Meeting with Dr. David Jackson
August 2, 1996

Meeting Summary FOR WHITE HOUSE

- The discussion during the Health Standards and Quality Bureau's meeting with David Jackson, M.D., focused on long-term care quality monitoring.

- Dr. Jackson presented his ideas for pilot implementation of an alternative to the present long-term care survey process, which would emphasize measurement of clinical outcomes and customer satisfaction and would eliminate regular onsite surveys. Complaint surveys would continue to be conducted.

- Richard W. Besdine, M.D., Bureau Director, indicated that HCFA is spending a great deal of time and money on development of quality indicators which will serve as the basis for quality assurance and improvement in the future, and which are integral to the kind of system proposed by Dr. Jackson. However, he voiced the following concerns about Dr. Jackson's proposal:

  1) Regular onsite inspections are necessary to identify a host of potential quality concerns. The survey process catches problems that are not easily uncovered through examination of currently-available outcome measures (e.g., what occurs in the kitchen, the nutritious value of meals).

2) While it's important to measure satisfaction, quality of care and patient satisfaction may be divergent. Often, patients and especially older ones are satisfied with the care they receive even though the quality of that care may be questionable.

3) Dependence on complaint surveys as a method of detecting serious abuses may not be as effective for nursing homes as it is for other settings. Most nursing home residents are cognitively impaired or do not have involved family members, making complaints about inadequate care unreliable as a warning system.

4) Quality indicators, on which this type of a monitoring system must depend, are in the very early stages of development. Development and evaluation of these indicators will take considerable time. Furthermore, we must be careful not to depend solely on indicators that have not been vigorously evaluated.

- With regard to testing a system such as the one proposed by Dr. Jackson, Dr. Besdine reiterated that the protection of our beneficiaries is our number one concern. HSQB is always examining ways to assure quality in nursing homes and will continue to consult with Dr. Jackson about his ideas, including this proposal. Just last month, Dr. Jackson participated in an HSQB-hosted conference on Quality Assurance.

THE WHITE HOUSE

WASHINGTON

May 2, 1996

David L. Jackson, M.D., Ph.D.
AssurQual, Inc.
1414 Key Highway
Baltimore, Maryland 21230

Dear Dave:

Thank you for your thoughtful letter and the copy of your proposal for improving long-term care quality. I agree that we must continue to explore new means for monitoring the quality of long-term care.

Since last year, Vice President Gore and I have been urging the Health Care Financing Administration to work with states, the health care industry, and consumer groups to develop and implement a more outcome-based quality assurance system. I am pleased to report that they are doing just that and are in the process of designing and implementing a national data system that would provide the information necessary to utilize outcome measurements or quality indicators.

With the help of the University of Colorado, the Agency has developed risk-adjusted clinical outcome measures for home health care. These quality indicators will enable HCFA and consumers to make informed choices concerning the quality of services received by beneficiaries. HCFA has also been discussing a project for Mississippi and Ohio with the American Health Care Association.

Initial efforts are also underway for exploring measures of satisfaction, procedures for auditing claims data, and methods for facilitating more effective quality improvement systems in nursing homes. For example, HCFA's Office of Research and Demonstrations is conducting a multi-state nursing home case-mix and quality demonstration in four states.

As always, I am grateful for your perspective. I have asked HCFA officials to arrange a meeting with you to discuss the best ways to proceed with a more outcome-based approach to quality improvement. With the help of informed and interested experts like you, we will surely succeed in our commitment to improve care and services for long-term care recipients.

Thank you ~~for taking~~ the time to write.

Sincerely,

Bill Clinton

TO PARKER: add to HCKLER and copy documents for Chris

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96 APR 11 P4:21

April 1, 1996

The Honorable William J. Clinton
President
The United States of America
1600 Pennsylvania Avenue
Washington, DC 20500-2000

Dear Mr. President:

I recently have had discussions with both Dr. Steve Gleason at the campaign offices and with Bruce Fried at HCFA. I shared with both of them a brief document (enclosed) I recently wrote at the request of the Chairman of the Board of the National Citizens Council for Nursing Home Reform. It describes a new approach to nursing home quality monitoring that would replace the present survey system with the public disclosure of objective, risk adjusted quality indicators. This would include strong protection for individual nursing home residents. But it would replace the present retrospective manual chart review designed to "find a problem, slap a wrist" with a much more quality improvement focused approach.

I believe that this approach has the strong support of the provider community and has been received with great interest by the State survey agencies with whom I have explored this concept (driven by a concern that it becomes increasingly difficult to do "more with less" unless there is a re-engineering of the basic process. Then it is possible to do "better with less"). I have also been working with the advocacy community to address their concerns with any change of the present OBRA survey process. I believe there is a real opportunity here to introduce a significant regulatory reform, which could simultaneously strengthen the ability to protect the frail elderly from poor quality care and to facilitate the effectiveness of efforts to improve quality services (i.e., "Continuous Quality Improvement"), to simplify the process, and decrease the costs - while accomplishing this with the support of the providers, the present state regulatory community and, hopefully, key components of the advocacy community.

Key officials in a number of states have expressed interest in attempting to craft a waiver program to evaluate the impact of this new approach. I believe you and the Administration can end up receiving substantial credit for this new initiative, if HCFA/HHS can get ahead of the states in articulating support for this approach to regulatory reform.

I would be pleased to discuss this proposal with any of your staff that would have an interest in more fully understanding its structure. Doty, Elizabeth, and I send you our prayers and thoughts. I am excited about the election campaign, and do hope I can find a way to get "plugged in" to the effort, now that we are here in the DC/Baltimore area (a campaign for re-election is certainly different than the 1992 effort; there is no need to create a de facto policy apparatus, etc. But I have carved out time to participate in any aspect that would be helpful, such as surrogate speaking, etc.).

Yours truly,

Dave Jackson

Enclosure: Disclosure Model for Quality Monitoring

110: lclinton.dlj

Draft

An Approach to Strengthening Long Term Care Quality Monitoring

Use of Risk-Adjusted Outcome Disclosure in Place of Present Retrospective, Chart Review Based Survey Process

David L. Jackson, M.D., Ph.D.

The passage of OBRA 1987 ushered in a new era for quality monitoring in Long Term Care for both Federal and State governments. These changes included many very positive improvements in the previous survey process were incorporated into the Post-OBRA changes -- and the never-ending process of refining this critically important quality monitoring function continues today.

OBRA introduced a long overdue emphasis in the survey process on residents' rights, privacy and dignity. These changes represent one of the critically important positive contributions to the survey system. However, there are some intrinsic aspects of the design of the present survey process that remain substantively and philosophically troubling. Modern concepts of quality management emphasize that systems that are retrospective and punitive are often quite counterproductive -- and almost never lead to real quality improvement. Yet the survey process today remains based primarily on retrospective chart reviews and is strongly punitive in its application. The system provides relatively few positive incentives for good performance.

Recently, new methodologies have been developed that permit the quantitative measurement (and hence the management) of clinical outcomes (through "quality indicators") -- and to track "customer satisfaction," the other key element in quality measurement. These converging events and issues present a real opportunity to implement (and evaluate) a real paradigm shift for the Federal and State quality monitoring and resident protection process.

One could establish a pilot implementation of an alternative to the present survey process. This alternative would include the following steps:

A) All LTC facilities would be required to implement a formal Quality Management process.

B) The survey process would be replaced by the periodic (every 6-12 months) public disclosure of risk adjusted clinical outcomes data. Customer satisfaction measures could be included in the future, as these measures are adequately included in the future, as these measures are adequately validated. These data would be in the public record and would be available to individuals, health care professionals and organizations that make referrals to long term care facilities.

C) Outside professionals (representing the State) would be physically in the facilities to perform three functions:

1. The complaint investigation function would be retained in essentially its present form. This program relates to protection of individuals. An outcomes based monitoring program can be a very strong statistical analysis tool for facilities and other interested parties. But it does not apply directly to isolated, individual resident related issues. These are important issues, but do not represent occurrences that are frequent enough to reach "statistical significance."

2. State authorized staff would visit facilities on a random basis to audit the accuracy of the disclosed data. If this audit were to uncover the purposeful submission of inaccurate/fraudulent data, the consequences would include substantial penalties (this would be the key area for limited, but powerful, punitive consequences).

3. State authorized staff would also visit facilities that experienced either a significantly "higher" or "lower" than expected incidence of the quality indicators that are being monitored. In these visits, the focus would be to learn from and/or report to the facility staff regarding strategies that have led to better outcomes than expected for various clinical conditions (what Dr. David Zimmerman has called "Taking STOK" or the Systematic Transfer of Knowledge). This final phase could be the most important step in truly improving the quality of care delivered -- and has the potential for much more powerful positive impact on quality than the present Survey process.

This approach requires a continuing commitment to the development of better and better measures of quality/outcomes. It also requires a level of information management that moves far beyond using computers to simply "print out" MDS forms and to send out the bills at the end of each month.

But we are now in the Information Age. A careful evaluation of the impact of this proposed new system for quality monitoring could lead to improvement in the quality of care, be far more efficient and less costly, and increase the positive dialogue amongst facility staff, residents and families, the professional community, the advocacy community, and the appropriate governmental agencies.