THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™
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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

We are writing on behalf of AMDA – The Society for Post-Acute and Long-Term Care Medicine, representing the nation's long-term care physicians and other health care professionals. We are responding to the recent CMS addition of a red hand "consumer alert icon" on Nursing Home Compare (NHC) for skilled nursing centers that have received an abuse or neglect citation. As a Society driven by the mission to improve outcomes for our patients in the post-acute and long-term care (PALTC) settings, we fully support all efforts that have the potential to improve outcomes for PALTC patients.

We acknowledge, without question, that some nursing homes have inadequate protections against patient and resident abuse. That any patients have suffered harm is unacceptable. We also agree that patients and families need better systems and tools to select facilities that will treat them with dignity and provide high-quality care. We fear, however, that the decision to add a "red hand/stop" icon to serve as a warning signal to patients that such a facility has had an abuse-related deficiency in the past may not be the best approach to achieve either greater transparency or better quality.

As physicians, medical directors and advanced practitioner partners of the PALTC interdisciplinary team, we truly believe that this approach will have unintended consequences, and in fact be counterproductive to achieving the high-quality patient outcomes for which we strive. It will also be clearly detrimental to the motivation and engagement of thousands of very hard-working front-line staff members. We outline below our reasoning for opposing this approach and suggest alternatives.

Violation of a fundamental patient safety principle

A fundamental principle in the field of patient safety is the establishment of a blame-free environment, in which individuals and organizations work systematically to report all errors and near misses without fear of reprimand or punishment. The Agency for Healthcare Research and Quality (AHRQ) has spent hundreds of millions of dollars to establish a patient safety network responsible for education, training, and the promotion of systematic approaches to prevent adverse events, including abuse and neglect. Central to this mission is AHRQ's message that healthcare facilities must establish blame-free

environments. The "red hand" approach to abuse and neglect violates this principle. The red hand does not provide accountability; it is instead a systematic attempt to blame facilities and/or healthcare personnel.

Additionally, we know from the adverse drug event literature that penalizing reporters results in decreased reporting. We saw this with the pain measures, which CMS recently removed from the Nursing Home Compare website and the Five-Star Quality Rating System, in part for a similar reason: Underreporting facilities "looked better" than those that reported. If we truly wish to root out abuse and neglect, the appropriate approach would be to encourage reporting by facilities and healthcare personnel. In other words, we should seek to increase reporting of abuse and neglect. In doing so, we will learn from our mistakes, not perpetuate them. As a suggestion, CMS might, for example, apply the red hand icon to nursing homes that fail to report abuse or neglect, rather than to all homes with abuse citations, whether self-reported or not.

A "just culture" engages organizations in preventing harm

Providing a just culture is critical to gaining engagement in efforts to prevent patient harm as well as improve quality. This key concept goes back to published work by W. Edwards Deming and others on total quality improvement. The abuse icon risks eroding all the strong efforts CMS has made to move from quality assurance to quality improvement. The prominent "stop and avoid" symbol may have the reverse effect of increasing the risk of abuse, as abuse is unlikely in open, healthy work cultures. Work cultures that promote penalties as opposed to negative reinforcement – and the red hand is more than a negative reinforcement; it is a penalty – are, paradoxically, more likely to see abuse rise. Also, we fear that promoting penalties will fuel further negativity about this care setting and will add to the already daunting staffing troubles that we face in America's nursing facilities.

The "red hand" approach lacks evidence of efficacy

The red hand approach has not been tested and is not evidence-based. The survey process, and survey findings, remain subjective and highly variable despite attempts to standardize them – efforts which we strongly support. Moreover, there remain concerns about the accuracy of the survey process as shown by the geographic variations in survey results. On the other hand, there is a well-established body of literature in implementation science demonstrating that true behavior change is rarely achieved through punishment. Rather, behavior change occurs through frank discussion of evidence-based approaches, positive reinforcement and collaborative efforts. We believe such an approach is possible for our nation's nursing homes and deserves to be explored further.

Through our role in taking care of patients and in serving as clinicians and medical directors of skilled nursing facilities (SNFs), we believe in acting on scientific, evidence-based approaches. Medical directors serve as the clinical and quality assurance leaders of facilities and serve in a statutory capacity. There are many good examples of innovative work being done around the country that has yielded very positive results. Unfortunately, those stories and ideas have not gotten into the mainstream, given the negative publicity and focus on adverse outcomes – promoted by over-regulation and the "all-or-nothing" approach to citations – this setting consistently receives. We strongly believe that creating hubs for sharing such ideas and working together will be a better approach to reducing abuse and neglect.

Undermining ACO/Preferred Provider Networks

Many organizations, including Accountable Care Organizations (ACOs), are establishing preferred networks of SNFs based on indicators that include staffing, quality metrics, resident outcomes such as return to the community, total cost of care, satisfaction and survey results, among others. Preferred post-acute networks

are carefully chosen and cultivated in a mutually beneficial manner to the patient, facility and health care organization. While truly abusive situations are always unacceptable, the effect of a poor survey outcome is already being considered in network selection.

With this CMS icon, however, organizations such as ACOs are caught in a quandary. A SNF with otherwise very good ratings and a long history of good service may have a single abuse citation caused by a single individual that is subjective to each survey team. This then places a "red hand" on a nursing home that produces excellent patient outcomes. The ACO is now forced to consider suddenly pulling the facility out of their post-acute network and using otherwise lower-quality facilities, which in turn negatively impacts many patients (instead of just one) as well as the fiscal integrity of the ACO. Survey results with one adverse finding, even abuse, should not warrant a nursing home's exclusion from a well-thought-out SNF preferred network, including in subsequent patient education.

Transparency of Clinical Leadership

The Society has been focused on providing transparency about the clinical leadership of nursing homes. As you know, the OBRA '87 law required that each facility hire such a clinical leader, a physician medical director who is tasked with overseeing the both the administrative and clinical quality of the facility. Yet, little to no information is publicly available to patients and their families about this role, or about the identity and qualifications of individuals serving in this capacity. As a 43-year-old organization working with nursing home medical directors, we have seen that poor and absent medical direction can lead to dire consequences at times of emergency; conversely, good medical direction can improve the quality of care, establish a more stable working environment for the clinical team, and help save lives.

It remains concerning to us that, despite the fact that one of the sentinel laws on nursing home quality, OBRA '87, reflected that the medical director was a sufficiently important position to require in statute, more than 30 years later, this position often has little to no relevance in the quality of nursing home care, including in the prevention of abuse and in the understanding of an abuse deficiency citation. We believe that providing a public information registry on individuals serving as nursing home medical directors would help patients and families in selecting a quality facility, one in which the medical director is a problem-solver and advocate in their corner who can make a difference in the facility. We have heard anecdotes of patients who turned a negative nursing facility experience to a positive one when they asked for and involved the medical director.

Providing information on the nation's nursing home medical directors could also provide CMS and other stakeholders the ability to reach out to medical directors to gain greater understanding of the latest developments and issues with nursing home abuse and neglect, as well as other clinical and regulatory concerns. Even CMS' own CMP grant-funded projects struggle and fail to determine the names and contact information for nursing home medical directors. This is unacceptable.

To that end, a group of stakeholders that comprise the Advancing Excellence in Long-Term Care Collaborative (included as an addendum) came together to write a letter to CMS requesting that such a public registry be established. We strongly encourage CMS to act on this request.

Abuse and neglect in nursing homes is never acceptable. Bringing it to light through reporting needs to be encouraged. We therefore urge CMS to rescind its decision to use the red hand icon, a damaging and punitive strategy that violates patient safety principles and is likely to reduce reporting rather than prevent abuse and neglect.

As always we stand ready to work with CMS and other stakeholders to help create and implement more effective and evidence-based strategies to reduce neglect and abuse, and to ensure quality of life and quality of care for those in our nation's nursing facilities. Please contact the Society's Director of Public Policy, Alex Bardakh, at abardakh@paltc.org or 410-992-3132 should you have any questions.

Sincerely,

Arif Nazir, MD, FACP, CMD, AGSF
President

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