



Nursing Home Care Quality

Twenty Years After The Omnibus Budget Reconciliation Act of 1987

December 2007

Prepared by

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RTI International

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EXECUTIVE SUMMARY

The year 2007 marks the 20th anniversary of the enactment of the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), landmark legislation that substantially changed the nursing home quality assurance system by changing the focus of regulation, establishing new standards, and revamping the inspection and enforcement process. In the years leading up to the passage of the nursing home reform amendments, there was widespread concern about poor quality of care and ineffective regulation of nursing facilities. Scandals and exposés about poor-quality care, abuse, and fraud in nursing homes were common. The passage of this landmark legislation was a rare example of the coming together of all interested parties—consumer advocates, industry, government, and researchers—to improve public policy and was an important example of a government-sponsored commission having a major impact on public policy.

This paper examines progress and problems in quality assurance in nursing homes over the last 20 years and considers the implications for the future quality of long-term care. In 2007, approximately 1.4 million people live in nearly 16,000 nursing homes nationwide. With roughly half of all nursing home care funded by Medicaid, and another 16 percent funded by Medicare, federal and state governments have a substantial interest in the care provided, particularly given the significant frailties of this population. More than two-thirds of elderly nursing home residents have multiple chronic conditions, 6 in 10 have multiple mental/cognitive diagnoses, and more than half are aged 85 and older.

OBRA 87 changed the previous federal system of regulating nursing homes in three important ways. First, OBRA 87 established new, higher standards that were much more resident focused than previous standards. The law established a number of quality-of-life rights, including freedom from abuse, mistreatment, and neglect and the ability to voice grievances without fear of discrimination or reprisal. Physical restraints, which had been quite common, were allowed under only very narrow circumstances and strict requirements were established limiting the amount of time that residents could be restrained. The law also upgraded staffing requirements for nursing homes, requiring facilities to have a registered nurse as director of nursing and licensed practical nurses on duty 24 hours a day, 7 days a week, and required a minimum of 75 hours of training for certified nursing assistants, who were also required to pass a competency test.

Second, OBRA 87 established an enforcement system for noncompliant nursing homes that incorporated a range of enforcement sanctions. States were required to conduct unannounced surveys, including resident interviews and direct observation of residents and their care, at irregular intervals at least once every 15 months, with the statewide average interval not to exceed 1 year. Noncompliant nursing homes were potentially subject to enforcement sanctions designed to match the severity of the nursing homes' deficiencies.

Third, OBRA 87 merged Medicare and Medicaid standards and survey and certification processes for nursing homes into a single system. This ended the confusion about the largely arbitrary and state-specific distinction between skilled nursing facilities and intermediate care facilities. The new standards were substantially higher than had existed for intermediate care facilities.

Over the past 20 years, nursing home care has changed, with some evidence of improvements over time. For example, the implementation of the Minimum Data Set (MDS) provides facilities with detailed and systematic information on the status of residents that can be used for care planning, to assess improvement and decline in resident status, and to identify quality-of-care problems. By 2007, fewer than 6 percent of long-stay nursing home residents had been restrained during the last 7 days. In terms of staffing, registered nurse staffing increased with the mandates of OBRA 87 and aides are now required to have at least a modest amount of training before starting to care for residents. And, the average number of deficiencies cited per facility has declined in recent years, although this measure may be an indicator of how vigorously the standards are being applied.

Yet challenges remain. More than 90 percent of all certified facilities were cited for one or more deficiencies in 2006, and nearly one-fifth of all certified facilities were cited for deficiencies that caused harm or immediate jeopardy to residents. Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appear to have reached a plateau. Substantial proportions of nursing homes are still cited for inadequate care. Staffing levels have been relatively stable for many years, despite the increased acuity and disability of residents. The best available studies suggest that the vast majority of nursing homes are significantly understaffed.

Looking to the future, there are several strategies that are receiving consideration for improving nursing home care that go beyond regulatory strategies. These approaches include reforming Medicaid and Medicare reimbursement, changing organizational culture, and providing more information to consumers. These options seek to change the organizational

incentives so that nursing homes will be motivated to improve quality of care and life. Another major direction in long-term care is the expansion of home and community-based services, both in the homes of consumers and in residential care facilities. Currently, relatively little is done to monitor quality of care in these noninstitutional settings.

In the 20 years since the passage of OBRA 87, substantial progress has been made in providing improved quality care to nursing home residents, yet significant problems remain. Many of the problems identified prior to the passage of OBRA 87 still persist. The 20th anniversary of the nursing home reform amendments provides an important opportunity to consider lessons learned, assess options for the future, and establish strategies for caring for an aging population in a range of long-term care settings.

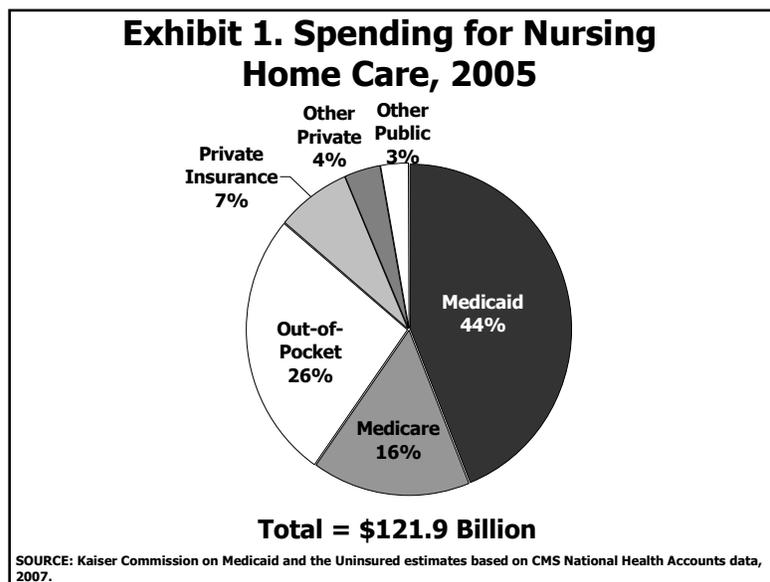
INTRODUCTION

Nursing homes are an important component of long-term care for older people and younger adults with disabilities. In June 2007, there were 15,827 nursing homes in which 1,425,484 people resided (American Health Care Association, 2007a). Medicaid and Medicare are particularly important sources of funding for nursing homes, with three-quarters of residents dependent on one of the two programs, principally Medicaid, giving the federal government an especially large interest in the care provided. In 2005, Medicaid and Medicare, together, accounted for 60 percent of spending for nursing home care. Medicaid spent \$53.6 billion on nursing home care and Medicare spent \$19.5 billion, for a total of \$73.1 billion (Kaiser Commission on Medicaid and Uninsured, 2007). Expenditures for nursing home care from all sources for 2005 are presented in **Exhibit 1**.

In order to receive Medicaid and Medicare reimbursement, nursing homes must be licensed by the state in which they are located and certified as meeting the federal quality standards for nursing homes. While the standards are federal, almost all of the actual inspections and most enforcement are conducted by state Departments of Health, giving states a major stake and

responsibility in the quality assurance process. Given the financial dominance of Medicaid and Medicare, it is not surprising that federal quality assurance standards, mandated inspections, and enforcement processes dominate the formal quality assurance system for nursing homes.

Nursing homes today provide both post-acute care and services for longer-term residents. In 2004 the typical long-stay resident was over age 85 (53 percent), female (76 percent) and widowed (60 percent) (Kasper and O'Malley, 2007). While the vast majority of nursing home residents were over age 65, about 10 percent were under age 65 (Decker, 2005). More than two-thirds of elderly nursing home residents had multiple chronic conditions and another six in ten had multiple mental/cognitive diagnoses (Kasper and O'Malley, 2007).



Nursing homes are serving a sicker population than in the past. For example, between 1985 and 1999, the proportion of nursing home residents who did not require assistance to eat, bathe, dress, and walk declined (Decker, 2005). Among elderly nursing home residents in 2004, disease prevalence was higher and multiple physical and mental/cognitive conditions were more common than in 1999, although the percentage of residents with a diagnosis of dementia remained roughly constant at just under one-quarter (Kasper and O'Malley, 2007).

The year 2007 marks the 20th anniversary of the enactment of the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which established the current federal framework for regulating nursing homes. This landmark legislation dramatically changed the quality assurance system for nursing homes by changing the focus of regulation, establishing new standards, and revamping the inspection and enforcement process. Although progress has been made, substantial problems remain with quality of care in nursing homes (Institute of Medicine, 2001; U.S. Government Accountability Office [GAO] 2005, 2007a, b). For example, the Administration on Aging's national ombudsman reporting system received more than 230,000 complaints in 2005 concerning nursing facility residents' quality of care, quality-of-life problems, or residents' rights (Administration on Aging, 2007).

This paper examines progress and problems in quality assurance in nursing homes over the last 20 years. The paper begins with a background section that reviews the problems that OBRA 87 was designed to address, briefly discusses the history that led to its passage, and describes the main elements of OBRA 87 as they relate to nursing home quality. The second section reviews trends in nursing home quality as evidenced by available reports of trends in citations for deficiencies, staffing, and quality indicators. It also analyzes the effect of the principal components of OBRA 87 and identifies areas of continuing problems. The third section identifies issues for quality assurance in long-term care for the future and some new strategies for improvement that have been proposed. The last section discusses the implications of the findings of the report for the future quality of long-term care.

BACKGROUND

The State of Quality Assurance in Nursing Homes Before OBRA 87

Concern about poor quality of care and ineffective regulation of nursing facilities dates back at least to the 1970s if not earlier (New York State Moreland Act Commission on Nursing Homes and Residential Facilities, 1975; U.S. Senate Special Committee on Aging, 1974; Wiener, 1981). Scandals and exposés about poor-quality care, abuse, and fraud in nursing homes were depressingly common.

In 1965 the legislation enacting the Medicaid and Medicare programs gave the U.S. Department of Health, Education, and Welfare the authority to set standards for participating nursing homes. However, the standards were weak and all but a few nursing facilities were able to meet the standards, despite reports of poor quality care. Federal legislation in 1967 and 1972 authorized the Department of Health, Education, and Welfare to develop and implement stricter standards. The 1967 legislation also authorized two categories of Medicaid nursing homes: skilled nursing facilities for residents requiring skilled nursing care and intermediate care facilities for residents requiring less nursing care and more personal care services. Prior to the enactment of OBRA 87, the system of federal regulations governing the certification of nursing homes under the Medicare and Medicaid programs had been essentially unchanged since the mid-1970s (Institute of Medicine, 1986).

The pre-OBRA 87 quality regulations focused on nursing homes' ability to provide care rather than the quality of care received by residents—in other words, structure rather than process and outcome (U.S. GAO, 1999). The standards primarily addressed such topics as the physical plant, the cleanliness of buildings, plumbing, food preparation equipment, broken windows, and lighting fixtures. Some measures were related directly to patient care, such as physical restraints, whether residents were properly exercised, and whether residents received proper grooming, but they were not the focus of the standards (U.S. GAO, 1987).

Management of the certification process under these standards was fragmented and quality assurance activities were limited. Although all surveys were conducted by state survey agencies, the Health Care Financing Administration, the predecessor to the Centers for Medicare & Medicaid Services (CMS), was responsible for enforcement and the final certification decision of nursing homes receiving Medicare payments, while states were responsible for the enforcement and the final certification decision of nursing homes receiving Medicaid (U.S. GAO, 1987). Surveys of nursing homes focused on whether there were written procedures in place—"paper compliance"—and could be conducted through a review of facility records

without observing residents (Hawes, 1997). Health Care Financing Administration oversight of the certification survey process by state agencies consisted of desk reviews of survey documents, visits to state agencies, and limited visits to selected facilities. The primary enforcement mechanism for state-certified Medicaid nursing homes was decertification for participation in Medicaid and Medicare, which was usually tantamount to closing the facility because of the high reliance on government revenues, and was seldom used. The General Accounting Office (1987) found widespread noncompliance with certification requirements. Many facilities were repeat offenders, and while they submitted plans of correction they never implemented them.

The regulatory process was further fragmented by differences in approach and resources committed to the nursing home certification process across states. For example, states were not consistent in making distinctions between the two types of nursing facilities: some states had almost no skilled nursing facilities; others had almost no intermediate care facilities (Institute of Medicine, 1986). Access to information about nursing facilities and residents also varied greatly among the states.

How OBRA 87 Came to Be Enacted

The roots of the passage of OBRA 87 can be traced to when Ronald Reagan became president in 1981. The Reagan Administration was philosophically skeptical of government regulation, believing that it placed unnecessary burdens on businesses for little societal gain. Very early on, the Administration focused on regulatory reform in the nursing home industry as the first of many industries for which it wished to change the regulations. Regulations that would have strengthened resident rights in nursing homes adopted in the final days of President Jimmy Carter's administration were withdrawn and the Health Care Financing Administration began a systematic examination of the Medicaid and Medicare nursing home quality standards, with an eye on eliminating unnecessary requirements. To many consumer advocates, these changes were tantamount to dismantling the existing quality assurance system. Leaks to the news media of proposed changes, especially to the *New York Times*, led to negative publicity and their disavowal by the White House and then-Secretary of Health, Education, and Welfare Richard Schweiker.

While efforts to revise nursing home quality standards ended, the Reagan Administration proposed new rules on Subpart S, which detailed the survey, certification, and enforcement process for nursing homes participating in Medicaid and Medicare. Among other provisions, these new rules allowed for self-surveys by providers under certain circumstances and "deemed" status, which would allow certification by a third-party organization to substitute for an

inspection by government agencies, both of which were strongly opposed by consumer advocates. Advocates believed that these provisions would have substantially weakened the inspection and enforcement process by relying on nursing homes to self-report their own problems and entrusting inspection and enforcement to a less rigorous process. In response, Congress twice passed legislation preventing these regulations from being implemented. After negotiations between the administration and Congress, a compromise was reached that would have the independent Institute of Medicine—part of the National Academy of Sciences—conduct a study of nursing home standards, inspections, and enforcement. It was hoped that by bringing in a neutral third party the impasse between the Administration and Congress would end.

The Institute of Medicine panel contained a broad range of providers, consumers, and researchers and was led by Sidney Katz, M.D., a prominent researcher on measuring disability. The report by the Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, was issued in 1986, and unlike some Institute studies, this report contained dozens of detailed recommendations that could be translated into legislation.

Following the issuance of the report, Elma Holder and Barbara Frank of the National Citizens Coalition for Nursing Home Reform convened the Campaign for Quality Care, which included all of the major stakeholders on nursing home quality. Although there were issues of contention between consumer advocates and the nursing home industry (such as whether to impose minimum staffing ratios), the committee hammered out a compromise bill that was supported by the industry and consumer advocates. Hearings before Congress, which featured actor Kirk Douglas, the honorary chairperson of the group, galvanized the House and Senate, especially since the bill had exceptionally broad support. Because of the rules governing reconciliation bills that made it hard to amend the bill and to veto it, the placement of the nursing home quality initiative in an omnibus budget reconciliation bill further increased its likelihood of becoming law. The Omnibus Budget Reconciliation Act of 1987 overwhelmingly passed Congress and was signed by President Reagan.

Major Provisions of OBRA 87

OBRA 87 changed the previous federal system of regulating nursing in three ways (Hawes, 1996). First, the law established new, higher standards that were much more resident focused than previous standards. Second, the law established an enforcement system for noncompliant nursing homes that incorporated a range of successful state enforcement sanctions. These were designed to provide graduated sanctions that would allow the enforcement

mechanism to match the severity of nursing home deficiencies. Third, the law merged Medicaid and Medicare standards and survey and certification into essentially a single system.

Setting Higher Standards

The first major component of the OBRA 87 reforms was to establish higher standards, with an emphasis on the resident. The general standard of the law was to promote “maximum practicable functioning.” Specifically, the law and regulations (42 CFR Part 483) established the following:

- Nursing facilities are responsible for assisting residents in the maintenance of activities of daily living, including the ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication (42 CFR Part 483.25a).
- Preadmission screening and annual resident reviews should be conducted for residents with mental illnesses and certain other chronic conditions to ensure that they are not inappropriately being held in nursing homes and that those appropriately placed in nursing homes receive appropriate services (42 CFR Part 483.112-116).
- Physical restraints are specifically prohibited for discipline or convenience, and specific indications are required for the use of antipsychotic medications to reduce their use as chemical restraints (42 CFR Part 483.13).
- A range of other support services should be provided or arranged, including social activities; medically related social services; dietary services; physician and emergency care services; and pharmacy, dental, and rehabilitation services such as physical, speech, and occupational therapies (42 CFR Part 483.15, .35-.60).
- That residents be assessed upon entry and periodically after that, and that the assessment be used to develop a written plan of care prepared and periodically reviewed and revised by a team including the attending physician and a registered nurse. The law specified the creation of a new, standardized, “reproducible,” comprehensive functional assessment tool that would be used to assess all residents. This tool would generate a data set to be used for clinical assessment and individualized care planning for each resident. These data were also to be a resource for facilities to measure and improve their overall performance, and available for regulators to track resident outcomes (42 CFR Part 483.20).

The law and regulations also established a number of quality-of-life rights along with the standards on quality of care (42 CFR Part 483). These rights included the right

- to freedom from abuse, mistreatment, and neglect;
- to freedom from physical restraints;
- to privacy;
- to accommodation of medical, physical, psychological, and social needs;

- to participation in resident and family groups;
- to be treated with dignity;
- to exercise self-determination;
- to communicate freely;
- to participate in the review of one’s care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and
- to voice grievances without discrimination or reprisal (42 CFR Part 483.10).

As a part of this emphasis on rights of residents against arbitrary actions by the nursing home administrator or other staff, OBRA 87 also included provisions giving residents more rights to communicate with regulators. The law specified that residents have access to a state long-term care ombudsman, established under the Older Americans Act. The law also guaranteed a resident the right to a personal attending physician. The law guaranteed that a resident would be transferred or discharged only for reasons of health, safety, welfare of the resident or other residents, nonpayment, or facility closure. In case of transfer or discharge, the nursing home was required to give notice and the resident had a right to appeal the decision.

OBRA 87 also revised and standardized the staffing requirements for nursing homes. Under the law, all nursing facilities were required to have a registered nurse as director of nursing, with licensed practical nurses on duty 24 hours a day, 7 days a week (Zhang and Grabowski, 2004). Nursing facilities were required to have a registered nurse on duty 8 hours a day, but this requirement was not linked to facility size (Harrington et al., 2000). A minimum of 75 hours of training was required for nursing aides, who were also required to pass a competency test. The law required “sufficient” staff and services to help residents attain or maintain the highest possible level of physical, mental, and psychosocial well-being, but no staffing ratios were established (Zhang and Grabowski, 2004). Nursing facilities were required to see that the medical care of each resident was supervised by a physician and that a physician was always available (42 CFR Part 483.40).

Revised Survey and Enforcement System

Under the law and regulations, states are required to conduct unannounced surveys, including resident interviews, at irregular intervals at least once every 15 months, with the statewide average interval not to exceed 1 year (42 CFR Part 483). These inspections also are to include interviews with family members and ombudsmen about residents’ daily experiences. They also are to include direct observation of residents and their care. These surveys are to be conducted by a multidisciplinary team of trained professionals (42 CFR Part 483.305-325).

Noncompliant nursing homes are subject to enforcement sanctions designed to match the severity of the nursing homes' deficiencies. These sanctions are designed to reflect the circumstances of deficiencies and the actual or potential harm to residents. For some violations, nursing homes have the opportunity to correct the deficiency before remedies are imposed. The law provides the following sanctions:

- directed in-service training of staff,
- a directed plan of correction,
- state monitoring,
- civil monetary penalties,
- denial of payment for all new Medicaid or Medicare admissions,
- denial of payment for all Medicaid or Medicare patients,
- temporary management, and
- termination of the provider agreement (42 CFR Part 488.320).

Merger of Medicare and Medicaid Standards and Processes

OBRA 87 established a single set of higher requirements for skilled nursing and intermediate care facilities, other than facilities for the mentally retarded, and made survey and enforcement the same. This single set of standards greatly simplified the process and ended the confusion about the largely arbitrary and state-specific distinction between skilled nursing facilities and intermediate care facilities. The new standards were also substantially higher than had existed for intermediate care facilities, thus disproportionately affecting Medicaid-only facilities. These unified requirements included support for resident functioning, special screening and reviews for mentally and chronically ill residents, limits on physical and psychotropic restraints, and a range of support services.

This movement to a single set of requirements made it more efficient for the federal government to use the combined Medicaid and Medicare conditions of participation for payment as leverage to obtain higher performance. As preconditions for payment under both programs, nursing homes were required to meet these standards for all of their residents, including private pay residents.

THE IMPACT OF OBRA 87 ON NURSING HOME CARE

Over the last 20 years, nursing home care has changed a great deal. This section reviews changes using a variety of data sources. In discussing the quality of the experience of nursing home residents, the domains of quality are often divided into quality of care and quality of life. While related, these domains are analytically separate and address separate parts of the care experience.

In long-term care, a major quality focus is on health and safety, including potential markers of poor quality such as malnutrition, bedsores, uncontrolled pain, and excessive use of hypnotics and antipsychotic medications. For example, quality of care assessments include whether nursing homes assist residents with eating, whether there is adequate staffing to assist residents at mealtime, and whether residents maintain an appropriate weight. As the statistics presented below demonstrate, the vast majority of existing regulations and quality measures focus on quality of care.

In contrast, quality of life refers to much more intangible factors, such as autonomy, dignity, individuality, comfort, meaningful activity and relationships, a sense of security, and spiritual well-being (National Citizens' Coalition for Nursing Home Reform, 1985; Noelker and Harel, 2000). These factors are, by definition, subjective, but they are critical to living a good and meaningful life. To continue with the feeding example, quality of life refers to the tastiness of the food, the ability to choose meals that fit with personal preferences and ethnic heritage, the friendliness and patience of the staff helping with feeding, and the willingness of the staff to let residents feed themselves to the extent possible, even if it takes additional time.

Almost all of the available quantitative data on nursing homes are on the quality of care rather than the quality of life. Quantitative data on the quality of nursing home care are available from several sources, most importantly

- nursing home survey data,
- quality indicators calculated from the Minimum Data Set (MDS), and
- complaints to state nursing home ombudsmen.

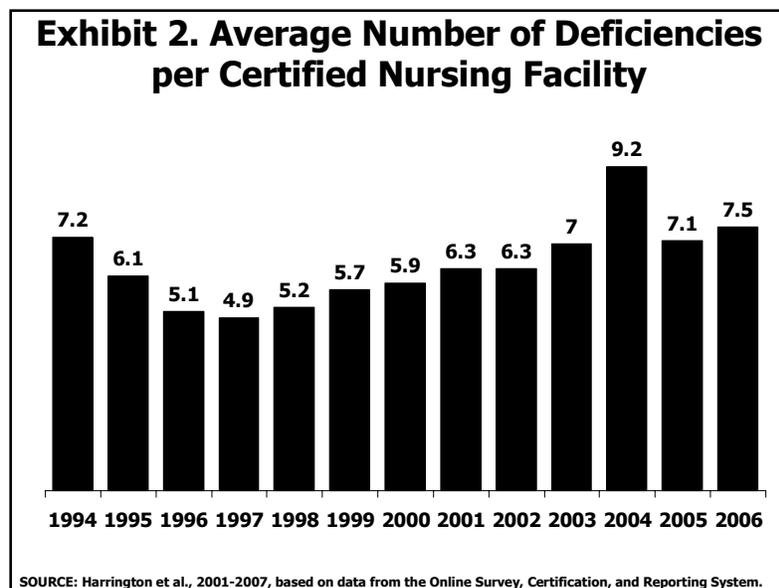
CMS compiles the results of inspections by nursing home surveyors to determine compliance with the requirements for participation in the Medicaid and Medicare programs and consolidates them into the Online Survey, Certification and Reporting system. Key data about all nursing home residents (including private pay residents) are also collected as part of the federally mandated MDS, which gathers functional and medical information on residents on a periodic

basis. MDS data are used to construct quantitative “quality indicators” (Zimmerman et al., 1995). CMS uses these quality indicators as part of the survey and certification process and makes 19 of them available to the public on its Nursing Home Compare website (<http://www.medicare.gov/NHCompare>; the indicators are defined in the **Appendix**). Finally, the Administration on Aging-funded Ombudsman Program receives and investigates complaints about nursing homes. The main advantage of these data is that they are an indication of quality as perceived by the consumer. Each set of data has its own strengths and weaknesses, making it difficult to draw definitive conclusions about the status of nursing home quality in the United States and their trends over time.

Trends in Survey Deficiencies

Researchers at the University of California, San Francisco, have tracked national trends in deficiencies of facilities cited by state surveyors from 1994 to 2006 (Harrington et al., 2007). While these data provide a valuable longitudinal view of the status of nursing homes by independent surveyors, variations—within states, across states, and across time—in how and whether surveyors cite facilities means that the data must be interpreted with caution. Thus, it is not clear whether the trends in the data are the result of changes in nursing homes or changes in the application of the surveys. (See below in the section on enforcement for a further discussion.) Comparable data are not available for the pre-OBRA 87 period.

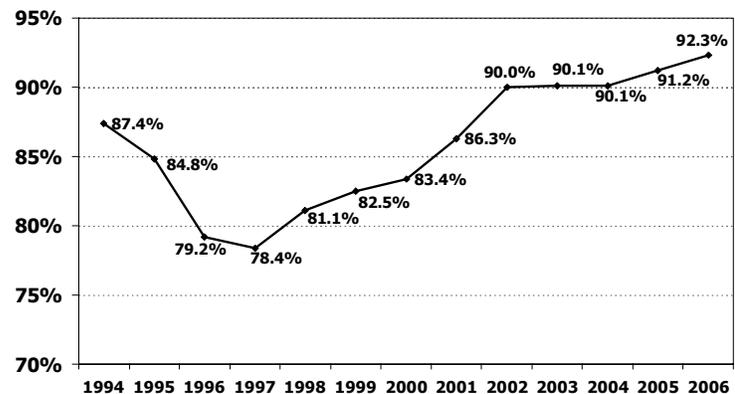
Overall, the average number of deficiencies per certified nursing facility decreased from 7.2 in 1994 to 4.9 in 1997, followed by a gradual increase to 7.5 in 2006 (with a spike to 9.2 in 2004) (**Exhibit 2**). From another perspective, the proportion of facilities with no cited



deficiencies rose from 12.6 percent in 1994 to 21.7 percent in 1997; since then the percentage of facilities with no deficiencies has fallen substantially, reaching 7.7 percent in 2006 (**Exhibit 3**).

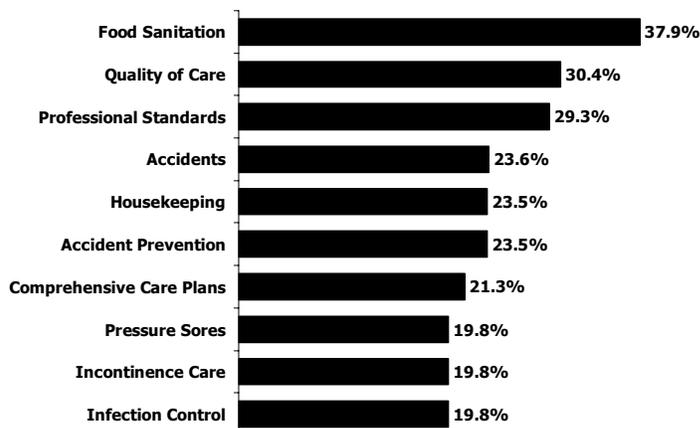
The 10 most commonly cited deficiencies during 2006 suggest that, for most categories, about one-fifth of facilities received citations, although not necessarily the same facilities (**Exhibit 4**). While the list includes housekeeping and food sanitation, which are not necessarily directly related to resident care, 23.6 percent of facilities were cited for accidents, 19.8 percent of facilities were cited for deficiencies related to pressure sores and related to incontinence care, and 30.4 percent of facilities were cited for quality-of-care deficiencies.

Exhibit 3. Percentage of Certified Nursing Facilities with Deficiencies



SOURCE: Harrington et al., 2001-2007, based on data from the Online Survey, Certification, and Reporting System.

Exhibit 4. Percent of Certified Nursing Facilities Cited for Deficiencies in 2006



SOURCE: Harrington et al., 2001-2007, based on data from the Online Survey, Certification, and Reporting System.

Beginning in July 1995, surveyors also began to rate the scope and severity of each deficiency. The percentage of facilities with deficiencies that caused harm or immediate jeopardy to residents rose from 25.7 percent in 1996 to 30.6 percent in 1999, before declining dramatically to 15.5 percent in 2004; the percentage of facilities with such deficiencies rose slightly to 18.1 percent in 2006 (**Exhibit 5**). Thus, these

serious deficiencies affect almost one-fifth of all nursing homes. Comparable data are not available for earlier periods.

Assessments and the Minimum Data Set

The provision of OBRA 87 that has likely had the greatest impact on the day-to-day processes of nursing home care is the requirement for an assessment using a federally mandated form. Prior to

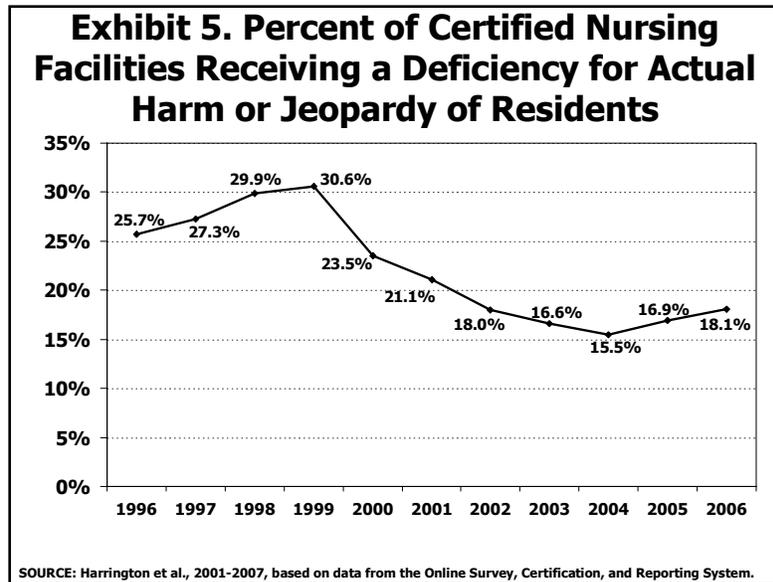
OBRA 87, studies found that assessment information was often inaccurate, incomplete, and unrelated to a care plan (Hawes, 1997).

OBRA 87 requires nursing homes to use a uniform Resident Assessment Instrument for all nursing home residents. The Resident Assessment Instrument provides a comprehensive,

structured approach to determining a resident's need for care and treatment in preparing a plan of care. The instrument must be administered on admission to the nursing home, at least annually thereafter, and when any significant change in status occurs. The Resident Assessment Instrument includes a standardized set of data elements (the Minimum Data Set) on the resident's medical, physical, functional, and affective status, and more detailed Resident Assessment Protocols that represent common problem areas or risk factors for nursing home residents. Although the studies did not rely on a random sample of facilities and the test environment did not always match that for routine use of the instrument, the reliability and validity of the MDS has been found to be good (Institute of Medicine, 2001). These data are now routinely reported to CMS and provide a wealth of information about nursing home residents.

In addition, the MDS has been used to develop quality indicators for nursing homes (Zimmerman et al., 1995). Compared to inspection reports, they focus on resident "outcomes" rather than the structural characteristics of the nursing home or the processes by which the nursing home provides care. Thus, these measures leave how to accomplish the outcomes to the individual nursing home, avoiding micromanagement.

The MDS-derived quality indicators are divided into those that apply to people who have long-term or chronic care needs and those that apply to people who use nursing homes only for short stays. Importantly, there is no summary or overall rating or ranking of facilities. These measures appear to be correlated with other measures of quality. For example, Carter and Porell (2006) found that variations in hospitalization risk among nursing home residents were explained in part by facility performance on quality indicators.



As shown in Exhibits 6 and 7, with few exceptions the quality indicators have been quite stable between 2002 and 2007. Among chronic care residents, the exceptions are that there has been:

- a decline in physical restraints from 9.7 percent in 2002 to 5.6 percent in 2007;
- a decline in pain, from 10.7 percent in 2002 to 4.5 percent in 2007 (and, among post-acute care residents, a decline in pain from 25.4 percent in 2002 to 20.7 percent in 2007); and
- an increase in residents receiving the pneumococcal vaccine, from 77.1 percent in 2006 to 81.1 percent in 2007.

Several concerns have been voiced about the use of MDS data for quality assurance purposes. First, some nursing homes may do well according to some indicators and poorly according to others, making summarizing the overall performance of a facility into a single score problematic, which limits their utility for consumers (Arling et al., 2005). Second, the relatively small size of most nursing homes and the modest

prevalence of the measured quality problems create difficult statistical issues in determining which facilities are providing poor quality of care. For example, some of the more serious quality indicators, such as decubitus ulcers, do not involve many residents, even in poor facilities. Given the relatively small number of residents in nursing homes (the average facility has about 90 residents), random variation in the prevalence of decubitus ulcers may be substantial, thus making it difficult to distinguish good from fair or poor facilities. Third, risk adjustment is

	2002	2003	2004	2005	2006	2007
Physical Condition and Depression-Related Measures						
Depression	-	-	15.3%	15.0%	14.7%	14.4%
High-Risk Pressure Ulcer	-	-	14.3%	14.0%	13.1%	12.8%
Physical Restraints	9.7%	8.6%	7.6%	7.1%	6.4%	5.6%
Pain	10.7%	7.6%	6.3%	6.4%	5.2%	4.5%
Low-Risk Pressure Ulcer	-	-	2.8%	2.7%	2.5%	2.3%
Physical Functioning and Weight Loss-Related Measures						
ADL	15.4%	16.1%	16.2%	16.6%	16.6%	16.1%
Mobility	-	-	13.3%	13.9%	13.6%	13.0%
Weight Loss	-	-	-	9.6%	9.0%	9.1%
Bedfast	-	-	4.4%	4.4%	4.3%	4.4%
Urinary System-Related Measures						
Incontinence	-	-	46.5%	47.5%	47.8%	48.8%
Urinary Tract Infections	-	-	8.3%	8.6%	8.7%	8.8%
Catheter	-	-	6.1%	6.3%	6.0%	5.9%
Vaccinations						
Influenza Vaccination	-	-	-	-	87.0%	87.0%
Pneumococcal Vaccination	-	-	-	-	77.1%	81.1%

Source: American Health Care Association, 2007a. Based on CMS Nursing Home Compare data. Figures are for the first quarter of 2003-2007 and the second quarter of 2002 (first quarter figures were not available), and the 4th quarter of 2006 for Vaccinations (where first quarter figures were not available).

	2002	2003	2004	2005	2006	2007
Post-Acute Care Quality Measures						
Pain	25.4%	22.9%	22.0%	22.4%	21.7%	20.7%
Pressure Ulcer	-	-	20.7%	19.9%	18.3%	17.5%
Delirium	3.7%	3.0%	3.2%	2.9%	2.5%	2.1%
Influenza Vaccination	-	-	-	-	73.3%	73.2%
Pneumococcal Vaccination	-	-	-	-	68.8%	73.7%

Source: American Health Care Association, 2007a. Based on CMS Nursing Home Compare data. Figures are for the first quarter of 2003-2007 and the second quarter of 2002 (first quarter figures were not available), and the 4th quarter of 2006 for Vaccinations (where first quarter figures were not available).

statistically complicated and open to methodological challenge. In the end, facilities can only be held accountable for the care they provide, not their outcomes.

Although designed initially for care planning and for providing the data for quality indicators, use of the MDS has expanded to provide the basis for categorizing nursing home residents into Resource Utilization Groups, which is the casemix adjustment system used for Medicare prospective payment for skilled nursing facilities. The Resource Utilization Groups classification system is also used by many state Medicaid prospective payment systems.

Although the multiple uses of the MDS reflect positively on the versatility of the information collected, the fact that it is used for payment and regulatory purposes also raises questions about the accuracy of the data. A key issue is that facility staff fill out the MDS largely unsupervised by surveyors and rarely is the accuracy of the assessments checked. One factor that may improve the accuracy of the data is that the incentives go in the opposite direction for reimbursement and quality measurement. On the one hand, in order to maximize Medicare and Medicaid reimbursement, providers have a strong incentive to make residents look as disabled as possible, at least initially. On the other hand, providers have strong incentives not to report deterioration in the status of residents that could trigger investigation by state surveyors. In addition, different processes of data collection across facilities may produce different results (Harrington et al., 2003b).

**Administration on Aging’s
Long-Term Care
Ombudsman’s Data**

The Administration on Aging’s Ombudsman Program investigates complaints about nursing homes. As shown in **Exhibit 8**, the total number of complaints about nursing homes has increased significantly from 186,234 in 2000 to 241,684 in 2005 (Administration on Aging,

2007). These complaints represent judgments about quality of care and life from the perspective of nursing home residents and their families.

Total Complaints		Type of Complaints				
Year	Nursing Facilities	Residents’ Rights	Resident Care	Quality of Life	Administration	Not Against Facility
2005	241,684	68,587	78,198	60,936	21,149	12,814
2004	227,721	63,689	75,481	53,112	20,642	14,797
2003	226,376	69,912	73,756	47,249	21,362	14,097
2002	208,762	65,889	66,501	41,423	22,119	12,830
2001	209,663	65,372	67,483	41,757	22,718	12,333
2000	186,234	56,829	60,785	36,326	20,791	11,503

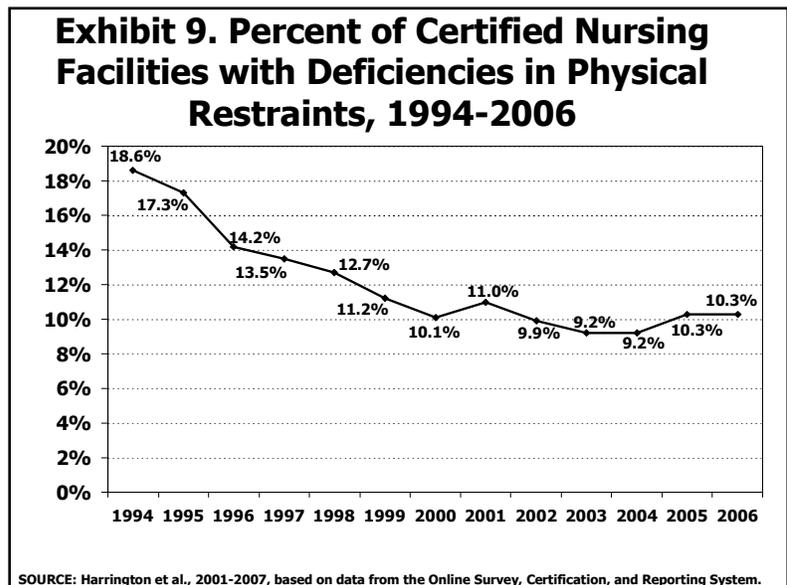
Source: U.S. Administration on Aging.

Physical and Chemical Restraints

Many observers believe that one of the biggest improvements in nursing home care since the passage of OBRA 87 is the reduction in the use of physical restraints in nursing homes (Institute of Medicine, 2001). Physical restraints are mechanical devices, materials, or equipment that restrict freedom of movement or normal access to one's body. Aside from the limitation of one's freedom and the implied assault on one's dignity, restraints can decrease muscle tone and increase the likelihood of incontinence, pressure sores, depression, and other problems. In the late 1980s, the prevalence of physical restraint use was estimated to be as high as 41 percent, with wide variability across facilities (Strumpf and Tomes, 1993).

OBRA 87 strongly discourages the use of restraints and prohibits nursing homes from using restraints unless they are medically indicated and ordered by a physician. Under OBRA 87, residents have the right to be free from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat residents' medical symptoms. Nursing home residents have the right to refuse treatment, including the use of restraints. Importantly, OBRA 87 requires that residents cannot be kept in restraints indefinitely; residents must be released from restraints and exercised at least every 2 hours.

Studies conducted following the implementation of OBRA 87 found a reduction in the use of restraints. In one set of studies, use of physical restraints in 268 facilities in 10 cities dropped from 38 percent prior to the implementation of OBRA 87 to 28 percent following the implementation of OBRA 87 (Hawes et al., 1997; Phillips et al., 1996). Other studies have also found declines in the use of restraints (Capezuti et al., 1996; Castle and Mor, 1998; Ejaz et al., 1994; Graber and Sloane, 1995; Sundel et al., 1994). As shown in **Exhibit 9**, the percentage of facilities cited for improper use of restraints declined significantly through the mid-1990s and then leveled off between 2000 and 2006 (Harrington et al., 2007).



Nursing Home Staffing

It is often asserted that the quality of care in nursing homes is impaired because staffing is inadequate, staff are insufficiently trained, and turnover is high, especially for certified nurse assistants (Decker et al., 2003; Stone and Wiener, 2001). Inadequate staffing is one of the most common complaints about nursing home care.

Low wages and lack of benefits along with difficult working conditions make recruitment and retention of nursing aides difficult (Stone and Wiener, 2001). Staff also account for the great bulk of nursing home costs, potentially creating a conflict with the incentives of prospective payment systems to keep costs low. As a result, some providers may be understaffed and the constant turnover adversely affects the ability of staff to understand the needs and preferences of individual clients and to develop a personal rapport with them. Difficulty in recruiting aides is likely to worsen over time as the number of people needing long-term care increases more quickly than the working-age population. Long-term care workers, such as personal care attendants, certified nurse assistants, and home health aides, receive low wages and generally lack fringe benefits such as health insurance and pension plans (Cousineau et al., 2000; Crown et al., 1995; Yamada, 2002).

Staffing Levels

OBRA 87 requires minimum staffing levels for registered nurses and licensed practical nurses. Specifically, Medicare and Medicaid certified nursing homes are required to have a registered nurse as the director of nursing; a registered nurse on duty at least 8 hours a day, 7 days a week; and a licensed nurse (registered nurse or licensed practical nurse) on duty the rest of the time. OBRA 87 also includes general language to the effect that nursing homes are “to provide sufficient staff and services to attain or maintain the highest possible level of physical, mental, and psychosocial well-being of each resident”

Neither federal law nor regulation provides specific guidance as to what constitutes “sufficient” staffing. Neither the Institute of Medicine report (1986) nor the law establishes specific staffing ratios, which was a concession by consumer advocates to the industry, which feared the increased costs. Although these staffing standards are rather modest, research has indicated that OBRA 87 had a positive effect on the quality of care, including a component that operated through increased staffing (Zhang and Grabowski, 2004). Data from the National Nursing Home Survey suggest that the implementation of OBRA 87 was associated with a 25 percent increase in staffing between 1985 and 1995, but staffing has been fairly flat since then, despite the increase in the disability levels of nursing home residents, discussed earlier

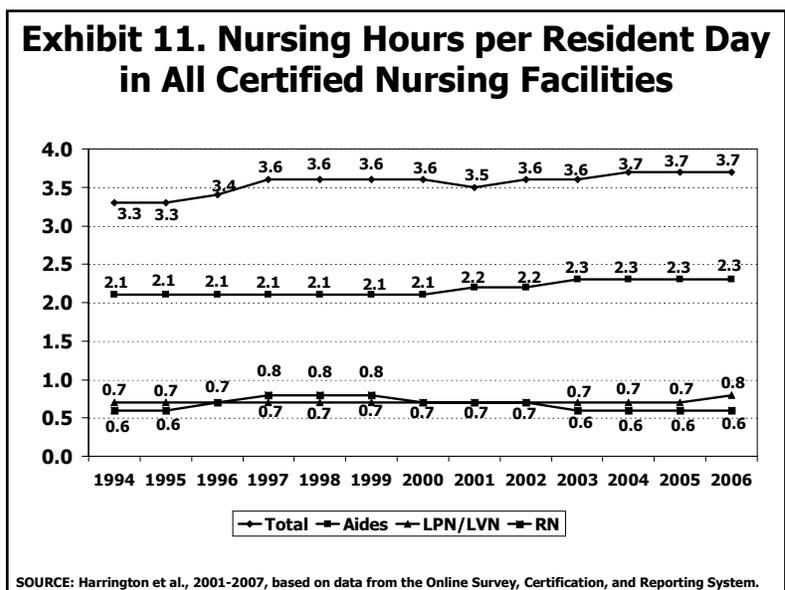
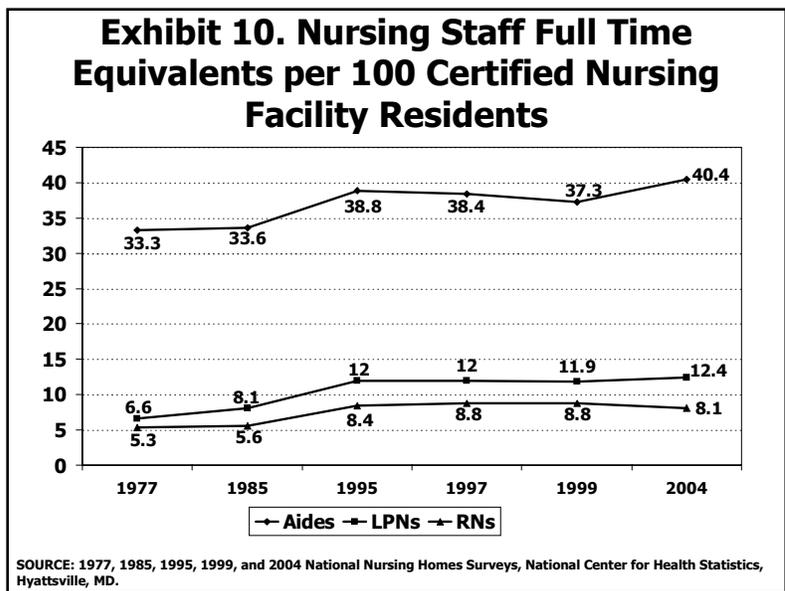
(Exhibit 10). Total staffing per 100 residents increased from 47.3 full-time equivalents in 1985 to 59.2 full-time equivalents in 1995.

Exhibit 11 presents staffing levels in hours per resident day for registered nurses (RNs), licensed practical (or vocational) nurses (LPNs), and nursing assistants, as reported by facilities for a 2-week period prior to when the most current state survey was conducted (Harrington et al., 2007). The staffing data report payroll hours and are not a direct measure of the hours of care delivered directly to residents.

Total nursing hours per resident day increased minimally from 3.3 to 3.6 hours over the 1994–2003 period. Since then, total hours per resident day have increased very slightly to 3.7. Thus, staffing levels have been flat for at least a decade, despite an increase in the disability levels of nursing home residents discussed earlier. Registered nurse staffing hours per resident declined by 25 percent since

1999 (Harrington et al., 2007). More recently, concern has developed over the effect of ownership by private equity firms and its effects on staffing levels. A recent investigative report found that staffing was reduced at 60 percent of nursing homes bought by large private equity groups from 2000 to 2006 (Duhigg, 2007).

It is important to note that staffing ratios vary widely across facilities. For example, in 1998 the median facility provided 3.21 hours per resident day of nursing time, but the 10th



percentile facility provided only 2.46 hours per day and the 90th percentile facility provided 4.66 hours per day (Harrington and Carillo, 2000).

While staffing ratios provide a first approximation of the amount of resources available to care for nursing home residents, these ratios are not perfect:

- There is no “risk adjustment” to these staffing levels to account for the level of care needed by the residents of a facility.
- The staffing information may be either inaccurate or out of date. For example, it is widely believed that many nursing homes increase staffing during the period when they expect to be inspected.
- The staffing data include nursing staff who have administrative as well as direct care responsibilities. Thus, the number of staff available to actually provide care is likely to be smaller than the numbers would indicate.

A number of efforts have analyzed the relationships between staffing and the quality of care and the possibility of establishing additional staffing ratio requirements. In 2001, CMS reported to Congress on the results of research performed under contract by Abt Associates. The objectives of the research, using data from a representative sample of 10 states including over 5,000 facilities, was to identify staffing thresholds below which quality of care was compromised and above which there was no further benefit of additional staffing with respect to quality. The project found that there were incremental benefits from increased nurse staffing until a threshold was reached, at which point there were no further benefits with respect to quality. Depending on the nursing home population, these thresholds range between 2.4 and 2.8 hours per resident day for nurse aides, 1.15–1.30 hours per resident day for licensed staff (RNs and LPNs combined), and 0.55–0.75 hours per resident day for RNs, respectively. The report noted that if these maximum total effect thresholds were implemented as requirements, 97 percent of all nursing homes would fail to meet one or more of these standards. The report to Congress (CMS, 2002) found “strong and compelling” statistical evidence that nursing homes with a low ratio of nursing personnel to patients were more likely to provide substandard care, and the study authors recommended a *minimum* staffing ratio of 4.1 hours of care per resident day, about 10 percent higher than *average* current staff levels.

The report also stated that existing nurse staffing data are not sufficiently accurate for determining compliance with any nurse staffing requirements that might be implemented, or for consumer information. The report stated that it appears feasible to replace the current reporting requirement with electronic submission of a limited set of staffing variables derived from payroll records and invoices from contract agencies, and the Department of Health and Human Services

recommended that there be a new provider requirement of electronic submission of staffing data based on payroll data and invoices from contract agencies.

A number of other studies have found a positive association between nurse staffing levels (especially for registered nurses) and the processes and outcomes of care in nursing homes (Institute of Medicine, 1996, 2001). For example, Harrington et al. (2000) showed that higher nurse staffing hours were associated with fewer nursing home deficiencies. And the Government Accountability Office found that the quality of care in nursing homes is related more to staffing than spending (U.S. GAO, 2002).

Many specific reports of poor-quality care (e.g., rushed feeding and not answering call bells) appear to be linked to inadequate staffing levels. In a review of the literature, Bostick and colleagues (2006) concluded that there is an association between higher total staffing levels (especially licensed staff) and improved quality of care, and a relationship between high turnover and poor resident outcomes.

As a result of these numerous findings, many clinicians, researchers, and consumer advocates have called for higher, more specific standards than those instituted by OBRA 87. The Institute of Medicine (2001) recommended that CMS develop minimum staffing levels for direct care based on casemix-adjusted standards. An Institute of Medicine (2003) report on *Keeping Patients Safe: Transforming the Work Environment of Nurses* recommended that CMS adopt the minimum staffing levels from the Abt study for all nursing homes, along with 24-hour registered nurse coverage. Specific staffing standards have also been proposed by the National Citizen's Coalition for Nursing Home Reform and a panel of experts led by Charlene Harrington, a nursing home expert at the University of California–San Francisco, which has recommended minimum staffing at the 80th to 90th percentile of current staffing in nursing facilities (Institute of Medicine, 2001).

In the absence of such federal standards, some states have instituted additional staffing requirements. In one study, 15 states had higher registered nurse standards and 25 had higher licensed nursing standards. Eight states required a registered nurse on duty 24 hours per day for facilities with 100 or more residents. Thirty-three states required minimum staffing for nursing assistants (Harrington and Millman, 2001).

As was true in 1987, the nursing home industry and many government officials oppose the imposition of higher and more specific staffing requirements, primarily due to cost concerns. They argue that the additional costs could be significant depending on the minimum staffing

level established. A preliminary analysis by CMS's Office of the Actuary estimated that increasing nursing home staffing to the recommended 4.1 hours per day per nursing home resident would increase total nursing home costs by \$7.6 billion, or 8.4 percent, in 2001 (CMS, 2001). Medicaid would incur perhaps two-thirds of these costs. Additionally, how staff are organized, supervised, and motivated is at least as important as the number of workers. Merely "throwing bodies" into a poorly run facility, they contend, will not improve quality of care. Further, the shortage of staff to work in long-term care makes higher staffing levels unrealistic. Recruiting and retaining workers is difficult (Decker et al., 2003). Thus, even with the best of intentions, it may be difficult to increase staffing levels.

Staff Training

OBRA 87 requires nursing assistants to receive a minimum of 75 hours of entry-level training, to participate in 12 hours of in-service training per year, and to pass a competency exam within 4 months of employment. OBRA 87 is silent on training requirements for other types of nursing home personnel. Yet one possible reason for poor quality in long-term care is that staff are not adequately trained. Especially with the increased acuity of nursing home residents and the greater complexity of care provided today, one strategy to improve quality of care is to significantly increase training requirements for all types of long-term care staff.

As nominal as the training requirements are for nurse assistants, they exceed what most other low-paid jobs require and may deter some people from working in the industry. On the other hand, the minimal training means that there is no career ladder for this type of work; it is the classic "dead-end job." There are three major issues involving staff training requirements:

- Although there is a logic to formal minimum training requirements, little research has been done to determine what those levels should be and what impact increased training has on quality of care.
- Training is not free. The costs of higher standards must be borne by workers, facilities, or the government.
- Higher training requirements may exacerbate staffing shortages by creating barriers to entry to working in long-term care. Despite this concern, 26 states require more than 75 hours of initial training and 13 of these require more than 100 hours (U.S. Department of Health and Human Services, Office of the Inspector General, 2002).

Inspection and Enforcement

Nursing facilities cannot operate unless they are licensed by the state in which they are located, and they cannot receive Medicare and Medicaid funding unless they are certified as meeting federal quality standards. The Institute of Medicine (1986) report noted "serious, even

shocking, inadequacies” in the enforcement of then-current nursing home regulations. It identified “large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed...[and that] temporarily correct their deficiency....and then quickly lapse into noncompliance until the next survey” (p. 146).

Survey and Certification

CMS relies on the states to administer the regulatory process; CMS’s regional offices oversee and monitor the state activities. CMS establishes specific protocols for state survey teams—generally consisting of registered nurses, social workers, dietitians, and other specialists—to use in conducting surveys. To monitor state compliance with federal rules, CMS performs federal comparative surveys in order to gauge the performance of the state survey systems. These procedures are intended to make on-site surveys thorough and consistent across states.

Although CMS has made a number of improvements in its survey and certification process, several problems have been identified:

- The U.S. Government Accountability Office (2005, 2007a,b) found inconsistency in how states conduct surveys. For example, Maryland identified actual harm and immediate jeopardy deficiencies in about 8 percent of the state’s nursing homes, while Connecticut found such deficiencies in approximately 51 percent of its facilities. Although possible, it seems unlikely that quality of care actually varies that much across states (U.S. GAO, 2007b). Comparing regular survey teams with other teams that surveyed simultaneously within a state, Lee and colleagues (2006) concluded that the survey process was reliable when assessing aggregate results, but only moderately reliable when examining individual citations.
- Although the understatement of serious deficiencies identified by state surveyors as measured by repeat federal surveys has declined, it continues to be a serious issue, one that has persisted for many years (U.S. GAO, 1987, 2000, 2003, 2007b). In fiscal year 2006, 28 percent of federal comparative surveys found serious deficiencies that were not identified in state surveys (U.S. GAO, 2007b).
- State budget problems have caused hiring freezes and resistance to increasing staff in survey agencies (Scully, 2003); federal spending for survey and certification totaled \$258 million in FY2006 and has been relatively flat for a number of years (U.S. Department of Health and Human Services, 2007). Survey and certification expenses are predominantly funded at the federal level, with the federal government funding 100 percent of the costs associated with certifying that nursing homes meet Medicare requirements and 75 percent of the costs associated with Medicaid standards (U.S. GAO, 2005). The states are responsible for the remaining 25 percent of the Medicaid portion of these surveys. Advocates for more aggressive regulation argue that additional funding would provide the resources needed to more actively monitor and enforce federal regulations. Studies have found that states that take more enforcement

actions and issue more civil money penalties are those that have higher state survey agency budgets from CMS (Tsoukalas et al., 2006; Walshe and Harrington, 2002).

- State survey agencies report that it is difficult to recruit and retain surveyors because of low salaries (U.S. GAO, 2005). Moreover, the long training period makes it difficult for states to replace surveyors when they leave or to increase the overall number of surveyors.

Enforcement

Regulations implementing the enforcement provisions of OBRA 87 did not take effect until 1995, 8 years after the passage of the law, in large part because of extended negotiations with the nursing home industry. The ultimate sanction is to decertify a facility from participation in Medicare and Medicaid, but OBRA 87 expanded the range of sanctions available to government regulators, adding civil money penalties, the ability to require staff training, and denial of payment for new admissions. Key steps taken by CMS to improve the enforcement process include revising the survey methodology, issuing additional guidance to strengthen complaint investigations, implementing quicker sanctions for homes cited for repeat serious violations, and strengthening oversight by conducting assessments of state survey activities (U.S. GAO, 2005).

There is substantial evidence of the inadequacies of current enforcement efforts:

- Historically, serious complaints by residents, members, or staff alleging harm to residents remained uninvestigated for weeks or months, and delays in the reporting of abuse allegations compromised the quality of available evidence, hindering investigations (U.S. GAO, 2005). More recently, CMS has focused attention on this issue (U.S. GAO, 2007b).
- When serious deficiencies were identified, federal and state enforcement policies did not ensure that they were addressed and remained corrected. To help address this, CMS established the Special Focus Program to identify and give special attention to facilities with a history of providing poor quality care. In an analysis of homes with serious quality problems in four states, the Government Accountability Office (2007) found that half of the facilities were out of compliance on subsequent surveys.
- Nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm to residents (U.S. GAO, 1987, 2000, 2003, 2007a,b). In its reports, the Government Accountability Office recommended that CMS should (1) improve the immediate sanctions policy, (2) strengthen the deterrent effect of certain sanctions, (3) expand the enhanced enforcement for homes with a history of noncompliance, and (4) improve the effectiveness of the agency data reporting systems on enforcement.
- The number of facilities receiving sanctions is low. Few nursing homes are decertified from the Medicare and Medicaid programs (U.S. GAO, 2007a,b). Moreover, few civil money penalties, holds on admission, and temporary management/receiverships are issued for serious violations of federal regulations (Harrington and Carrillo, 1999;

Harrington et al., 2004; Hawes, 2002; Tsoukalas et al., 2006). In 2004, 41 states collected 3,057 civil money penalties worth \$21 million, but civil money penalties were given for only 2 percent of deficiencies issued (Tsoukalas et al., 2006). When a sanction such as denial of civil money penalties is imposed, there is a significant time lag between when the deficiency citation occurs and the effective date of the sanction (U.S. GAO, 2007a). One estimate is that for appealed cases, it takes 420 days to collect civil money penalties, providing facilities with a substantial period of time before payment (U.S. Department of Health and Human Services, Office of the Inspector General, 2005).

Advocates of government regulation argue that enforcement remains too weak and that stronger regulation would greatly improve quality of care. Most recommendations by researchers (Institute of Medicine, 2001), consumer advocates, and the Government Accountability Office (2003, 2005, 2007) for strengthening the regulatory process involve more aggressive enforcement of existing regulations. This approach could be initiated by the federal government, but state governments could take the lead, if they so choose. For example, this could include the following:

- targeting chronically poor-performing facilities and working to change ownership or put them out of business;
- strengthening the severity rating of deficiencies to define more situations as serious;
- increasing training of surveyors;
- reducing the predictability of the timing of the survey;
- shortening the length of time for investigating complaints that allege actual harm to residents;
- imposing more fines and other penalties, especially for facilities that place residents in immediate jeopardy; and
- strengthening and making more consistent the federal oversight of state survey activities.

NEW DIRECTIONS IN LONG-TERM CARE

Looking to the future, there are several other strategies that are receiving consideration for improving nursing home care that go beyond regulatory strategies. These approaches include reforming Medicare and Medicaid reimbursement, changing organizational culture, and providing more information to consumers. These options seek to change the organizational incentives so that nursing homes will be motivated to improve quality of care and life. Another major direction in long-term care is the expansion of home and community-based services, both in the homes of consumers and in residential care facilities. Currently, little is done to monitor quality of care in these noninstitutional settings.

Reforming Medicare and Medicaid Reimbursement

Compared to acute care services, long-term care is much more heavily dependent on public sources of reimbursement (U.S. Congressional Budget Office, 2004). Thus, the reimbursement policies of Medicare and Medicaid are critical to the level of resources available to long-term care providers, and to the extent that more resources translate into better quality, public reimbursement is a key factor. In addition, the form and type of reimbursement can provide incentives or disincentives for high quality.

The Importance of Reimbursement Methodologies and Levels

Medicaid and Medicare long-term care reimbursement policies are particularly important as policy levers because federal and state policymakers have great control over both the level and methodology of payment. The federal government sets Medicare reimbursement policy and states have almost complete freedom in setting Medicaid long-term care payment rates (Wiener and Stevenson, 1998). Providers often argue for increased Medicare and Medicaid reimbursement rates as a way to improve quality of care, arguing that resources provided by public reimbursement are inadequate. BDO Seidman (2007), in a study for the American Health Care Association, estimated that unreimbursed Medicaid allowable costs for nursing homes were \$4.4 billion in 2007. An important feature of the long-term care market is that private payment rates are almost always higher than Medicaid reimbursement levels.

Not only is the level of payment important, but so is the method of payment. Payment for a range of services under Medicare has shifted from retrospective, cost-basis reimbursement to prospective payment. Payment levels vary according to selected characteristics of the individual, and a few selected characteristics of the provider, but not according to the actual costs incurred by each provider for treating each individual. Medicare pays prospectively for skilled nursing facility and home health care, as do almost all Medicaid programs.

Since prospective payment systems typically allow providers to keep the difference between the payment rate and the cost of providing services, it may provide incentives for providers to reduce costs related to patient care, which may adversely affect quality. Several studies (Konetezka et al., 2004, 2006; White, 2005) found that the implementation of the Medicare prospective payment system combined with the budget reductions of the Balanced Budget Act of 1997 were associated with declines in various levels of staffing.

There are two additional issues with increasing Medicare and Medicaid reimbursement rates as a strategy of improving quality of care in long-term care: First, the relationship between reimbursement levels and quality of care is complex, and simply raising reimbursement rates may not have a large impact on quality of care in nursing homes. Although research in this area is limited, some older nursing home studies have found that higher reimbursement is associated with more staffing but have failed to find a significant relationship to other measures of quality (Cohen and Spector, 1996; Nyman, 1988). In contrast, more recent studies have found a relationship between costs and quality outcomes in nursing homes, although the effect size is relatively modest (Grabowski, 2004; Grabowski & Angelelli, 2004; Grabowski et al., 2004). That is, relatively large increases in reimbursement are associated with relatively modest improvements in quality of care.

Second, higher Medicare and Medicaid reimbursement levels add to public costs. Thus, the dilemma for policymakers is that a dollar's worth of increased reimbursement may not yield a dollar's worth of quality improvement. Higher rates are diluted in a number of ways—including higher administrative expenses, profits, and inefficiency—that do not improve resident outcomes.

Pay for Performance

Another approach to linking reimbursement and quality in health and long-term care is “pay for performance,” the name given to integrating quality incentives directly into the payment mechanism. An ideal reimbursement system will incorporate both incentives to economize on costs and incentives to maintain and improve quality. This is the promise of pay for performance—combining prospective payment with incentive payments that vary according to measures of the quality of the care provided. An outcomes-based reimbursement demonstration implemented in 36 proprietary nursing facilities in the San Diego area from 1980 to 1983 found beneficial effects on access, quality, and cost of care (Norton, 1992; Weissert et al., 1983), but it took place over 25 years ago.

To explore this concept, CMS has started planning for a number of pay-for-performance initiatives (CMS, 2005). These demonstrations largely will focus on health care delivered under Medicare, but some will include persons dually eligible for Medicare and Medicaid (CMS, 2007). Some states, such as Minnesota, are also exploring ways to link Medicaid payments to quality (Kane et al., 2007).

CMS has funded the design of a pay-for-performance reimbursement system in anticipation of a multistate demonstration of a Medicare skilled nursing facility quality-based purchasing system. In one version, the proposed demonstration design (White et al., 2006) pay-for-performance system for skilled nursing facilities would have the following characteristics:

- Performance measures. The system should include four categories of performance measures: (1) nursing home staffing level and turnover, (2) rate of potentially avoidable hospitalizations, (3) MDS-based resident outcome measures, and (4) outcomes from state survey inspections.
- Linking nursing home performance to performance payments. Homes with overall performance scores that are in the top 20 percent of performance levels should qualify for a performance payment. Homes in the top 20 percent in terms of improvement should qualify for a performance payment in recognition of their better performance, so long as their performance is at least in the 40th percentile in the performance year. Under the demonstration no homes will face payment reductions as a result of poor performance.
- The size of the performance payment pool. The size of the payment pool should be based on whether the demonstration results in savings to the Medicare program. If there are no savings, then there would be no performance payments regardless of any quality improvements.

This reimbursement system design raises at least four issues with the pay-for-performance approach: First, there are substantial technical problems related to establishing unambiguous measures of “high” quality. There is a risk that facilities providing average or even low-quality care may qualify for financial incentives, sending the wrong or confusing message to providers. Second, quality incentive payments may “guild the lily” by providing additional funds to facilities that already are likely to be doing well financially because they may have a high percentage of private pay residents who pay charges greater than Medicaid. Thus, scarce public funds will go to providers that do not need any more resources. Third, and conversely, in CMS’s demonstration design, facilities that are below average can still obtain incentive payments if they improve substantially, providing additional funds to facilities whose performance is below average. Finally, although CMS must operate under Office of Management and Budget constraints requiring that demonstrations be budget neutral, high-quality nursing home care may

or may not result in Medicare savings, making the awarding of quality incentives dependent on something other than the nursing home's performance.

Changing Organizational Culture

Some observers have argued that the quality problems in long-term care, especially nursing homes, are the result of an organizational culture that is too hierarchical, too medical, and too bureaucratic. In response, a number of new approaches to structuring the social, cultural, and physical environments of the facilities have developed. The so-called Eden Alternative is probably the best known of these innovations in the nursing home sector (Thomas, 1994). This approach emphasizes community by linking the facility to the outside world—plants and animals are allowed, children interact with residents, and aides are empowered as an essential part of the care team. Many of these models involve physically redesigning the facility, emphasizing small “neighborhood” communities, and changing staffing patterns to promote continuity of care. This approach has led to the Green House movement, a particular embodiment of culture change for nursing homes that involves small facilities that are very homelike and where certified nursing assistants are deeply involved in decision-making (Rabig et al., 2006). In a study of Green House nursing homes in Mississippi, Kane and colleagues (2007) found generally higher satisfaction and quality of life in Green House homes than in the comparison group. Denmark has reformed its nursing homes along these lines (Stuart and Weinrich, 2001).

These innovations are intuitively appealing and appear to address many of the quality-of-life problems in traditional nursing homes. Encouraging these new care models by publicizing them and by providing implementation grants from federal and state governments and foundations might improve quality of care and life. In addition, federal and state regulations that hinder demonstrations could be modified.

While intriguing, these innovative programs are relatively recent and rare. Several issues confront advocates of using these models for quality improvement: First, although there has been a lot of media coverage, these innovations have not yet been rigorously evaluated or replicated under varying leadership, ownership, and case mix circumstances. In particular, some of the most dramatic changes may be the result of charismatic leadership, which may not be replicable when implemented on a broader scale. Second, implementing some of these models can be difficult because they are inconsistent with existing regulations. For example, the presence of birds or animals may violate sanitation requirements in some states, and some of the staffing arrangements skirt the boundaries of regulatory acceptability. Given that a number of facilities have implemented these changes, however, these barriers do not appear to be insurmountable.

Third, as the population in nursing facilities becomes more disabled and involves higher levels of medical complexity, some of the more medical characteristics of nursing facilities may be more appropriate than they were in the past and may be compromised by these new approaches.

However, any strategies must recognize that the average nursing home resident currently has 3.96 problems with activities of daily living (American Health Care Association, 2007b) and that there are approximately 16,000 nursing facilities in the United States. These facts make it difficult to design initiatives that will result in radical cultural change beyond a handful of facilities. Especially from a policy perspective, it is not clear how to change the culture of a large number of nursing homes.

Providing More Information to Consumers

One increasingly prominent approach to improving quality of care is to provide more information to consumers, their families, providers, hospital discharge planners, and others about the quality of individual long-term care providers (Harrington et al., 2003b; Mukamel and Spector, 2003). The underlying assumption is that the lack of information on the quality of individual providers results in a market failure. The premise of this approach is that armed with more information about quality of care, consumers will choose high-quality providers and avoid poor-quality providers (Bishop, 1988). Thus, in theory, market competition for residents and clients would force poor-performing providers to improve their quality of care or lose business. Hospital discharge planners, case managers, and others involved in the placement process could also use the information to advise individuals needing services and their families, steering them to high-quality providers. Lastly, providers could use the information to identify areas for improvement.

CMS has embraced this approach as a key component of its quality improvement strategy for a number of providers, including nursing homes, home health agencies, and end-stage renal disease dialysis facilities. Since 1998, CMS has operated the Nursing Home Compare website, which provides a wide variety of quality-related information about individual nursing homes (CMS, 2004). This website has been popular, averaging approximately 100,000 visits per month (U.S. House of Representatives Committee on Government Reform, 2002). In addition, there are websites that report quality information on individual nursing homes in California, Florida, Iowa, Maryland, Ohio, and Virginia (Shugarman and Garland, 2006). While older persons currently take little advantage of online information, such information may play a greater role in the future—less than one-third (31 percent) of persons aged 65 and older have ever gone online, but more

than two-thirds (70 percent) of the next generation of seniors (50- to 64-year-olds) have done so (Rideout et al., 2005). In many cases, the current users are relatives of people with disabilities.

Although there is widespread support for providing more information to consumers, the research literature on consumer response to quality of care information in health care is mixed, but mildly positive (Barr et al., 2002; Chernew and Scanlon, 1998; Hibbard et al., 2002; Knutson et al., 1998; McCormack et al., 2001; Short et al., 2002; Vaiana and McGlynn, 2002). And while Nursing Home Compare has received substantial publicity and is well known among policy analysts, its reach into the population at large is more limited. A recent study using focus groups found that few consumers used the Internet to obtain information for an impending nursing home placement, and few participants in the focus groups were aware of Nursing Home Compare (Shugarman and Brown, 2006). Moreover, Stevenson (2006) found that the impact of Nursing Home Compare on occupancy rates for facilities with high- and low-quality rankings was minimal.

Several factors may make consumer information on nursing homes less effective in influencing consumer choice than information for other health care, such as managed care or health insurance plans: First, the information provided is fairly technical, and it is not clear that consumers understand it. The Nursing Home Compare website, for example, lacks a summary rating for a facility or a star system, as is typically found in *Consumer Reports*. However, research on nursing homes surprisingly suggests that quality of care is not highly correlated across care domains (Mukamel and Brower, 1998; Mukamel and Spector, 2002; Porell and Caro, 1998). Thus, some facilities and agencies may rate highly on some dimensions of care but poorly on others. Second, the ability of information to guide decisions is only as good as the information provided. As noted above, some observers contend that MDS information may be inaccurate since it is filled out by providers.

Third, there may be structural problems in the nursing home market that limit competition based on quality. For example, high nursing home occupancy rates in many parts of the country (American Health Care Association, 2007a) potentially limit consumer choice of providers. High nursing facility occupancy rates may also reduce the desire of facilities to compete based on quality since they can fill their beds at lower-quality levels (Cohen and Spector, 1996; Grabowski, 2001; Nyman, 1985). High occupancy rates especially may limit competition for Medicaid nursing facility residents, for whom reimbursement is lower than for private pay residents.

Fourth, characteristics of the nursing home placement process may make use of consumer information difficult. Many nursing home decisions are made on an urgent basis (e.g., discharge from the hospital), and consumers may not have the time to thoroughly research a variety of nursing homes. Individual consumers are usually quite sick, disabled, or cognitively impaired, making it hard for them to be active consumers; friends and relatives often act as decision makers in their place. Placements in nursing homes often involve a great deal of family stress and emotion (Shugarman and Brown, 2006). Moreover, conventional wisdom holds that searches for nursing home agencies are typically made in very small geographic areas, limiting the number of possible provider choices (Mukamel and Spector, 2003). In some areas, especially rural communities, there may be only one provider, making quality-of-care data less compelling to consumers because there are no alternatives.

Providing More Home and Community-Based Services

Probably the most common critique of the long-term care delivery system is that there is an institutional bias. Indeed, most people strongly prefer to remain in the community. First, older people strongly prefer home and community-based services to institutional care. In one study, 30 percent of older people indicated that they would rather die than move to an institutional setting, with an additional 26 percent “very unwilling” (Mattimore et al., 1997). A 2003 study found that 81 percent of persons over age 50 would prefer to avoid nursing home care even if they needed 24-hour care (AARP, 2003).

Over the last 20 years, states, prodded by the federal government, have worked to expand and reform the role of home and community-based service. The U.S. Congressional Budget Office (2004) estimated that 32 percent of total (public and private) long-term care spending for older people was for home and community-based services in 2004. In FY 2006, home and community-based services were 29 percent of Medicaid long-term care expenditures for older people and working-age adults with physical disabilities (Burwell et al., 2007). With the rebalancing of the long-term care system underway, more and more people with disabilities will be receiving services outside of nursing homes, either at home or in residential care facilities such as assisted living facilities.

Quality Assurance for Home Care

Developing standards for and measuring quality of home care is difficult, partly because of the special characteristics of home care (Wiener and Tilly, 2003). First, home and community-based services cover a very large number of disparate services—from highly technical, medical services to nonskilled homemaker services. Thus, some standards that would make sense for

some services do not apply to others. Second, by definition, home care takes place in a very large number of physically dispersed locations, making data collection difficult and expensive. Third, it is an open question as to the extent that providers should be held accountable for adverse client outcomes given that most home care workers spend only a limited amount of time in a consumer's home, unlike the situation in nursing homes (Kane et al., 1994). Fourth, quality measures are not well developed and collecting data from persons with cognitive impairments is difficult and expensive to do adequately. Fifth, states are reluctant to establish detailed standards for home care because they fear replicating the rigidity of the nursing home setting.

Nonskilled home care services, such as personal care, are subject to much less regulation than either nursing facilities or home health agencies (Wiener et al., 2002; Wiener and Tilly, 2003). Medicaid home and community-based services waivers require states to have a quality assurance plan as part of these programs, but the content of those plans is left up to each state. CMS assesses state Medicaid quality assurance plans to ensure that states fulfill basic procedures in ensuring quality of care for services provided under the waiver. In a review of Medicaid waiver programs for older people, the Government Accountability Office (2003) found that there were quality problems in many of them. No federal requirements apply to Medicaid personal care services that are provided outside of the home and community-based services waivers. In response, CMS is requiring more detail on state plans for quality assurance under the waiver. There are no specific federal quality requirements for personal care and other home care services.

A major new development in home and community-based services is the expansion of consumer-directed home care, where the consumer rather than an agency is responsible for the hiring, scheduling, directing, monitoring, and firing of the worker (Infield, 2005; Wiener et al., 2002). CMS is promoting consumer-directed services through the Real Choice Systems Change Grants and the Independence Plus Initiative (O'Keeffe et al., 2005). A number of other countries, including the United Kingdom, Germany, and the Netherlands, are also promoting this type of care (Wiener et al., 2003). For those persons who do not feel comfortable with or are not able to be so actively involved in the decision-making process, more traditional agency-directed care remains available (Tilly and Wiener, 2001).

Compared with agency-directed care, consumer-directed services lack the standard quality assurance structures of required training of paraprofessionals, supervision by professionals, licensing, and inspections. Most states (and countries) have taken fairly minimalist approaches to monitoring quality, relying mostly on complaints and case manager interaction with clients to identify problems (Tilly and Wiener, 2001; Wiener et al., 2003). In place of

formal quality assurance mechanisms, consumer-directed programs rely on the ability of clients to fire unsatisfactory workers and to hire replacements to assure quality—in other words, the market. In addition, a substantial portion of consumer-directed workers are family members or friends, who may be more likely than a stranger to want to provide high-quality care. Despite the lack of regulation, a growing body of research suggests that consumer-directed services are at least as good as and may be better than agency-directed care (Benjamin et al., 1998; Foster et al., 2003; Schore et al., 2007; Wiener et al., in press).

Expansion of Residential Care Facilities, including Assisted Living Facilities

Residential care facilities, such as assisted living facilities, adult family homes, and board and care homes, are an important and growing component of long-term care services. Because of a lack of standard definitions across states, the estimates of the number of residential care facilities and residents vary widely, but range from 400,000 to 800,000 persons aged 65 or older (Spillman and Black, 2005). A recent study of state-licensed residential care estimated that there were 36,500 residential care facilities nationally with 937,601 units/beds in 2004 (Mollica, Johnson-Lamarche, and O’Keeffe., 2005). A substantial portion of residential care facility residents overlap with nursing home residents; for example, a study of assisted living facilities in 1998 found that almost a quarter of residents had problems with three or more of the activities of daily living and a third of residents were cognitively impaired (Hawes, Phillips, and Rose, 2000). State interest in this form of care is fueled by a desire to offer a full array of home and community services, reduce nursing home utilization, and achieve the economies of scale of nursing home care without the undesirable institutional characteristics.

There is no federal regulation of residential care facilities except under Medicaid home and community-based services waivers. While the vast majority of persons in residential care facilities pay privately, approximately 121,000 residents in 2004 received Medicaid funds to help pay for their care, largely through home and community-based services waivers and the personal care option (Mollica et al., 2005). Oregon and Washington are two states that rely heavily on assisted living facilities, adult family homes, and other forms of residential care facilities to serve people with disabilities. In 2004, 37 states had Medicaid home and community-based services waivers covering residential care facilities. Twenty-nine states and the District of Columbia reported in 2004 that they include provisions regarding assisted living concepts such as privacy, autonomy, and decision making in their residential care regulations or Medicaid standards.

Most residential care facility residents pay privately, but Medicaid and Supplemental Security Income beneficiaries are increasing (O’Keeffe and Wiener, 2004). States have almost

total responsibility for non-nursing home residential care. As a result, there is no standardization across states in terms of definition of various types of residential care, and state regulatory requirements vary greatly (Mollica, 2002). Thus, it is impossible to compare facilities across states (Mollica, 2002; O’Keeffe and Wiener, 2004). Many facilities lack the amenities, services, and philosophy of more comprehensive, high-service settings (Hawes et al., 2000). In a change from 10 years ago, all states now license or regulate residential care facilities, although the standards, inspections, and enforcement vary greatly. As a result, little is known about quality of care and quality of life in residential care facilities for people with disabilities, including compliance with state regulations, staffing patterns, or resident outcomes.

While the growth of these facilities would seem to be a market response that consumers want these type of services, there is reason to be concerned about quality of care. A study of six states that use Medicaid to pay for services in residential care settings found stakeholders almost universally concerned about perceptions of insufficient and untrained staff and the potential impact on quality of care (O’Keeffe et al., 2003). Similarly, a U.S. General Accounting Office (1999) study of residential care and assisted living in four states found insufficient, inadequate, and untrained staff, as well as significant rates of medication errors. The National Study of Assisted Living for the Frail Elderly in 1998 found many positive aspects of assisted living facilities, but also found that residents reported unmet needs for assistance with using the toilet (26 percent), locomotion (12 percent), and dressing (12 percent). Most residents (58 percent) also reported that adequate numbers of staff were not always available (Hawes et al., 2000). Finally, articles in the popular media have raised concerns about quality and inadequate staffing in residential care facilities (McCoy & Appleby, 2004a, b; McCoy & Hansen, 2004).

FUTURE OUTLOOK

The Omnibus Budget Reconciliation Act of 1987 was designed to address a range of poor-quality care, such as lack of assessments and care plans, the use of restraints, inadequate staffing, and resident abuse, by establishing new, stronger standards. It was also designed to reform and strengthen the inspection and enforcement process for nursing homes. The passage of this landmark legislation was a rare example of the coming together of all interested parties—consumer advocates, industry, government, and researchers—to improve public policy and was an important example of a government-sponsored commission having a major impact on public policy.

In the 20 years since the passage of OBRA 87, real progress has been made in providing good quality care to nursing home residents. For example, the implementation of the MDS provides facilities with detailed and systematic information on the status of residents that can be used for care planning, to assess improvement and decline in resident status, and to identify quality of care problems. While the information is available to facilities, it is not clear how much nursing homes use it. The use of physical restraints has declined substantially and the organizational culture that promoted their use has declined. In terms of staffing, registered nurse staffing increased with the mandates of OBRA 87 and aides are now required to have at least a modest amount of training before starting to care for residents. And, finally, there has been a marked decline in the proportion of facilities that have been cited for putting residents in immediate jeopardy or causing actual harm, although it is a matter of considerable dispute as to whether it is actually instead a measure of the decline in the vigor of enforcement.

While improvements in care have occurred, significant problems remain. Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appeared to have plateaued. Substantial proportions of nursing homes are still cited for inadequate care. Staffing levels have been stable for many years, despite the increased acuity and disability of residents. The best available studies suggest that the vast majority of nursing homes are significantly understaffed and that Medicare prospective payments may have unintentionally contributed to this situation. While CMS has made a number of improvements in its enforcement system, many of the problems identified in the original Institute of Medicine report—underreporting of serious deficiencies, failure to impose sanctions, long delays between initial citation and imposition of sanctions, and poor quality facilities cycling in and out of compliance—remain.

In looking to the future of improving quality of services in long-term care, several issues emerge:

- *The public sector bears a special responsibility for ensuring quality of long-term care.* Many people using long-term care services are severely ill or have physical or cognitive disabilities that make it difficult for them to successfully advocate for themselves. In addition, nursing homes, in particular, are total institutions, where people live their lives 24 hours a day, making them vulnerable to retribution if they complain or make trouble. People with disabilities living in the community can likewise be dependent on their home care workers for such basic activities as getting out of bed, again making it difficult for them to complain about services. Moreover, much more than for acute care, long-term care is dominated by public spending—Medicare, Medicaid, and state programs. Thus, policymakers have a fiduciary responsibility to make sure that the public's money is well spent.

- *Nursing homes will continue to be an important component of long-term care, but more and more people will receive their care at home or in residential care facilities, such as assisted living facilities, leading some to question whether the reach of patient protections should be broadened.* At the time of the passage of OBRA 87, nursing home care was almost the only service option for people with disabilities in many states. Expansion of public funding for home care, principally through Medicare and Medicaid, and private financing for residential care facilities has changed the long-term care landscape significantly. Ensuring quality of care in these settings faces many practical challenges, such as the multiplicity of services, the lack of standards, and the geographic dispersion of the beneficiaries.
- *Staffing issues—staffing levels, stability, and training—continue to be seen as critical to the quality of care in nursing homes.* The existing shortage of staff suggests that convincing additional people to work in long-term care will require higher wages and benefits, as well as changes in organizational culture. Thus, achieving higher staffing ratios and training will likely require giving existing workers better compensation than they currently receive. Given the heavy dependence of long-term care on Medicare and Medicaid, additional funding would be required from federal and state governments. To date, government has been unwilling to make this investment, but it is likely that the pace of quality improvement in nursing homes will be slow without more staff.
- *New organization structures for nursing home ownership and operation may present new challenges in providing high-quality care.* While very little is known about them, the recent involvement of private-equity companies in nursing home care has been accompanied by complex corporate structures that may reduce the ability to hold individuals and organizations accountable for the care that is provided in these facilities (Duhigg, 2007). On the other hand, the private equity firms involved contend that they are providing vital funds to an industry that has had little access to capital markets and that they are concerned about quality of care.
- *Many quality initiatives are geared toward punishing or avoiding inferior-quality care rather than establishing incentives for providers to provide good—even high-quality—care.* Demonstration projects could be developed that provide financial incentives to high quality of care. Although conceptually appealing, these projects face substantial technical problems and the risk of providing financial rewards to providers that are of low quality is not trivial. However, government regulation is a blunt instrument, and the inevitable reality is that surveyors can only directly observe care a very small percentage of the time. Ultimately, long-term care providers are responsible for the care provided in their facilities and by their organizations.
- *While there is general consensus about the quality of care standards established by OBRA 87, consumer advocates and the nursing home industry are far apart in terms of enforcement.* Consumer advocates argue for stricter, more consistent enforcement of the standards, with the explicit goal of eliminating poor performers from the field. They focus on the policing function of inspectors in nursing home regulation. The industry, on the other hand, contends that it is well-meaning in the care that it provides, even when the care is not always perfectly provided, and feels that nursing homes should be appropriately compensated for improvements.

- The political saliency of long-term care quality issues and the consistency of government attentiveness to the issue are uneven. Interest by policymakers tends to be cyclical. Quality of care scandals publicized by the media tend to focus attention on these issues only for a limited period of time. The stories about poor-quality care subside and the topic fades from attention, especially for top policymakers who have competing demands for their attention. It is hard to make progress without sustained attention by high-level policymakers.

In the 20 years since the passage of OBRA 87, real progress has been made in providing improved quality care to nursing home residents, yet significant problems remain. Many of the problems identified in the original Institute of Medicine report persist. The 20th anniversary of the nursing home reform amendments provides an important opportunity to consider lessons learned, assess options for the future, and strategies for caring for an aging population in a variety of long-term care settings.

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APPENDIX

CMS Nursing Home Compare Quality Measures

Quality Measures	MDS Observation Time Frame*
Long-Stay Measures	
Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	Looks back 7 days
Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Looks back 7 days
Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Low-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Long-Stay Residents Who Were Physically Restrained	Looks back 7 days
Percent of Long-Stay Residents Who are More Depressed or Anxious	Looks back 30 days
Percent of Low-Risk Long-Stay Residents Who Lose Control of Their Bowels or Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Spent Most of Their Time in Bed or in a Chair	Looks back 7 days
Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Looks back 7 days
Percent of Long-Stay Residents with a Urinary Tract Infection	Looks back 30 days
Percent of Long-Stay Residents Who Lose Too Much Weight	Looks back 30 days
Short-Stay Measures	
Percent of Short-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Short-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Short-Stay Residents With Delirium	Looks back 7 days
Percent of Short-Stay Residents Who Had Moderate to Severe Pain	Looks back 7 days
Percent of Short-Stay Residents With Pressure Sores	Looks back 7 days

*When multiple MDS items with more than one “look back” timeframe are used to calculate the measure, this table displays the longest “look back” timeframe.



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