



**STATEMENT
Of
Neil Pruitt, Jr.**

***On Behalf Of The*
AMERICAN HEALTH CARE ASSOCIATION**

Before The

**House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing On
In the Hands of Strangers: Are Nursing Home Safeguards Working?**

May 15, 2008

Thank you Chairman Stupak, Ranking Member Shimkus, and members of the Committee. I am grateful for the opportunity to be with you here today – and to offer our profession’s perspective on both the successes and remaining challenges we face in ensuring ready access to quality nursing home care for the frail, elderly, and disabled Americans we serve. My name is Neil Pruitt, I am Chairman and Chief Executive Officer of the UHS-Pruitt Corporation, and I am honored to be here today representing the American Health Care Association (AHCA).

For nearly forty years, since 1969, my family-owned company has been providing professional healthcare services throughout the Southeast. With nearly 8,000 employees, we touch the lives of more than 18,000 patients, residents and clients daily. UHS-Pruitt has a rich and long-standing tradition of quality and a “commitment to caring.” The mission we embrace that drives our work every day is “Our family, your family, ONE FAMILY; Committed to loving, giving and caring; United in making a difference.”

On behalf of the profession responsible for caring for our nation’s most vulnerable citizens, I am proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead – when, as we all know, demand for long term care will by all accounts dramatically increase.

Americans are living longer and our nation’s aging population is growing – many of whom have medical or cognitive conditions which require care in a nursing facility. Currently more than three million Americans rely on the care and services delivered in one of the nation’s nearly 16,000 nursing facilities each year. The forecast for the demand for nursing facility care is alarming. A March 2008

report from the National Investment Center for the Seniors Housing & Care Industry (NIC) indicates that the demand for long term care services will more than double by 2040.

I am proud of the efforts and initiatives advanced by the association that I represent today that seek to enhance and improve quality of care and services provided in our nation's nursing facilities each day.

Quality – AHCA's First Priority

Long before the words quality and transparency were the catch words of the federal government and their oversight of healthcare, they were truly the compass for the American Health Care Association and its member facilities.

Our association's long-held mission clearly states, "our goal is to provide a spectrum of patient/resident-centered care and services which nurture not only the individual's health, but their lives as well, by preserving their connections with extended family and friends, and promoting their dignity, respect, independence, and choice."

AHCA has been working diligently to change the debate regarding long term care to focus on quality – quality of life for patients, residents and staff; and quality of care for the millions of frail, elderly and disabled individuals who require our services. We have been actively engaged in a broad range of activities which seek to enhance the overall performance and excellence of the entire long term care sector. While keeping patients and their care needs at the center of our collective efforts, we keep challenging ourselves to do better, and enhance quality.

The Facts Speak for Themselves – Quality & Outcomes Are Improving

The Online Survey, Certification and Reporting (OSCAR) data tracked by the Centers for Medicare and Medicaid Services (CMS) clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies in our nation's skilled nursing facilities.

A few examples which highlight some of the positive trends in nursing facility care according to data tracked by CMS:

- Nationally, direct care staffing levels (which include all levels of nursing care: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs)) have increased 8.7 percent between 2000 and 2007 – from 3.12 hours per patient day in 2000 to 3.39 hours in 2007;
- The Quality Measure¹ tracking pain for long term stay residents vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007 – more than a 50 percent decrease;

¹ **Quality Measures** track nursing facility residents who have and are at risk for specific functional problems needing further evaluation. Improvements in these measures indicate positive trends in patient outcomes, but it is important to clarify that the quality measures do not reflect a percentage of the entire population, rather the percentage of those who are at risk and have the condition.

- The Quality Measure tracking the use of physical restraints for long stay residents dropped from 9.7 percent in 2002 to 5.6 percent in 2007;
- The Quality Measure tracking pressure ulcers for post-acute skilled nursing facility patients (many of whom are admitted to the nursing facility with a pre-existing pressure ulcer) improved by 23 percent over the course of four years, from 20.4 percent in 2003 to 15.8 percent in 2007; and
- Substandard Quality of Care Citations as tracked by CMS surveys were reduced by 30 percent in five years – from 4.4 percent in 2001 to 3.1 percent in 2006.
- In January 2006, the Government Accountability Office stated that from 1999-2005 there was a nearly 50 percent decrease in the “proportion of nursing homes with serious quality problems.”

Satisfaction of patients and family members is a critical measure of quality. AHCA has recognized this vital link between satisfaction and performance, and has urged facilities to conduct such assessments for more than a decade. In recent years, we have encouraged facilities to use a nationally-recognized company, *My InnerView*, to conduct consumer and staff satisfaction surveys to establish a national database for benchmarking and trend analysis. Last year’s independent survey of nursing home patients and their families indicates that a vast majority (83%) of consumers nationwide are very satisfied with the care provided at our nation’s nursing homes and would rate the care as either good or excellent.

AHCA remains committed to sustaining – and building upon – these quality improvements for the future.

Culture of Cooperation – Leading to Continued Improvement

Positive trends related to quality are also evidenced by profession-based initiatives including *Quality First* and the *Advancing Excellence in America’s Nursing Homes* campaign – both of which are having a significant impact on the quality of care and quality of life for the frail, elderly and disabled citizens who require nursing facility care.

Quality First, which was established in 2002, set forth seven core principles that reflect long term care providers’ commitment to continuous quality improvement, leadership and transparency. This profession-based initiative led not only to improvements in care and processes, but to the development of the National Commission for Quality Long-Term Care. In December 2007, the Commission released its final report which addressed four critical components of long term care – quality, workforce, information technology & financing. We encourage Congress to take the recommendations of this commission under consideration – and further investigate their feasibility.

Quality First and other initiatives have been recognized by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of CMS Dr. Mark McClellan, and by former CMS Acting Administrator Leslie Norwalk last year when she stated in a column she wrote for

Provider magazine: “Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with *Quality First* – a volunteer effort to elevate quality and accountability...Quality measurement has worked in nursing homes...Collaborating to measure quality of long-term care, report it, support it, and improve it – that’s the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford.”

AHCA is a founding partner of the *Advancing Excellence in America’s Nursing Homes* campaign – a coordinated initiative among providers, caregivers, consumers, government and others that promote quality around eight measurable goals. This campaign takes a step further than previous initiatives. It not only measures outcomes, but it establishes numerical targets and benchmarks. It also promotes best practices and evidence-based processes that have been proven to enhance patient care and quality of life.

This voluntary initiative is working – and outcomes and processes are improving in the nearly 7,000 participating facilities. In December 2007, the campaign announced that for the first three quarters of the initiative, there was progress in reducing the incidence of pressure ulcers in nursing homes, reducing use of physical restraints, managing pain for long term nursing home residents, and managing pain for short stay, post-acute nursing home residents. Our association is diligently working to increase the number of facilities that actively participate in this program and embrace the concepts embodied in the *Advancing Excellence in America’s Nursing Homes* campaign.

In his November 2007 testimony before the U.S. Senate Special Committee on Aging, Acting CMS Administrator Kerry Weems praised the *Advancing Excellence in America’s Nursing Homes* campaign, stating, “This campaign is an exceptional collaboration among government agencies, advocacy organizations, nursing home associations, foundations, and many others to improve the quality of nursing homes across the country.”

Further, in the CMS 2008 Action Plan for (Further Improvement of) Nursing Home Quality, the agency states that it “plan[s] to strengthen our partnerships with non-governmental organizations who are also committed to quality improvement in nursing homes...The unprecedented, collaborative [*Advancing Excellence in America’s Nursing Homes*] campaign seeks to better define quantitative goals in nursing home quality improvement. The purpose of this campaign is to align the strategies of the many partners who have expressed their commitment to excellent nursing home quality.”

We applaud CMS for their commitment to further enhance care quality and outcomes through this partnership of stakeholders. The effort truly embodies the culture of cooperation which is critical in effectively enhancing care and sustaining quality improvements.

We are engaged in discussions with the Office of Inspector General (OIG) regarding quality issues for long term care. AHCA and member organizations – including UHS-Pruitt – were active participants in a 2007 OIG and Health Care Compliance Association roundtable. This provided us the opportunity to educate both the federal government and other stakeholders on our profession’s current quality improvement efforts and initiatives. As a result, UHS-Pruitt and other AHCA member companies have created and implemented “quality dashboards.”

In an August 2006 speech before the National Governors Association, U.S. Department of Health and Human Services Secretary Mike Leavitt proclaimed that the nursing facility profession has moved forward in addressing financial integrity and transparency. Secretary Leavitt stated, “a wonderful thing is happening in the nursing home industry – they started posting their quality measures and their prices...and [because of] public disclosure of them they immediately began to improve and the price got lower and the care got better because the providers themselves said we don’t want to be in a place where we are compared negatively because it will affect our market.”

In total, the increased focus on resident-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration and the dissemination of best practices models of care delivery is paying off. AHCA remains committed to its long-standing practices and programs which seek to improve the quality of care for our nation’s most frail, elderly and disabled who require long term care services, and enhance the quality of life for patients and caregivers alike.

Current Regulatory System

Twenty-one years ago, passage of the *Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87)*, which contained the *Nursing Home Reform Act*, ushered in an era of change in our approach to patient care. Congress made the care mandate very clear: all certified facilities must “attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.”

The *OBRA ‘87* mandate was intended to move care in new directions, and it did.

The law required a comprehensive evaluation of each patient using a uniform assessment tool – the Minimum Data Set (MDS). It was equally important that each facility needed to create and use an ongoing quality assessment and assurance committee; this offers a platform from which each facility can evaluate the daily processes and procedures that generate positive patient outcomes.

The resident-centered, outcome-oriented, consistent system of oversight that was originally intended has failed to focus on Quality Care.

Today we are in danger of abandoning the original intent of *OBRA 87’* in favor of a regulatory system that defines “success” and quality in a regulatory context that is often measured by the level of fines levied and the violations tallied – not by the quality of care, or quality of life, as was the original intention.

In fact, a January 2006 GAO report on nursing home oversight indicates that the nation’s Survey and Enforcement System for nursing homes is consistently inconsistent, with significant variations from state to state. AHCA and our members have long maintained that a one-dimensional punitive approach does not get to the overall goal of achieving quality care.

Today’s regulatory construct is based upon yesterday’s nursing facility and does not account for the shift in the patient mix and the type of care and services being delivered. Independent studies validate the fact that skilled nursing facilities are providing intensive rehabilitation and nursing care to a

growing number of short-stay patients who return to their home and community, often within one month. At the same time, an increasing percentage of the nation's nursing facility population has significant cognitive difficulties – including advanced Alzheimer's disease – and more disabilities. Despite changes in patients and care provided, changes to the oversight system have not kept pace.

AHCA believes that achieving a sustained level of quality care will only be fully realized when there is a collaborative effort to recognize and implement improved health care technologies and best clinical practices designed to improve and enhance patient outcomes. This type of culture change is essential to appropriately address the needs of a growing patient population and a shrinking pool of caregivers.

A cooperative approach that is producing tremendous results and effectively improving the care and outcomes in our nation's nursing facilities is the partnership between facilities and Quality Improvement Organizations. These professionals share best practices and techniques, and working with the facilities in partnership, they identify opportunities and provide assistance for improvement. In fact, nursing homes working with QIOs in a national collaborative project, successfully reduced the incidence of the most serious bed sores by 69 percent in one year.

Today, we know far more about promoting quality, and we have better tools with which to measure it than we did twenty years ago. We need to intelligently change the regulatory process to allow and encourage us to use what we have learned – to place quality over process, care over procedure, and most importantly, put patients at the forefront.

We believe that such a reformed, fair and effective survey process should embody three guiding principles:

- Surveys should be fair, accurate and consistent,
- Surveys should protect the health and safety of residents, and
- Surveys should focus on areas requiring improvement.

We must revamp the system to ensure that the quality of life of the residents is emphasized, consistent with the intent of *OBRA '87*.

Now is the time, Mr. Chairman, to move to such a system.

Recognizing Barriers to Improving Quality

The vast majority of nursing homes across the nation provide the type of high quality, compassionate care that patients, residents and their families want and deserve. However, we recognize that there is a very small fraction of nursing homes that do not meet high standards of excellence and care quality. Begun in 1998, the Special Focus Facility (SFF) program has brought more attention to bear on nursing homes that have a poor survey history. Sadly, some of these facilities ultimately close, resulting in trauma to the patients who must move from their home, their families, and the staff.

There should be incentives – rather than the current disincentives – for new high quality operators to take over troubled facilities and improve the care for patients and the entire environment for staff, patients and family members alike.

UHS-Pruitt has a history of purchasing facilities with the SFF designation – or those that have had a troubled survey record – and turning them into top tier nursing facilities. We have had great success working with the regulatory agencies in Georgia, North Carolina and South Carolina to improve the quality of care delivered to those that we serve. I am proud of our organization’s ability to improve under-performing facilities and make them a better place for patients to receive high quality care and services. However, these efforts do not come without risk or difficulties.

Last year, we acquired a facility in Monck’s Corner, South Carolina, which we subsequently renamed UniHealth Post Acute Care- Monks Corner. This was a facility with the SFF designation, and it needed significant investment to reform the facility from an outdated “old time nursing facility” to an updated and reformed environment that embraces many constructs of culture change, implements advances including information technologies, and has increased staff levels.

Prior to our purchase, this facility had been issued a Medicare notice of termination and efforts were underway to relocate the more than 130 patients in the facility. Further to my knowledge, the center was one of the first to enter into a settlement agreement with CMS. Upon transfer of ownership this agreement was renamed a Systems Improvement Agreement. It is my belief this type of agreement is a model for Government/Provider collaboration for improvement of care in underperforming nursing centers. Before purchase, UHS-Pruitt presented a performance improvement plan to CMS and the South Carolina Department of Health and Environmental Control (DHEC). Both regulatory agencies offered valuable feedback on the past performance of the facility and the likely effectiveness of our plan to address historic performance deficiencies. Our team holds periodic briefings with CMS and DHEC. These briefings are honest and open and focused on achieving outcomes that ultimately will benefit the patients served by UniHealth Post Acute Care- Monks Corner.

While I am the first to admit, the facility is still far from perfect, we are proud of our efforts and the outcomes we have witnessed. This facility has seen significant improvement and UHS-Pruitt was publicly recognized by CMS regarding our intervention and success in improving this facility, stating that the facility “is on track to graduate from the Special Focus Facility Initiative provided it can sustain the improvements over time.” We agree with Administrator Weems’ statement of November 2007 that “the Special Focus initiative can pay great quality-of-care dividends for nursing home residents.”

However, as I stated earlier, it is not an easy process, nor is it without significant risk.

It has been almost eight months since we acquired this property. Over this time, we have made considerable investment in enhancing and improving the facility, and as CMS attested, they have witnessed significant advancements. However, at this time, we still have not been approved for Medicare certification, and thus have not received any Medicare payments for the improved care and services we continue to provide. This is a barrier that precludes many potential buyers from purchasing a facility and it should be eliminated in order to better facilitate exemplary operators acquiring troubled facilities.

We know how encouraging the purchase of troubled facilities can generate success, but there remain significant barriers with the current change of ownership process. This must be recognized and changed.

When a reputable individual or entity steps forward to purchase, the new owner not only acquires the physical structure, but the entire survey history as well – including deficiency citations, and fines and penalties incurred. For example, if the facility has had their nurse aid training suspended, that will also carry over under the new ownership.

In order to encourage new investment in troubled facilities that may face closure, Congress and CMS should revise the rule for transfer of ownership to lessen the burden on the new owner/operator and consider the suspension of certain fines and penalties when purchase of the facility is demonstrated to be an arms length transaction. This will help in two ways: 1) assuming the facility is not yet closed, it may negate the need to transfer patients, which can have serious psychological and medical consequences; and 2) it will encourage individuals and entities to purchase a problem facility in order to improve it and restore quality of care by removing insurmountable obstacles at the outset which might otherwise discourage them from making the purchase.

In short, new owners and operators should not be penalized for past performance under previous owners, but rather encouraged to invest their financial resources and commitment to the improvement and ultimate success of the facility.

A Stable, Well-trained Workforce is the Building Block of Quality Long Term Care

All of us in this profession are acutely aware that human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce. However, America's long term care system is currently suffering from a chronic supply and demand problem when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

We are committed to partnering with Congress, the Administration, and other long term care stakeholders to ensure a qualified and well-trained staff is in place to care for our nation's elderly and disabled today – and in the coming years when the current crisis will hit epidemic proportions unless government intervenes. But as a first step toward this laudable goal, we agree with the *National Commission for Quality Long-Term Care* that there must be recognition that the long term care workforce is “a critical component of the nation's labor force – separate and distinct from the health care labor market.”

A recent report by this same quality commission highlighted this impending catastrophe when it stated “even if we set the somewhat conservative goal to maintain the current ratio of paid long-term care workers to the current population of 85-year-olds, the long-term care workforce would have to grow by two percent a year – to the tune of 4 million new workers – by 2050.”

The high demand for long term care workers is already documented by the federal government. A recent study by the Department of Health and Human Services (HHS) and Department of Labor (DOL) estimates the U.S. will need between 5.7 million to 6.5 million nurses, nurse aides, and home health and personal care workers by 2050 to care for the 27 million Americans who will require long term care – up more than 100 percent from the 13 million requiring long term care in 2000.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that “efforts to recruit and train new nursing staff are estimated to cost nursing facilities over \$4 billion each year – more than \$250,000 annually for each nursing home in the nation.

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the American Association of Colleges of Nursing found in its annual survey that more than 40,000 qualified applicants were not accepted into nursing programs primarily because of insufficient nurse faculty for the 2007-2008 academic year.

AHCA is Leading Efforts in Transparency in Health Care

As was reinforced by former CMS Administrator Norwalk and HHS Secretary Leavitt, the long term care profession was the first among health care providers to subscribe to true transparency and publicly available information as to our performance. We were willing partners with CMS and HHS in disclosing more information that we hoped would be helpful to consumers when facing a difficult decision for choosing a nursing facility.

We firmly believe that calls for increased disclosure on details such as minimal ownership of a nursing facility will not drive – nor contribute to – the improvement of care or services in facilities nationwide. We must look to empower those individuals, such as administrators or facility operators, who make the decisions which impact the care that is delivered daily.

The disclosure of more information does not necessarily lead to better quality or better informed consumers. In fact, disclosure of confusing, inaccurate or conflicting data leads to greater misunderstanding. Rather than promoting disclosure for disclosure’s sake, we must ensure that available reported data is in the best interest of consumer needs. The culture of cooperation should be engaged to ensure that the data reported is the correct – and most useful – information for consumers to make an informed decision as to a quality nursing facility.

Rather than the current construct of reportable data, we believe that other data components must be considered such as: family and patient satisfaction, staff turnover, patient outcome trends, the specialties and focus of the facility, and the patient acuity. Above all else, we must work together to

ensure such data is accurate, up to date and presented in a fashion that is easily understandable and useful to consumers.

Stability is Critical for Profession to Sustain Quality Gains

It is important to recognize the nursing home of the 21st century is far different from its predecessors, and while it's excellent news that patients are returning home more quickly, threatened cuts to Medicare funding are increasingly problematic when caring for older, sicker, and more medically complex patients.

A recent report from the United Hospital Fund documents the growing role that skilled nursing facilities play as providers of short-term care for individuals recuperating after a hospital stay. The report finds that the "number of patients staying in a nursing home for less than two months more than tripled," from 1996 to 2005.

Just last week, CMS issued a proposed rule for fiscal year 2009 payments to skilled nursing facilities, which would cut Medicare Part A payments for skilled nursing care by \$770 million in the first year alone, or \$5 billion over five years. Cutbacks of this magnitude not only threaten the progress we have achieved working with the federal government to improve care quality, but reduce our profession's ability to maintain quality improvement initiatives taking place on the front lines of care that are currently making a difference in the lives of our residents and those caregivers providing critical care and rehabilitative services.

These cuts are exacerbated by the chronic underfunding by Medicaid for care and services provided in our nation's nursing facilities. A recent *BDO Seidman/Eljay, LLC*, study projected that states cumulatively underfunded the actual cost of providing quality nursing facility care by \$4.4 billion in 2007. The analysis further showed the average shortfall in Medicaid nursing home reimbursement was \$13.15 per patient day in 2007 - a 45 percent increase from 1999.

And while financial stability is an essential component of delivering high quality long term care services, it is just as critical for the profession to maintain a stable workforce. Nearly 70 percent of skilled nursing operating costs are labor-related. Ongoing funding shortfalls have a major impact on the front lines of care and negatively influence staffing, jeopardize intra-facility quality improvement efforts, and even may cost the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

So we ask you Mr. Chairman, how can dedicated providers of skilled nursing care meet the ongoing demands of the federal government for increased staffing levels and sustained quality improvements with reduced funding?

Ensuring Adequate & Appropriate Safeguards

I am here today to discuss ways we can improve the regulatory process and ensure that current safeguards are adequate and appropriate.

One inherent flaw with the current survey process is that it is incredibly subjective by nature – this is because the review inherently relies upon individual interpretation of a situation. With different interpretations by individuals and survey teams, it is easily understandable why there is great variability in the process. This reality was highlighted in a recent analysis by LTCQ, which found that for states with more than five survey districts, there were significant differences from one district to another. The data illustrated that there was a wide range of interpretation, in particular, for skin care standards and medication administration.

There is, however, one system that shows promise in reducing the human interpretation and subjectivity of the current process – this is the Quality Indicator Survey (QIS). We applaud CMS’s latest attempt through the automated QIS survey process to minimize human variability. Although it is far too early to draw comprehensive conclusions on QIS, AHCA is cautiously optimistic that the process will help correct some of the inadequacies of the current system.

We believe that it is possible to do a better job of accurately identifying those facilities that need a more thorough, detailed review during an annual survey versus those facilities that, although not perfect, consistently reflect quality care and substantial compliance with the regulatory requirements. In identifying these facilities, we feel it would enable the CMS surveyors and the QIOs to focus their limited resources on the facilities and patients that will benefit most from additional attention. Such changes, we feel, would lead to a smarter, more effective survey system.

Recommendations for a Smarter Oversight System

- We ask that Congress consider establishing a pilot program in a few states that would allow funds collected through civil monetary penalties (CMPs) to be put back into the system to improve quality care. In my home state of Georgia, the CMPs were used effectively in a quality improvement program that assisted facilities in paying for an automated quality dashboard and customer satisfaction surveys. In Arkansas, the state is using CMP funds to fund their Local Area Network for Excellence as part of the *Advancing Excellence in America’s Nursing Homes* campaign and funding satisfaction surveys to determine how residents, families and staff feel about the facility and services received. These are just two examples of how the collected funds can be reinvested into facility improvements.
- In order to encourage new investment into troubled facilities that may face closure, Congress and CMS should consider the suspension of certain fines and penalties when a facility is being purchased in an arms length transaction by an individual or entity that has no connection to the previous owner. This will help in two ways: 1) assuming the facility is not yet closed, it may negate the need to transfer patients, which can have serious psychological and medical consequences; and 2) it will encourage individuals and groups to purchase a problem facility in order to improve it by removing insurmountable obstacles at the outset which might otherwise discourage them from making the purchase.
- Congress should consider creating a national commission that includes all stakeholders in long term care – CMS, owners/operators, caregivers, families, residents, and advocacy organizations – in order to best determine what information would provide assistance to consumers, and how

it should be made available. Current information on Nursing Home Compare and other online resources is often times outdated and confusing. By determining what is helpful to consumers, the commission can create improved resources that are more user-friendly, and contain meaningful information.

- Congress should amend the charter of the Medicare Payment Advisory Commission (MedPAC) to require the Commission to consider operating margins of all government payers, the adequacy of all government funding, and the effects of the interaction between the Medicare and Medicaid programs on nursing facilities. This approach will enhance economic stability and quality improvements.
- We encourage CMS to provide evidentiary legal protections for information disclosed by those facilities that are voluntarily participating in the *Advancing Excellence in America's Nursing Homes* campaign. Facilities who participate in such programs have made a public commitment to high quality care – and there should be incentives for facilities to make that same, voluntary commitment to track and improve eight measurable goals.
- We support the idea of posting more complete staffing data on Nursing Home Compare for consumer use. This data would include all caregivers in a facility, including physical and occupational therapists, speech-language pathologists, nurse practitioners, and all contract nurses to truly reflect the number of hands-on caregivers in each facility. The staffing levels should also be placed in context on Nursing Home Compare with an indication of the patient mix or acuity in the facility, providing a better indication as to why a facility may have a higher or lower level of staffing.
- We also urge Congress to pass *The Long Term Care Quality & Modernization Act of 2007* (H.R. 4082). This important legislation, authored by Representatives Earl Pomeroy (D-ND), Shelley Moore Capito (R-WV) and Tom Allen (D-ME) aims to enhance long term care by encouraging policy changes that will promote quality of care in the nation's long term care settings, and modernize payment and other systems to keep pace with advances in medicine and medical technology. The field of providing care to the nation's long term care patients is changing, and so should the laws that help govern it. Specifically, the bill would:
 - Enhance quality by training long term care providers and state surveyors together on rules and regulation to enhance compliance;
 - Modernize outdated “consolidated billing” rules that have not kept pace with advances in medical technology and medicines to treat cancer;
 - Amend a recent HHS rule regarding treatment of nursing home residents with diabetes;
 - Update Medicare rules requiring that patients spend three days in a hospital before being admitted to a skilled nursing facility;

- Protect Medicare Part B beneficiaries by extending the current exceptions process for outpatient therapy services;
- Direct the Secretary of Health and Human Services to create a Long-Term Care Quality Advisory Commission. The purpose of the Commission is to develop and facilitate implementation of a national plan for long term care quality improvement;
- Remove barriers in place in order for more nurses to receive assistance through the *Nurse Reinvestment Act*;
- Study the growing crisis of shortages in the nurse and physical therapy professions; and
- Enhance quality of long term care facilities by updating current tax law regarding the reconstruction and modernization of nursing homes and other long term care settings

We agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation's most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

Thank you for the opportunity to offer these comments on behalf of millions of professional, compassionate long term caregivers and the millions of frail, elderly, and disabled Americans they serve each day. I look forward to responding to your questions.

###