

Comments of Paul R. Willging, Ph.D.

Good Afternoon Chairman Grassley, Senator Breaux, and Members of the Committee. My name is Dr. Paul Willging, and I am the Executive Vice President of the American Health Care Association. AHCA is the federation of 50 affiliated state associations which represent over 11,000 non-profit and for-profit nursing facilities, assisted living, and subacute care providers nationwide.

I appreciate the invitation to appear here today to address the serious concerns outlined by the General Accounting Office (GAO), and engage you in what I hope will be a dialogue aimed at finding solutions to these complex and troubling problems. Hopefully, the title of this hearing will not be indicative of a "gotcha" type attitude where sound-bites and anecdotes prevail at the expense of solutions and commitment of resources.

While we appreciate the opportunity to review a draft of the GAO report nearly two weeks ago, our comments today are based upon our recollection of that draft since all notes taken were confiscated by GAO before we left the room. While we have serious concerns about the methodology of the report and the superficial understanding of the process on the part of its authors (which I will address later), we agree with each of the four recommendations made by GAO. In fact we believe some of them do not go far enough toward improving caregiving and the process of measuring nursing home quality of care.

Let me state at the outset that we take very seriously the responsibility for care entrusted to us by our residents. The American Health Care Association was founded in 1949 to promote professional standards in the delivery of high quality care, in short: we do not tolerate neglect in our facilities. The examples of poor care, neglect, and horrible stories we heard yesterday are abhorrent and intolerable. We firmly believe that providers who allow this type of mistreatment to occur should be closed down. It is critical to note, however that they are by no means the norm, nor are they even prevalent in nursing facilities in California or the nation. We are not before you today to assign blame or point the finger at other responsible parties. Nor are we here to trade horrific anecdotes which don't suggest solutions or seek to understand the complexities involved in caring for the very old population. We are here to promote a dialogue that is long overdue concerning the care of our nation's frail elderly and the resources public policy is willing to dedicate toward solving this problem.

Insight into caregiving

In so many ways, nutrition, hydration and diet are central to the well being and quality of life of our residents. They are the very basic among the hierarchy of needs which our caregivers have pledged to provide. But don't be fooled, it is very easy to think of the basic human needs of eating and drinking and falsely assume that this is a simple problem with easy solutions.

The issues surrounding nutrition and hydration are highly complex, and inter-related with most other aspects of geriatric medical conditions and long term care provision. It is critical that you as policy makers understand this point.

There is no doubt in my mind that we could address this issue head-on and reduce malnutrition dramatically and prolong life significantly. As you are aware, we previously identified the high use of physical and chemical restraints in nursing facilities as a problem. Since then, we have made tremendous strides in reducing use of restraints in nursing facilities. The chart in figure I (attached) shows the decrease we have been able to accomplish.

Mr, Chairman, the same could be done with regard to nutrition and hydration if we work together to

address the issues intelligently and responsibly, and dedicate sufficient resources to their resolution.

It is important to know that nutrition and hydration are not nursing facility problems, they are aging problems regardless of where one ages. They need to be addressed across disciplines between the director of nursing, dietitian, physical therapist, occupational therapist, social worker and especially among family members. Noted geriatrician, and long term care nutritionist, John E. Morley stated in the May issue of the *Annals of Long Term Care*, that in the United States, it is estimated that 40% of nursing facility residents are malnourished, 44% of home health patients are malnourished, and 50% of hospital patients are malnourished. The case in nursing facilities is complicated by the trend toward higher acuity rates at admission. Most nursing facility admissions come from some other setting be it home care, assisted living, or the hospital. A recent study observed a malnutrition rate of 54% among patients newly admitted to long term care facilities, and some studies have shown a rate as high as 85%. Regardless of the fact that they come to our facilities malnourished, it is crucial to their well-being that we identify and correct these problems as quickly and continually as possible.

To the layperson, it f s often difficult to understand why eating and drinking adequately such a significant problem. Allow me to briefly list the problems that contribute to poor nutrition and hydration and the impact they have on resident well-being and quality of life.

It is widely accepted that one's body weight decreases in old age. However, malnutrition is not a normal response to the aging process. To understand the complexity of risk assessment, early detection and prevention in long term care settings one must look more closely at the many possible causes. Among the problems which contribute to weight loss among the elderly are: the universal loss of taste and smell as one ages, dysphagia (trouble swallowing) which occurs in 40-60% of residents, dementia (43% of residents), difficulty chewing, depression, medication effects, cognitive impairment, constipation, lack of mobility, chronic disease, social situations, and the natural decline in the neurotransmitters which regulate hunger, thirst, satiation and food intake. In other words, eating and drinking adequate and balanced amounts is less natural for the frail elderly. Caregivers must spend a significant amount of time ensuring that these individuals eat and drink properly.

The effects of dehydration and malnutrition are many. These conditions cause weight loss and can ultimately lead to skin breakdown, cognitive impairment, reduced infection control, incontinence, urinary tract infection and vulnerability to other illness. In addition to quality of life reasons, nursing facilities and all caregivers should have a plan to ensure proper nutrition and hydration. Providing those services are more demanding than they may first appear, and the consequences of poor nutrition and hydration can have extremely serious impacts on the individual, the facility and the long term care system.

Weight loss is the first manifestation of hydration and nutrition deficiencies, and as such, is an important factor in early detection and intervention of those problems. For this reason, weight loss is an accepted quality indicator (QI) by the Health Care Financing Administration (HCFA). These quality indicators have been developed to point to possible problems in care delivery in an outcome measurement system. Any quality expert will tell you though, it is not an outcome in and of itself, it is a symptom. Both caregivers and inspectors need to be absolutely certain that they look at any quality indicator in the context of total resident condition and care delivery circumstances. For example, pressure ulcers are also a quality indicator, and California has a nearly 9% incidence of pressure ulcers. This may seem like a high amount, but upon investigation one will see that 66% of those resident had pressure ulcers upon admission. This means that the indicator may not necessarily indicate actual bad care, but only point to the possibility of a problem. The error of mistaking a symptom for a cause is among the most prevalent mistakes contained in the draft GAO report.

GAO Report

Mr. Chairman, I commend you for allowing us to move beyond superficial charges and to have a substantive dialogue on this critical issue. We welcome a more thorough investigation in response to the terrible allegations made in Time Magazine's reporting on California's nursing facilities. Allow me to spend a few minutes on the circumstances which prompted your call for this report, and analysis and comment on the GAO report itself

Last October, the magazine ran a sensationalized story with the headline "Fatal Neglect", which chronicled several residents who received poor care in nursing facilities. The story was prompted by a trial attorney who studied all nursing home death certificates in a six-year period which listed malnutrition, dehydration, urinary tract infection, bowel obstruction, or pressure ulcers. After his review he then alleged that 3,113 deaths in nursing facilities were the result of neglect.

Mr. Chairman, this type of reporting follows a trend which is all too common and disturbing. They identify a few cases where people receive poor care then paint the entire industry with a broad brush. Are there bad facilities where people receive poor care? Unfortunately the answer is yes. Are they the exception rather than the rule? The answer is again yes. The vast majority of nursing facilities provide high quality services and care for their residents. While providing proper nutrition and hydration are challenges, they have been and are the subject of intense debate throughout our industry and concerted efforts to continually improve upon their prevention and treatment.

The main question which you requested GAO to analyze and report to your committee was the merit, if any, of the charges made by this attorney. The GAO has not been able to ascertain any causal link between the conduct of nursing facilities and the death of these residents.

These allegations that 3,113 deaths in nursing facilities were the result of neglect, must not go unchallenged. In the words of former Labor Secretary Donovan, "where do we go to get our reputation back?" This cycle of sensational and well covered (if unsubstantiated) allegation followed by no attention to its repudiation is disturbing. The overwhelming preponderance of caregivers labor long and hard, under difficult conditions, for little reward other than to make the daily lives of our elderly residents a little better. It is wrong to blame them for deaths which occurred naturally.

The GAO was asked to review the extent of this problem and develop solid recommendations to reduce and eliminate it. Instead it failed to make substantial comment on the merits of these allegations, and produced a report heavy on anecdote and light on solution. The GAO targeted the worst performing facilities; those with 5 or more avoidable deaths per 100 residents, with malnutrition, dehydration, or pressure ulcers indicated on their death certificates. You should be aware that while these are common items to be found upon the death certificate of any elderly or chronically ill person, they are seldom the actual cause. Nevertheless, the GAO targeted the worst of these facilities. Out of a universe of over 1350 facilities, GAO investigated the records of only 15 of the poorest performing facilities (or about one-tenth of one percent). In those 15 facilities' records, the GAO looked at the records of only 62 of the most difficult cases out of an estimated 1,600 residents during 1993 and found that in the cases of 34 of those residents, care was "unacceptable" and which "may have endangered their health or safety." If out of alleged 3,113 cases of negligent death, the GAO found among the worst performers, 34 cases which MAY HAVE endangered resident safety and health, that is equal to nearly one-one hundredth of one percent.

There are many other concerns with the GAO report. The report was not carried out with any regard to clinical procedure, or thorough investigation of causes of the symptoms found. The total number of

facilities visited by GAO was 3 out of 1,470 in the State of California. Is there anyone in this room who believes that this is a statistically significant sample, or in any way enables them to draw broad conclusion about nursing facility operations is CA, much less nationwide?

Additionally, the GAO report made many errors which belie a lack of understanding of the inter-relation of conditions and risk factors which lead to problems with nutrition, hydration, and diet. In many cases a quality indicator was mistaken for an outcome. In many other instances the draft confused regulations, misunderstood statute, and combined state and federal citations to come up with higher total numbers of citations.

Among the most egregious errors was the creation of entire new categories of citation with scary titles intended to titillate the press, only to hide the fact that the underlying violations may be quite minor. For example, one category of violation, made up by GAO for this study, entitled "Caused Death or Serious Harm", included paperwork violations for documents or check marks missing from a file. In another example the deficiencies in a category they called "Serious Harm or Potentially Life Threatening," were attribute to 30% of all facilities.

That sounds bad, but the fact is that HCFA has spent a decade developing a matrix measuring both scope and severity of a violation. The HCFA category of Substandard Quality of Care has been in use for years and is much less subjective. According to this more objective and accepted standard, only 6% of facilities in California were cited as giving Substandard Quality of Care. Unfortunately for GAO 6% substandard does not get good headlines. It means that 94% of facilities in CA do not give substandard quality of care. GAO needed to regroup citations into newly made up categories to come to a number that looked like a bigger problem. As you can see from the report, 30% of facilities had citations which fell into their invented category "Serious Harm or Potentially Life Threatening". This group included citations for environmental hazard, which could include a broom leaning against a wall. While a potential safety hazard it is unlikely the misplaced broom would ever be life threatening. In this instance, this type error made up a category containing 259 out of 407 cases that caused "Serious Harm or Potentially Life Threatening". But by including more minor violations the category grew from the 6% substandard to 30%. This is typical of the oversimplification and broad brush tarring that this GAO report is built from.

In short, this report, which has many clinical flaws, intentionally selected poor performing nursing facilities, and upon reviewing records of several years, found - - you guessed it - - poor care. While targeting 15 of the poorest performing facilities out of 1,400 may get you sensational press attention, it is both unprofessional and irresponsible to present this sample to the Senate Special Committee on Aging as a representative sample of care being given in California.

We at the American Health Care Association are dedicated to working towards a system which does not tolerate neglect or abuse, and which improves continually over time. This report and the hearing have not been structured in a way that is conducive to finding solutions, and until we decide to have a substantive debate free from rhetoric, we will not solve this problem where it does exist. The following are serious and thoroughly considered recommendations which will go a long way toward empowering caregivers, protecting residents, and improving our ability to give the highest quality care in our facilities.

Comment on GAO Recommendations

First let me state unequivocally, that despite our disagreement with the methods and tone of the GAO report, we support each of its conclusions. The only difference is - - we do not feel they go far enough to

enhance and improve quality of care or foster quality improvement.

In addition to the four recommended changes to the regulatory process made by the GAO, the AHCA feels strongly that real change and quality improvement can only be made through internal facility processes. These changes are all designed to empower the care giver with the information and skills to define, measure, communicate, and improve quality of care at the facility level.

The major thrust of each of the GAO recommendations is to improve the current survey and certification process at the state and federal levels. We concur that the current system is ineffective and inefficient. In fact, HCFA has said of the same process for hospitals:

"The current system of process-oriented requirements with an enforcement approach that focuses on providers that do not have the required structures and procedures in place, no longer represents the best available method of assessing hospital quality of care." (Fed. Reg. Vol. 22, No. 1 12/19/97 pp. 66726-66763)

I would agree, and ask why then would this be the best method for assessing and improving nursing facility quality of care? In fact, HCFA went farther to comment on the process-based approach of today's survey bureaucracy which admittedly does not measure quality of care using outcomes but largely process by looking for requirement compliance.

"There are no data supporting the link between structure and process requirements, and positive patient outcomes" (Fed. Reg. Vol. 22, No. 1 12/19/97, pp. 66726-66763)

This is something the provider community has known for a long time, and we are glad to see HCFA acknowledging it. Unfortunately, hearings like this have become an annual event where we trot out horror stories, beat up on the caregivers, the media has a field day, and we end up proposing a "solution" which is only tinkering with a system that is fundamentally flawed without committing any additional resources to addressing the problems. When things do not improve, we are shocked! Albert Einstein defined insanity as doing the same thing again and again, and expecting a different result. Why then would we expect a different result from the GAO's recommendations? They propose minor changes in a regulatory scheme which has been fraught with failure.

The key to the GAO report's problem is given away by the first sentence of the conclusion to the report, which in the draft I saw said "The responsibility of protecting and caring for nursing home residents rests with the state and federal governments." This is not only dead wrong, but is the key to the flawed paradigm. The simple fact is that the responsibility for protecting and caring for nursing facility residents rests firmly on the shoulders of the care providers in that nursing facility! The question is whether we want to help, encourage, and empower them to do a better job, or do we want to set up additional requirements which will take from their time and resources to make government feel better about watching them do their job.

Therefore, the first recommendation of the GAO - - to make the survey less predictable -is something we agree with. Regardless of whether surveys are predictable, quality care should be continuous. It does not depend on when a regulator might make a visit. While we support this recommendation, it falls far short of the type of solution we should be striving for. Quality should not be monitored on a four day snapshot every 15 months. It should be scientifically measured every month and plotted continuously over time using benchmarks that enable providers to know where they may have problems and need improvement.

The second recommendation, again from my memory of the draft, was to redo the sampling process to

allow surveyors to focus on care needs. Again, we feel this should go farther. With the new MDS, state and federal surveyors will be able to sit at their desks and see which facilities have problems with pressure ulcers, and send a team of dietitians and wound specialists to those facilities before a problem causes harm. Electronic measurement will create a host of opportunities to target surveys and spend scarce resources where it is needed most.

The third recommendation was to do away with the grace period for corrective action for repeated problem offenders. We agree. The "yo-yo" facilities which can not stay in compliance need to revisit their approach to care planning. This should help that effort.

Lastly, GAO recommended that HCFA and states re-implement a mandatory on-site revisit for findings of actual harm, Substandard Quality of Care, and complaint surveys. This could be helpful in protecting the residents, and we feel might only be abused to the extent that the complaint system has been.

It must be noted that NONE OF THE GAO's RECOMMENDATIONS DO ANYTHING TO DIRECTLY IMPROVE CARE! We could have the greatest and most expensive regulatory bureaucracy in the world and still not improve quality of care in nursing facilities. The following are steps that, if implemented, would actually improve care and resident satisfaction in our nation's nursing facilities.

AHCA Recommendations

1. Implement a system of continuous measurement of resident outcomes.

AHCA's recommends the use of data-driven outcomes measures based upon clinical quality indicators to assess quality in every facility continually over time. This is not some "Star Wars" scenario which might become available in the future this system is being used in over 1,000 facilities today. While GAO makes reference to these QIs and the values of the electronically-transmitted Minimum Data Set (MDS) as a regulatory tool, we believe the far greater value of this MDS information is in providing caregivers with independent assessment of their performance, and showing them the areas where they need to improve before problems become severe enough to cause resident harm. Let there be no mistake, **QUALITY CAN ONLY BE IMPROVED INTERNALLY.** Quality cannot be ensured through compliance with external regulatory guidelines. The long term care industry, as the entity charged with providing care, must deliver quality based on a thoroughly developed, highly researched model. This is the key to continuous quality improvement in nursing facilities. Supplement this clinical information with resident and family satisfaction scores, and you have a model quality improvement program which puts the health and happiness of the resident first, and empowers the staff to measure, communicate, and improve quality in our nation's nursing homes. Equally important is the fact that those facilities which provide poor care and do not improve will be highlighted by the system and will be subject to the full weight of the regulatory process until they improve care or are precluded from providing care.

2. Take responsibility for adequate payment rates

If we are serious about addressing this issue, the Federal Government should exert some control over the adequacy of payment rates set by the states. I will mercifully not ask for a show of hands among committee members who voted to repeal the Boren Amendment to get a few dollars in last year's BBA. If today we all agree the nursing home standards are so important, why did the Senate vote that states do not have to pay for them less than one year ago? In California, where per capita income is high, and the cost of living is high, the Medicaid rate paid to care for a resident is only \$83.04 per day. There are only 13 states in the country that pay a lower Medicaid rate than California.

For that \$83 dollars and 4 cents, a facility must feed, bathe, help toilet, give room and board, around the clock medical care, nutritional supplements, wound care, and all the support staff for over 66% over residents. You can not deny the link between payment and quality. However that is exactly what many in this body have done.

The federal government allows states to pay less than the cost of a night in a hotel room to providers expecting them to provide round the clock lifecare for our mothers and fathers and grandparents.

3. Enact and fund a national criminal background check system.

AHCA has worked extensively with Senators Kohl and Reid of Nevada on this committee to put in place a nationwide system which would catch these criminals before they can harm another vulnerable, elderly resident. Currently there is no system to prevent abusive and dangerous staff from moving across state borders and working in facilities after they have been convicted of abusive or criminally negligent acts. This is an oversight which must be addressed.

4. Focus additional staff on feeding

Mr. Chairman, you have been a leader in striving for improvement in this area. You have worked with the industry to allow additional employees and part-time workers to help out at mealtimes, even if it is just sitting with an Alzheimer's resident and prompting them to eat. Family members and volunteers are allowed to come into facilities and feed family members, but in most communities, at most meals they don't. The problem is that current regulations prohibit the activities director or administrative staff from taking part in assuring that residents can get the extra help they need at mealtimes. HCFA says that any one who helps feed residents must go through a 75 hour course and certification and become a certified nurse aide. This policy needs to be revisited.

We would further like to take this opportunity to initiate work with HCFA toward developing improvements and updates in nurse aide training courses to focus on special needs residents beyond just providing rudimentary assistance with the activities of daily living. Additionally, a feeding only course should be offered for part time feeders and administrative staff who can help out a busy mealtimes. We also encourage facilities to form interdisciplinary nutrition management teams and to use advance directives when establishing a nutrition risk protocols. These are among the steps which can be taken to directly improve care at the hands-on caregiver level.

Conclusion

Once again, I thank you for the opportunity to appear before you today. The members of the American Health Care Association feel strongly about the allegations that have been made and the report which focuses of poor performing facilities. These providers have dedicated their lives to the most difficult of job of caring for the chronically ill and frail elderly day and night. The broad brush with which this report paints them is neither accurate or constructive.

What this report tells us is that there is a small minority of nursing facilities that are providing poor care. Thank you GAO. Now let's move beyond the anecdotal. Lets do a real study that examines why we have some poor quality facilities. Lets do a report that alerts providers, caring providers, to the dangers and warning signs of these conditions and measures can be taken to prevent them. Lets have the regulators and the industry work together to solve this problem with the same spirit of cooperation we exhibited on the restraint issue.

When this hearing is over, and the media stories have all been filed it will be once again only the providers who wake up each morning and face the hard challenges of maintaining weight, nutrition, hydration, skin integrity, and overall quality of life for our parents and grandparents. We should be helping them. We should be giving them the tools they need to evaluate their care, and to learn about new and effective interventions in these areas.

As I have said before, none of the GAO recommendations accomplishes any of that. The recommendations are all focused on governmental inspections and interventions. The mistaken assumption that it is the responsibility of government to care for the elderly has led us to a system where tremendous resources are spent on and by governments. Government can not provide long term care, government can only govern. At the risk of repetition, I will state again: quality of care can only be improved internally. When you learn this lesson, only then can we craft intelligent solutions to the problems before us.

These recommendations will go a long way toward improving the ability of caregivers to measure, communicate and improve the quality of care they provide in their facilities. I look forward to working with you and other members of this committee to take these steps toward clinical outcome measurement, adequate funding of programs, and empowerment of the providers of care to improve quality in their facilities.

Addendum to Statement of Paul Willging

Good afternoon, Chairman Grassley, Senator Breaux, and Members of the Committee. I am Dr. Paul Willging, executive vice president of the American Health Care Association. AHCA is a federation of 50 affiliated associations. We represent more than 11,000 nonprofit and for-profit nursing facilities, assisted living and sub-acute care providers nationwide.

Senator Grassley, on behalf of the women and men who provide care for our nation's elderly and disabled, let me commend you and the members of this Committee for your long-term commitment to this country's seniors and for being the catalyst that sparked this latest round of inquiry and proposals.

The past week, I have had the opportunity to read the draft GAO report and view the President's announcement of initiatives toward the nursing home industry.

First, I would like to say that the vast majority of our facilities do provide conscientious care. So let me begin by making it clear why I am here today:

- I am here today to speak on behalf of the overwhelming majority of nursing facilities that are meeting or exceeding government standards and that, in fact, are doing a good job.
- I am here on behalf of every administrator who double, triple and quadruple check to make sure that no patient has been neglected.
- I'm here on behalf of every doctor who answers the phone at 3 a.m. and rushes to our facilities to attend to a patient's needs.
- And I'm here on behalf of every nurse and nurse assistant who has learned to feed, clean and bathe elderly people with gentleness, dignity and compassion.

These are the kinds of people who make up our association and who make me proud to be a part of it.

These are the caregivers who welcome your involvement. They want to work with you to do even better. And what about the remaining few? While a small percentage, it still involves a large number of elderly people. About that small percentage, something must be done. It will be done. And we want to help you do it.

I recognize that this hearing is designed to focus on recommendations contained in the recent GAO report. While I am not sure the GAO report represents the best scientific methodology, the incidents of suffering GAO reveals are a concern to all Americans.

Let me tell you the AHCA's position:

- No matter how small the universe of bad actors may be, it can never be small enough.
- No matter how few elderly people suffer from neglect or poor treatment -- even if that number is only one -- one is too many.
- No matter how many of our facilities are doing a good job, our task will not be complete until every owner and caregiver accepts the responsibility to continuously improve nursing home quality -- or finds another line of work.

I am here to tell you that AHCA agrees with the principles outlined in the GAO report. We also take the same attitude with respect to President Clinton's recommendations on identifying and eliminating from this field abusive or dangerous people by creating a national criminal background check system. As many of you know, we not only agree with the thrust of these recommendations, we were the first to advocate them.

And let me say simply and directly that when it comes to the issue of abuse and neglect of the elderly, we support a zero tolerance policy.

We need to focus on making poor nursing home providers become good ones. And those facilities that will not comply should simply be shut down.

The GAO report focused on the very serious issue of malnutrition and dehydration in the elderly. We've long advocated the recommendation now before this committee to allow more categories of nursing home employees to participate in feeding our residents. Fighting dehydration and malnutrition among the elderly is a constant challenge, one in which we need to engage as many caregivers as possible.

Last week President Clinton said there is cause for concern "when people living in nursing homes have as much to fear from dehydration and malnutrition as they do from the diseases of old age." Let me say that if any resident is malnourished because he or she has been neglected, then that is a scandal, that is a tragedy -- and that should be a crime.

About this issue, however, let me add a note of caution.

Maintaining nutrition and hydration are challenging tasks for nursing home caregivers for one reason: there are disorders and illnesses common among the elderly that affect their willingness to eat or take in fluids. And this is true whether they are at home, in a nursing home or in a hospital.

The extent of this challenge is borne out in the May issue of *Annals of Long Term Care*. John E. Morley, a noted geriatrician and long-term care nutritionist, found that more than half of all patients

entering nursing homes were already suffering from malnutrition.

We believe that a collaborative effort is critical to improving care for the elderly -whether that improvement is related to nutrition, hydration and pressure ulcers or to other important caregiving issues. In the past several years AHCA has worked with others to develop nutrition guidelines that are designed to improve caregiving techniques. These guidelines have been helpful, not just for members of our association, but for anyone who cares for an elderly person, whether at home or in a hospital. We would welcome the involvement of government to make these guidelines available to caregivers throughout the country.

Mr. Chairman, we also know that together we can make great progress in the area of pressure ulcers. Although 66 percent of residents had pressure ulcers upon admission to California nursing homes, attentive care reduced the problem to 9% of nursing home residents. We are committed to reducing that number even further.

After all, it was the AHCA that helped identify the high use of physical and chemical restraints in nursing facilities, and we took action to dramatically reduce their use.

I know we can also take the lead among health care providers to improve care in the areas of nutrition, hydration and pressure ulcers.

There are other action-items before this committee that we support, and we want to help you fulfill.

Last year, AHCA -- together with the National Association of Attorneys General -recommended legislation that would create a national criminal background check system. While many states currently have state background check systems, they fall short of allowing a nursing home to ensure that prospective employees have no record -- in any state -- of abuse or other criminal activity. Therefore, we support the efforts of Sens. Herb Kohl and Harry Reid for moving this legislation forward.

We also support the creation of a National Abuse Registry, and AHCA will help make it work. There is no better way to enforce a zero tolerance policy than to enact a nationwide sanction on abusers

When it comes to the publication of survey results on the Internet, let me say that AHCA believes that we must provide as much useful information as possible to consumers so that they can make appropriate choices-- that meet their needs or those of their loved ones. For example, providers and regulators in Massachusetts very recently announced an initiative that will allow consumers to access a report card on the state's nursing homes through the Internet. This report card system is easy to understand and helps consumers in the very important process of facility selection. We believe an approach like this, one that provides consumers with a more informed choice, also improves the system.

In fact, when it comes to measuring and monitoring quality, AHCA has developed -- and has made available to our members -- a complete system designed to help providers improve quality. It's rooted in the belief that we must be able to understand which care practices result in clinical improvement and, importantly, customer satisfaction. We have created a software package that allows facilities to collect data on their patients and monitor quality continuously. Facilities can even compare their efforts to other facilities in the field. To put it simply, our system creates an early warning system for facilities to step up quality efforts to protect residents and improve care.

There is an old adage: what you measure you can manage. We don't need standards that measure minutia. We do need standards that effectively help a facility manage -- and improve -- quality care.

What I am arguing for here is refocusing what we measure when we evaluate the quality of nursing home care. At present, a nursing home in which someone has left a stack of canned vegetables on the kitchen floor, can be listed for a violation.

The danger in this kind of book-keeping standard is that it can make nursing homes that do a good job caring for residents appear to be bad. The second danger is that inspectors spend so much time on these minor infractions, they cannot focus on the poor providers, the ones who are failing to deliver good care.

We believe there is a better way to do this.

An inspection report should be designed to look at the results of clinical care. More than that, it should score the level of satisfaction from the only people who are truly qualified to make those determinations -- the residents and families themselves.

AHCA is committed to being on the front lines of quality improvement in long term care.

We are ready to be judged by the people we serve.

I can think of no better way to get to the essence of care. I can think of no better way to put the health and happiness of the residents first. And I know of no better way to let our caregivers measure and improve the quality of nursing homes.

The people we are caring for today are members of a truly extraordinary generation of Americans.

The generation that came of age during the Depression.

The generation that fought and won a World War.

The generation that made America prosperous, conducted a civil rights revolution, put a man on the moon and won the Cold War.

These are the people we serve today.

We want to work with you to do right by them.