Testimony of David R. Zimmerman, Ph.D.

Professor, Department of Industrial and Systems Engineering
Director, Center for Health Systems Research and Analysis

University of Wisconsin–Madison

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing
May 15, 2008

Good Morning.

My name is David Zimmerman. I am a Professor of Health Systems Engineering in the Department of Industrial and Systems Engineering at the University of Wisconsin-Madison, and I am the Director of the Center for Health Systems Research and Analysis at UW-Madison. I am also the President of the Long Term Care Institute, a non-profit organization created to assist in the monitoring of quality of nursing home care in organizations with Corporate Integrity Agreements with Office of the Inspector General within the Department of Health and Human Services.

I have been conducting research in nursing home quality of care and performance measurement for more than 25 years. For more than a decade researchers at our Center have been involved in projects funded by the Center for Medicare and Medicaid Services (CMS) to improve the quality assurance process. We also developed the original set of quality indicators—now called the "Quality Indicators/Quality Measures"—based on a standardized nursing home resident assessment instrument referred to as the Minimum Data Set. More recently at the Long Term Care Institute, we have been involved in more than 15 nursing home monitoring engagements with national and regional nursing home corporations, covering more than 1000 nursing homes and 100,000 nursing home residents. We have done this monitoring work as part of our involvement in the aforementioned corporate integrity agreements between nursing home organizations and the DHHS Office of the Inspector General.

As researchers and monitors, our clinicians and systems analysts have conducted visits to more than 1000 nursing homes in the past eight years. We have observed or participated in more than 100 quality improvement meetings, including more than 30 such sessions at the corporate

level of organizations. I have spoken to at least 15 corporate boards or board committees and met with individual board members about quality of care issues. So we have been observing and analyzing the care of nursing home residents—and the systems that govern this care—from the bedside to the boardroom. This experience has given us important insights into the world of quality assurance and quality improvement in nursing homes and the corporations that own some of them.

If there is one thing that is very clear from our monitoring experience it is that there is tremendous variation in the quality of care by facility, by unit and area of care within a facility, by district and region, and across nursing home corporations as a whole. Significantly, even the best performing organizations have pockets of mediocrity in performance, while at the other end of the spectrum, even in the worst performing organizations there are promising signs of good care. It is this inconsistency that, while probably not surprising, represents one of the most difficult challenges to overcome and yet also represents a significant opportunity to take a "systems" approach to improving nursing home quality of care. There are other significant and common inferences that we can draw from our monitoring experience and I address these inferences in the remainder of my remarks. What have we learned from this rich experience, can help make some sense of the variety of legislative proposals that are currently under consideration in both Houses of Congress.

Transparency on Ownership and Care Providers

I noted in previous testimony six months ago, to the Senate Select Committee on Aging, that there has been increasing attention on the quality of nursing home care because of the rise in the number of ownership transactions between regional and large nursing home corporations, including ownership transfers from a public corporation to entities commonly referred to as private equity firms. I noted at that time that the issue at the heart of this debate was not necessarily private equity ownership, but rather **transparency**. Nothing I have seen in the past six months has changed my position on this matter.

It is still undeniable that the purchaser and recipient of nursing home care have the right to know who is providing that care. When that purchaser is the federal government, which spends billions of dollars on nursing home care every year, the case for complete transparency is compelling. There are two levels of transparency that should be required:

1. Who owns the entities that are responsible for the provision of care?
2. What (or at least how many) individuals are providing the care?

The propositions with respect to ownership transparency are simple:

- The federal government should have the right to know, with complete transparency, the complete ownership structure of every nursing home participating in the Medicare and Medicaid program, including any entity with which the owners of the nursing home contract to provide care. Ownership information should also be provided on any owner(s) of the "bricks and mortar assets," that is the physical structure and associated property, including information about all contract provisions pertaining to the lease arrangements.
- It is the responsibility of the care provider organization to "produce" this transparency. That is, it is the obligation of the entity providing the care for which they are reimbursed, and not the purchaser of care, to make sure that full and complete information about the ownership of all entities responsible for care decisions is available. The complete ownership structure of all entities involved in the provision and administration of resident care should be fully available to CMS, either through routine reporting or through unambiguous, immediate, and completely forthcoming submission and explanation of the material upon request.
- The principle of transparency should apply no matter what level of complexity in the labyrinth of organizational structures exists. The more complex the web, the greater the need for more detailed transparency. And, the greater the complexity, the more reasonable it is that the originator of that complexity ought to have the responsibility for explaining it to the purchaser of care.

With respect to information about who provides the actual care, the principles are equally simple:

- Nursing home owners should report the staff resources, on a resident-time basis, that are devoted to resident care—not just once a year as currently but on a routine basis.
- This information should be based on payroll data, which exist in accessible form for virtually every nursing home in the country.
- The technological means exist to submit and receive staffing data, in a standardized format, for the entire nursing home industry. Reasonable people representing all stakeholders can make sound decisions about how to structure the definitions into a

common taxonomy. Acuity-based staffing, which is to date far less common in practice than in pronouncement, can be taken into account if necessary.

Compliance, Corporate Integrity Agreements, and Independent Monitoring

We have learned a great deal about monitoring nursing homes, as well as the corporate integrity agreements under which monitoring engagements operate and the corporate compliance functions which are a major focus of those monitoring efforts. First, we have some pretty solid preliminary evidence that monitoring has had a positive impact on improvement in regulatory outcomes, at least for the national and regional corporations. Our preliminary analysis suggests that monitoring and corporate integrity agreements that include monitoring provisions have improved the survey performance of the monitored organizations, in terms of lowering the number of deficiencies and, given that, the likelihood of what we call "severe deficiencies." It is difficult, of course, to tease out the impact of monitoring from other trends in survey deficiencies over that same time period, but our initial efforts to utilize statistical models to control for those other trends suggest that there has been a positive, net impact of monitoring. I caution that we are still working on these analyses, as well as further analysis to determine whether monitoring has had an impact on resident clinical and functional status. We have made a firm commitment to having an independent source review the methodology and results of our work; we are presently making arrangements for that review. That caveat noted, the initial findings are quite positive. In addition, we have substantial anecdotal evidence, including feedback from the providers themselves, that monitoring has had a productive impact on their quality assurance and quality improvement initiatives.

What advantages does the monitoring of internal compliance and quality assurance programs bring to the table? We believe the presence of monitors and the monitoring activities have elevated the importance of the internal compliance function within the organizations themselves. Having a more important and a more prominent compliance function within the facility, we believe, not only improves the quality of care, but also imbues within the organization an enhanced "culture of quality" by making compliance a more visible and integral part of the leadership and management of the organization. Our experience has been that this increased presence and visibility, as well as the existence of a more direct line of communication between compliance and top leadership—including the board—has an effect beyond just

increasing specific quality improvement initiatives. It can help put "quality of care" on an equal footing with financial stewardship within the organization.

Another advantage of the monitoring presence is that it can help to expand the quality assurance function beyond individual facilities to levels of the organization that can more effectively "make things happen" to implement quality initiatives, and help to sustain them, throughout the organization. This ability to observe and assess, as well as impact, quality assurance throughout the organization is one most difficult challenges for the current regulatory process. We must have a way of aggregating accountability and responsibility for quality assurance above the individual facility to higher levels in the organization.

Yet another important contribution of the monitoring process, we believe, is its emphasis on the ***systems*** of care and quality assurance at all levels of the organization. One of our most important insights from our monitoring work has been the importance of developing and sustaining effective systems of care, which—along with good policies and procedures—can promote more consistent care, across units, facilities, and districts and regions of organizations. Often times we found that good care was evident in particular facilities, or units within facilities, but consistency was missing so that effective care practices were too "hit or miss." Presumably one of the expected benefits of having a network of facilities is that consistency in care systems, practices, and policies, can be ensured. But too often we found that such consistency was lacking, and it was through continuous interaction with the organization, including at the top levels, that this commitment to consistency and capability to bring about consistency was achieved.

A critical corollary point is that implementing and sustaining good systems of care—and quality assurance—demands loyalty to what we have come to refer to as the "V-word: ***validation***." Too many times we found that those responsible for the oversight of quality in monitored organizations would accept without validation assurances of compliance with policy or that care protocols were being carried out as documented or reported; yet validation did not confirm that this was true. When quality assurance efforts included validating "that what was said was happening, was indeed happening"—consistently rather than occasionally—then care quality improved markedly. Validation—of policies and care practices, at the most granular level—must be a fundamental part of any effective quality oversight function.

This validation must include a focus on staffing levels and staff competencies, as well. Validation of staffing levels through crosswalks of schedules and payroll information, combined with occasional spot-checks of the number of staff on facility units, is critical to the credibility of stated staffing levels. Staff competency is becoming one of the most important requirements in nursing home care, especially with the increasing complexity of the post-acute care population we now observe in the nursing home setting. Nursing home leaders acknowledge that the lack of adequate competency is one of their most serious problems, and one of the sources of greatest provider risk, that they face in today's environment.

Along with this increased emphasis on competency, there must be a firm, unalterable commitment to not admitting residents if a nursing home does not have sufficient, competent staff or equipment and other necessary resources to meet the needs of residents. This calls, in turn, for a clear commitment to the dominance of clinical considerations over marketing in the admission decisions made at the nursing home and corporate level. There is no doubt about the real and difficult challenges the current environment places on nursing homes; but there can be no compromise on the principle that clinical considerations must be the deciding factor in whether to admit a resident.

Conclusion and Suggestions

There is a common thread running through these insights that we have gained in the course of our monitoring work. It starts with the simple principle that if we are going to see meaningful improvement in the quality of nursing home care, the provider community has to step up to the plate and meet its responsibility to build and sustain strong internal systems of compliance and quality assurance. This is not to say that a strong regulatory presence has outlived its usefulness; quite the contrary, a strong enforcement program is essential, both because those in need of protection represent the most vulnerable population in our society, and because the level of commitment and capability within the industry is not sufficient to instill confidence that quality can be assured without external scrutiny and regulation.

We believe that there are some hopeful signs on the horizon to improve the functioning of the regulatory process. For example, the recent "focused facility" initiative on the part of CMS can help to more effectively triage problematic facilities and organizations, which will help allocate scarce regulatory resources more efficiently to those problem entities in greater need of

closer scrutiny. We have several suggestions to improve the functionality of the "focused facility" project. One recommendation is to increase the consistency of the program in terms of the criteria on which facilities and organizations are selected. Another recommendation is to ensure that there is more consistency across the country in the specific protocols that are used to bring the focused facilities into compliance, as well as the protocols used by the oversight agency to confirm that the stated remedial actions are taking place.

We also believe that the "focused facility" initiative can provide a good testing ground for some of the concepts I suggest in my testimony. In this regard we endorse the suggestions made by Lew Morris on behalf of the OIG's office; the focused facility project would be an excellent place to test some of these suggestions.

Effective internal compliance programs are an essential component of meaningful quality assurance in our nursing homes. There can be no substitute for transparency in this care setting, and transparency necessitates greater internal accountability and compliance in nursing home organizations. More effective internal compliance, in turn, means that nursing home organizations must be prepared to validate that:

- All levels of the organization are capable of consistently implementing and sustaining policies, protocols, and systems that promote and assure high quality resident care
- All levels of the organization can ensure sufficient and competent staff to deliver that care; and
- All levels of the organization can monitor and oversee standardized care systems of meet individual resident needs.

For nursing home organizations that have not demonstrated this internal compliance capability, outside monitoring resources should be available to provide external review and validate the commitment and capability of the organization, and to assist them in strengthening this internal compliance function. In an environment of increasing demand for services to an extremely vulnerable population, we must rely on both internal provider compliance functions and external oversight to ensure that compliance is present.

One final note is in order. As a nation, we have, necessarily, focused a good deal of attention on the nursing home setting in our efforts to ensure that our vulnerable elderly citizens get the care they deserve and need. If we are to truly accomplish the goal of giving those citizens the care they so richly deserve, then we need to expand our focus to include the other care

provider settings that feed into skilled nursing facilities. In particular, this must include greater scrutiny of acute care hospitals, whose discharge practices have placed enormous pressure on skilled nursing facilities, and who themselves are often inadequately prepared to provide the complex care needed by elderly patients with functional impairments in addition to the usual medical co-morbidities common to the usual hospital patient population. It also means that we must turn our attention to home care and the plethora of community-based programs that provide services to the elderly in far more diffuse and less-scrutinized settings.

This concludes my remarks.