MOVING TO A HIGHER LEVEL: HOW COLLABORATION AND COOPERATION CAN IMPROVE NURSING HOME QUALITY

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Subcommittee on Oversight and Investigations
"In the Hands of Strangers: Are Nursing Homes Safeguards Working?"

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Thank you, Mr. Chairman, for this invitation to testify today. I am Dr. Mary Jane Koren, a geriatrician by training, and I've been involved with nursing homes for over 25 years. I've taken care of nursing home residents, taught medical students and geriatric fellows in nursing homes, and done research on nursing home quality. In addition, I was the director of New York State's Bureau of Long-Term Care, which oversaw the survey and certification process for New York's over 600 nursing homes, pilot-tested a new federal survey process for HCFA [now the Centers for Medicare and Medicaid Services], and implemented the Nursing Home Reform Law, OBRA'87, in New York. More recently—only last year—I sat by my father's beside in a nursing home during his final months.

I have also been privileged to be a member of the National Commission for Quality Long-Term Care, chaired by former Senator Bob Kerrey and former House Speaker Newt Gingrich. Currently, I am an assistant vice president of The Commonwealth Fund, where I manage a program aimed at improving nursing home quality, and I have the honor of serving as this year's chair of the steering committee for Advancing Excellence, the Nursing Home Quality Campaign, which already has recruited over 43 percent of the country's nursing homes as participants.

I thank Chairman Stupak and Ranking Member Shimkus—and every member of the Committee —for conducting this hearing on nursing home quality, since recent events have brought to light significant issues with the nursing home oversight system and raised important questions about how better quality may be achieved. I would in no way dispute many of the concerns expressed here today, but I am here to tell you about some of the positive changes that have been occurring and that continue to spread across the industry, and to make several recommendations for actions that you, as members of Congress, could take.

As a former survey director, I would like to say that I believe a strong survey and enforcement process is vitally necessary. Beyond government's responsibility to be a prudent purchaser of services, it has the obligation to protect the safety and well-being of all members of "the community," holding providers responsible for meeting regulatory requirements. I would note that I was fortunate in New York, where the public health law

does not permit a business corporation to operate a nursing home unless its stock is owned by natural persons or by a limited liability company (LLC) whose membership interests are owned by natural persons—statutory requirements that made accountability easier to ascertain. Nevertheless, while recognizing that the regulatory process is a highly legitimate function, there is no doubt it could be improved. Smarter use of available data could make it more consistent and fairer to providers and use of input from residents could make it more responsive to unmet needs; in addition, it should provide additional, useful information for the public.

However, while the regulatory process is an important mechanism to uphold a minimum standard of performance, it has not proven itself to be the most effective method for lifting performance over and above that minimum threshold of nursing home of quality. That being said, the nursing home component of the Quality Improvement Organization (QIO) program, in conjunction with two voluntary initiatives, one longstanding and the other relatively new, are moving nursing homes to a higher level of performance. I would like to briefly describe these very promising developments in the field of nursing home quality.

The first is what's known as "culture change," a grass roots movement that has since come together as the Pioneer Network, which began about 15 years ago when a number of providers used OBRA'87's previously untapped potential for person-centered, or resident-centered, care to turn nursing homes into homes. Picture a nursing home where you can stay up to watch the end of the ball game, get yourself a midnight snack, and be assisted to bed by an aide who's gotten to know all your little quirks and enjoys listening to your stories. This is light years away from the usual way of doing business, but it's an approach to service delivery that is as applicable for someone staying in a nursing home for five days as for someone staying for five hundred days.

This type of transformation is not just wishful thinking, as is shown in the findings from a recent Commonwealth Fund-supported national survey of nursing homes, which paint a hopeful, if still somewhat mixed, picture: At least one-third of the field say they are actually doing something to try to make themselves resident-centered. For example, they are giving residents more choice in determining their daily routine and empowering frontline workers. Another 25 percent, although they have not yet started on the journey to making changes, have leaders within the facility committed to the principles of resident-centered care. Interestingly, staff resistance to change is seen as one of the major barriers to adoption. Likewise, the survey found that adopters are beginning to see a positive impact on their bottom line. (The full report can be accessed at www.commonwealthfund.org.)

The visibility of the culture change movement was increased when the QIO program's 8th Scope of Work borrowed from the movement's focus on deep system change for its contract tasks. Some of these, such as decreasing the very high levels of turnover so endemic in the industry and increasing the consistent assignment of nurses' aides to a given resident, are fundamental steps for improving quality. At the same time, CMS's office of survey and certification has been extremely forward-thinking. It has developed tools for providers and others, such as its "Artifacts of Culture Change," and sponsored webcasts for surveyors about resident-centered care in order to ensure that the survey process itself is not a barrier to innovation.

The other positive development is the Nursing Home Quality Campaign, Advancing Excellence. As I mentioned, I have the honor to chair the campaign's national steering committee, which is made up of a coalition of over 30 organizations, including provider associations, health care professionals, unions, consumer advocates, and representatives from CMS. The members of the steering committee have now been collaborating on the campaign's activities for two years, something which represents one of the campaign's most noteworthy successes, since it has brought us together to focus on attacking the problem of how to improve care in nursing homes—not, as in the past, on attacking each other. I should also note that this campaign is a true public–private partnership, since it would not be where it is today without the help and support it has received from CMS. While the campaign builds off of Quality First and CMS's Nursing Home Quality Initiative, it has several unique features, not the least of which is that:

- It is open to all nursing homes, even those not belonging to an association or not working with a QIO. So far, almost 7,000 nursing homes have joined the campaign, with Arkansas enjoying the distinction of being the first state to enroll 100 percent of its nursing homes.

- Nursing homes not only must agree to work on three of eight target areas,[1] which were chosen to reflect the QIO program's contract tasks, but they have to measure and report back on their progress.

- Forty-nine state-level coalitions, called Local Area Networks for Excellence (LANE), have been started; 38 of them are convened by a QIO. They are already showing promise as an efficient way to share good ideas and provide technical assistance to nursing homes across the country.

[1] The target areas are: 1) reducing pressure ulcers; 2) reducing use of physical restraints; 3) improving pain management for long-term residents; 4) improving pain management for short-stay residents; 5) establishing individual targets for quality improvement; 6) assessing resident/family satisfaction with care; 7) improving staff retention; and 8) improving staff assignment so residents receive care from the same caregivers.

We believe that this is a campaign on behalf of nursing home residents, not only on behalf of nursing homes. Therefore, consumers are being actively recruited in order that we may hear directly what it is residents want. Already, over 1,500 consumers have joined the campaign, and many attended last year's LANE conference in Fort Worth, Texas. Likewise, frontline staff are being encouraged to join, and educational materials prepared, specifically to engage them in utilizing evidence-based practices—because we realize that in the "high touch" setting of a nursing home, quality ultimately rests in their hands.

We have been tracking the data now for the first four quarters of the campaign. Results so far are very encouraging: participant homes are improving at a faster rate for the clinical goals than homes that haven't signed onto the campaign. I have included a set of charts with my testimony to show where progress is being made.

In addition to these two examples of change from within industry, the National Commission for Quality Long Term Care, co-chaired by Former Senator Bob Kerrey and Former Speaker Newt Gingrich, laid out a series of recommendations in its final report (issued in December 2007) for improving long-term care that merit consideration. Although today's hearing is focused on nursing homes, it is well not to lose sight of the big picture, since consumers use multiple long-term care services and move between many settings. Therefore, the Commission's recommendations, while organized under the headings of quality, workforce, technology, and financing, are applicable across services and inextricably interconnected.

The Commission echoed much of what has been learned through the culture change movement in that it urged that as we consider how to evaluate and monitor quality, there is a need to transform the culture of long-term care to become *person-centered*, not provider-centered, and to broaden the focus beyond just quality of care to the equally important area of quality of life. Surveyors rarely ask residents some of the essential questions in this regard, such as 'Do you feel safe, well cared for, valued as a person, and comfortable here—that is, do you feel *at home*?' and 'Are you encouraged to make decisions about your care and do people listen to what you say?'

Already, CMS is taking steps on multiple fronts to ensure that the consumers' voices are heard not just during the survey but during the assessment process as well, since the new MDS-3 will ask providers to gather more information directly from residents, not from third parties. Likewise, state survey agencies are testing ways to gather better information about quality of life and share it with facilities. An example is the Rhode Island Department of Health's "Individualized Care Pilot" (supported under a grant from The Commonwealth Fund), which has generally been positively received by

nursing homes in that state, since it links quality-of-life problems identified by surveyors with technical assistance from the state's QIO. This is a model of collaboration that bears further examination, because it removes the surveyors from the role of consultant yet offers assistance to providers anxious to address problems.

I would conclude my remarks by observing that there is no silver bullet that will make all nursing homes good places to live and to work. There are however, a number of specific steps Congress could take that would support current voluntary efforts, while at the same time improving transparency and the regulatory process. They are:

1. That the CMS website, Nursing Home Compare, include information on
   - multiple staffing characteristics, such as turnover rates for all levels of nursing and administrative staff and use of agency staff, as well as the rate of consistent assignment of nurses' aides calculated using a standardized formula; and
   - whether or not a home is participating in the Nursing Home Quality Campaign.

2. That CMS be charged with developing payment methods that would reward nursing homes participating in the campaign and/or achieving results on adopting resident-centered care practices, incorporating those payment methods into Medicare, and working with states to incorporate them into Medicaid.

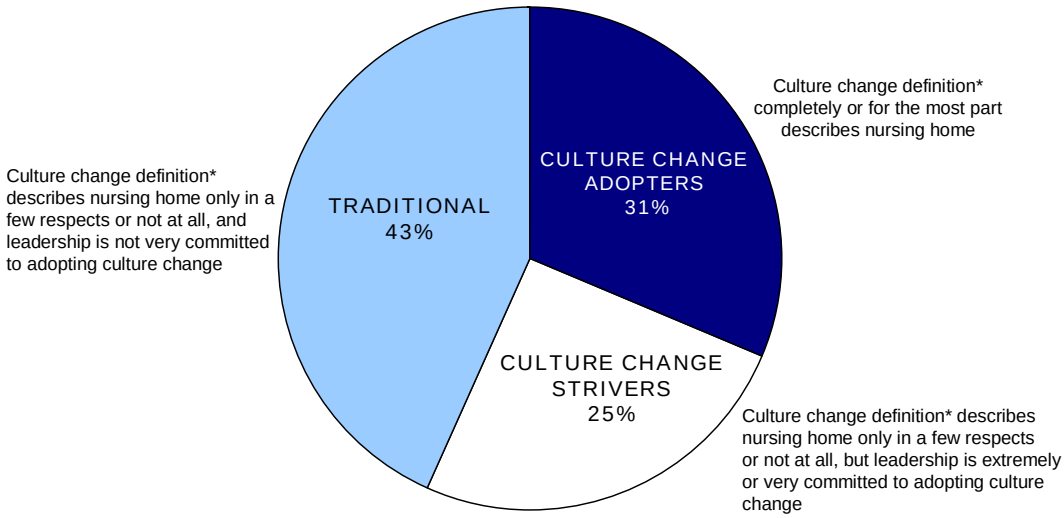
3. That the QIO program
   - be designated as the appropriate locus for technical assistance to providers, rather than the survey agency, and that CMS fund and conduct a demonstration project that tests a collaborative role for the QIO with state survey agencies, as is being tried in Rhode Island;
   - continue, through future scopes of work, current funding support for the campaign, which is critically important to the continuance of this successful model for systemwide improvement; and
   - direct the QIOs to play an active role in campaign activities, including working with the Nursing Home Quality Campaign on both clinical and systems measures needed to promote resident-centered care.

4. That CMS be directed to vigorously pursue its work on using resident input to improve the assessment, care planning, and survey processes.

I thank you for your attention and for providing me with the opportunity to address the Committee.

Figure 1. Nursing Home Adoption of Culture Change, 2007

Distribution of Combined Measures of Facility Engagement in and Leadership Commitment to Culture Change or a Resident-Centered Approach*

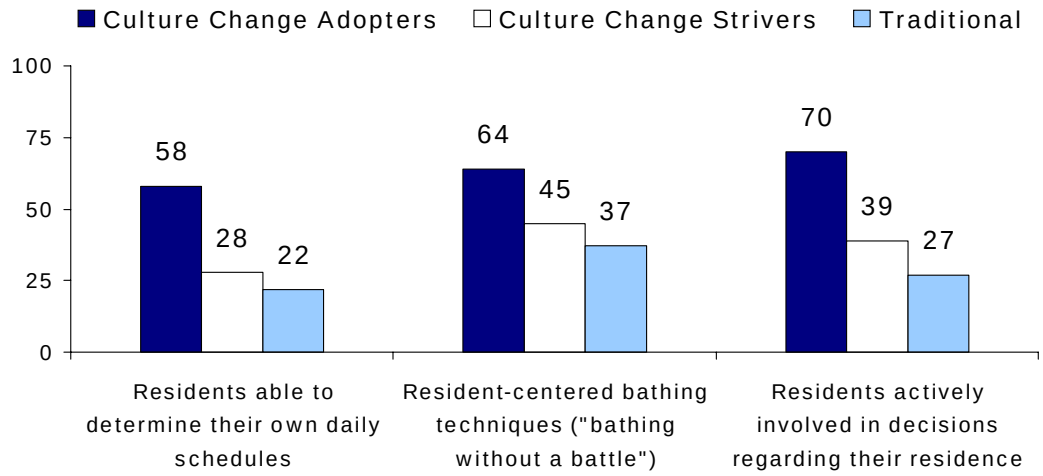


*Culture change or a resident-centered approach means an organization that has home and work environments in which: care and all resident-related activities are decided by the resident; living environment is designed to be a home rather than institution; close relationships exist between residents, family members, staff, and community; work is organized to support and allow all staff to respond to residents' needs and desires; management allows collaborative and group decision making; and processes/measures are used for continuous quality improvement.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 2. Residents' Ability to Determine Their Own Daily Schedules and Make Decisions Varies Widely Between Culture Change Adopters and Traditional Nursing Homes

Percent of facilities indicating they are currently implementing the following initiatives

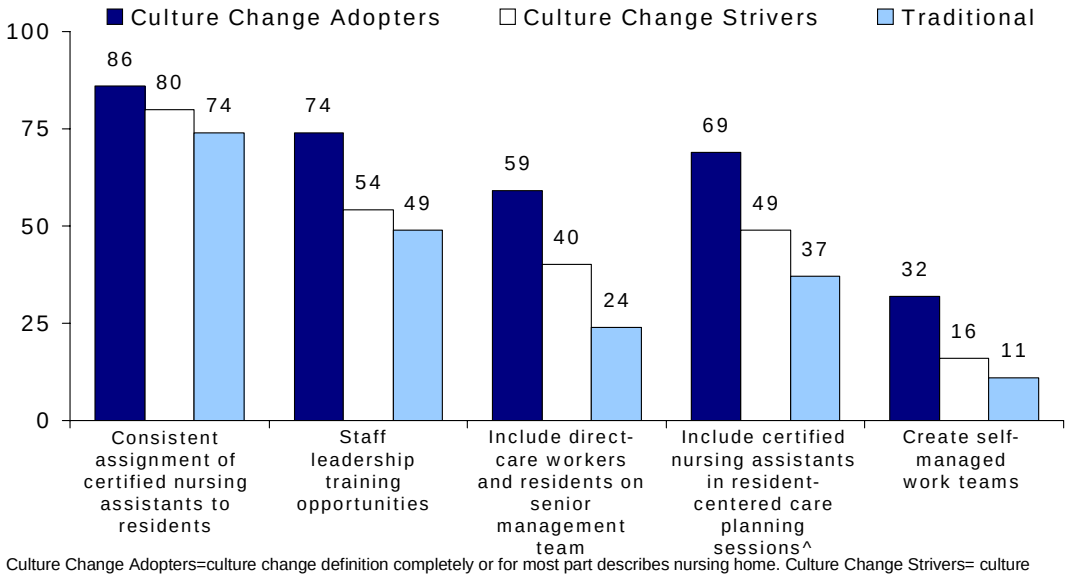


Culture Change Adopters=culture change definition completely or for most part describes nursing home. Culture Change Strivers= culture change definition describes nursing home only in a few respects or not at all but leadership is very/extremely committed to the adoption of culture change. Traditional=culture change definition describes nursing home only in a few respects or not at all AND leadership is less than very/extremely committed to the adoption of culture change.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 3. Traditional Nursing Homes Lag Behind Culture Change Adopters in Staff Leadership, Empowerment, and Autonomy

Percent of facilities indicating they are currently implementing the following initiatives



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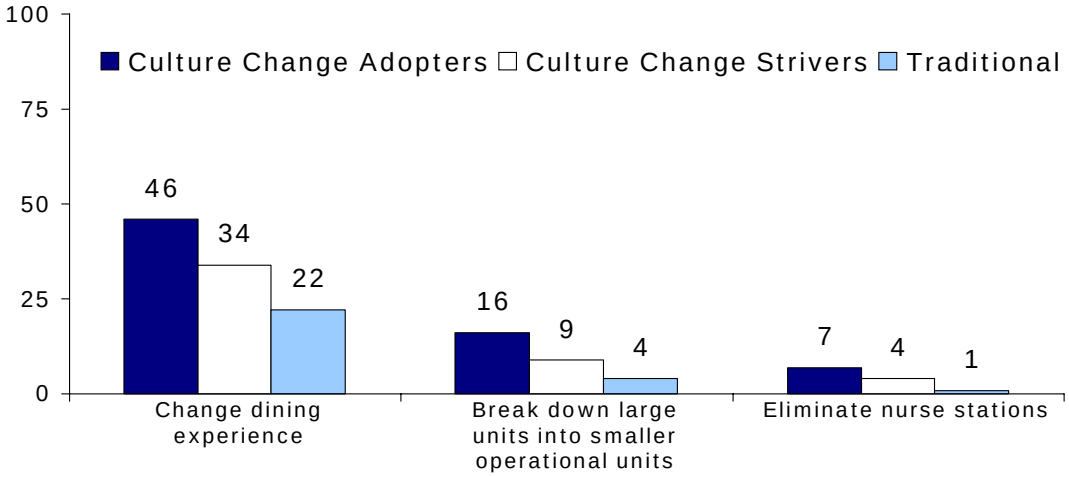
^ For instance, utilizing the "I Care" or "First Person" approach.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 4. Few Nursing Homes Have Changed Their Physical Environments, but Nearly Half of Culture Change Adopters Have Altered the Dining Experience

Percent of facilities indicating they are implementing the following initiatives



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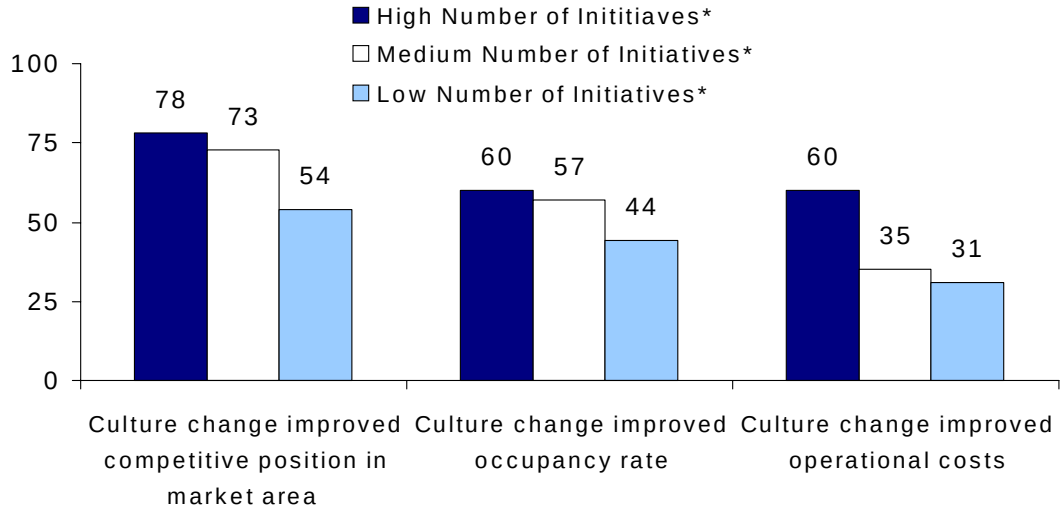
Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 5. Improvements in Business and Operations are Greatest in Homes That Have More Culture Change Initiatives Under Way*

Base: Definition of culture change describes this nursing home completely, for the most part, or in a few respects

Percent of nursing homes indicating that culture change has had the following impacts



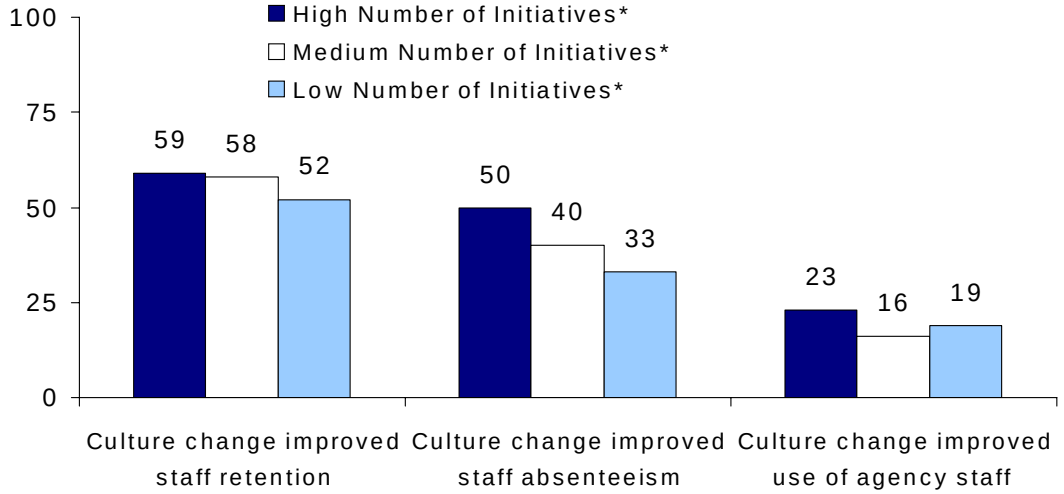
*Respondents were asked whether their home was currently implementing any of eleven different resident-centered, staff, or physical environment initiatives associated with culture change. High=7 or more initiatives; Medium=4 to 6 initiatives; Low=3 or less initiatives.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 6. Staffing Improvements Are Greatest in Homes That Have More Culture Change Initiatives Under Way*

Base: Definition of culture change describes this nursing home completely, for the most part, or in a few respects

Percent of facilities indicating that culture change has had the following impacts



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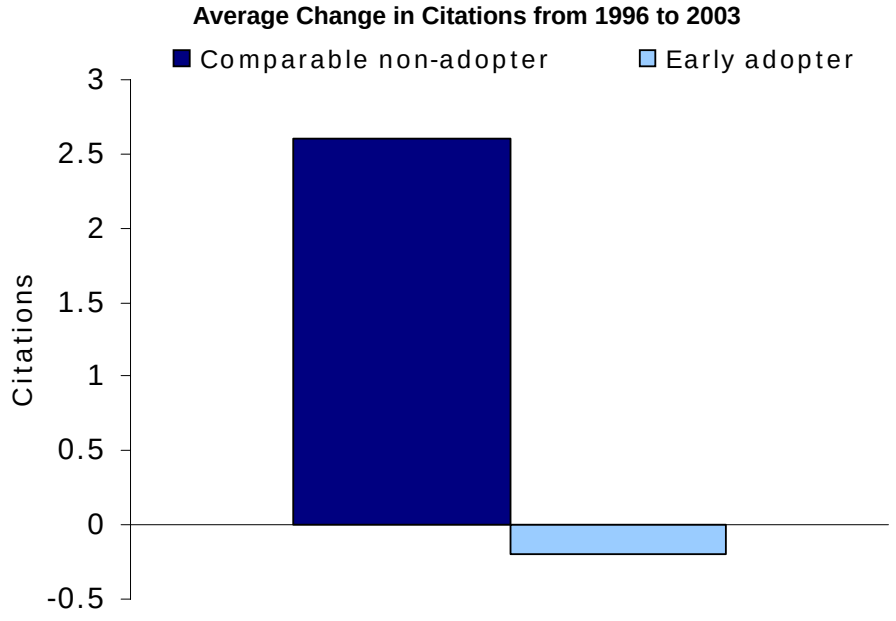
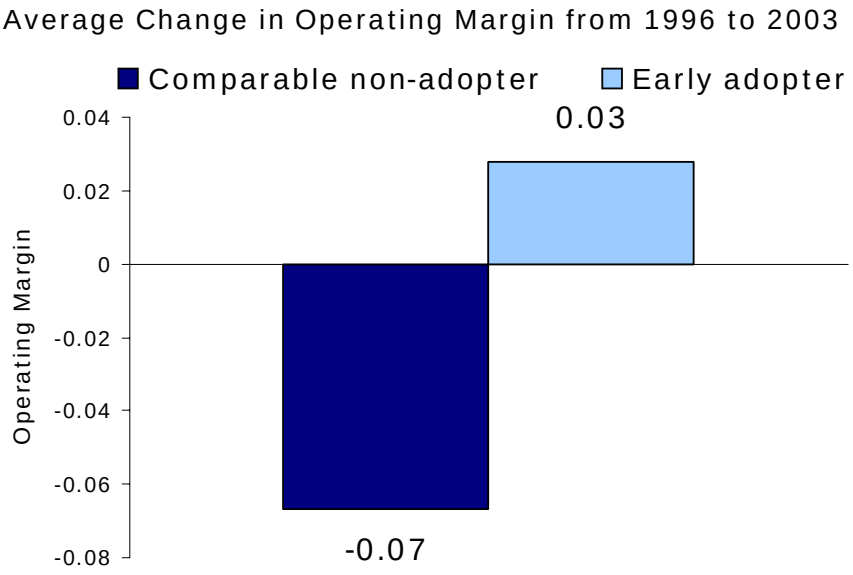
Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 7. Culture Change Adopters Receive Fewer Citations for Violations Than Non-Adopters*



Source: *Elliot, A. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement* (available from Pioneer Network, http://www.pioneernetwork.net/news-and-events/PreliminaryResearchSupportsNursingHome.php)

Figure 8. Culture Change Adopters Have More Positive Operating Margins



Source: *Elliot, A. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement* (available from Pioneer Network, http://www.pioneernetwork.net/news-and-events/PreliminaryResearchSupportsNursingHome.php)

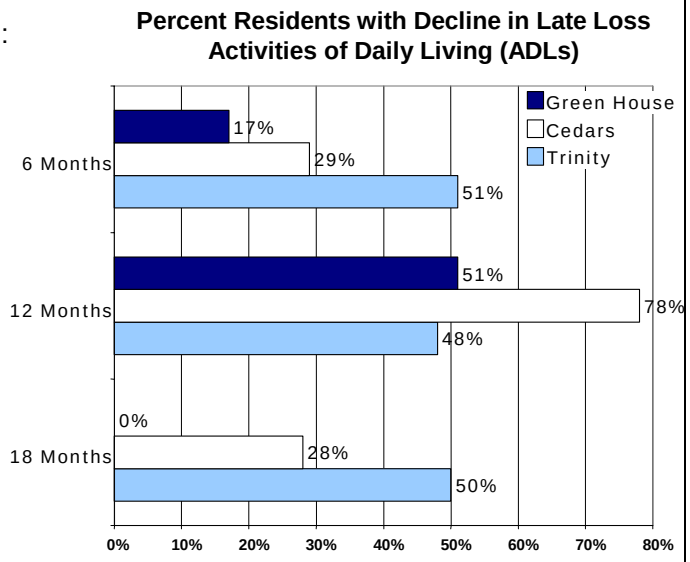
Figure 9. Residents and Staff of the First Green House* Have Positive Outcomes

Green House residents had:

- A better quality of life
- Greater satisfaction
- Better or equal outcomes

Green House staff felt:

- More empowered to assist residents
- Knew residents better
- Greater intrinsic and extrinsic job satisfaction
- Wanted to remain in the job



* A Green House is a small group nursing home for 10 residents.
The first one was in Tupelo, MS.
Source: R. A. Kane, T. Y. Lum, L. J. Cutler et al., Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program, *Journal of the American Geriatrics Society,* June 2007 55(6):832–39

Figure 10a. Nursing Home Participation in the Nursing Home Quality Campaign: State Participation as of May 8, 2008

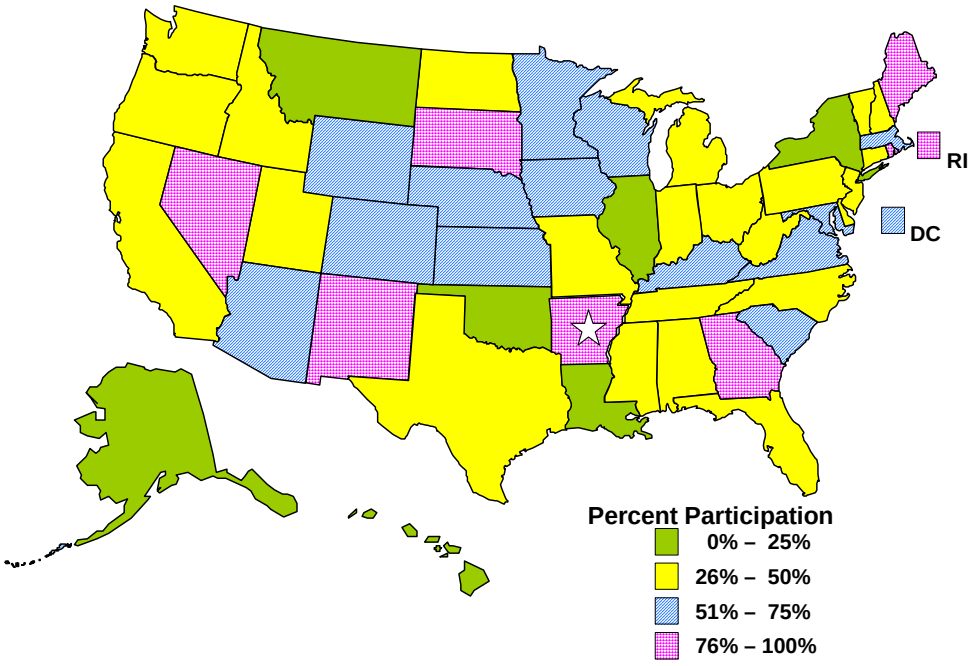
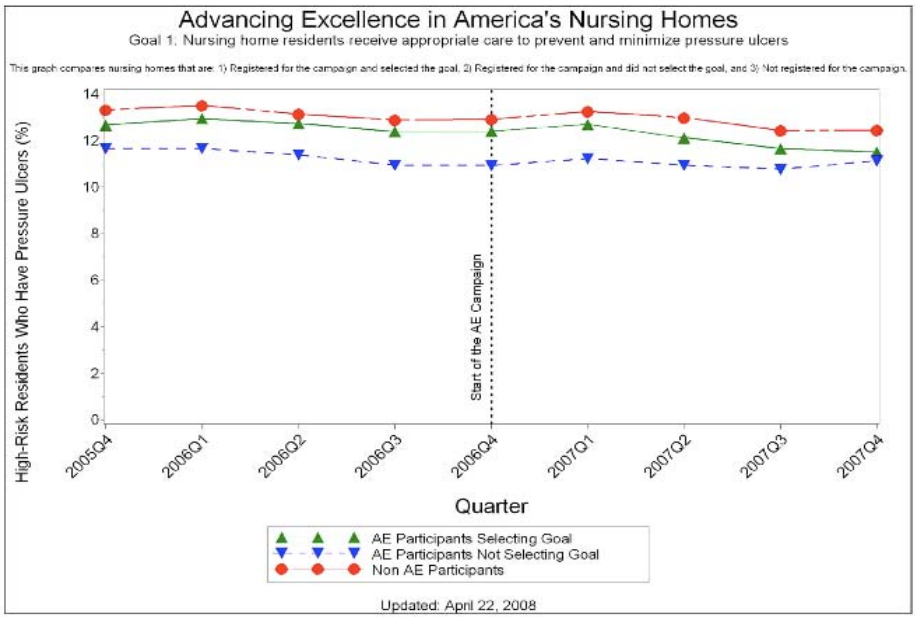


Figure 10b. Nursing Home Participation in the Nursing Home Quality Campaign: State Participation as of May 8, 2008

AK	6.70%	KY	52.70%	NY	18.00%
AL	47.80%	LA	23.30%	OH	44.60%
AR	100.00%	MA	67.50%	OK	22.60%
AZ	62.20%	MD	53.80%	OR	35.50%
CA	25.50%	ME	82.30%	PA	49.20%
CO	69.00%	MI	27.50%	RI	87.20%
CT	38.10%	MN	51.40%	SC	51.40%
DC	60.00%	MO	44.10%	SD	88.20%
DE	47.70%	MS	29.40%	TN	38.40%
FL	32.70%	MT	17.40%	TX	34.30%
GA	96.40%	NC	37.10%	UT	44.10%
HI	17.00%	ND	36.10%	VA	65.30%
IA	50.60%	NE	59.70%	VT	37.50%
ID	35.10%	NH	45.70%	WA	48.30%
IL	20.80%	NJ	30.70%	WI	56.50%
IN	32.10%	NM	91.70%	WV	45.00%
KS	64.20%	NV	81.30%	WY	51.30%

Source: Advancing Excellence in American's Nursing Homes website (www.nhqualitycampaign.org)

Figure 11. Campaign Participants are Lowering Pressure-Ulcer Rates Faster Than Non-Participants



This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-RI-NHQIOSC-042008-245

Figure 12. Campaign Participants Are Eliminating Restraint Use More Rapidly Than Non-Participants

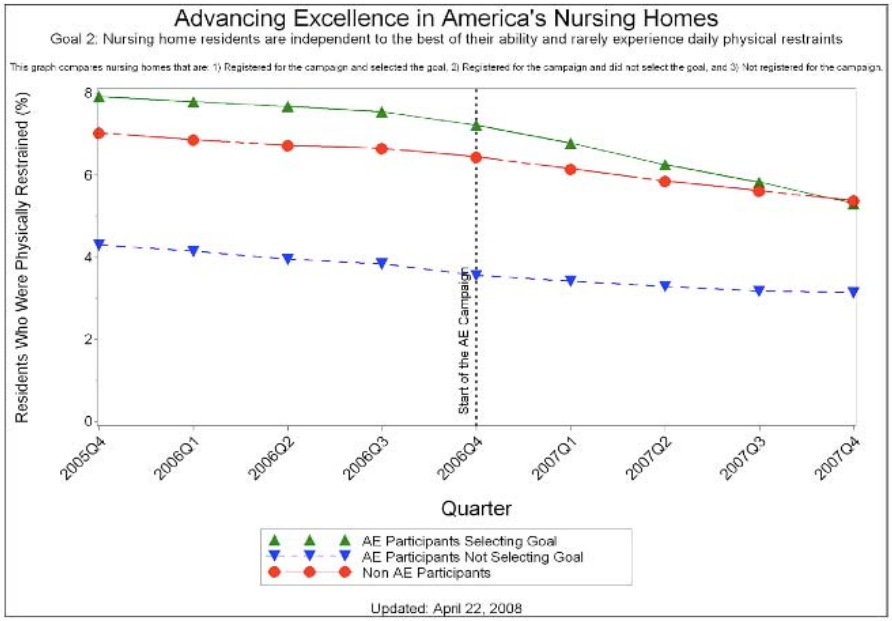


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Figure 13. Campaign Homes Are Improving Pain Management for Long-Stay Residents Faster Than Are Non-Campaign Homes

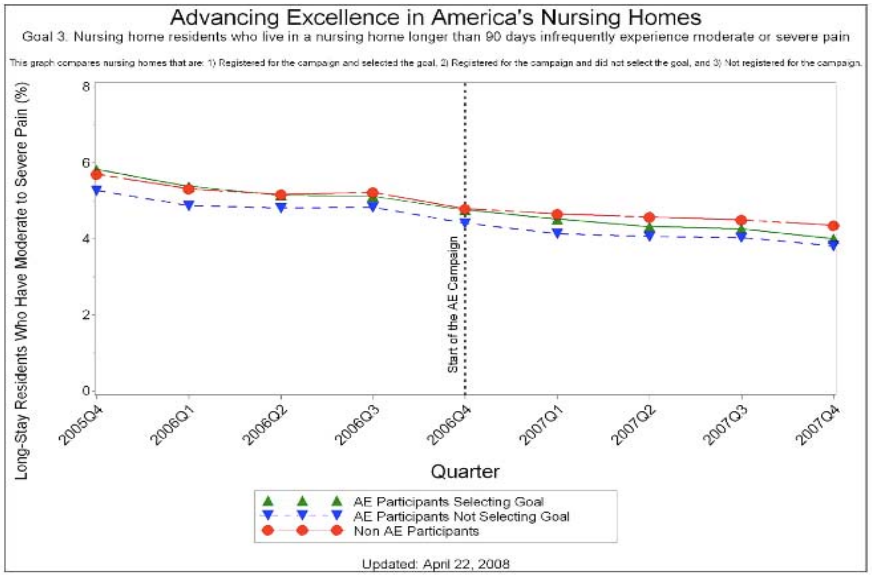

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Figure 14. Campaign Homes Are Improving Pain Management for Post-Acute Care Residents Faster Than Are Non-Campaign Homes

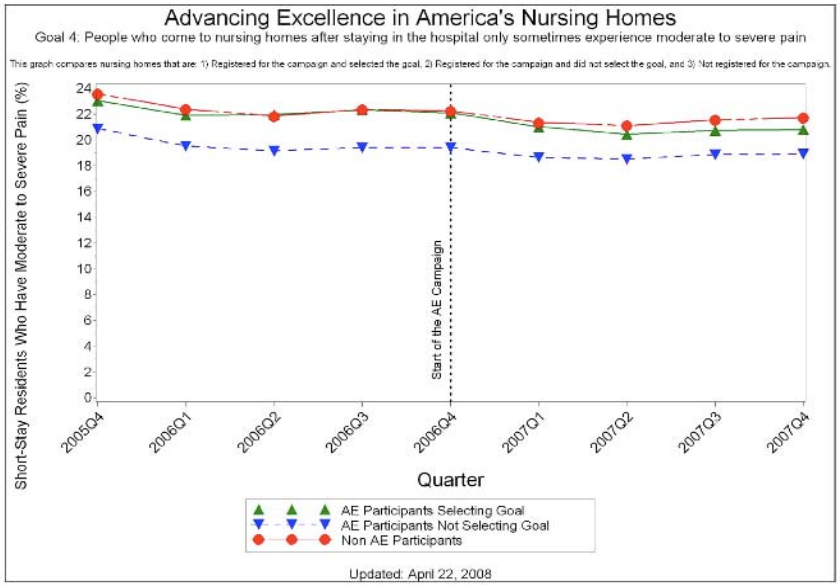

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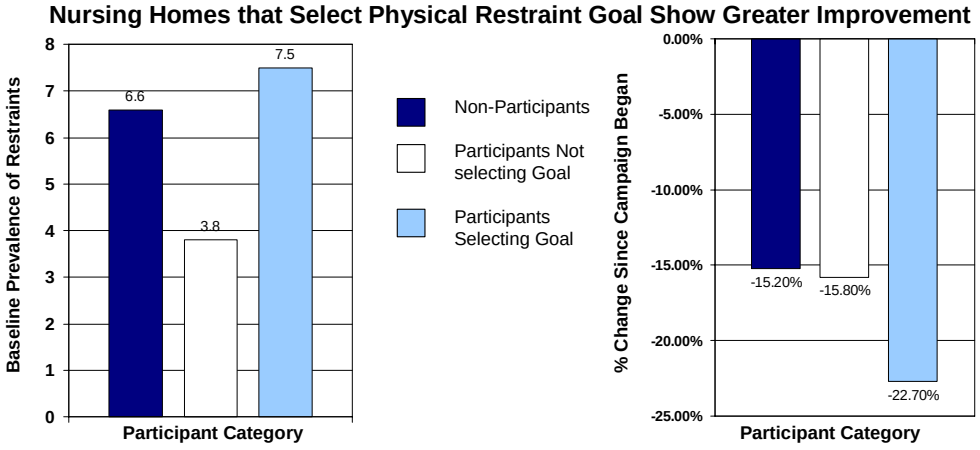
Figure 15. The Nursing Home Quality Campaign Is Showing Results



- 6808 nursing homes (43%) have joined the Campaign*
- Significant representation of for-profit facilities is seen
- Improvements are being seen in other goal areas too
- Given positive trends the Campaign will continue past its original 2 year timeframe

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health & Human Services. The contents presented do not necessarily reflect CMS policy. Data through one year (four quarters).

Figure 16. Advancing Excellence in America's Nursing Homes: Progress Toward Goals

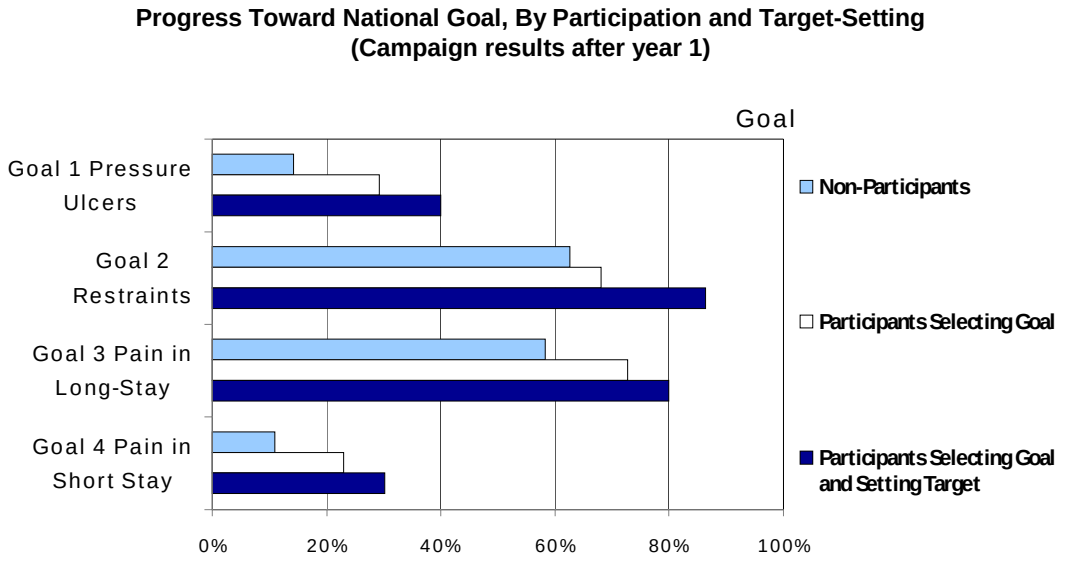


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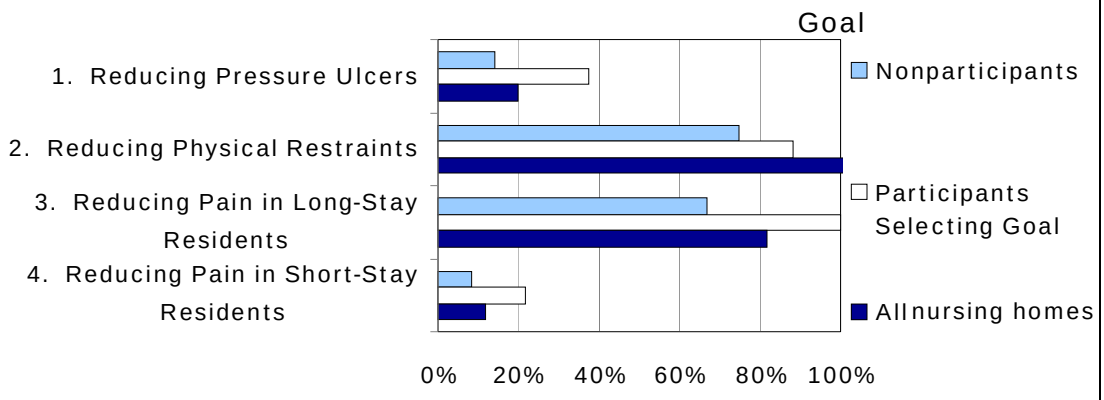
Figure 17. Advancing Excellence in America's Nursing Homes: Progress Toward Goals, Part 2



Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health & Human Services. The contents presented do not necessarily reflect CMS policy. Data through five quarters.

Advancing Excellence in America's Nursing Homes: Summary of Results

- Ongoing improvement toward five Campaign goals
- Goal selection associated with faster improvement
- Target selection associated with faster improvement
- Goal 2—reducing physical restraints—achieved national target for:
  - Objective A, restraint use at or below 5% (at 4.9%)
  - Objective B, 50% of homes with restraint use below 3%
- Goal 3, reducing pain for long-stay residents: near national target for:
  - Objective A, national average at or below 4% (at 4.2%)
  - Objective B, 30% below 2% (~35% have met threshold)

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Advancing Excellence in America's Nursing Homes: Summary of Results, Part 2

- The number of frail nursing home residents is on the rise
  - More short-stay residents
  - More residents at high risk for pressure ulcers
  - → Challenge for achieving absolute reduction in numbers (Objectives C and D for all goals)
- Majority of facilities have not set targets

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.