:** 6 **Number of Beds:** 104 **License Expires:** Oct-31-2007 **Owner:** HQM OF SEBRING, LLC **Appealed**	**Facility corrected deficient practice and has a standard status as of May-2-2006. Beginning Mar-25-2006, survey inspectors determined that the nursing home did not:** Assure that all physician orders are followed as prescribed, and if not followed, the reason is recorded in the resident's medical record during that shift. (Class = III, Scope = Pattern, Recited on Apr-06-2006 and corrected on May-02-2006) Provide adequate and appropriate health care and protective and support services to all residents. (Class = I, Scope = Isolated, Cited on Mar-25-2006 and corrected on May-02-2006) Establish an internal risk management and quality assurance program, the purpose of which is to assess resident care practices. (Class = II, Scope = Pattern, Cited on Mar-25-2006 and corrected on May-02-2006) **Number of times facility has appeared on the *Watch List*: 4**
MARY LEE DEPUGH NURSING HOME ASSOCIATION, INC. 550 W MORSE BLVD. in WINTER PARK **County:** ORANGE **AO:** 7 **Number of Beds:** 40 **License Expires:** Dec-31-2006 **Owner:** MARY LEE DEPUGH NURSING HOME ASSOCIATION, INC.	**Facility corrected deficient practice and has a standard status as of Aug-16-2006. Beginning Jun-20-2006, survey inspectors determined that the nursing home did not:** Assure that all physician orders are followed as prescribed, and if not followed, the reason is recorded in the resident's medical record during that shift. (Class = III, Scope = Isolated, Recited on Aug-01-2006 and corrected on Aug-16-2006) Develop a comp care plan for eachresident that includes measurable objectives/timetables to meet medical, nursing, mental and psychosocial needs. (Class = III, Scope = Isolated, Recited on Jun-20-2006 and corrected on Aug-01-2006) Provide adequate and appropriate health care and protective and support services to all residents. (Class = II, Scope = Isolated, Cited on Aug-01-2006 and corrected on Aug-16-2006) Provide residents privacy in treatment and in caring for personal needs. (Class = III, Scope = Isolated, Recited on Jun-20-2006 and corrected on Aug-01-2006) Treat residents courteously, fairly, and with the fullest measure of dignity and to provide a written statement and an oral explanation of the services provided. (Class = III, Scope = Isolated, Recited on Jun-20-2006 and corrected on Aug-01-2006) **Number of times facility has appeared on the *Watch List*: 16**

Bankrupt Nursing Homes

During the three months covered by this Watch List, the following nursing homes were either bankrupt or were associated with companies that were bankrupt. Please refer to AHCA's web site for the latest revisions: www.fdhc state.fl.us or www.floridahealthstat.com.

MIAMI GARDENS CARE CENTRE
190 NE 191ST STREET in MIAMI

Selecting a Nursing Home

Selecting a nursing home is a very important decision. That's why the Agency for Health Care Administration encourages citizens to tour any nursing home being considered for a loved one, interview staff and talk with residents about the facility and refer to information listed in the *Florida Nursing Home Guide* to aid in this decision making process.

The *Guide* provides the following information about specific nursing homes: inspection history, ownership status, special services, charges or deficiencies and ratings. The *Guide* also suggests community-based alternatives to traditional nursing home care and questions to ask when choosing a facility. This *Watch List* reflects facilities that did not meet minimum standards, at any time, during April 01 to June 30 2006. To request a copy of the *Guide* or the quarterly *Watch Lists*, call (888) 419-3456. These publications are also available on the AHCA web site at www.ahca.myflorida.com or www.floridahealthstat.com.

Licensure Status

Nursing homes are licensed as standard or conditional. A **standard** license indicates the facility meets minimum standards and a **conditional** license indicates that the facility did not meet, or correct upon follow-up, minimum standards. Immediate action is required for deficiencies that pose a threat to resident health or safety.

The Inspection Process

The state Agency for Health Care Administration inspects nursing homes each year. The survey includes a facility tour; interviews with residents, families, staff, visitors and volunteers; assessments of resident rights, protections and activities; and medical record reviews.

As necessary, the Agency also investigates consumer complaints against nursing homes. Nursing homes are required by law to post state inspection reports.

Health Quality Assurance Area Offices

North Florida	Central Florida	South Florida
Tallahassee 850-922-8844	St. Petersburg 727-552-1133	Ft. Myers 239-338-2366
Gainesville 386-418-5314	Orlando 407-245-0850	W. Palm Beach 561-840-0156
Jacksonville 904-359-6046		Miami 305-499-2165

Explanation of Terms

Deficiencies - Failure to meet established standards. Within 10 days of inspection, nursing homes are required to submit a written Plan of Correction detailing how the deficiencies will be corrected. State inspectors conduct follow-up visits to monitor the facility's progress. Given the complexity of the survey process, even the highest quality facilities may have some minor deficiencies. Severe deficiencies may result in fines, restriction of patient admissions, change of ownership, or closure.

Class - Each deficiency cited is "classified" as a Class I, II, III, or IV.

A **class I** deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

A **class II** deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

A **class III** deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

A **class IV** deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident.

Scope - Deficiencies are given a scope by the agency according to the extent of the impact of the deficiency.

Isolated deficiencies are those affecting one or a very limited number of residents, or involve one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations.

Patterned deficiencies are those where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by the reported occurrence of the same deficiency practice but the effect of the deficient practice is not found to be pervasive throughout the facility.

Widespread deficiencies are those in which problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents.

Under Appeal — Under Florida law, nursing homes have a right to challenge state inspection results. A conditional rating remains in effect until the appeal is settled or the deficiencies are corrected.

Stephen L. Guillard
Executive Vice President and
Chief Operating Officer
333 N. Summit Street
P.O. Box 10086
Toledo, Ohio 43699-0086
419-252-5500

ManorCare

November 29, 2007

Hon. Herb Kohl
Chairman
Special Committee on Aging
United States Senate
330 Hart Senate Office Building
Washington, DC 20510

Hon. Mel Martinez
United States Senate
356 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Kohl and Ranking Member Martinez:

I write to request that our statement be included in record for the November 15, 2007 Subcommittee hearing on "Trends in Nursing Home Ownership and Quality." We welcome the opportunity to go on record to clarify some of the inaccurate statements made at the hearing. In particular, we would like to address issues related to the transaction, its structure and transparency, the financial viability of the company, and the operation of the company after closing. I would be grateful if you would include this letter in the formal hearing record.

Separation of the Real Estate and Operating Entities

Witnesses at the hearing suggested that Manor Care and Carlyle were separating real estate and operating assets in an effort to minimize transparency and limit liability. Nothing could be further from the truth.

While there will be changes in the corporate structure post-transaction, Manor Care will continue to own and manage both the operations and real estate of the company. Responsibility and accountability will continue to lie with Manor Care.

More specifically, each operating company will be:

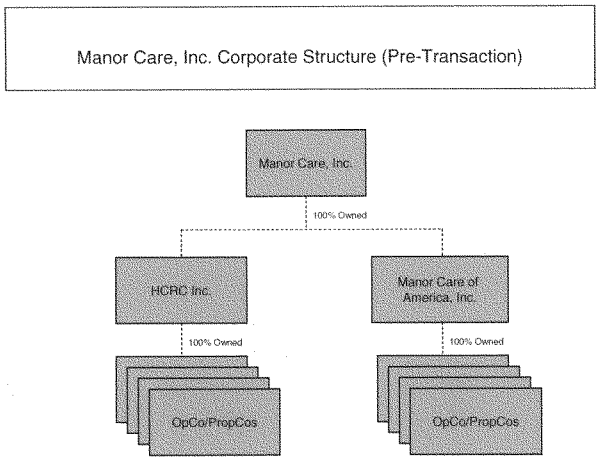
- An indirect, wholly owned subsidiary of Manor Care, Inc.
- Insured by Manor Care, Inc.'s general and professional liability coverage described below. Manor Care will be insured at the same level post-transaction as it is today.
- Managed by the same Manor Care leadership team currently in place.

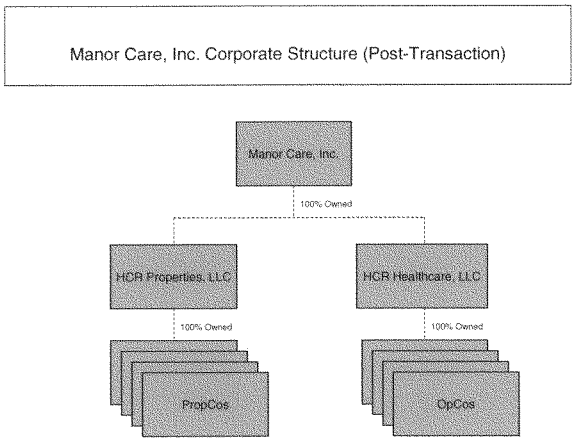
In order to finance the transaction, Manor Care has arranged financing secured by Manor Care's real property. Because the real estate financing is secured only by real estate, our lenders required that the real property be organized in newly formed limited liability entities tied to the specific mortgage for each of the lenders.

This structure in no way affects the day-to-day operations of the skilled nursing facilities. It is also not a shield against ultimate liability of Manor Care - all of the assets will still be owned 100% by the parent company, Manor Care, Inc.

Manor Care shares your goals with respect to transparency, and has ensured that state regulators responsible for oversight of the industry have all essential information on our structure and ownership.

Manor Care's current general and professional liability program consists of $125 million primary and excess insurance including a $5 million self-insured retention, as well as $100 million in property risk insurance provided by some of the largest and highest rated insurers and re-insurers in the marketplace. The current coverage will not be affected by the change of ownership and will continue in place after the closing of the transaction.





Again, Manor Care will own and be responsible for all of its operations and real estate.

Financial Strength of the Company

After this investment, Manor Care will be the most financially solvent long-term care company in the United States. The Carlyle Group will be investing approximately $1.3 billion in equity in the company -- twice the level of equity that is on our balance sheet at the present time.

Our ability to service our increased debt results from the fact that we will no longer be making interest payments associated with prior debt, repayments of existing debt, share buybacks or quarterly dividends to our public shareholders. During the past five years, the amounts that the company has paid for these items (which will not occur in the future) approximate or exceed the new debt service obligations on an annual basis. Manor Care will be able to adequately fund our obligations and ensure continued quality care to our patients and families.

Manor Care's financial viability has been reviewed by an independent third party, Duff and Phelps, which has provided our Board of Directors an opinion attesting to the solvency and viability of the company subsequent to the transaction. Our Board of Directors has dutifully represented the interests of our shareholders and our company in ensuring that this arrangement with The Carlyle Group is in the best interests of all stakeholders, including our patients, families and employees, as well as our shareholders.

Quality of Care

Testimony at the recent hearing referred to a New York Times article which concluded that quality of care at nursing homes has deteriorated after being acquired by private equity firms. As the Committee has been made aware, the findings of the New York Times have been put into serious question as a result of reports completed by both the Agency for Health Care Administration of the state of Florida and by the firm, LTCQ, which is led by

researchers from Harvard and Brown Universities and which specializes in data analysis of long-term care companies.

We urge the Subcommittee to thoroughly assess and validate the assertions of the New York Times. Private investment in the long-term care sector has been a critical factor in providing essential capital since 1940 and remains a vital element today, whether in the form of equity or debt. It is interesting that both of the studies referenced above indicate that there is no evidence to support that the quality of care suffers when a facility is owned by a private equity firm or an investment company.

In terms of our company, Manor Care is a leader in quality short-term post-acute services and long-term care. With more than 500 overall sites of care in 32 states, nearly 60,000 caring employees, and facilities spanning a care continuum of skilled nursing and rehabilitation centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home care agencies, Manor Care was first in the industry to broadly measure patient care outcomes, with a continuing emphasis on meeting patient care goals. Our company has invested in clinical skills and technology to produce desired outcomes for patients who require more complex medical care and intensive rehabilitation, and does so in an environment that is more home-like than traditional providers (e.g., acute care hospitals). We provide high-acuity care to many of our patients, as well as chronic care services, and we do so in a cost-effective manner, ensuring that individuals receive care in the most appropriate setting.

Our principal mission is to have our patients use long-term care services as an interim step between the acute care setting and their primary residence. Our company discharges 150,000 patients a year from our skilled nursing facilities. We are very proud that nearly two-thirds of these individuals stay in our centers for less than 40 days and half less than 30 days. Our strong medical, nursing and rehabilitation programs facilitate a shorter-term use of our centers, which enables us to provide more care to individuals throughout the United States. As part of our commitment to the best in care, we are expanding technology in our organization, increasing the use of physician and nurse extenders, broadening our information dissemination, improving the lives and involvement of our employees, and working to bring improved programs of care and services to our patients and their families.

Finally, regardless of the validity of the New York Times article, Manor Care's performance should be judged on its own merits – and, we are confident that this transaction positions us to continue and improve quality care for our patients and residents.

Management and Expertise

The Carlyle Group believes that the best investment approach is to allow Manor Care to continue doing what it is already doing so successfully – delivering quality care -- and they intend to maintain the model that has shown proven results. The current management team at Manor Care will continue to operate the company, and there will be no staffing reductions within our caregiver ranks due to the investment. We felt it was important to assure our patients, families and employees that at no time have we considered, nor will we implement, a staffing reduction in our centers as a result of this transaction. To that end, we provided assurances in writing to them, copies of which are included with the accompanying materials.

The Manor Care Board will continue its Quality Committee and additionally appoint an independent and well-regarded committee of experts to advise the Quality Committee and Board on quality of care. And Manor Care will continue publishing its Annual Report on Quality, a copy of which is available to the public on our website.

Again, we want to reiterate that within our transaction we will have the same management, staffing, policies and procedures, and protocols and controls, as well as additional oversight within our Board of Directors.

We view our participation in the overall health care system very seriously. We are pleased to have worked with your agency in the initial Quality First program and have moved forward to ensuring that all of our skilled nursing centers are involved with the Advancing Excellence program. We are committed to quality measurement and initiatives and will continue to work to increase transparency for our patients, families and referral groups on the issue of quality.

Summary

Manor Care has provided exceptional and comprehensive health care services to millions of individuals over its history. We acknowledge and take seriously our responsibility to ensure that the care provided to our patients and families is consistent with all appropriate rules and regulations as well as all appropriate medical and clinical standards. We also believe that our structure, financial viability, governance and commitment to quality provide our patients and their families with the assurances that the Subcommittee on Health of the Ways and Means Committee is seeking from financial sponsors and management professionals.

In closing, we are appreciative of this opportunity to provide additional information on the transaction between Manor Care and The Carlyle Group, and appreciate this opportunity to reaffirm our commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made Manor Care the most uniquely successful and respected provider in our industry.

Please let us know if you have any questions or if we can elaborate further on any of these key points.

Sincerely,

Stephen L. Guillard
Executive Vice President
Chief Operating Officer

HCR·ManorCare

October 1, 2007

To Our Family Members:

Recently, it was announced that our parent company, Manor Care, is being acquired by The Carlyle Group. Carlyle is a private equity firm that makes investments in a wide variety of leading companies and industries, and they are investing in our company precisely because we are the widely recognized leader in providing quality long-term care and post-acute rehabilitation for about 250,000 patients across the country each year. Most importantly, Carlyle recognizes and appreciates the role that our caregivers and support personnel have played in our success and will continue to play in meeting the needs of our patients and residents in the future.

With the completion of this transaction expected to occur before year-end, the names of our shareholders will change, but almost everything else will remain the same. In fact, Carlyle and our senior management team have reconfirmed their commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made our organization the most uniquely successful and respected provider in our industry.

Over the years, HCR Manor Care and many of its employees have been widely recognized and honored for their capabilities, performance and professionalism. Because of our long record of excellence, it is hard to understand why some misinformed union activists have recently chosen this moment to spread ridiculous and inaccurate comments about what they think this change in our ownership means for the patients we care for. I want to assure you there is no basis for their offensive and potentially slanderous comments.

Carlyle joins us in embracing our Circle of Care philosophy and the HCR Manor Care Vision Statement which reflects our commitment to providing quality health care services. We have been guided by this vision since our company's beginning, and it will continue to reflect our priorities as we grow in the years ahead.

I am confident you will find that our new partnership with Carlyle will reinforce our commitment to quality care for our patients and residents and their families. With this commitment and the dedication of our caregiver team, we will continue to strive to provide the best care and caring in our industry.

Sincerely,

Stephen L. Guillard
Executive Vice President and Chief Operating Officer

HCR·ManorCare

October 1, 2007

To All HCR Manor Care Employees:

Recently, it was announced that our parent company, Manor Care, is being acquired by The Carlyle Group. Carlyle is a private equity firm that makes investments in a wide variety of leading companies and industries, and they are investing in our company precisely because we are the widely recognized leader in providing quality long-term care and post-acute rehabilitation for about 250,000 patients each year. Most importantly, Carlyle recognizes and appreciates the role that our caregivers and support personnel have played in our success, and that we will continue to rely on your capabilities and performance to meet the needs of our patients and residents in the future.

With the completion of this transaction expected to occur before year-end, the names of our shareholders will change, but almost everything else will remain the same. In fact, Carlyle and our senior management team have reconfirmed their commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made our organization the most uniquely successful and respected provider in our industry.

Over the years, HCR Manor Care and many of you have been widely recognized and honored for our capabilities, performance and professionalism. Because of our long record of excellence, it is hard to understand why some misinformed union activists have recently chosen this moment to spread ridiculous and inaccurate comments about what they think this change in our ownership means for all of us and the patients we care for. Suffice it to say, there is no basis for their offensive and potentially slanderous comments, and you shouldn't be distracted by their desperate attempts at union organizing.

Carlyle joins us in embracing our Circle of Care philosophy and the HCR Manor Care Vision Statement which reflects our aspirations, both personally and professionally. As you know, our Vision begins with, "We, the employees of HCR Manor Care, are dedicated to providing the highest quality in health care services." We have been guided by this vision since our company's beginning, and it will continue to reflect our priorities as we grow in the years ahead. Our success will also continue to be dependent on the skills and commitment of our caregivers and their support organization, to work together in a respectful and collegial manner to meet the needs of those who are entrusted to us for their care.

I invite you to join me as we all look forward to this new partnership with Carlyle and the opportunities we have to grow and provide quality care to our patients and residents throughout the country. I sincerely thank you, our caring employees and the organization that supports them, for your commitment to our patients and residents and their families, and I am proud that because of your dedication, we will continue to strive to provide the best care and caring in our industry.

Sincerely,

Stephen L. Guillard
Executive Vice President and Chief Operating Officer

STATEMENT FOR THE RECORD

SUBMITTED TO

THE SPECIAL COMMITTEE ON AGING

ON

NURSING HOME TRANSPARENCY AND IMPROVEMENT

November 15, 2007

WASHINGTON, D. C.

For further information, contact:
Rhonda Richards/Kirsten Sloan
Federal Affairs Department
(202) 434-3770

On behalf of AARP's nearly 40 million members, thank you for holding this important hearing today on nursing home quality. It has been twenty years since the enactment of national standards for nursing home quality in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). While the quality of care in our nation's nursing homes has improved over the last twenty years, significant progress still needs to be made. The recent *New York Times* article examining the sub-par quality of care in nursing homes owned by private equity firms is the latest reminder that quality of care in our nation's nursing homes is an ongoing issue. Approximately 16,000 nursing homes in this country provide care to about 1.5 million of our most vulnerable citizens. Federal and state governments have a responsibility to help ensure high quality for these residents, especially since Medicaid, and to a lesser extent Medicare, pay for a majority of nursing home services. This hearing offers an opportunity to assess the quality problems still lingering and to examine potential solutions to improve quality for all nursing home residents.

A Call to Action

On September 23rd, the *New York Times* published an expose´ detailing the results of its own investigation into the quality of care in nursing homes purchased by private investors, including private equity firms. The *Times* investigation found that private investor owned nursing homes cut expenses and staff, scored worse than national rates in 12 of 14 quality indicators, and created

complex corporate structures that obscured who controlled them and who is ultimately responsible for the quality of care they provide. These findings and others in the article are disturbing, but unfortunately are not new. Private equity firms are not the first nursing home owners to use complex corporate ownership and real estate structures – some nursing home chains have used structures like this already.

AARP supports congressional hearings – like this one – to examine nursing home quality problems, including concerns raised about facilities owned by private equity firms, and begin to look for ways to address these problems. Concerns about nursing home quality are not limited to any one state, owner or type of owner, and quality problems can harm residents regardless of where they occur. We believe that investigation by the Government Accountability Office (GAO) could also shed additional light on these issues and potentially offer constructive steps to improve quality.

Examples of Quality Problems

In recent years, media stories, GAO reports, and investigations by the Department of Health and Human Services' Office of Inspector General have revealed specific nursing home quality issues. Many facilities do provide high quality of care and quality of life to their residents. Some facilities are even transforming their culture to offer smaller more homelike settings with private

rooms, more choice for residents, and more control to staff that is more likely to stay at the facility and provide consistent high quality care. However, there are also facilities that show significant quality deficiencies on their annual inspections that can cause harm to residents. Effective enforcement of quality standards and remedies, including closure, is important for these and all facilities.

Some nursing homes and their owners have taken steps that can make it more difficult for regulators and consumers to hold these facilities accountable for quality care. For example, corporate restructuring where a nursing home chain splits itself into single purpose entities (some owning the individual nursing home, others leasing and operating the facility, yet others holding the real estate) can obscure and complicate the answer to the question, "Who is responsible for the quality of care?" in any particular facility. The answer may not be just one entity or group of individuals, and they may not be easy to identify. When a regulator looks to assess a penalty for a deficiency, or consumers and their families seek to hold facilities accountable for poor quality of care, it can be more difficult for the regulator to collect a penalty or for the consumers to hold facilities liable for quality of care.

Disclosure requirements can provide important information about who has an ownership interest or controls a company or facility. But when a facility is owned by a private equity firm, the facility is no longer subject to certain public disclosure requirements. One should be able to identify the individuals or

corporate entities that are responsible and accountable for the operation and quality of care in the facility. Transparency and accountability are vital for all facilities, regardless of their ownership.

Staffing in nursing homes also has an important impact on quality. Better staffing levels and well-trained staff with low turnover can improve quality of care for nursing home residents. Yet facilities may not always have sufficient staff, and additional resources provided to facilities for staff do not always result in staffing improvements.

It is also important to have reliable and up-to-date data on staffing levels in facilities -- not just data that is collected once a year when a facility receives its annual survey. Accurate and reliable staffing data is important to consumers and their families when they choose a nursing home for their loved one. In addition, the Medicare Payment Advisory Commission (MedPAC) has recommended that the Department of Health and Human Services (HHS) Secretary direct skilled nursing facilities (SNFs) to report nursing costs separately from routine costs when completing the SNF Medicare costs reports. MedPAC also notes that it would be useful to categorize these costs by type of nurse (registered nurse, licensed practical nurse, and certified nursing assistant). This information would allow MedPAC to examine the relationship between staffing, case mix, quality, and costs.

In addition, staffing in nursing homes and other long-term care settings could be improved by addressing the serious need for an adequate, stable, and well-trained workforce. Direct care workers, such as personal care assistants, home care and home health aides and certified nurse assistants, provide the bulk of paid long-term care. Long-term care workers should receive: adequate wages and benefits; necessary training and education, including opportunities for advancement; more input into caregiving; more respect for the work they do; and safer working conditions.

Despite the reforms in OBRA '87 and improvements in care since that time, GAO has found that a small but significant share of nursing homes continue to experience quality-of-care problems. Last year, one in five nursing homes in this country was cited for serious deficiencies – deficiencies that cause actual harm or place residents in immediate jeopardy. GAO has also noted state variation in citing such deficiencies and an understatement of them when they are found on federal comparative surveys but not cited on corresponding state surveys. In addition, some facilities consistently provide poor quality care or are "yo-yo" facilities that go in and out of compliance with quality standards. Almost half the nursing homes reviewed by GAO for a March 2007 report – homes with prior serious quality problems – cycled in and out of compliance over five years and harmed residents.

These are examples of some of the challenges and issues that should be addressed to improve nursing home quality. In some cases, better enforcement of existing standards and requirements may solve the problem. In other cases, additional steps may be needed to address the problem.

Finally, we note that some nursing home residents may choose and be able to get the services they need in a home-and community-based setting with sufficient support from family and/or professional caregivers.

State Role

States play an important role in ensuring nursing home quality. For example, states license nursing homes to operate, conduct the annual surveys of nursing homes, and are also a payer and overseer of quality through the Medicaid program. State laws and regulations regarding nursing home quality vary, but there may also be useful models and lessons learned from state experiences. Rhode Island passed omnibus nursing home legislation in 2005 that took several steps, including requiring nursing home applicants to set financial thresholds and providing the state with additional tools to detect and address potential deficiencies, such as the appointment of an independent quality monitor at the facility's expense.

Ideas for Consideration

This hearing and others can help Congress learn about some of the problems and challenges to providing quality of care in our country's nursing homes, and help identify possible ideas and solutions that Congress, the Centers for Medicare and Medicaid Services (CMS), and others might pursue to improve nursing home quality, accountability, transparency, and staffing. AARP suggests the following ideas for consideration:

- Ensure that Medicare provider enrollment documents capture complete information on all entities and individuals with a significant direct or indirect financial interest in a nursing facility or chain;

- Require nursing facilities and chains to update their enrollment data at least every three years regardless of whether or not there has been a change in ownership;

- Review and revise current Medicare provider agreements to take account of new corporate organizational structures to ensure accountability for compliance with all Medicare requirements;

- Accelerate implementation of the Provider Enrollment Chain and Ownership System (PECOS) to include all enrollment data for nursing homes and chains;

- Link PECOS provider enrollment data to nursing home survey results and other relevant data to allow for better analysis of trends in outcomes in nursing home quality;

- Require nursing homes to report quarterly in electronic form data on staffing by type of nursing staff (registered nurses, licensed practical nurse, and certified nurse aides), turnover and retention rates, and the ratio of direct care nursing staff to residents. Require CMS to disclose this improved staffing data on the Nursing Home Compare website for consumers;

- Revise Medicare cost reports for nursing facilities to require separate cost centers for nursing services, other direct care services, and indirect care services;

- Audit staffing and cost report data at least every three years and impose sanctions for failure to report or for filing false information;

- Use civil monetary penalties collected for nursing home quality violations under Medicare to directly address urgent needs of nursing home residents;

- Enact the Elder Justice Act (S. 1070/H.R. 1783) and the Patient Safety and Abuse Prevention Act (S. 1577/H.R. 3078); and

- Finally, effectively enforce existing nursing home quality standards and penalties for violating these standards, and provide adequate resources to enforce these standards.

Conclusion

AARP is pleased with the renewed attention and interest that Congress has shown in nursing home quality. We look forward to working with members of this committee and your colleagues on both sides of the aisle to further improve the quality of life and quality of care for our nation's nursing home residents.

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