Statement for the Record
American Association of Homes and Services for the Aging

The Nursing Home Reform Act Turns Twenty:
What Has Been Accomplished, and What Challenges Remain?
May 2, 2007

The American Association of Homes and Services for the Aging (AAHSA) appreciates this opportunity to submit a statement for the record of the Senate Special Committee on Aging's hearing on the effectiveness of the federal nursing home standards enacted under the Omnibus Budget Reconciliation Act of 1987 (OBRA).

AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Seventy percent of our members are faith-based. Our members offer the continuum of aging services: home and community based programs, adult day programs, continuing care retirement communities, nursing homes, assisted living, and senior housing.

There is no question that the quality of nursing home care has improved since OBRA's enactment. The recent report by the Government Accountability Office on federal enforcement (GAO-07-241) noted that the number of serious care deficiencies cited declined from 2000 through 2005. GAO commented that the decline may reflect improved quality and we would argue that that is the case. The quality of enforcement, like the quality of care, probably always will be susceptible to improvement. However, unless it's to be argued that twenty years of effort by Congress, federal and state enforcement agencies, consumer advocates and nursing homes themselves have been completely ineffective, it must be admitted that care in the vast majority of nursing homes is far better today than it was twenty years ago. We have to get beyond the assumption that a decline in deficiency citations and enforcement activity means that enforcement agencies must not be doing their jobs effectively.

We are now twenty years beyond the statute's effective date and even further beyond the early-1980s research on which the statute was based. As long-term care has diversified and consumer choices in care settings have multiplied, nursing home populations have changed. Long-term nursing home residents today are older and have greater care needs than the nursing home populations of previous decades. In addition, nursing homes now have significant populations of younger, short-stay patients for whom the nursing home is not their permanent home but instead is a place of recuperation from an illness or injury following a hospitalization.

At the same time, care practices and providers have changed, evolving toward a focus on person-centered care and culture change, exemplified by the development of Green Houses, the dissemination of the Eden alternative, the Wellspring initiative, and other movements that have

raised the standard of care, particularly the Pioneer Network. OBRA measures compliance with minimum standards of quality; the provider-led initiatives encourage and recognize excellence in care that goes beyond the minimum.

AAHSA supported the passage and implementation of OBRA '87. We were one of the initial members of the Campaign for Quality Care, the coalition coordinated by the National Citizens' Coalition for Nursing Home Reform, which worked to reach consensus on twelve key areas of nursing home reform. We have continued to serve on various committees and workgroups to develop a reasonable and equitable implementation of the regulations and interpretive guidance resulting from the OBRA requirements. As a national association we remain an advocate for the presence of these federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of their existence.

However, after twenty years' experience with the federal nursing home standards and in view of the evolution of the long-term care field, we think it's fair to ask whether there are parts of OBRA that no longer contribute to the quality of care or even are counterproductive. That is why we welcome today's examination of the status and potential of the OBRA nursing home standards.

OBRA's Significance and Accomplishments

OBRA's nursing home quality reform provisions enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. It put residents' rights in the forefront, guaranteeing them the opportunity to continue exercising those rights and a voice in treatment and daily life decision-making.

One of the most significant transformations resulting from OBRA's passage was the shift in focus of regulatory oversight from facilities' <u>capacity</u> to provide care, "paper compliance" with requirements, to one on <u>resident outcomes</u>, that is, the actual care provided. OBRA focused needed attention on systematic, multi-disciplinary assessments and care-planning and provided critical tools to accomplish this. The statute also provided a framework for collecting, electronically transmitting, analyzing, and disseminating potentially useful and nationally standardized information on patient progress and outcomes.

OBRA also placed nursing facilities in the unique position of being the only kind of health care provider to be mandated to guarantee specific resident or patient outcomes. Under requirements for both Resident Assessment (CFR 483.20) and Quality of Care (CFR 483.25), nursing facilities must "provide and assure that each resident receives the necessary care and services to attain and maintain [his/her] highest practicable physical, mental, and psychosocial well-being." The interpretive guidelines for these requirements (State Operations Manual) states that, "Facilities must ensure that each resident obtains optimal improvement or does not deteriorate [within the limits of the resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process]."

This language not only focuses on resident outcomes as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status.

Person-Centered Care and Culture Transformation

Restraint Reduction

The vast reduction in the use of physical and chemical restraints on nursing home residents is one of the signal accomplishments of OBRA. In the name of protecting residents against injury, the use of restraints previously was the standard of care. Today, the CMS Nursing Home Compare website indicates that restraint use is down to six percent of nursing home residents. OBRA has imposed many restrictions on the use of restraints, which can only be used to treat medical symptoms, for brief periods, according to a doctor's order, with extensive assessment and care planning and frequent reevaluations of their continued use. The prevailing presumption in the field now is against the use of restraints and restraint reduction is a key quality indicator in the many initiatives that CMS, consumer advocates, and nursing homes have mounted to improve nursing home care.

In fact, Kendal Corporation, an AAHSA member, pioneered restraint reduction through their Untie the Elderly program, which debuted at AAHSA's annual meeting in 1986. In 1989, Kendal partnered with the Senate Aging Committee on a symposium on the elimination of physical restraints. Since that time, Kendal has expanded the initiative to 215 programs in 35 states and Canada.

Quality Initiatives from the Field

Going beyond the minimum requirements in OBRA, AAHSA and many of our members have developed and implemented initiatives to improve not only the quality of care but also the quality of life of people living in nursing homes. AAHSA's own five big ideas for the future of aging services include cultural transformation: the creation of a healthy nursing home workplace based on respect for caregivers, team building and management, continuous quality improvement, and resident centered care.

A few examples of quality initiatives in which our members have taken a leading role:

Pioneer Network

Ten years ago, nursing home leaders who wanted to change the dynamics of our field to reflect life and growth began meeting together to find common areas for research and reform. The Pioneer Network was established in 2000 as the umbrella organization for the culture change movement. Its members work with long-term care professional organizations, facilities and their staffs in implementing fundamental changes in the operations of nursing facilities. Several AAHSA conferences have included educational sessions led by Pioneer Network members. Nursing homes that have implemented Pioneer principles are reporting improved staff retention

and resident outcomes. Nine states have formed culture change coalitions. The Network has now expanded to include providers of home- and community-based services.

Wellspring

Wellspring, an initiative begun by a group of AAHSA members in Wisconsin, integrates federal quality indicators, best practices and a new management paradigm to dramatically improve resident outcomes and cost efficiency. Fundamental to the Wellspring program is the concept that the definition of quality care is created by top management, but that the best decisions about how the care is delivered to each resident are made by the front-line staff who know the residents best. This empowerment is achieved through extensive line staff education in the form of "care resource teams", shared decision-making and enhancing critical thinking skills of all staff. The program is lead by a geriatric nurse consultant who utilizes other clinical experts for teaching best practices.

Group process is central to Wellspring. The shift from traditional autocratic management structure to staff empowerment where line staff have equal responsibility for resident outcomes is what has made Wellspring unique. Key components are establishing permanent staff assignments to groups of residents and allowing staff to do their own scheduling.

Because of the initial success Wellspring achieved - 98% resident/family satisfaction, a cut in the CNA turnover rate from 105% to less than 30%, a waiting list of CNA applicants, high staff retention, and good survey results – the program now is being replicated in nursing homes in several states.

Eden Alternative

Several years ago, Dr. Bill Thomas began a program to combat the loneliness, helplessness and boredom that many nursing home residents experienced. His program has now been replicated across the country, and participating nursing homes commit to creating human habitats, with residents at the center, surrounded by plants, animals and children. Elders in these communities have the opportunity to both give and receive care, to engage in meaningful activity, and to experience variety and spontaneity. A vital part of the Eden Alternative is the de-emphasis on top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the elders or into the hands of those closest to them.

Green Houses

Green Houses, also the brainchild of Dr. Thomas, build on the concepts of the Eden Alternative. These projects emphasize small communities for elders and staff where necessary medical care is provided, but is not the focus of activity. The Green House is intended to replace large institutions with small, social settings for six to ten elders. Elders have private rooms and baths, situated around a common kitchen and dining area. Elders have access to outdoor gardens and patios and can choose their own activities throughout the day without the imposition of any kind of sleeping or eating schedule. Green House projects now are being planned or operated in eighteen states.

Advancing Excellence in America's Nursing Homes

Advancing Excellence in America's Nursing Homes is a two year, coalition-based campaign concerned with how we care for elderly and disabled citizens. This voluntary campaign:

- Monitors key indicators of nursing home care quality
- Promotes excellence in caregiving for nursing home residents
- Acknowledges the critical role nursing home staff have in providing care

The campaign builds on the success of other quality initiatives like Quality First, the Nursing Home Quality Initiative (NHQI), and the culture change movement. Campaign goals include creating a culture of person-centered, individualized care and an empowered workforce in nursing homes. The campaign has brought together all long-term care stakeholders, including consumer advocates, medical and quality improvement experts, and enforcement agency officials.

Several hundred nursing homes already have enrolled and committed to working on three out of eight quality indicators: reducing high risk pressure ulcers, reducing the use of daily physical restraints, improving pain management for short-stay, post-acute patients and for longer term nursing home residents, establishing individual targets for improving quality, assessing resident and family satisfaction with the quality of care, increasing staff retention; and improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Quality First

Our Quality First initiative, begun in 2002, is a philosophy of quality and a framework for earning public trust in aging services. More important, it is a renewal of our commitment as aging-services providers to help older adults and their loved ones live their lives to their fullest potential. Through Quality First, we work in partnership with all stakeholders - government, consumers and the people we serve and their families - to create quality of care and quality of life in aging services.

AAHSA Quality First provides all AAHSA members with opportunities to reaffirm their public commitment to quality; assess their strengths and opportunities for improvement; pursue continuous quality improvement based on the belief that improvement is always possible; and earn the public's trust and the confidence of consumers. A majority of our members have signed the Quality First covenant, and we are encouraging all of our members to use the tools provided for assessment of areas in which services may be improved.

Remaining challenges

Staffing

OBRA contains no set levels of staffing, and the statute's general prescription that staffing must be sufficient to keep residents at the highest practicable level of functioning has been criticized as

inadequate. However, the most recent staffing study by the Centers for Medicare and Medicaid Services concluded that there was insufficient data on which to recommend specific staffing levels for nursing facilities. In addition, nursing homes face the same nursing shortage that prevails throughout the healthcare field, and are at a competitive disadvantage as compared to other health care providers in recruiting and retaining the staff they and their residents need.

A recent report to the National Commission for Quality Long-Term Care by the Institute for the Future of Aging Services described a workforce crisis in the long-term care field and made a number of recommendations for meeting this challenge. The report listed the need to bring more people into the long-term care field, to provide more competitive wages and benefits, to improve working conditions and job quality, to make larger and smarter investments in education and workforce development, to develop new models of service delivery and to moderate the demand for hands-on care through the application of technology.

AAHSA is working on all of these fronts. We encourage our nursing home members to open their doors to nursing schools and to offer opportunities for rotation through their facilities. We have also supported the concept of career ladders for nursing assistants to enter the field of professional nursing. Since 1989, under a grant from the Patient Care Division of Proctor and Gamble, we have sponsored an annual scholarship program for nursing assistants to become RNs or LPNs. In addition, we have many nursing facility members who have independently developed scholarship or tuition assistance programs to enable nurse aides under their employ to become registered (RNs) or licensed practical nurses (LPNs).

The application of technology to aging services is one of our five big ideas for the future of aging services. A few years ago, we established the Center for Aging Services Technologies, which has brought together researchers, technology companies, and long-term care providers to develop and apply technological solutions to aging services issues. These initiatives promise greater efficiency and quality in service delivery at the same time that they will give consumers more choices in the services they may obtain and the settings in which they receive them.

To address the issue of job quality, the Institute for the Future of Aging Services has undertaken the Better Jobs Better Care campaign and several other initiatives to research and demonstrate organizational changes that make nursing homes attractive places to work.

Congress has a role to play in growing staffing resources in our field. The Nursing Workforce Development programs under Title VIII of the Public Health Service Act educate nurses, enable them to remain current with developments in their field and enhance their ability to supervise other staff. The programs also include loans to increase the number of qualified faculty at nursing schools, which have had to turn away thousands of applicants for nursing education due to faculty shortages. These programs have been flat-funded for the last several years as the nursing shortage continues to grow. Additional resources are essential to meet the rising need for nursing care, and we urge an increase in funding to $200 million for these programs in fiscal 2008.

Furthermore, the IFAS report noted the need for more parity in wages and benefits between acute and long-term care settings. Because approximately seventy percent of the cost of nursing home care is paid under Medicare and Medicaid, governmental payment policies disproportionately

influence the amount of resources that nursing homes have available to compensate their staff. The Long-Term Care Quality Improvement Act, H.R. 1166, introduced in the House during the last Congress, would have required the Department of Health and Human Services to study the adequacy of the entire package of funding for long-term care, Medicaid as well as Medicare.

This legislation also called for nursing homes to report separately on their Medicare cost reports the amounts they spend on wages and benefits for nursing staff, by staff level, breaking out the figures for registered nurses, licensed professional nurses, and certified nurse assistants. Since staffing is so integral to the quality of care, we felt that this requirement would be a strong first step toward aligning payment incentives with quality. Under current policies, Medicare pays for skilled nursing at the same rate whatever the quality of care provided. We understand that the Centers for Medicare and Medicaid Services now are beginning to develop policies to tie payment incentives to quality and we welcome this initiative.

In addition, the IFAS report noted that the negative public perception that is fostered through the media and sensational reports that focus only on the harmful incidents and occurrences in nursing facilities is demoralizing to front-line workers. We recognize and concur that incidents of bad care are intolerable. However, the kind and compassionate care that is provided on a daily basis by the vast majority of nursing home staff members goes without notice. Portraying the entire nursing home profession in a negative light is unfair to the many dedicated staff who work continuously to assure quality care to the residents they serve. Not only does this do a disservice to these individuals, but it results in a chilling effect on our ability to recruit and retain competent, caring individuals. The long-range impact of "negative-only publicity" on our organizations is inestimable.

Recommended changes in OBRA

As indicated, we support OBRA and feel that it has led to significant improvements in the quality of nursing home care. However, some provisions of the statute no longer meet the needs of today's nursing home consumer. As implemented in the State Operations Manual, the federal survey and certification system fails to give consumers a reliable means of choosing the best nursing home care for themselves or their loved ones. Inconsistency in survey results and the imposition of remedies with a limited right of appeal may cause consumers to avoid facilities that in fact are providing good care. In addition, CMS efforts to improve state inspections and enforcement and crack down on problem providers still fail to target bad providers, as noted in the recent GAO report. Oversight authorities must expend the same amount of time and resources on facilities with exemplary records as they do on those demonstrating chronic or serious quality of care problems, and facilities that consistently fail to provide appropriate quality of care remain in business.

The nurse-aide shortage has compounded the counter-productivity of the two-year disqualification of nurse-aide training programs for facilities found to be out of compliance with certain standards. An inability to train nurse aides, once compliance has been achieved and demonstrated, results in a potential compromise to quality of care that is inappropriate and unnecessary.

America's seniors and their families need a quality assurance system that enables them to choose facilities that provide excellent quality of care and quality of life. An approach must be developed that allows surveyors and care-giving staff to work not only on promoting and achieving sustained compliance, but on meeting individual care needs and expectations to improve care. Nursing home care is evolving, and we need a resident-focused system that fosters continuous quality improvement. The focus of the survey and enforcement process should be on fixing problems and offering expert guidance rather than on punishment.

SOLUTIONS: AAHSA strongly urges passage of legislation similar to H.R. 3437, the Nursing Facility Quality Improvement Act introduced in the last Congress, which addressed the following issues:

- **Nurse-aide training:** Convert the present two-year disqualification from nurse aide training for facilities that are out of compliance with federal quality standards from an automatic consequence to one of the range of remedies available. Frequently loss of nurse aide training programs results from noncompliance completely unrelated to the training program or direct care. Facilities that have quality problems generally need to hire more staff and provide more training. The loss of the training program has a particularly severe impact on rural facilities where alternative training sites may not be accessible.

- **Joint training for providers and surveyors:** To ensure a uniform understanding of quality requirements and related expectations, the bill provided for joint training of surveyors and nursing home staff at least annually, and would require surveyor training to include hands-on experience at a nursing facility.

- **Alternative approaches to enforcement of nursing home quality standards:** Waivers should be available for a limited number of states to develop and explore innovative approaches to measuring quality of care through demonstration projects. Many states have begun to move in this direction but do not have the resources to conduct parallel quality assurance systems. OBRA is twenty years old; states might be able to demonstrate ways in which it could be strengthened.

- **Remove barriers to the takeover of poor performers by new owners with good records of compliance:** A facility's compliance record and any enforcement remedies sustained by a previous owner transfer to a new owner. This forces competition between the new owner's resources to restore quality of care and services to the residents, and the previous owners' liabilities related to compliance and financial penalties. Faced with carryover liability for heavy fines by a consistently poor performer, healthier facilities are unlikely to step in to try to turn a problem facility around. In areas where long-term care services are limited, residents may have few or no alternatives to remaining in a poor facility, and facilitating new management would be in the residents' best interests.

- **State flexibility on termination for facilities not in substantial compliance:** States should not be required to terminate facilities from the Medicare and/or Medicaid program(s) at 180 days based on any level of noncompliance. Under the current mandate, termination and potential closure of a facility can automatically result from situations of minor consequence.

States should be given flexibility to take into account the potential risk and negative impact to residents who are in facilities that are subject to termination or closure based on noncompliance that may be isolated, and/or where no harm has occurred.

- **Informal dispute resolution process:** Since severity and scope determinations ultimately lead to the imposition of remedies, facilities must be allowed to challenge more determinations during informal dispute resolution, just as they currently can challenge the existence of a deficiency. Facilities should also be allowed the right to review before an independent, impartial decision-maker.

- **Allow citations to be appealed even if no penalty is imposed:** Under current requirements, facilities are left with no recourse when a determination of noncompliance is made, but no remedy is actually imposed. To further ensure the integrity of the enforcement system and because of the impact these citations have on their compliance records and consumer perception, it is essential that providers have the ability to pursue all incorrectly cited deficiency determinations.

- **Civil monetary penalty funds:** The existing mandate that states use civil monetary penalty funds to improve resident care must be better enforced; many states have not adopted programs to implement this requirement and the monies collected are being used for other purposes. To fulfill the mandate, CMP funds should be used for surveyor training, consultation and technical assistance to facilities in developing and implementing quality improvement or resident care protocols.

Conclusion

At this twentieth anniversary of OBRA's passage, it is appropriate for all stakeholders to take stock of the progress that has been achieved in the last two decades and the ways in which the highest quality nursing home care can be ensured and achieved for the oldest and most vulnerable Americans. Of course there are still improvements needed in the quality of care and enforcement, but we hope that this retrospective also will celebrate the ways in which nursing home care has advanced since OBRA was enacted. AAHSA commits itself and its members to continuous improvement in the quality of care and services we provide, and we look forward to working with the Senate Special Committee on Aging to ensure continued progress in our field.