

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

I am here to testify about the concerns of state survey agencies. AHFSA represents the leaders of the state survey agencies across the country. AHFSA was established in 1970 to provide a forum for state directors to share information, to work in an organized fashion with HCFA, provider organizations, other government agencies, and to promote the highest quality health care services within each state. The AHFSA mission statement, fact sheet and current board of directors are attached for your reference. State agencies monitor care through state licensing activities and as contractors with HCFA for federal survey and certification activities. Our responsibilities cover all categories of health care facilities licensed in our respective states as well as all categories certified for Medicare and Medicaid participation. Survey agencies play a pivotal role in monitoring and mandating quality. State surveys remain the best deterrent to poor care.

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

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

One example is the implementation of staggered nursing home survey schedules. HCFA issued final instructions on December 29, 1998, effective January 1, 1999. However, states were faced with numerous issues that had to be addressed to operationalize this policy directive. Conditions of employment, union contracts and funding for overtime and/or shift differential pay were considerations that almost 50% of our members have had to work through in order to stagger survey starting dates and times to include weekends and evenings. Implementation of this type of change can not be instantaneous. Also, when staggered surveys were first done, we found that the survey process required

modification in areas such as the tour of resident units at night or the ability to obtain resident roster information in order to select a sample of residents for assessment. Additionally, to truly have surveys that are less predictable, which is the intent of the staggered survey initiative, the statutory requirement of a statewide 12-month average survey cycle and the one-size-fits-all nature of the required standard survey process deserve another look.

We believe that states are virtually all compliant with the requirement that 10% of surveys begin on nights and weekends, with the revisit policy and with extra monitoring of two special focus facilities per state. A plan to deal with poor performing nursing home chains has not been fully developed to date. The states have not received instructions from HCFA about how to address this initiative, other than the original guidance memo of September 25, 1998, which was general in nature. Further work is needed to define what constitutes a nursing home chain among the various corporate structuring options and lease arrangements in the health care industry and to share chain information quickly across states.

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

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

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

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

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

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

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

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

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

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

The March directive from HCFA regarding complaint investigations is an area where states are not in compliance with HCFA's instructions. We are not aware of any states that were able to implement this directive if they were not already investigating all alleged actual harm complaints within ten days. To do so would require either directing staff away from other efforts and into investigating complaints, or bringing on additional trained staff. Since no state to our knowledge has been relieved of other HCFA requirements for conducting surveys, states that were non-compliant with this directive before it was issued will remain non-compliant until more trained staff are put on the front lines. Only after this directive was issued, did HCFA ask the states whether additional resources would be required. Not surprisingly, virtually every state gave a "Yes", answer to this inquiry. HCFA now has to find additional funds to implement this directive. Once funds are made available, it will be six months to one year before additional trained staff will be certified to conduct investigations. As a whole, the states are not even close to being able to comply with this requirement, and, until we know when additional funds will be available, we can't even predict how long it will take to become compliant. AHFSA has expressed these concerns directly to HCFA during face-to-face meetings and in the correspondence included as Attachment #6.

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

1. Planning

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

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

new opportunity to restrict the expansion of poor performing chains.

2. Improving Quality

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

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

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

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

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

Publication of nursing home performance information is another very effective tool to promote quality in a competitive field such as long term care. HCFA's publication of survey results on the Internet, the inclusion of comparison group percentages on the quality indicator reports, and state specific performance information available by Internet are examples of information systems to build upon to improve care as well as to inform consumers.

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

AHFSA as an organization has undertaken several initiatives to improve the quality of the survey process. The best practice component of the annual training conference is one. The Association Quality Assurance and Training Committee, in conjunction with HCFA, developed the Principles of Documentation that are now incorporated into the HCFA deficiency writing software nationwide.

AHFSA developed the quality review tool for the principles of documentation and the software addition. AHFSA has gone on to develop an Investigative Skills Course based on the Principles of Investigation to improve surveyor performance.

3. Resources

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

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

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

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

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

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

Again, we need to look long range at options for better utilizing survey resources, such as more

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

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

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

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

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