

STATEMENT OF DENNIS STONE M.D., MBA, CMD
Representing the California Association of Health Facilities

Mr. Chairman and members, I am Dr. Dennis Stone, speaking on behalf of the California Association of Health Facilities which is a non-profit, professional organization dedicated to improving health care. CAHF's membership is comprised of more than 1,500 licensed long term care facilities serving a wide spectrum of health needs in settings which include: skilled nursing, intermediate, subacute, mental health, rehabilitation and residential; along with providers of services for persons with developmental disabilities. Nearly 100,000 trained medical, professional and support service staff care for 200,000 Californians residing in these member facilities each year. CAHF is affiliated with the Quality Care Health Foundation, the Council of Long Term Care Nurses of California and the American Health Care Association.

I am an MD graduating from University of Oregon Medical School. In addition, I have served as a medical director in nursing homes and am certified by American Medical Directors Association. I have been the corporate medical director for Regency Health Services and Beverly Health and Rehabilitation, Inc. I am the vice president of American Medical Directors Association and have served as president of the California Association of Medical Directors. I have an MBA in Health Services Management and a certification in gerontology.

I will make some comments and then would be happy to respond to your questions. Although I have heard descriptions of the content and recommendations of the GAO's report, I am at a disadvantage not having had a copy of the final report to review, but my comments will address quality of care issues in California nursing homes.

Health care providers in nursing homes do not condone poor quality of care. I am shocked and dismayed that once again the issue of quality of care in California nursing homes is being addressed through innuendo, poor investigative and research processes and utilization of data from a survey and enforcement system that is misleading, unfair and inconsistently applied.

There is no question that care issues do occur, but the real question is, could unfortunate incidents have been avoided by the implementation of available care or, due to other factors, were allegations of poor care unavoidable outcomes. It appears, once again, the assumption has been made that all negative patient outcomes such as decubitus ulcers, malnutrition, incontinence and dehydration are caused by the lack of or inadequate implementation of care interventions and that nursing home providers of care are to blame.

This assumption ignores current scientific research which demonstrates that care of the aged is an extremely complex area further complicated by the "normal aging" process, the rights of the patient to end of life treatment at the end of life stage, and lack of established "gold standards" for care interventions and defined outcomes for such interventions. All of the care needs of the older adult patient can not be readily isolated because of the synergistic effect of the physiological, social, economic and psychological changes concomitant with aging. For example, we see survey deficiency statements which equate optimum caloric intake with guaranteed optimal nutrient intake and desired patient outcomes (e.g., lack of skin breakdown). It is not possible to attribute malnutrition or even weight loss to any single cause because they are due to a combination of factors. Yet the data, which shows that some nursing homes do not comply with Medicare/Medicaid nutrition and hydration requirements, are often predicated on a single causal relationship. The same holds true for other areas of care such as incontinence. Urge, overflow, stress and functional incontinence are lumped together and no differentiation is made as to whether or not appropriate interventions are feasible. For example, a demented patient, who is incapable of following instructions, is unable to implement certain care

modalities. It is not a simplistic cause and effect relationship as the "enforcement" data bases would lead the less informed to believe.

Geriatric medicine and care of the geriatric patient is still in its infancy and far from the exact science that health care in younger adult patients is reaching. Geriatric patients are less like each other and much more individualism of care is needed. It is one of the great challenges for people who practice in this area. Just as the mislabeling of normal aging as a disease may be the result of lack of knowledge of physiological changes brought about by aging, so too there is a great risk in sensationalizing health conditions of the aged patient as caused by lack of and/or poor care interventions. There is no one simple "cookbook " approach to treat patients who, at 65+, have the identified effects of aging i.e., (decreased bone density, decreased fat and muscle mass); multiple chronic diseases for which medications are being given; and impaired mental and physical capabilities. For example, fifty percent of patients in California nursing homes have dementia and/or mental illness and forty to fifty percent need some assistance with activities of daily living. Many have exercised their rights to forgo end of life treatment interventions. Forty-six percent of the patients in California nursing homes have executed an advance directive.

There is no question that malnutrition in the aged is a tremendous problem. Studies have estimated occurrences of malnutrition in fifty percent of the population in hospitals and forty percent of nursing home patients. Other studies have shown that fifty-four percent of patients admitted to nursing homes are malnourished. Most nursing home admissions-come from acute hospitals.

Does the malnutrition occur because the patient has refused nutrition? What about the patient's other pathology such as depression and/or normal aging occurrences such as decline in ability to taste and decrease in sense of smell which has lessened the drive to obtain nutrition? Have the patients disease processes decreased or obliterated his or her ability to digest, assimilate and utilize nutrients? Or, is it because patient food preferences, eating abilities and pathology, that is responsive to treatment, is not being addressed through the provision of care? The survey data from California would have lead you to believe that it is a question of poor quality of care. We do not believe that this is a fair measurement of quality of care. Quality of care issues need to be fairly identified and appropriately addressed. I have attached a recent journal article to this testimony which addresses some of these issues.

Funding

Patient acuity levels continue to rise in our state, but the reimbursement for care has essentially remained stagnant. California's average Medicaid reimbursement ranks 34th among the states, far below the U.S. average. Efforts to continue to improve care at reasonable costs have been difficult when sixty-five percent of nursing home patient's care is paid for through the Medicaid program. Congressional actions last year to eliminate the Boren Amendment only makes this problem worse. Quality care is not free -- it requires reasonable funding levels.

The concept of "Best Practices", long ago implemented by California providers, and quality improvement need much more attention than is currently being paid to them. effectiveness of these programs needs to be measured. Currently, patient outcome data measurement is predicated on negatives- incontinence, decubitus ulcer, malnutrition and dehydration. We need to focus on positive measurements, lack of incontinence, skin integrity, maintenance of reasonable body weights and hydration levels. We need to ask what the care interventions are that work.

The Association has always been supportive of research efforts. Many of its members have participated in much needed research done through the University of California system, the Andrus Center and the

Rand Corporation to name a few. In addition, the Association has advocated for a survey alternative model based on quality improvement and measurement of positive outcomes. We would like to see this model implemented on a pilot basis. Unfortunately, the current leadership at HCFA is not willing to even consider this innovative approach.

Regulatory Revision

Adding to the difficulty of defining innovative approaches to care has been the regulatory system which at times restrains the implementation of solutions for care issues. For example, today, a dietary aide can not feed a patient in a nursing home unless the aide has been through the CNA certification program due to HCFA's interpretation of regulatory requirements. In California, our CNA training programs have double the nationally required number of hours (150 hours). A more cost effective solution would be to have specialized training programs i.e., put a dietary aide through a special nutrition and feeding program. In an era where cross-training and the team concept have been ingrained in the educational and business world, health care providers are prohibited from utilizing available staff to their maximum level. The interdisciplinary team concept contained in the OBRA regulations is limited. Additional state licensure requirements which, for example, state that all three meals must be given within 14 hours add to this burden. This is hardly a requirement that recognizes the individuality of the patient. Health care regulations and policy need to be revised to allow for innovative approaches to care.

Data

The limitations of information tools used to collect data must be recognized. The survey and certification system, based solely on the individual surveyor judgment, has been shown in studies to have serious flaws. The study done by Abt Associates to evaluate the survey process found that, in California, fifty percent of the surveys did not address patient outcomes in the deficiency statement showing noncompliance with regulatory requirements.

The Minimum Data Set (MDS) tool which is now being used to collect patient specific information has flaws. Valuable information is missing from this tool and has made it necessary for providers to develop other patient assessment tools to collect information necessary to the care of the patient. Yet this is the data collection tool which will drive reimbursement, focused enforcement and research. We must remember that it collects **minimum** data. Data, such as this, which contains indicators such as pressure sores, incontinence and dehydration should only be used as indicative of a possible care issue and not as a measurement of the quality of care. The misuse of data to define quality of care is ethically and morally wrong and, in cases such as this, is a grave injustice to the committed personnel who care for the nation's aged in nursing homes.

I thank you for your time and would be happy to answer any questions.