

**Testimony Prepared By**  
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**June 30, 1999**

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

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

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

A critical element in HCFA's first set of changes to the survey process is the systematic use of the MDS Quality Indicators in that process. The MDS Quality Indicators were developed by researchers at the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison in the early and mid-1990's, as part of the Multi-State Nursing Home Case Mix and Quality Demonstration. The MDS QI's, as they are called, are based entirely on information in the Minimum Data Set (MDS), which is part of the Resident Assessment Instrument, an assessment process mandated for use with all nursing home residents in the United States. The NOS QI's were developed through an iterative process of data analysis and clinical input. Seven national clinical panels representing the primary disciplines involved in nursing home care provided clinical input throughout the development process. Researchers at CHSRA analyzed MDS data from several million MDS records covering six states in the course of the development process. The product of this effort was the formulation of 30 quality indicators covering 12 domains or dimensions of care. The 30 indicators were subjected to pilot testing to determine their feasibility for use in the quality assurance process. Validation studies were also conducted to determine the accuracy of the MDS items comprising the QI's, and the validity of the indicators in predicting quality of care problems. Accuracy rates were quite high, in the 70-90% range, and the indicators were found to substantially increase the likelihood of identifying a care problem when one existed in a facility. The MDS QI's were later reduced to 24, covering 11 domains of care, when a new version of the MDS and quarterly supplement was implemented.

The MDS QI's provide information on resident condition and processes of care at the individual resident level and they provide overall facility rates as well. The QI's provide information on a variety of aspects of resident status and care processes. They cover areas reflecting the physical functioning ability of residents; their cognitive and emotional status, for example whether they are suffering from depression and, if so, whether the resident receiving antidepressant therapy; whether the resident is on antipsychotic medication, whether they are physically restrained, whether they have skin care problems such as

pressure sores, whether they are incontinent, and if so whether they are receiving some form of toileting program, and many other aspects of resident status and processes of care. Some of the QI's are adjusted to take into account the fact that residents may be at higher or lower "risk" of having the condition reflected in the QI. Most of the QI's provide information on the number of residents who have the relevant condition at a particular point in time, but a few of them reflect a change in condition over time.

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

An important corollary to the development of the QI's has been the development of software to permit facilities and state survey agencies to create and run Quality Indicator reports instantaneously. Under the direction of project leader Richard Ross, systems researchers at the Center for Health Systems Research and Analysis have developed software that enables facility staff members to access both facility and individual Quality Indicator reports on their facility through a web site access mechanism. State survey agency staff can access reports on any facility in the state in the same manner. A pilot test of the software was conducted in the state of New Jersey this spring, and the software is currently being deployed in state survey agencies throughout the country. This software will become an integral part of both the state survey agency quality assurance process, and individual provider quality improvement initiatives.

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

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

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

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

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

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

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

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

We need to see substantial improvement in the following areas:

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

As a point of contrast, consider the Peer Review Organization program, with its millions and millions of dollars perennially reserved for quality improvement activities, and protected, at least to some extent, from the political process--all, I might add, with precious little oversight. Interestingly, it appears that PRO funding has had an impact on the way decisions are made even in the nursing home quality assurance area--and there are those of us who have come to view that impact as problematic. I have found that because the PRO funding is so "convenient" and easily accessible, in too many cases important decisions about program development activities and contractors-in nursing home quality assurance--are made on the basis of the availability and convenience of PRO funding mechanisms rather than on the basis of merit. Decisions about how quality assurance development money is spent, and who provides the services under contract, must be based on how to best get the job done, and not which pot of money happens to be available for that purpose.

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

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

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

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

5. Involvement--There must be more formal explicit involvement of all the relevant constituencies in the survey and quality assurance process. In particular, there needs to be greater formal involvement of three critical groups: (a) consumers, (b) the provider community, and (c) the state survey agencies that operate as HCFA's close partners. HCFA cannot operate in a vacuum as it seeks to maintain the proper direction of the quality assurance process, while having to respond to the constantly changing long term care and

political environment. Consumers, providers, and state agency partners have a responsibility (and I believe a desire) to participate and all three parties have much to contribute. It is time to bring them into the process, formally and explicitly.

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

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

(B) Find effective ways to truly work with consumers, providers, and regulatory professionals at both the state and federal level to institute programs that can provide (1) information and (2) appropriate incentives to identify care problems and fix them, and to engage in meaningful quality improvement as a first order commitment. There can be no retreat from the standards of care that we demand or the responsibility of providers to meet them--but we need to find a more effective way to make the improvements in a way that energizes and fortifies the commitment of those who must make it happen.

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

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