

An Assessment of Strategies for Improving Quality of Care in Nursing Homes

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Purpose: Despite substantial regulatory oversight, quality of care in nursing homes remains problematic. This article assesses strategies for improving quality of care in these facilities. **Design and Methods:** This article reviews the research literature on eight strategies: strengthening the regulatory process, improving information systems for quality monitoring, strengthening the caregiving workforce, providing consumers with more information, strengthening consumer advocacy, increasing Medicare and Medicaid reimbursement, developing and implementing practice guidelines, and changing the culture of nursing facilities. **Results:** Although individual approaches vary, several themes emerge. First, several strategies require substantially more resources and will increase costs. Second, the research literature does not provide much guidance as to the effectiveness of these options. Third, several strategies assume a degree of data sophistication on the part of nursing homes that may not exist. Fourth, regulation is likely to continue to be the main strategy of quality assurance. Finally, the political saliency of nursing home quality issues is uneven. **Implications:** Quality of care in nursing homes is a major issue for which there is no simple solution.

Key Words: Long-term care, Nursing facilities, Regulation, Quality indicators.

Concern about poor quality of care and ineffective regulation of nursing facilities dates back at least to the 1970s if not earlier (U.S. Senate Special Committee on Aging, 1974; Wiener, 1981). In the last major national legislative response to perceived problems, the Omnibus Budget Reconciliation Act of 1987

(OBRA 87) raised quality of care standards for facilities that participate in Medicare and Medicaid and strengthened federal and state oversight. After the implementation of OBRA 87, several studies found improvement in the quality of care in nursing facilities, especially related to the use of physical and chemical restraints, prevalence of dehydration and stasis ulcers, and use of catheters (Fries et al., 1997; Hawes et al., 1997; Phillips et al., 1996, 1997).

Despite these improvements, there are substantial signs of continuing poor-quality care in nursing facilities and problematic government oversight (Institute of Medicine, 2001). In a series of studies, the U.S. General Accounting Office found that one fourth of nursing facilities nationwide had serious deficiencies that caused actual harm to residents or placed them at risk of death or serious injury, and 40% of these homes had repeated serious deficiencies (U.S. General Accounting Office, 1998, 1999a, 1999b, 2000). The Administration on Aging's national ombudsman reporting system recorded 186,234 complaints in 2000, nearly 100,000 of which concerned resident care or quality-of-life problems (Administration on Aging, no date).

What constitutes "quality" in nursing homes is complicated, but two themes run through much of the research and policy literature. First, a distinction is often made between "quality of care," which refers to the technical competency of medical and quasi-medical services, and "quality of life," which refers to such factors as consumer choice and autonomy, dignity, individuality, comfort, meaningful activity and relationships, sense of security, and spiritual well-being (Noelker & Harel, 2000). These separate dimensions may go together in specific facilities or they may not, but there is clearly a tension between nursing homes as places that take care of often very sick people and places where people live their lives. Second, the vast bulk of research and public policy in this area is focused on measuring, assessing, and deterring "poor" quality rather than encouraging "high" quality in nursing homes. To many observers, however, high-quality care is more than simply the absence of negative outcomes and regulatory deficiencies.

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The goal of this paper is to analyze strategies that have been proposed to improve quality of care and life in nursing facilities. These strategies can be broadly grouped into three categories. One class of strategies is designed to increase mandatory external pressure on nursing facilities to improve quality of care; these approaches include strengthening the regulatory process, improving information systems to allow more sophisticated regulatory monitoring, and most proposed initiatives involving the long-term care workforce (e.g., minimum staffing ratios). A second group of approaches increase voluntary external incentives to improve quality of care; these initiatives include providing consumer information on quality of care, increasing support for consumer advocacy, and changing Medicare and Medicaid reimbursement. A third category includes voluntary strategies by nursing homes to change their internal operations directly; these strategies include implementing practice guidelines and changing the organizational culture of nursing facilities.

Mandatory and External

Strengthening the Regulatory Process

The centerpiece of current efforts to improve quality of care and life in nursing facilities is direct regulation. 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 the federal quality standards. Because 76% of nursing home residents in 1999–2000 depended on Medicare or Medicaid to finance their care, all but a small number of facilities participate in one or both programs (American Health Care Association, 2001). Federal standards, survey processes, and enforcement mechanisms overwhelmingly dominate the quality assurance system. The Centers for Medicare and Medicaid Services (CMS) relies on the states to actually administer the process; CMS's regional offices oversee and monitor the state activities. Most of the recent critique of inadequate regulation involves allegations of weak enforcement rather than inadequate nursing home quality standards (with the exception of staffing levels; U.S. General Accounting Office, 1998, 1999a, 1999b).

The traditional regulatory model presumes that there is a known, minimally acceptable way to provide care and that the purpose of government rules is to make sure that providers do not fall below that level. Enforcing regulations is a classic policing function in which providers who do not meet the regulatory requirements are identified and punished. Critical to the policing model is an arms-length relationship between the regulators and facilities. Over the last 4 years, CMS has announced a variety of efforts to strengthen the regulatory process, including targeting chronically poor-performing

facilities, increasing training of surveyors, expanding the list of problems on which surveyors are to focus, improving the procedures for sampling residents whose care is to be reviewed, reducing the predictability of the timing of the survey, and strengthening the federal oversight role.

Critics of existing federal and state regulation argue that the current regulatory system has numerous deficiencies. First, they argue the nursing facility regulations are not evidence-based and do not measure what is important. Despite OBRA 87, federal and state regulations still emphasize inputs, manuals, paperwork, and structural capacity rather than resident outcomes.

Second, regulators are alleged to be inconsistent in their application of the rules, resulting in a systematic variation across states in the strictness of enforcement. For example, in 1998, the average facility in the United States had 5.2 deficiencies, but the average varied from a low of 1.9 deficiencies in New Jersey to a high of 14.2 deficiencies in Nevada (Harrington et al., 2000a). On its face, it is difficult to believe that quality of care actually varies that much across states.

Third, opponents of stricter regulation also argue that detailed rules stifle innovation, with few incentives for doing more than the minimum. In this view, too many providers concentrate their energies on meeting the minimum requirements instead of excellence. The dilemma is how to give good quality facilities more flexibility, while still requiring substandard facilities to meet detailed standards. The risk is that providers might use less prescriptive standards to provide inadequate care.

Fourth, providers complain that the current strict regulatory environment has “poisoned” the relationships between nursing homes and state surveyors in ways that are not productive. Moreover, they contend that the unrelentingly negative view of nursing homes in the media has made it extremely difficult to recruit and retain high-quality staff.

Fifth, many proposals for improving the regulatory system require substantially more financial resources for gathering information and for surveying facilities and enforcing sanctions. Lack of funding for nursing facility quality assurance at both the federal and state levels has been a chronic problem, with federal appropriations essentially level funded for many years.

Finally, whereas regulatory sanctions are meant to punish the owners or administrators of poor-quality nursing facilities, it is hard to separate the residents from the nursing homes. For example, decertifying a facility will eliminate a poor-performing provider, but doing so is legally difficult in our capitalist society because it arguably involves a “taking” of property by the government. It also requires relocation of residents, which is both hard to achieve because of relatively high nursing home occupancy rates and its disruption to residents' lives and social

relations. Even “intermediate sanctions,” such as freezing admissions of new Medicare or Medicaid beneficiaries or imposing civil money penalties, will result in reduced cash payments to facilities, which may need to be spending more money on staff and other services. This ability of nursing homes to hold residents “hostage” is a major constraint on the willingness of regulators to impose tough sanctions.

Improving Information Systems for Quality Monitoring

Valid, reliable, and timely data about nursing facility residents and the care they receive are fundamental to all strategies for monitoring and improving quality of care. It is essential both to outside regulators and to individual providers. Key data about all nursing home residents are collected as part of the federal-mandated minimum data set (MDS). Originally designed for needs assessment and care planning, the MDS periodically collects information on resident functional and medical status. Since 1990, nursing homes have been required to collect MDS data for every resident upon admission, when there are major changes in health status, and at least annually. Since June 1998, all nursing homes have been required to submit the MDS information electronically to CMS on a quarterly basis.

Although not developed as a quality assurance measure, MDS data are now also being used to construct quantitative “quality indicators” on accidents, behavioral and emotional problems, cognitive problems, incontinence, use of psychotropic drugs, decubitus ulcers, physical restraints, weight problems, and infections (Zimmerman et al., 1995). CMS uses these quality indicators as part of the survey and certification process both to help measure quality and to identify specific residents who may be receiving poor-quality care.

At least three concerns have been voiced about the use of MDS data for quality assurance purposes. First, the data may not be accurate, especially now that it is being used for regulatory purposes, as well as care planning. A key issue is that facility staff fills out the MDS. If CMS uses this data to punish the facility, staff have incentives to alter reporting to avoid these negative sanctions. However, a recent CMS-funded study found good levels of reliability in MDS-derived quality indicators, at least among the study facilities (Morris et al., 2002).

Second, quality indicators face difficult statistical issues. Some of the more serious quality indicators, such as decubitus ulcers, do not involve very many residents, even in poor facilities. Given the relatively small number of residents in nursing homes (the average facility only has about 90 residents), random variation in the prevalence of decubitus ulcers may be substantial. In addition, case-mix adjustment may be

crucial to properly identifying poor performers, but these adjustments are quite complicated to perform, requiring Bayesian multilevel hierarchical modeling (Angellilli, 2000). Failure to risk-adjust the measures would punish facilities that admit more severely disabled and medically complex residents.

Third, although, in theory, poor performance on the quality indicators is supposed to trigger additional investigation to establish whether poor-quality care is actually provided, advocates, researchers, and regulators may be inclined to take them, in and of themselves, as evidence of poor-quality care. For example, CMS is starting a five-state pilot project to make 11 quality indicators widely available to consumers with the explicit assumption that they measure quality of care (U.S. Department of Health and Human Services, 2001). This may or may not be the case. However, a recent CMS-sponsored study found a substantial number of quality indicators to have a high degree of validity and a significant number of additional ones to have a good level of validity (Morris et al., 2002). As mentioned previously, though, merely the absence of negative outcomes still may not identify a facility in which we would want to live our lives.

Strengthening the Caregiving Workforce

Nursing home care is a service that is provided by people, not machines. Three approaches have been proposed to improve nursing home care by strengthening the caregiving workforce. The first strategy is to increase the amount of personnel in nursing homes by mandating higher minimum staffing ratios. The second approach is to increase the required minimum training of people who work in nursing homes, especially certified nurse assistants. The final mechanism is to improve wages, benefits, and working conditions in nursing homes to attract and retain “better,” more qualified staff.

Staffing Ratios.—Federal standards for staffing in nursing homes do not specify particular quantities of staff. Although OBRA 87 requires that nursing facilities have licensed nurses on duty 24 hours a day, an RN on duty at least 8 hours a day 7 days a week, and an RN Director of Nursing, these requirements are not adjusted for facility size or case-mix. Instead, the law requires that the facility have “sufficient” staff to provide nursing and related services to attain or maintain the “highest practicable level” of physical, mental, and psychosocial well-being of every resident. But federal law and regulation do not provide specific standards or guidance as to what constitutes “sufficient” staffing. The number of personnel per resident varies widely across facilities. For example, in 1998, the median facility provided 3.21 hours per 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, Carillo, & Wellin, 2001). A recent CMS report to Congress concluded that a majority of nursing facilities were understaffed (Health Care Financing Administration, 2000).

A number of studies have found a positive association between nurse staffing levels (especially for registered nurses), and the processes and outcomes of care (Institute of Medicine, 1996, 2001). For example, Harrington and colleagues (2000c) showed that higher nurse staffing hours were associated with fewer nursing home deficiencies. Many reports of poor-quality care (e.g., rushed eating and not answering call bells) would appear to be linked to inadequate staffing levels.

Many clinicians, researchers, and consumer advocates consider the federal nursing home staffing standards to be too vague and have called for higher, more specific standards. Based on expert opinion, the National Citizens' Coalition for Nursing Home Reform (1995) and another expert panel (Harrington, Kovner, Mezey et al., 2000b) have recommended minimum staffing at the 80th to 90th percentile of current staffing in nursing facilities (Institute of Medicine, 2001). A new CMS report to Congress 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 day (CMS, 2002).

The nursing home industry and many government officials oppose the imposition of higher and more specific staffing requirements for several reasons. First, they argue that 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. Second, a major difficulty in setting standards is that there is little empirical, quantitative research on what the minimal staffing level should be. Up until the recent CMS study, all of the proposed standards rely solely on expert opinion and fail to adjust for case-mix, which is the primary determinant of staffing needs. Third, depending on the minimum staffing level established, additional costs could be significant. The recent CMS-sponsored study estimated the incremental costs of its proposal at \$7.6 billion a year, an 8% increase over current spending. In part because of the costs involved, the Bush Administration does not plan on proposing minimum staffing levels for nursing homes. Fourth, the current staffing shortage makes it difficult to implement any initiative to mandate increased staffing levels (Stone & Wiener, 2001).

Staff Training.—One possible reason for poor quality in nursing homes is that staff is not ade-

quately trained. Especially with the increased acuity of nursing home residents and the greater complexity of care needed today, one strategy to improve quality of care is to significantly increase training requirements for all types of nursing home staff.

Certified nurse assistants make up the largest proportion of caregiving personnel in nursing homes and provide most of the direct care, but they receive little formal training. OBRA 87 requires nursing assistants to receive a minimum of 75 hours of entry-level training, to participate in 12 hours of inservice training per year, and to pass a competency examination within 4 months of employment. Some states, such as California, require longer periods of training (Harrington, Kovner, Mezey, et al., 2000b). As minimal as the training requirements are, they exceed what most other low-skill, low-paid jobs require, and may deter some people from working in the industry. On the other hand, the minimal training also means that there is no career ladder for certified nurse assistants.

There are three major issues involving staff training requirements. First, although there is a logic to formal minimum training requirements, there is no research on what those levels should be and what the impact of increased training has on quality of care. Second, training is not free. The facility, the worker, or some third party must pay for it. Third, higher training requirements may exacerbate the staffing shortage by making it more difficult to work in nursing home settings.

Wages, Benefits, and Working Conditions.—Although cyclical economic conditions significantly affect demand for paraprofessional workers, low wages and benefits (along with difficult working conditions and heavy workloads) make recruitment and retention of nursing aides difficult, even when unemployment rates are high (Stone & Wiener, 2001). 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.

Nursing home workers, especially nurse assistants, receive low wages and generally lack fringe benefits. According to the Bureau of Labor Statistics, the median hourly wage for nursing aides in 2000 was \$8.61 (Bureau of Labor Statistics, 2002). Using pooled Current Population Surveys from 1995 and 1997, Leavitt (1998) found the median yearly earnings for nursing home aides to be only \$11,000. Besides earning low wages, these workers also receive few fringe benefits, such as health insurance and pension coverage (Crown, Ahlburg, & MacAdam, 1995).

Higher real wages and benefits for nursing assistants should help draw more marginal workers into the labor force. Moreover, increases in the relative compensation for nursing home staff could

help reallocate available low-wage workers to the long-term care sector. Elasticities of labor supply across occupations with few education and training requirements are relatively high (Ehrenberg & Smith, 1997), and the numbers of workers who might be available for such shifts are substantial. Obviously, providing higher wages and benefits could also provide a better life for workers. In recent years, several states have passed wage-pass throughs in their Medicaid reimbursement rates requiring that higher payments be passed on to workers (Stone & Wiener, 2001).

Raising wages faces three difficulties, although they are not technically insurmountable. They are more a problem of political will. First, although it is always difficult to increase government spending, the recent recession, federal and state tax cuts, and the aftermath of the terrorist attacks of September 11th make it especially difficult now. Many states are considering reimbursement cuts rather than increases (Johnson, 2002). Second, making sure that reimbursement increases result in wage and benefit increases is not always easy to verify, although increased regulatory oversight could solve this problem. Third, no empirical research confirms that increased wages and benefits result in improved recruitment and retention or have an impact on quality of care. Thus, although there is a strong logic in favor of increased wages, policy makers do not have confidence that the impact of higher wages will be worth the cost.

Voluntary and External

Providing Consumers With More Information

One popular strategy for improving the quality of care is to provide consumers (and their families) with more information about quality of care in individual nursing homes, which they can use to help choose facilities. The premise is that, armed with information about quality of care, consumers will choose high-quality facilities and avoid poor facilities. Thus, market competition will force improvements in quality of care. The relatively nontechnical nature of much of nursing home care means that consumers should be able to make choices based on quality (Bishop, 1988). The assumption is also that merely making the information available to providers will motivate action on their part.

Although many states operate their own consumer information programs, the premier example of this approach is CMS's "Nursing Home Compare" Web site, <http://www.medicare.gov/NHCompare/home.asp>. Operating since 1998, this Web site provides information about individual nursing homes in a searchable database, including information on general characteristics of the facility (e.g., whether its ownership is for-profit or nonprofit) and residents (e.g., percentage of residents who are very dependent

in eating), citations for deficiencies in meeting the federal certification standards, and staffing ratios. It is a very popular source of information about nursing homes, receiving about 100,000 visits a month (U.S. House of Representatives Committee on Government Reform, Minority Staff, 2002).

Although there is widespread support for providing more information to consumers, there are a number of concerns about this approach. First, to date, there is no research on the impact of providing information about individual facilities on consumer choice of facilities or on quality of care. Many nursing home placements are made on an urgent basis, and consumers may not have the time or ability to thoroughly research a variety of nursing homes. Searches are typically made in small geographic areas, limiting the number of possible choices. In addition, although nursing facility occupancy rates have fallen, they are still relatively high, limiting consumer choice, at least for those who cannot wait for a placement. Nursing homes also may discriminate against racial minorities and are likely to prefer private pay to Medicaid beneficiaries because payment rates are higher (Swan, Estes, & Harrington, 1995; Wallace, Levy-Storms, Kingston, & Anderson, 1998). Moreover, it is not clear that consumers are able to interpret the information provided, especially because an overall rating (as in *Consumer Reports*) is not provided on the federal Web site and is rarely provided on state Web sites.

Second, the information on nursing homes inevitably draws on existing regulatory data about facilities or residents, the potential problems of which already have been discussed. This data may also be incomplete or out-of-date. Until 2002, the "Nursing Home Compare" Web site excluded more than 25,000 violations reported as a result of complaint investigations outside of the regular facility survey (U.S. House of Representatives Committee on Government Reform, Minority Staff, 2002). Of particular concern is that these excluded violations, including a substantial portion of the more serious citations. In response to this study, CMS now includes these deficiencies.

Strengthening Consumer Advocacy

Consumer advocacy programs perform a range of functions, including assisting with individual complaints and mediating conflicts, advocating public policies to improve quality of care, educating the public about quality of care and consumer protection, and raising the salience of quality-of-care issues. In perhaps their most notable achievement, consumer activists spearheaded the passage of the Nursing Home Reform Act in OBRA 1987. Strengthening consumer advocacy groups involved with nursing home quality issues would be a way of changing the balance of power among stakeholders,

helping to ensure continuing attention to the issue and providing political support for strong regulation.

A number of groups represent the interests of nursing home consumers. The Long-Term Care Ombudsman Program, created by the Older Americans Act, is the largest program devoted to the interests of consumers at both the individual and system levels. In the view of some observers, this program has been underfunded (Institute of Medicine, 1995). OBRA 87 also provides for the right of residents and family members to organize resident councils in nursing facilities. Finally, a variety of independent advocacy groups—including the National Citizens' Coalition for Nursing Home Reform, Center for Advocacy for the Rights and Interests of the Elderly, California Advocates for Nursing Home Reform, the Center for Medicare Advocacy, and the National Senior Citizens Law Center—have been active in issues of nursing home quality.

Consumer advocacy, however, faces major structural limitations. In terms of policy advocacy, consumer groups at the state and local levels are often limited by their reliance on volunteers, for whom advocacy is not their main occupation. As a result, just attending meetings and public hearings can be difficult, because they are usually held during the workday when volunteers are at their paying jobs. In addition, local advocacy groups often lack the technical expertise needed to translate broad values and goals into specific recommendations for policy and legislative changes. In terms of consumer advocacy on the behalf of specific individuals, fear of retaliation against residents by nursing home staff may keep residents and their families from protesting poor conditions (Institute of Medicine, 1995).

Increasing Medicare and Medicaid Reimbursements

As noted previously, approximately three quarters of nursing home residents depend on Medicaid and Medicare to pay for their care (American Health Care Association, 2001). The reimbursement policies of these two programs are, therefore, critical to the level of resources available to nursing homes. Medicaid and Medicare nursing home reimbursement policy is particularly important as a policy lever, because federal and state officials have great control over both the level and methodology of payment.

Two recent developments have directed new attention to the relationship between reimbursement and quality of long-term care. First, the federal Balanced Budget Act of 1997 repealed federal minimum standards for nursing home reimbursement (the Boren amendment), giving states virtually unlimited freedom in setting nursing home payment rates. The nursing home industry has warned that

Medicaid reimbursement rates are already too low and that further reductions would adversely affect the quality of care. Second, the Balanced Budget Act of 1997 established a new prospective payment system for Medicare skilled nursing facility care that has adversely affected a substantial portion of the nursing home industry (Childs, 2000). Nursing home bankruptcies have raised concern that quality of care may deteriorate in these facilities.

There are two major issues with raising Medicare and Medicaid reimbursement rates. First, the relationship between reimbursement levels and quality of care is not simple, and it is not clear that higher reimbursement rates will improve quality of care. Although research in this area is limited and rather old, some studies have found that higher reimbursement is associated with more staffing, but failed to find a significant relationship to other measures of quality (Cohen & Spector, 1996; Nyman, 1988).

Second, higher Medicare and Medicaid reimbursement levels obviously add to public costs. Thus, the dilemma for policy makers is that a dollar's worth of increased reimbursement does 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.

Voluntary and Internal

Developing and Implementing Practice Guidelines

Although the previous strategies rely on forces outside of nursing homes to either force nursing homes to improve quality of care or to provide incentives to do so, a strong argument can be made that nursing homes themselves must take responsibility to improve quality of care. In particular, nursing homes must take responsibility for changes at the microlevel, where individual caregivers interact with individual nursing home residents. To help providers provide better technical care, practice protocols have been developed for a number of conditions, including incontinence, restraints, pressure ulcers, pain, and depression. These guidelines aim to bridge the gap between the clinical research literature and providers, often in algorithms or steps to guide assessment and treatment (Institute of Medicine, 2001). The fact that most nursing facility care involves relatively low-tech services arguably ought to make these protocols easier to develop and to implement. Thus, quality of care might be improved by developing more protocols, and encouraging nursing homes to use them. A limitation is that these protocols have not addressed quality of life issues, and it is not clear that those aspects, which in many ways represent staff attitudes, can be reduced to practice protocols.

To date, however, there is little evidence that guidelines are routinely or effectively implemented in

nursing homes or even that existing guidelines are widely known by direct-care nursing home staff (Schnelle, Ouslander, & Cruise, 1997). Even when protocols have been successfully implemented and shown to be effective, their use has not continued often after the sponsoring research project ended.

There are at least two major barriers to the use of protocols. First, practice guidelines often require more, not less, staff, that are typically not available in nursing homes (Beck et al., 1997; Rogers et al., 1999). In a study of the implementation of an effective incontinence and exercise protocol that reduced wetness and improved ambulation, Schnelle, Cruise, Rahman, and Ouslander (1998) found that the new procedures required four to six times as much time for these tasks as staff normally provided.

Second, to the extent that protocols address care that is monitored in regulatory standards and measure performance against those standards, providers seem to prefer to record unsubstantiated compliance rather than risk sanctions from surveyors concerning inadequate performance. In a study of physical restraint protocols, Schnelle and colleagues (1997) report that, despite improved performance, the study nursing homes abandoned the new procedures after the project ended. A major reason for doing so was that surveyors accepted paper compliance recorded in the record as meeting the care standards, even though it was inaccurate. Nursing home supervisors preferred the perfectly charted but inaccurate outcomes to the more objective but imperfect reality because it resulted in fewer regulatory problems.

Changing the Culture of Nursing Facilities

Given chronic problems of quality of care and quality of life in nursing homes, new approaches to structuring the social, cultural, and physical environments in nursing facilities have developed, with the goal of making them more homelike, less institutional, and less medical. The so-called “Eden Alternative” is probably the best known of these innovations (Thomas, 1994). This approach emphasizes community by linking the facility to the outside world—plants and animals abound, children interact with residents, and aides are empowered as an essential part of the care team. Many of these models involve redesigning the facility, emphasizing small neighborhood communities, and changing staffing patterns to promote continuity of care. Denmark has reformed its nursing homes along these lines (Stuart & 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 might improve quality of care and life.

Although intriguing, these innovative programs are rare and relatively recent. At least five issues confront advocates of using these models for quality

improvement. First, although there has been a lot of media coverage, these innovations have not been rigorously evaluated, nor replicated under varying leadership, ownership, and case-mix circumstances. In particular, some of the most dramatic changes may be the result of charismatic leadership that may not be replicable when implemented on a broader scale. Second, implementing some of these models can be difficult because they violate existing regulations. For example, the presence of birds or animals violate sanitation requirements, 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 case-mix 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. Fourth, as with the care protocols discussed previously, these approaches may end up requiring more staff and higher costs. Fifth, there are approximately 17,100 nursing facilities in the United States, making difficult dissemination of radical cultural change beyond a handful of facilities (American Health Care Association, 2001). Especially from a policy perspective, it is not clear how to change the culture of a large number of nursing homes. A few states—including New Jersey, New York, and Texas—have provided grant money for providers to “edenize” their facilities (Stone & Wiener, 2001).

Conclusions

Few observers of long-term care services are happy with the overall quality of care and quality of life provided in nursing homes. Despite a considerable regulatory apparatus, quality of care in nursing homes is problematic in many facilities. In part because of the questionable quality of care of many nursing homes, few people would choose to live in them if a choice is possible.

Quality of care in nursing facilities remains a major problem for which there are no simple solutions. However, there is no shortage of proposed initiatives to improve care. These options for reform include strengthening the regulatory process, improving information systems for quality monitoring, strengthening the caregiving workforce, providing consumers with more information, making consumer advocacy stronger, changing Medicare and Medicaid reimbursement, developing and implementing practice guidelines, and changing the culture of nursing homes.

All of the possible options for reform face formidable political and financial barriers in addition to questions about their efficacy. In reviewing

these approaches, several themes emerge. First, although simply “throwing money” at the problem is unlikely to be effective, several of the strategies require substantially more resources that cost money. Given the heavy dependence of nursing homes on Medicare and Medicaid, additional funding will be required from the federal and state governments. Unfortunately, the current fiscal and political environments make additional public money an uphill struggle. Nonetheless, increasing staffing and raising wages of nursing home workers seem likely to be a necessary precondition to improving quality of care and should be a high priority.

Second, despite the plethora of possible approaches, the research literature does not provide much guidance as to the relative effectiveness of different strategies. Most approaches have not been evaluated as to their effectiveness. Research funded by CMS, other federal agencies, and private foundations should now focus less on measurement issues and more on which approaches actually improve quality of care. Particularly high priority should be given to rigorously evaluating the Eden Alternative and other culture change initiatives, the effectiveness of providing consumer information on quality of nursing homes, and the impact of raising wages and providing fringe benefits to nursing home workers.

Third, several of the strategies presuppose a relatively sophisticated ability on the part of nursing homes to develop, analyze, and use data, and then to implement management changes. It is not clear that many nursing homes have the organizational capacity that is envisioned in some of these approaches. To address this problem, it is worth considering the proposal by the Committee on Improving Quality in Long-Term Care of the Institute of Medicine to establish “centers for the advancement of quality in long-term care,” which would initiate research, demonstration, and training programs for providers to redesign care processes consistent with best practices and improvements in quality of life (Institute of Medicine, 2001).

Fourth, for whatever flaws it may have, regulation is now and is likely to continue to be the main policy mechanism to improve the quality of care in nursing homes. Additional administrative resources should be funded at both the federal and state levels. That regulation is likely to be increasingly data-driven. Although the emphasis is likely to remain on punishing bad care, public policy makers need to find a way to establish incentives for providers to provide good care and also to find a way to incorporate quality of life concerns into the survey and certification process. Government regulation, though, is a blunt instrument and the inevitable reality is that surveyors can only directly observe care a very small percentage of the time. Ultimately, nursing homes themselves are responsible for the care provided in their facilities.

Fifth, and finally, the political saliency of nursing home quality issues and the consistency of government attentiveness is uneven. Interest by policy makers tends to be cyclical. Exposés in the media and by government agencies tend to focus attention on these issues only for a limited period of time. After a while, the stories about poor-quality care subside, and the topic fades from attention, especially for top policy makers. It is hard to make progress without sustained attention. Here, it is critical that consumer advocacy organizations be funded, either privately or publicly, so that they can keep the issue on the political agenda.

Although some nursing homes provide good quality care, an unacceptable number provide inadequate care. A frank assessment is that the prospects for systemwide improvement are not high. But there is no doubt that nursing facility residents deserve better quality of care than they receive. And, with the aging of the baby boom generation, more of us are likely to spend part of our lives living in nursing homes.

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