An examination of the nursing home industry

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AN EXAMINATION OF THE NURSING HOME INDUSTRY

BY

CRAIG LABORE
BA, Saint Anselm College, 2000

THESIS

Submitted to the University of New Hampshire in Partial Fulfillment of the Requirements for the Degree of

Master of Arts in Political Science

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DEDICATION

To Lucien Lanoie
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ABSTRACT

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Craig Labore

University of New Hampshire, May, 2007

Quality of care remains an issue plaguing the nursing home industry. Over the next twenty years, nursing homes will become inundated with members of the “baby boomer” generation. The goal of this research project was to examine approaches to improving the quality of care in nursing homes in The United States. Three reforms were identified. First, there needs to be improved communication between CMS, regional offices and state agencies. Second, create a training program which trains surveyors and nursing home administrators in a nursing home setting. Finally, there must be collaboration between CMS and nursing home industry leaders in policy-making decisions.

May, 2007
INTRODUCTION

People enter nursing homes for a variety of reasons. For some, their stay is short-term; to continue convalescence which they began while hospitalized; for others, their stay is permanent, because they can no longer care for themselves; thus requiring long-term care (LTC). LTC is defined as a, "broad range of personal, social, and medical services that assist people who have functional or cognitive limitations in their ability to perform self-care and other activities necessary to live independently" (Pandya, 2001). In 1997, sixty-seven percent of people who left nursing homes had stayed for three months or fewer. "Overall, in 1997, the average length of time since admission among all residents currently living in a nursing home was 2.5 years" (Pandya, 2001).

The topic of nursing homes rarely surface during the course of daily conversation. However, when the subject does arise, it is usually centered on some form of malfeasance, as was the case of nursing home officials at St. Rita’s Nursing Home in Louisiana, who abandoned thirty-four of their residents during Hurricane Katrina; or when reports are published depicting sub-standard care practices throughout the industry. Nursing homes have become a topic which people do not speak of. Perhaps this is due to issues
of poor care, or because of the association between nursing homes and mortality. Whatever the reason may be, "The nursing home has been viewed as the refuge of last resort, avoided by potential residents and health care professionals alike" (Binstock et al., 2006 p. 146).

Throughout the history of The United States, nursing homes have had a negative connotation associated with them. From the outset, nursing homes were places where those who could not afford the cost of healthcare were sent. The early 1900's witnessed the creation of "poor farms" or "almshouses." Absent a federal assistance program to assist in paying for the care of poor elderly or disabled individuals, states relied on these institutions to provide care for impoverished elderly, or disabled citizens. These institutions were widely known for their inadequate care and dilapidated buildings. States encouraged this stigma as a way of encouraging individuals to avoid reliance on them for care (Public Broadcasting Service).

The passage of President Roosevelt's "New Deal" witnessed the promotion of the idea that elderly citizens were deserving of federal benefits on the basis of need. In August 1935, The Social Security Act was signed into law by President Roosevelt; "The act provided matching grants to states for Old Age Assistance (OAA) for retired workers" (Public Broadcasting Service). In order to discourage the
use of "poor farms", or "almshouses," individuals residing in these institutions were not eligible for OAA benefits (Public Broadcasting Service). This prohibition led to the creation of private nursing homes. Private nursing homes allowed individuals to live in a healthcare facility and still be able to collect OAA payments.

It was not until the 1950's that a series of amendments to the Social Security Act began to appear. One of these amendments included a requirement that states institute a form of licensing for nursing homes. Another amendment removed the ban on providing OAA payments to individuals residing in public healthcare facilities. In an attempt to improve the quality of care residents of nursing facilities were receiving, 1954 witnessed the creation of federal grants which established the building of nursing homes in conjunction with hospitals. This amendment accomplished two objectives. It created nursing homes constructed to resemble the physical structure of hospitals, and it transformed nursing homes from being part of the welfare system, to part of the healthcare system (Public Broadcasting Service).

In 1960, the first reports of nursing home scandals surfaced. These scandals uncovered issues ranging from noncompliance in staff and code requirements, to issues of financial irregularities. For the next twenty-five years,
the prevalence of nursing home scandals continued to increase throughout the country. In 1972, The United States Congress passed Public Law 92-603, which up to that point, was one of the largest pieces of legislation ever enacted. Public Law 92-603 contained several nursing home reforms, most notably, a new law requiring Medicaid, "reimburse nursing homes on a "reasonable cost-related basis," with the hope that the facilities would provide better care. Previously, most states used relatively arbitrary fee schedules" (Public Broadcasting Service).

In 1977, The United States Department of Health and Human Services established the Health Care Financing Administration (HCFA) to serve as an oversight mechanism for the Medicare and Medicaid programs, and related quality assurance activities. From this point on, HCFA assumed the responsibility for regulating all aspects of the nursing home industry.

It is important to examine this area of the American health care system because a significant percentage of the American population known as "baby boomers," are entering the retirement phase of their lives. Consequently, over the next twenty years, the population in nursing homes throughout the country is expected rise. In recent years, there has been an effort to combat this inevitable rise in nursing home population, (as well as, due to continued
budget cuts in state Medicaid programs) to steer individuals away from nursing homes and into less costly alternatives, such as assisted living, or in-home services (Hudson, 2005). Although these measures may provide temporary relief to already bloated state Medicaid budgets, they are not practicable on a long-term basis.

Home-care services are not feasible for a prolonged period due to the high financial costs associated with the care provided. Individuals requiring twenty-four hour care can expect to pay on average close to $3,000 per week.

The operating philosophy of assisted living facilities is to provide services to those requiring assistance with certain activities of daily living such as bathing, or dressing. The staff of these facilities are not trained, nor expected to provide services beyond these basic activities (i.e. toileting, medication disbursement).

As residents in assisted living facilities continue to grow older, and eventually require more assistance than assisted living will provide, or no longer possess the financial means for home-care services, it will become increasingly important for nursing homes throughout the country to provide quality care for the country’s elderly population.
This report will comprise an examination of the nursing home industry in The United States. My objectives in undertaking this research were to investigate:

1. What regulations must nursing homes in The United States follow when providing services to residents in order to meet federal and state nursing home standards? Are these regulations the same for all nursing homes regardless of facility size?

2. What is the process for ensuring nursing homes follow these regulations? Which agencies, at the federal and state level are responsible for ensuring nursing homes meet these regulations?

3. What is the current state of the nursing home industry in The United States today? Has the current amount of regulation within the industry had a positive or negative effect on the industry?

4. What are the views of nursing home industry groups such as the American Health Care Association and the American Association of Homes and Services for the Aging as to the current state of the industry? What positions do they advocate for improving the quality of nursing homes?

Areas to be covered will include an analysis of the two central pieces of nursing home legislation, the 1987 Nursing Home Reform Act, and the 1998 Nursing Home
Initiative. In addition, an examination of both the federal survey process of nursing homes, and the complaint investigation process; the state of nursing homes in The United States today; the perspective of the nursing home industry in relation to the current state of the industry from the two prominent interest groups, the American Association of Homes and Services for the Aging and the American Health Care Association; and finally, three potential approaches to ensure the type of quality care nursing home residents deserve.

The data collected for this report includes articles from newspaper accounts, as well as sociological, law, and political science journals pertaining to the current state of nursing homes in The United States; how the federal and state Medicaid survey system of Medicare/Medicaid approved nursing homes operates; the differences between for-profit, non-profit, and government-operated nursing homes and which is more likely to have fewer deficiency citations; and the complaint process for family members and options available to them in addressing quality issues. I also had the opportunity to interview three nursing home administrators from the New England area, to gain further insight into the role of a nursing home administrator, and hear their views on topics such as regulation within the industry and
approaches to improving the quality of care for nursing home residents.

After conducting research for this report, it is my opinion that the nursing home industry in The United States is in a state of disarray. The two central pieces of legislation implemented by congress have not been effective in achieving their stated goals of ensuring quality nursing homes. Granted, the 1987 Nursing Home Reform Act established the survey process for nursing home inspection, however, there has been a lack of communication between the Centers for Medicare and Medicaid Services (CMS) and state agencies charged with conducting these surveys. This lack of communication has carried over to the process of conducting complaint investigations, where the individuals responsible for conducting the investigations do not know the definition of "Actual Harm." The survey and complaint investigation process has been examined on several occasions by the General Accounting Office and the Office of Inspector General for the Department of Health and Human Services. These agencies have found a lack of communication between the federal government and state agencies. Suggested remedies for improvement in areas lacking consistency have not been fully addressed by CMS. Furthermore, the regulation process within the nursing home industry is deterrence based; assuming nursing home
providers are guilty from the outset, resulting in non-effective working relationships between surveyors and providers.
CHAPTER I

THE U.S. GOVERNMENT'S RESPONSE TO POOR CARE

During the 1980's, news articles began to surface depicting graphic accounts of the poor quality of care nursing home residents were receiving throughout the country. These press accounts were supported by empirical research also indicating a multitude of issues regarding poor care. Care problems such as, "excessive medication regimens, the inappropriate use of restraints, unsanitary conditions, and physical abuse were commonplace in many nursing homes" (Castle, 2001, p. 74). In 1983, upon an increasing outcry from concerned citizens, The United States Congress requested The Institute of Medicine conduct an examination into the state of American nursing homes. The resulting report served as an indictment for poor quality and became a catalyst for a movement to improve American nursing homes.

Federal Government Reforms

1987 Nursing Home Reform Act

Published in 1986, The Institute of Medicine report found, "residents of nursing homes were being abused, neglected, and given inadequate care" (Klauber & Wright,
2001). The Institute of Medicine proposed an extensive reform of the nursing home system in The United States. This reform came with the passage of the Nursing Home Reform Act (NHRA), part of the Omnibus Budget Reconciliation Act of 1987. The goal of the NHRA was to ensure, “residents of nursing homes receive quality care that will result in their achieving or maintaining their “highest practicable” physical, mental, and psychological well-being” (Klauber & Wright).

According to Castle (2001) the key components to the NHRA are: (1) the requirement that nursing homes provide appropriate health services to all residents; (2) the creation of the ombudsman program; (3) training provisions for staff, specifically, nurse aides; and (4) an annual review of nursing home residents. The Health Care Financing Authority (now known as the Centers for Medicare/Medicaid Services) was responsible for the development of regulations to address these components.

In order to meet the requirement that nursing homes offer appropriate health services to residents, the NHRA mandates nursing homes provide for, or arrange physician, nursing, and rehabilitative services, as well as pharmaceutical, dental care, and medically related social services. Nursing homes are required to make available the same quality of services to all residents, regardless of
payment method (i.e. personal resources, or Medicare/Medicaid reimbursement).

A key mandate to the NHRA was the requirement that residents have access to state advocates, or Ombudsmen, to assist residents and families in resolving disputes and grievances. The NHRA also focused on the training of nurse aides, because it is estimated they provide between eighty to ninety percent of resident care in most nursing homes; "It was mandated that nurse aides must complete 75 hours of training and pass a competency examination" (Castle, 2001 p. 75). In conjunction with the training requirement, a registry compiling a list of nurse aides who successfully satisfied these requirements was to be maintained by each state.

Another important component of the NHRA was the creation of the Resident Assessment Instrument (RAI). The RAI was developed for the review and assessment of nursing home residents. Nursing homes participating in the Medicare/Medicaid programs are required to use the RAI to assess all new residents upon initial admission to the facility; on an annual basis; and with any significant change in the status of a resident’s condition (Castle, 2001). The RAI is composed of three elements; the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and a manual of utilization guidelines. The MDS is a three
hundred item summary assessment of nursing home residents; “It was created to measure a resident’s functional status, health conditions, services received, demographics, payer source, and advance directives. During the assessment process, the MDS can ‘trigger’ more in-depth evaluations” (Castle, p. 76). There are eighteen RAPs which guide the in-depth evaluation of a resident's needs and fosters clinical decision making. Because the RAI focuses attention on residents’ functioning, early treatment and prevention of illness is likely (Castle).

One of the more significant steps taken in the NHRA was the creation of a Residents Bill of Rights. The Residents Bill of Rights states all nursing home residents have the right to freedom from abuse, mistreatment, and neglect; the right to freedom from physical restraints; the right to privacy; the right to accommodation of medical, physical, psychological, and social needs; the right to participate in resident and family groups; the right to be treated with dignity; the right to exercise self-determination; the right to communicate freely; the right 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 the right to voice grievances without discrimination, or fear of reprisal (Klauber & Wright, 2001).
In order to monitor whether nursing homes are meeting the requirements set forth by the NHRA, the law called for the establishment of a certification process, requiring states conduct unannounced surveys and resident interviews at irregular intervals at least once every fifteen months. The surveys focus on resident rights, quality of life, quality of care, and the services provided to them.

If a survey indicates failure on the part of the nursing home in meeting NHRA requirements, the enforcement phase begins. The severity of the penalty is dependent upon whether the deficiency cited places a resident in immediate jeopardy; whether the deficiency is an isolated incident, or part of a pattern; or whether the deficiency is widespread throughout the facility (Klauber & Wright, 2001). For certain deficiency citations, a nursing home has the opportunity to take corrective action prior to sanctions being imposed. Sanctions that can be imposed on a nursing home include directed in-service training of staff; directed plan of correction; state monitoring; civil monetary penalties; denial of payment for all new Medicare or Medicaid admissions; denial of payment for all Medicaid or Medicare patients; temporary management; and termination of the Medicare/Medicaid provider agreement.
1998 Nursing Home Initiative

With the passage of the Nursing Home Reform Act, it appeared appropriate measures were being taken to address the quality issues plaguing the nursing home industry in The United States. However, in 1997 after widespread reports of mistreatment and inadequate care among residents of California nursing homes, The United States Senate Committee on Aging held a hearing to examine the continuance of poor care nursing homes residents were receiving. As part of the hearing, the General Accounting Office (GAO) presented a report which revealed that, "despite the requirements of the Nursing Home Reform Act, weak enforcement put many residents at risk of substandard care" (Wright, 2001). These findings were not exclusive to California nursing homes, but were indicative of nursing home care throughout the country. The GAO concluded its report by recommending federal and state oversight be strengthened to better protect nursing home residents.

In July 1998, the Health Care Financing Administration (HCFA) published a report examining the effectiveness of the current survey and certification process for nursing homes. The report found, "...the Nursing Home Reform Act of 1987 had resulted in improved resident outcomes; it also concluded that many of the enforcement processes were not working as intended" (Wright, 2001).
Based on the findings of the GAO and HCFA reports, the Clinton Administration announced The 1998 Nursing Home Initiative, designed to improve the enforcement of nursing home quality standards. According to Wright (2001), some of the approaches set forth in The Nursing Home Initiative included, staggering nursing home inspections by state agencies, with a set number of inspections occurring on weekends and evenings; inspecting nursing homes which are repeat offenders on a regular basis, while at the same time, not decreasing the frequency of inspections for other facilities; making certain state survey agencies enforce sanctions against facilities with serious violations, and ensuring sanctions are not lifted until an onsite visit verifies compliance.

The 1998 Nursing Home Initiative was to have buttressed the NHRA. However, subsequent investigations and reports found this was not the case. According to Wright (2001) key findings from these reports included: in 1997-1998, over one/fourth of nursing homes nationwide (27%) received citations for violations which caused actual harm to their residents, or placed residents at risk of death or serious injury; another forty-three percent of nursing homes were cited for violations which created a potential for more than minimal harm. During annual surveys, surveyors' routinely neglected significant care issues (i.e. pressure
sores, malnutrition, and dehydration.) "This problem reflected both weaknesses in state survey methods and the predictable timing of the surveys" (Wright, p. 2). Other findings indicated complaints made by residents, family members, or nursing home staff frequently went uninvestigated for weeks at a time; over half of nursing homes throughout the nation had fewer than the minimum number of nurse aide time per resident to avoid harming residents. As a result of these findings, HCFA was charged with working to implement additional steps in order to improve enforcement of quality standards.

Conclusion

Newspaper accounts depicting poor care within the nursing home industry led to the passage of the Nursing Home Reform Act in 1987. The goal of the NHRA was to ensure nursing home residents received quality care resulting in their achieving or maintaining their "highest practicable" physical, mental, and psychological well-being. In 1997, reports resurfaced describing continued poor care in American nursing homes. The 1998 Nursing Home Initiative was created to strengthen the enforcement of nursing home quality standards. Again, subsequent reports following the implementation of The Nursing Home Initiative indicated continued poor care in the American nursing home industry.
These findings pointed to the nursing home survey process as the reason for continued poor care.
CHAPTER II

KEEPING AN EYE ON NURSING HOMES

Regulations

There are over one hundred fifty regulatory standards nursing homes must abide by in order to remain compliant with federal regulations. These regulations cover an array of areas pertaining to resident life; from specifying standards for the safe storage and preparation of food; to protecting residents from physical and mental abuse, or inadequate care practices. Several key regulations include: having sufficient nursing staff (42 CFR §483.30); conducting a comprehensive and accurate assessment of each resident’s functional capacity (42 CFR §483.20); preventing the deterioration of a resident’s ability to bathe, dress, groom, transfer and ambulate, toilet, eat, and communicate (42 CFR §483.25); providing, if a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene (42 CFR §483.25); ensuring residents do not develop pressure sores, and, if a resident should develop a pressure sore, providing the necessary treatment and services to promote healing, prevent infection, and prevent the formation of new sores (42 CFR §483.25); ensuring residents receive adequate supervision and assistive
devices to prevent accidents (42 CFR §483.25); providing each resident with sufficient fluid intake to maintain proper hydration and health (42 CFR §483.25); the promotion of each resident's quality of life (42 CFR §483.15); maintaining the dignity and respect of each resident (42 CFR §483.15); ensuring residents have the right to choose their schedules, activities and health care (42 CFR §483.40); and providing pharmaceutical services to meet the needs of each resident (42 CFR §483.60) (Nursinghomealert.com, 2007).

Regulation within the nursing home industry is designed to, “prevent resident abuse and neglect and assure quality of care for residents. Quality care, by definition, is care that is free of abuse or neglect” (Lenhoff, 2005, p. 10). Inspections of Medicare/Medicaid approved nursing homes are conducted by representatives from the Centers for Medicare and Medicaid Services (CMS). A significant portion of the Medicare and Medicaid dollars spent each year is used toward covering nursing home care and services for elderly and disabled. In fact, Medicaid has become the number one source of payment for nursing home residents. Federal spending for nursing home care is expected to continue rising. Fiscal year 2005 projections for Medicaid spending on nursing home care were $121.7 billion, and by 2015,
projections are for Medicaid spending to be $216.8 billion (Borger et al., 2006).

There are a variety of payment options for long-term care in The United States. Payment options range from private pay, tax-deductible individual and institutional contributions, as well as several different federal and state payment sources. Due to the variety of payment options available to nursing home consumers, there are several entities at the federal, state, and local levels of government with jurisdiction over the long-term care industry (Lenhoff, 2005).

State governments are responsible for overseeing the licensure of all nursing homes. Certification of a nursing facility requires a state surveyor to complete at minimum, a Life Safety Code (LSC) survey, and a standard survey (Centers for Medicare and Medicaid Studies, 2006). State governments are also charged with the duty of monitoring nursing homes seeking eligibility to provide care for Medicare and Medicaid beneficiaries (Medicare.gov, 2006). CMS contracts with each state to conduct on-site inspections of Medicare/Medicaid eligible nursing homes in order to determine whether the facility is in compliance with the minimum requirements set forth in the Medicare and Medicaid quality and performance standards. CMS provides funding for the majority of the costs associated with
Medicare/Medicaid certification. CMS also oversees the performance of state survey agencies to ensure federal regulations are implemented appropriately (Walshe, 2001).

Responsibility for monitoring nursing homes is placed with either the state health department, or the state department of health and human services. Inspections of participating nursing homes are conducted an average of once per year. If a nursing home continuously fails to meet minimum standards, inspectors may choose to visit the facility on a more frequent basis.

The state also investigates complaints pertaining to nursing home care through the office of the Long-Term Care Ombudsman. Each state was required to establish an Ombudsmen program as a result of the 1978 amendments to the Older Americans Act of 1965 (Lenhoff, 2005). Ombudsmen resolve issues of individual residents; visit facilities on a regular basis; provide information and referrals about facility selection and quality of care to prospective consumers; assist resident and family councils; promote the rights of residents; and represent the needs of residents and their interests to public officials (Lenhoff, 2005).

Survey Process

The survey process involves a combination of observation and review. During a survey, the survey team, consisting of trained professionals, and a minimum of one
registered nurse, observe the care process for residents; staff/resident interaction, and the overall environment; review the facilities clinical records; interview a sample of residents and family members to ascertain what life is like within the nursing home; and interview nursing and administrative staff. The survey team then gathers data collected during the inspection and determines whether the nursing home is meeting the individual needs of its residents (Medicare.gov, 2006). In addition to determining compliance, the state also provides recommendations for appropriate enforcement actions to the state Medicaid agency as well as to the regional office for Medicare (Centers for Medicare and Medicaid Services, 2006).

Depending on the severity of issues uncovered during the survey, there are a number of sanctions available to address facilities found to be in non-compliance. Prior to any disciplinary action being taken by CMS, the agency must first consider the extent of harm(s) to the residents. Sanctions include the use of monetary fines; denial of Medicare/Medicaid payments; assignment of a temporary manager; or placement of a state monitor within the facility. Should the facility not take the necessary actions to correct problematic behaviors, CMS then has the authority to terminate its provider agreement with the offending nursing home. Consequently, the nursing home
looses its certification to provide care for Medicare/Medicaid beneficiaries. Any beneficiaries residing in the facility are then transferred to another Medicare/Medicaid certified facility within the state (Medicare.gov, 2006).

There are significant costs associated with regulation practices within the nursing home industry. According to Walshe (2001) CMS and state governments spent $382.2 million in 2000 on operating the state licensing and certification agencies which implement both federal and state nursing home regulations. There are also costs assumed by nursing homes. Nursing homes incur costs on two levels. The first pertains to the nursing home working with regulators: preparing for survey visits; data collection; and responding to complaint investigations. Secondly, costs are incurred when operational changes are implemented in order to comply with regulations (Walshe).

Complaint Investigation

In addition to enforcement of nursing home regulation, CMS also investigates nursing home complaints via state agencies which receive these grievances. Sections 1819(g)(4)(a) and 1819(g)(5)(a) of the Social Security Act require each state to maintain procedures and an adequate staff to investigate and report on any nursing home complaint they receive. The State Operations Manual (SOM),

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produced by CMS, outlines the process which state agencies are required to follow when addressing complaint investigations. The requirements of the SOM are contractually binding on all Medicare-certified and Medicare/Medicaid certified nursing homes (Department of Health and Human Services & Office of Inspector General, 2006).

The SOM requires a three phase approach be followed when processing a complaint regarding a nursing home. The first phase, Intake, occurs when a state agency receives an initial complaint. The investigating agency compiles a comprehensive report consisting of information concerning the complainant and the nursing home; the individuals involved in, or affected by the incident; a description of the allegation; how and why the complainant believes the allegation occurred; and the complainant's expectation for resolution of the allegation. During the Intake phase, the SOM also directs the agency to inform the complainant about its policies and procedures in addressing complaint investigation; the course of action the agency plans to take; the anticipated time-frame for resolution; and the contact information of a member of the agency for follow-up by the complainant (Department of Health and Human Services & Office of Inspector General, 2006).
The second phase of complaint investigation is Triage and Prioritization. The SOM requires that an individual possessing knowledge of current clinical standards and federal requirements prioritize each complaint received by the agency. There are three priority categories complaints are placed in. The priority category which the receiving agency places the complaint is very important, as the category determines the action taken, and timing of the investigation (Department of Health and Human Services & Office of Inspector General, 2006).

The first priority category, the most serious of the three, is “Immediate Jeopardy.” The SOM defines “Immediate Jeopardy” as “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident” (Department of Health and Human Services & Office of Inspector General, 2006, p. 2). If the state agency determines the complaint falls within this guideline, the agency is required to investigate onsite within two working days of receiving the grievance. The second priority category is “Actual Harm (high).” A complaint falls within this category when a nursing home’s alleged noncompliance with one or more requirements or conditions, may have caused harm which negatively impacts the individual’s
mental, physical, and/or psychosocial status, and is of such consequence to the individual's well being that a rapid response by the state agency is required (Department of Health and Human Services & Office of Inspector General, 2006, p. 2). State agencies must be at the facility to investigate complaints of "Actual Harm (high)" within ten working days upon receiving the grievance. The third priority category, titled "All Others," comprises all complaints deemed not to fall within the first two categories. Once a complaint is prioritized in this category, the agency must decide whether to conduct an onsite investigation; perform a "desk review;" or refer the complaint to another agency more equipped to address such a grievance (Department of Health and Human Services & Office of Inspector General, 2006).

The third and final phase of complaint investigation is the Follow-Up. Upon completion of the inquiry, the investigating agency must provide the complainant and the nursing home with a written report of the findings. The SOM requires the agency to include specific information in the report such as acknowledgement of the complainant's concerns; the agency's authority to investigate such complaints; a summary of the agency's investigative methods; an explanation of the agency's decision-making process; a summary of the agency's findings; a description
of follow-up action, if any; and referral information to other agencies, when appropriate (Department of Health and Human Services & Office of Inspector General, 2006).

The investigation process outlined in the SOM is designed to ensure investigations relating to nursing home complaints are followed in the appropriate manner. However, 2004 State Performance Standard reports indicated many state agencies failed to meet the standard guidelines for investigating nursing home complaint allegations. Twenty-one state agencies failed to meet the designated time-frames for investigating "Immediate Jeopardy" complaints, while thirty-seven state agencies failed to meet the established time-frame for investigating complaints assigned "Actual Harm (high)" (Department of Health and Human Services & Office of Inspector General, 2006).

Conclusion

There are over one hundred fifty regulatory standards nursing homes must follow to remain in compliance with federal regulations. Regulation within the nursing home industry is designed to prevent resident abuse and ensure quality of care. Surveys are conducted by state agencies, either the Department of Health and Human Services, or the Health Department. These agencies are under contract with the Centers for Medicare and Medicaid Services, which oversees the operation of the Medicare and Medicaid
programs. The survey process involves a combination of both observation and review. In addition to enforcement of nursing home regulation, CMS also investigates nursing home complaints via state agencies which receive the grievances. Despite guidelines established in the SOM, state agencies investigating nursing home complaints failed to meet the time-frame requirements set forth in the SOM.
CHAPTER III

TODAY'S NURSING HOMES

There are three types of nursing homes in The United States: for-profit, non-profit, and government operated. For-profit nursing homes are facilities operated to make a profit for a corporation, or an individual owner. According to the Centers for Medicare and Medicaid Services (CMS), there are 10,759 for-profit nursing homes in The United States, comprising 65.4% of the total number of facilities in operation (Centers for Medicare and Medicaid Services, 2003). Non-profit nursing homes are facilities governed by community-based volunteers working to ensure the organization remains true to its mission statement (American Association of Homes and Services for the Aging, 2006). According to CMS, there are 4,676 non-profit nursing homes, comprising 28.4% of nursing homes operating in The United States (Centers for Medicare and Medicaid Services, 2003). Government-operated facilities comprise the final category of nursing homes. These facilities are operated by either the federal, state, or county level of government. CMS figures indicate there are 1,011 government-operated nursing facilities, comprising 6.1% of the total number of nursing homes across the country. The nursing home industry averages annual profits of $100 billion a year.
As of 2006, there were approximately 18,000 nursing homes in The United States; 1,900,000 beds; a total population of 1,600,000 residents; and an occupancy rate of eighty-seven percent (National Center for Health Statistics, 2006). Approximately ninety percent of nursing home residents are over age sixty-five; while almost half are over age eighty-five (Kapp, 2003). The average daily cost for a private room in a nursing home in The United States is over $70,000 per year, or $192 per day (Kaiser Family Foundation, 2004). Three out of five residents in nursing homes rely on the Medicaid program to pay the costs associated with their care (Kaiser Family Foundation). Federal law mandates Medicaid programs cover elderly and disabled individuals who do not have the financial means to pay for their nursing home stay. To become an eligible participant in the Medicaid program, an individual must not have more than $564 in income per month, or no more than two thousand dollars in assets. Typically, individuals who do not have the financial resources to cover the costs associated with their care “spend down” their assets until they become eligible to qualify for Medicaid benefits.

Medicare is also a source of payment for nursing home care, although it does not play a significant role in the financing of nursing facility costs. Medicare will cover up to one hundred days of nursing home care for individuals
requiring skilled, or rehabilitative nursing care following a hospital stay.

The financial cost of staying in a nursing home places a significant monetary burden on individuals, as well as the federal government. However, there is also a cost assumed by the nursing home itself in providing care to residents. Significant operating costs, such as staffing, employee compensation and benefits, dietary services, and utility costs. Most noteworthy in relation to costs would be the dramatic increase in liability insurance rates due to a rise in litigation. According to a CMS report on the health care industry market, the number of law suits per one thousand beds, and the average claim size have nearly tripled since the early 1990’s. As of 2003, a portion of the largest nursing home chains throughout the country, such as Beverly Enterprises Inc., have seen their insurance accruals grow fifty percent, to sixty-six million dollars. Kindred Healthcare Inc. has also seen their insurance accrual grow fifty percent, to eighty-two million dollars (Centers for Medicare and Medicaid Services). According to Kapp (2003), some nursing home corporations reported they spend more money on liability insurance than they do on raw food. These significant increases have caused smaller nursing homes to file for bankruptcy, while larger chains
have taken steps to divest facilities in states with exorbitant liability costs.

Recently, civil lawsuits have become a second form of legal oversight for the nursing home industry (Lenhoff, 2005). From a family member’s perspective, civil lawsuits provide justice for loved ones harmed by an operator’s negligence, and also serve as a deterrent toward future misconduct. Nursing home litigation has become one of the fastest growing areas of health care litigation in The United States. The most commonly litigated nursing home claims are cases where residents are placed in severe harm, "In order of frequency, the most litigated claims are: wrongful death; pressure ulcers; dehydration and weight loss; emotional distress; falls; improper restraint use; medication errors; and sexual assault" (Lenhoff, p. 36). According to Lenhoff, a recent national survey of litigators found that damages awarded in nursing home cases totaled as much as $1.4 billion, and the average recovery of $406,000/claim, is twice the amount typically awarded in medical malpractice suits. These considerable damage awards, "are designed to compensate the plaintiff for serious injuries..., to punish and deter future similar misconduct by the defendant, and to change the cost-benefit analysis for facilities providing poor care" (Lenhoff, p. 37).
According to Kapp (2003), nursing homes can also be sued for discrimination in their provision of services to residents. "Mandates of the Americans with Disabilities Act and the Rehabilitation Act, as well as their state counterparts, regarding affirmative obligations to accommodate the disabled are fully applicable to nursing homes" (Kapp, p. 69). Nursing homes may also face legal challenges based on claims that because the facility, "provided substandard services, it violated express or implied provisions of its contract (admissions agreement) with a resident" (Kapp 2003, p. 69).

The continued presence of issues such as the growth of legal action within the nursing home industry and financial worries due to skyrocketing insurance premiums are just part of the constant assault on the nursing home industry as a whole, especially on the competence and integrity of certain facilities and their staffs (Kapp, 2003). National newspaper accounts, government reports, nursing home reform advocacy group reports, too numerous to mention, depict a continued struggle on the part of the nursing home industry as a whole to abide by the reforms set forth in the NHRA and subsequent reform efforts. These reports lead to an already vociferous cry for greater regulation within the nursing home industry. Nursing home industry groups are constantly faced with the challenges associated with
addressing these scandals from poorly performing facilities, while at the same time, attempting to portray the industry in a positive light.
CHAPTER IV

THE VOICE OF A CONCERNED INDUSTRY:
INTEREST GROUPS AND THE POSITIONS THEY ADVOCATE

Nursing homes are operated in a stressful environment. From concerns about annual inspections, to increases in liability insurance; nursing home operators, regardless of facility size, must ensure all regulations are being met at any given time. There is a common perception among operators that, "the multiple inspectors and entities surveying nursing homes each seem to be not only antagonistic toward them, but each enforcing their own particular set of standards" (Kapp 2003, p. 63). Nursing home operators feel they are unfairly targeted by state surveyors and that there are inconsistent, unclear, and contradictory expectations of them (Kapp).

In addition to regulatory fears, nursing home operators are weary of the growing use of criminal prosecutions. Stevenson and Studdert (2003) conducted an examination of attorneys who listed "nursing home" or "long-term care" law among their practice areas. A sample consisting of four hundred sixty-four attorneys from forty-three states was identified. The authors received responses from two hundred seventy-eight attorneys from thirty-seven states for a response rate of sixty percent. "Respondents reported
personally handling a total of 4,677 nursing home claims in the twelve months prior to the survey. Respondent firms were involved in 8,256 claims..." (Stevenson & Studdert, p. 221). Of the 4,677 claims filed, more than half involved deaths, with the next most frequent claims being related to pressure ulcers/bed sores, dehydration/weight loss, and emotional distress. Children of residents were the primary initiators of claims filed. The attorneys in the sample stated eight percent of the claims filed went to trial, while nearly half of the claims resulted in verdicts for the plaintiff. "The average recovery amount among paid claims—whether resolved in or out of court—was approximately $406,000 per claim, nearly twice the level of a typical medical malpractice claim ($207,000)" (Stevenson & Studdert, p. 223).

Kapp (2003) states politically ambitious local and state prosecutors are, "charging nursing home staff, including physicians who treat residents in the facility, with abuse and neglect of residents; and, in the case of deceased residents, even homicide" (Kapp, p. 64). Incidents depicting failures on the part of nursing homes to care for their residents has lead to national attention. This increased awareness has made it difficult for nursing homes to, "encourage the reporting of matters like pressure ulcers, which resident advocates routinely equate with
neglect" Kapp (2003, p. 65). Consequently, pressure ulcers are going un-reported for fear of the facility facing legal action for neglect.

According to Kapp (2003) another legal challenge nursing homes are facing addresses attempts by the facility to defraud the Medicare and Medicaid programs. Federal prosecutors, working in conjunction with the Department of Health and Human Services' Office of Inspector General have secured criminal indictments against nursing homes on the premise that nursing homes have submitted bills to the Medicare, or Medicaid program for payment, when the care the facility provided was sub-standard, thereby attempting to defraud the government operated programs; a violation of the False Claims Act, which carries a civil monetary penalty of between five and ten thousand dollars per false claim submitted. According to Kapp the submission of these bills either via mail or electronic transfers makes it possible for the government to also invoke the Mail and Wire Fraud Acts, which are offenses under the Racketeer Influenced and Corrupt Organizations Act.

Nursing home industry groups are constantly faced with the challenges of addressing nationally publicized accounts depicting inadequate care practices in poorly performing nursing homes. It is an arduous task undertaken by these groups to comment on incidents of resident abuse, while at
the same time attempting to portray the industry as one which provides quality care for the nearly 1.6 million residents in nursing homes throughout The United States. National groups, such as the American Association of Homes and Services for the Aging (AAHSA) and the American Health Care Association (AHCA) continuously stress the importance of not judging the industry as a whole, based on the isolated incidents of poorly performing nursing homes. These groups also emphasize the importance of building valuable partnerships with both the federal and state governments to improve the quality of care for residents.

**AAHSA**

The American Association of Homes and Services for the Aging (originally known as the American Association of Homes for the Aging) was created by a group of senior housing and long-term care leaders in New York State in 1961. These individuals envisioned an important role for non-profit nursing facilities as leaders in the field of aging services; "They believed in the social components of care and advocated for the residents of their facilities, not just for their own self interests" (American Association of Homes and Services for the Aging, 2007).

The AAHSA is committed to the advancement of six consumer-oriented ideals relating to aging services in The United States. The first ideal—dignity of all persons at
every stage of life includes individuals who receive and provide long-term care services. The AAHSA’s advocacy plans align law and regulation with evidence-based culture change that focuses on the dignity of individuals. The second ideal pertains to services people need, when they need them, and in the place they call home. Among other things, AAHSA works to strengthen nursing homes in terms of quality, constructive regulation, and sufficient resources. The third aging service ideal pertains to quality people can trust. This is achieved through AAHSA’s implementation of its Quality First Initiative. The organization works in concert with stakeholders at all levels of government, facilities, as well as individuals and their family members, who are in need of long-term care services. The fourth ideal is mission-driven, not-for-profit values. This involves customer-centered services, stewardship, as well as ethical conduct, open lines of communication and the equitable treatment of all concerned parties. The fifth ideal involves advocacy for the right public policy—for the right reasons. This ensures older citizens have the ability to stay healthy and independent as long as they can. The sixth and final aging service ideal relates to leadership through shared listening. Achievement of this principle allows the AAHSA to advance their ideals by working to make the long-term care industry better from
within, through interactions with individuals willing to commit openly to a cause and share their knowledge and advance principles together for the common good of those receiving long-term care services (American Association of Homes and Services for the Aging, 2007).

**AHCA**

The American Health Care Association (AHCA) represents almost 12,000 long-term care providers, employing more than 1.5 million caregivers. The organization "represents the long-term care community to the nation at large—to government, business leaders, and the general public" (American Healthcare Association, 2006). The AHCA also serves as a force for change within the long-term care industry by providing information, educational services and administrative tools which attempt to enhance the quality of long-term care facilities at every level (American Healthcare Association).

In July 2003, Mary Ousley, then chairman of the American Health Care Association, testified before the U.S. Senate Finance Committee on the progress those within the long-term care industry were making in improving the quality of care for nursing home residents. During her testimony, Ms. Ousley stated the long-term care industry is facing economic uncertainties due to critical reductions in funding for Medicare and Medicaid programs in many states,
in addition to increasing insurance liability costs (Ousley, 2003). Ms. Ousley stressed that publicized incidents of resident abuse were the exception, not the rule, and that the AHCA was committed to working with the federal government to improve substandard providers, or to force their removal from the long-term care industry.

Ms. Ousley’s testimony was centered around a 2003 report published by the General Accounting Office (GAO) which found that over an eighteen month period there was an almost thirty percent reduction in the number of “Actual Harm” deficiencies within the nursing home industry. The GAO concluded these results were due to an understatement of deficiencies during the survey process. Ms. Ousley believed this finding indicated the trouble with the survey process for nursing homes; it can not distinguish between an oversight problem, and actual quality improvement. AHCA members believe the true barometer of quality is not found in deficiency ratings, but in patient outcomes.

In regards to quality improvement, AHCA believes the best course of action for improving quality in nursing homes is found internally, rather than from external oversight. Regulatory efforts are important. However, they do not lead to sustained improvements in quality of care. Changes in patient outcomes and care giving must come from an internal process: “Internal quality improvement and
quality management systems must be customer centered. These systems must be based on solid, well-understood policies and procedures and resident care protocols" (Ousley, 2003, p. 4). Such policies, procedures and protocols will enable a facility's interdisciplinary team to monitor the multiple clinical conditions as well as the care process, which will in turn lead to improved outcomes for residents. It is through these systems that quality is measured, communicated and improved, and ultimately, will lead to fewer deficiencies and improved compliance with federal and state regulatory expectations (Ousley).

The AHCA is a strong proponent of the Nursing Home Quality Initiative (NHQI). The Nursing Home Quality Initiative, developed in partnership with input from nursing home groups, government agencies, as well as academic and research institutions, was introduced by the Centers for Medicare and Medicaid Services (CMS) in 2002. The NHQI serves as an expansion of Nursing Home Compare, a service which provides prospective consumers with information about a facility's inspection results, its characteristics (i.e. number of beds), and staffing levels. The NHQI enables an individual to make comparisons between several facilities on a nationwide basis to include various quality indicators among the other characteristics covered by Nursing Home Compare (Hilliard, 2005).
There are two operational goals associated with the NHQI. First, the NHQI provides individuals researching nursing homes with information about the quality of care within that specific nursing home by providing minimum data set results based on quality measures on the Medicare Nursing Home Compare website. Secondly, the NHQI assists providers by providing facilities with complementary clinical resources, quality improvement materials, and assistance from Quality Improvement Organizations located in every state (Centers for Medicare and Medicaid Services, 2007). Though Ms. Ousley’s testimony came during the preliminary stages of the NHQI, she stated the AHCA was supportive of the program because it took the necessary steps to ensure quality of care continues to improve and evolve in a manner which best meets the needs of residents.

The AHCA believes patient, family, and staff satisfaction should be key components in the measurement of quality; "We recommend that Congress allow CMS to use measures in addition to the survey process to assess patient outcomes and their satisfaction..." by taking these steps, "CMS will then have the requisite legal latitude and authority to develop better measures of quality of care in skilled nursing facilities..." (Ousley, 2003, p. 8).

In addition to quality improvement, AHCA is working to improve other aspects of the nursing home industry. One of
several areas the organization would like to see improvement pertains to the survey process for nursing homes. According to AHCA one of the biggest challenges faced by a nursing home pertains to how surveyors interpret various requirements of industry regulations. The AHCA believes there is a lack of consistency among surveyors applying the interpretations of requirements and corrective action, not only between the different CMS regions throughout the country, but in some instances, among surveyors within the same region. In order to rectify this issue, the AHCA would like to see the creation of a program which trains current and newly hired surveyors, as well as nursing home operators, in a facility for a period of five days. This would provide surveyors with "frontline" experience in the daily operations of a nursing home and allow them the opportunity to see the issues operators are confronted with during the course of their day (American Health Care Association, 2007).

Another area the AHCA believes reform is needed is nurse-aide training. A component of the 1987 OBRA, the Nurse Aide Training and Competency Evaluation Program specifies times when a facility is prohibited from providing in-house nurse-aide training to its employees. If during the course of an inspection, surveyors find substandard quality of care resulting in the implementation
of penalties (i.e. civil monetary penalties in excess of $5,000; the imposition of the denial of payment; an extended, or partially extended survey) the facility loses its right to conduct on-site nurse aide training for a period of two years (American Health Care Association, 2007). According to the AHCA there are instances where the finding of substandard quality of care does not indicate a problem directly related to care giving. In such cases, the facility’s inability to offer nurse aide training is unjust. In addition, the two year prohibition is instituted regardless of when the facility corrects the offending behavior(s). The AHCA would like to see The United States Congress take corrective measures to amend The Nurse-Aide Training and Competency Evaluation Program to allow facilities to resume on-site training of nurse aides once the offending behavior(s) have been corrected, and demonstrated compliance has been achieved (American Health Care Association).

There are two other areas which the AHCA would like to see reforms made. The first pertains to the increasing shortage of nursing staff within nursing homes. The United States health care system is in the midst of a shortage in nursing staff, and the long-term care sector has not been able to avoid the lack of nursing staff. According to AHCA figures, "Over 15 percent of registered nurse, 13 percent
of licensed practical nurse, and 8 percent of certified nursing aide positions—a total of 95,000—are vacant nationwide” (American Health Care Association & National Center For Assisted Living, 2007). In addition to directly impacting the quality of care residents receive, the shortage of nursing staff also affects the financial operations of a nursing home. American Health Care Association and National Center for Assisted Living figures indicate the cost of staff turnover in nursing facilities is estimated at just over four billion dollars a year. According to Seavey (2004) using The United States Bureau of Labor Statistics calculations in considering the costs borne by facilities in relation to the loss of direct-care workers, such as overtime for remaining staff, recruiting costs, temporary help, and the training of newly hired employees; the total cost of turnover ranges from $4,200–$5,200 per employee.

To help combat this shortage, The United States Congress enacted The Nurse Reinvestment Act (NRA) in 2002. The legislation provided funding for scholarships and loan repayment programs for nursing students and nursing graduates who obtained employment in a critical shortage sector, or with under-served or high risk groups such as the elderly. A key stipulation to the NRA was that in order for a graduate to participate in the loan repayment
program, they could not be employed in a for-profit nursing facility (this exclusion is set to expire this year).

To help alleviate a portion of the shortage in nursing staff within the long-term care sector, the AHCA, in partnership with the National Center for Assisted Living (NCAL) requested Congress amend the NRA to permanently remove the exclusion of loan repayment for graduates working in for-profit facilities. The organizations also requested Congress earmark a percentage of funding for the long-term care sector, in addition to creating a national nursing database which would forecast future supply and demand changes within the industry (American Health Care Association & National Center for Assisted Living, 2007).

The second area the AHCA would like to see a reform made pertains to the financing of the long-term care system; more specifically, the Medicaid system. According to a joint press release by the AHCA and the NCAL, "Today, two out of three nursing home residents depend on a financially fragile patchwork of federal and state Medicaid programs to pay for their long term care" (American Health Care Association & National Center For Assisted Living, 2007). The organizations believe factors such as increased life-span due to medical advances and the decline in the ratio between workers and retirees will soon push Medicaid beyond its capacity to provide financial assistance for
seventy-seven million rapidly aging “baby boomers” (American Health Care Association & National Center For Assisted Living).

In order to address this issue, both the AHCA and the NCAL, support legislation providing an “above the line” tax deduction of premium costs associated with long-term care insurance. Such a deduction would encourage individuals to purchase costly private long-term care insurance, resulting in a reduction in government spending on long-term care costs associated with the Medicaid Program. The two organizations also support proposals allowing individuals to purchase private long-term care insurance through the utilization of 401k and IRA savings, without penalization, or the use of reverse mortgages— a loan which enables homeowners aged sixty-two and over to borrow against the equity in their home, without having to sell the home, give up the title to the property, or take on a new monthly payment (American Health Care Association & National Center For Assisted Living, 2007).

Conclusion

Nursing home operators must ensure all regulations are being met at any given time. Industry groups such as the American Association for Homes and Services for the Aging and the American Health Care Association work to promote alternatives which alleviate some of the concerns of
nursing home operators. The AHCA is a prominent voice in the nursing home industry. The organization works to bring attention to issues such as nursing shortages; nurse aide training; financing options for costs associated with long-term care; and improving the surveyor training process for nursing home inspections.
CHAPTER V

WHERE DO WE GO FROM HERE?

Despite the passage of reform efforts such as the Nursing Home Reform Act and the Nursing Home Initiative, as well as measures such as the Nursing Home Quality Initiative, it appears quality of care concerns still remain an issue plaguing the nursing home industry. In August 2006, Consumer Reports, financed by a grant from The Commonwealth Fund, found quality nursing homes still hard to come by. The 2006 report was the fifth in a series examining nursing home data which the consumer publication has published since 2000. Titled, “Nursing homes: Business as usual,” the report comprised the survey results from 16,000 nursing homes across The United States. The report found for-profit nursing homes were more likely to be cited for poor care than non-profit and government-operated facilities.

Several questions arise from data found in accounts such as the Consumer Reports findings. As the American population continues to grow older, an increasing segment of the populace will likely need nursing home care. According to Blumenthal et al. (2003) more than forty-three percent of all individuals who turned sixty-five in 1990 or later will enter a nursing home during their lifetime.
The likelihood of use rises dramatically with age, "rising from 17 percent for those 65 to 74 years of age to 60 percent for persons aged 85-94, the fastest growing segment of the population" (Blumenthal et al., p. 131). A greater sense of urgency must be placed on ensuring America's nursing homes become places where those no longer capable of caring for themselves receive the quality care they are entitled to. But what steps can be taken to ensure quality issues no longer plague the nursing home industry?

Suggestions for Change

**Increase Regulation**

Kapp (2005) states an increase in regulation assumes the nursing home is untrustworthy and needs to be monitored and controlled by consumers and regulators, rather than looked at as a partner in the process of providing quality care for nursing home residents.

Walshe (2001) wrote about regulation within the nursing home industry and the different forms (i.e. deterrence, compliance, and responsive) regulation can take. Regulators employing the deterrence model of regulation view the organizations they regulate as calculating entities driven to succeed in their respective field, and are not opposed to breaking rules in order to accomplish organizational goals. Accordingly, practitioners of deterrence regulation
approach the regulation process in a formal, legalistic, and sanction-oriented manner (Walshe).

Compliance regulators view the organizations they regulate as well-intentioned and willing to comply with regulators. They approach the regulation process with an informal, supportive, developmental approach, and resort to the use of sanctions as a last resort (Walshe, 2001).

The final form of regulation, known as responsive regulation, is a hybrid of the deterrence and compliance models. The approaches regulators assume are adapted in response to the behaviors of the organizations being regulated. Many of the benefits associated with compliance regulation, such as cooperation, information sharing, and negotiated agreements are utilized; with the use of sanctions and other incentives for compliance available to the regulator should such action be deemed necessary (Walshe, 2001).

Regulators within the nursing home industry practice deterrence regulation. Emphasis is placed on the development of formal, written regulations; the use of surveys; the issuance of deficiencies for non-compliance; and enforcing sanctions for failing to meet regulations. The use of deterrence regulation within the nursing home industry has resulted in strained relationships between regulatory agencies and nursing home providers. Most
importantly, deterrence regulation prohibits regulators from using their discretion when conducting surveys, and prevents them from providing advice or assistance to nursing home operators. Interestingly, other countries utilize a less deterrence based regulatory system, and approach regulation with a more informal and supportive process, while relying on the use of sanctions as a last resort (Walshe, 2001).

According to (Walshe, 2001) regulation within the nursing home industry is fragmented in three ways. First, the responsibility of regulation is divided between The Centers for Medicare and Medicaid Services (CMS) of the federal government, and the agency’s regional offices which develop and set guidelines and oversee the actions of state survey agencies. This fragmentation causes communication problems between the central and regional offices as well as decreases the effectiveness of regulatory efforts.

Second, regulatory responsibility is split between CMS and state survey agencies and, "the relationship does not appear to be an easy one, marked more by bureaucratic direction and dissonance than by real interagency dialogue or collaboration" (Walshe, p. 136). State agencies have a difficult time achieving the mandates set forth by CMS in the State Operations Manuel (SOM) with the resources provided to them by CMS. Also, state survey agencies have
what Walshe describes as "dual accountability" to CMS and to their respective state government; which leads to the creation of conflicts between the two groups.

The third form of fragmentation relates to the fact that there are two systems of regulation; federal certification for Medicare/Medicaid services, and state licensure. This dual system of regulation results in duplication, occasional conflicts and considerable confusion between the groups (Walshe, 2001).

Survey Process

Another potential approach for improving nursing home quality could be found in addressing the survey process itself, and the role of surveyors.

In 2003, the General Accounting Office (GAO) released a report titled "Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline." Following an examination of 2002 survey data, the report found one in five nursing homes in The United States had serious deficiencies which caused residents "Actual Harm," or placed them in immediate jeopardy. Most importantly, the GAO found significant understatement on the part of surveyors, in relation to care problems which should have been classified as "Actual Harm" or higher. The GAO concluded there were several factors contributing to this understatement, such as confusion on the part of surveyors.
about the definition of harm, as well as "inadequate state supervisory review of surveys to identify potential understatement; large numbers of inexperienced state surveyors; and a continuing, significant problem with survey timing being predictable to nursing homes" (United States General Accounting Office, 2003, p. 2). The report also found states failed to meet response guidelines when responding to complaints alleging "Actual Harm." State agencies attributed poor response time to a lack of clear guidance from CMS on the definitions of complaint terminology, an increase in the volume of complaints, in addition to insufficient staff levels to handle increases.

The GAO concluded its report by providing CMS with several recommendations to strengthen the survey system. These recommendations included the development of more structured guidance for surveyors to address inconsistencies they find in the scope and severity of deficiencies cited across the country; refining state agency performance standard reviews to ensure states are held accountable for nursing homes to be in compliance with federal nursing home quality standards; and the implementation of a national complaint tracking system to provide states with additional complaint investigation guidance.
The ASPEN Complaint/Incidents Tracking System (ACTS) became operational on January 1, 2004. CMS required state agencies to enter all complaint investigation data in the system. Each complaint entered into ACTS contains information from the intake phase through resolution of the complaint. Data found in report filing includes key dates; the prioritization level of the complaint; overall findings; proposed action by the agency; and the reason the complaint was closed (Department of Health and Human Services & Office of Inspector General, 2006).

A program implemented by CMS to aide state agencies during the survey process is the Federal Oversight and Support Surveys (FOSS) program. The FOSS program allows CMS to observe a state agency during the complaint, or survey investigation process. At the conclusion of the investigation, the CMS regional survey representative discusses the team's performance, and if appropriate, will identify surveyor training needs, and provide the state agency with a numerical rating of the surveyor(s) performance (Department of Health and Human Services & Office of Inspector General, 2006).

Implementing the suggestions found in the GAO report for improving the survey system provided CMS and state survey agencies with a structure for improving the survey process. Ironically, a 2006 report by the Department of
Health and Human Services Office of Inspector General (OIG) detailed similar issues pertaining to the investigation of complaints and surveyor findings which the GAO report three years earlier had found. For instance, in 2004 state agencies did not investigate seven percent of complaints alleging "Immediate Jeopardy" in the required two day timeframe. The OIG report also found state agencies cited staff shortages and insufficient training as hindrances to timely complaint investigations. CMS regional offices reported state agencies within their regions had difficulty recruiting and retaining qualified staff, because nursing home complaint investigations require clinical and regulatory knowledge. According to CMS, employees lacking knowledge in these specialized areas experience difficulty in completing investigations in an appropriate and timely manner. Officials in state agencies and CMS regional offices explained, "a rise in complaint volume, high staff turnover, and the demands of higher priority State agency tasks all contribute to insufficient complaint investigation staffing levels at the State agencies" (Department of Health and Human Services & Office of Inspector General, 2006, p. 10).

Another key result in the OIG findings pertained to the difficulty states reported in the use of the ACTS system. Most states received training prior to the implementation
of the ACTS system; however the training did not sufficiently prepare the agencies for use of the system. States reported the training occurred far in advance of the implementation date of the complaint tracking system. Consequently, those whom received training failed to recall specific operating details: “The only classroom training CMS offered was in April 2002, which was over a year and a half prior to ACTS implementation” (Department of Health and Human Services & Office of Inspector General, 2006, p. 11). In addition to the early training period, CMS also updated some components of the ACTS system prior to implementation, which in turn, made portions of the training outdated by the time the system became operational.

Increase Nurse Staffing

Nurse staffing receives a significant amount of attention as a possible solution to improving quality in nursing homes (Zhang, Unruh, Liu, & Wan, 2006). In order to meet federally mandated staffing levels established in the 1987 NHRA, nursing homes are required to have “sufficient staff” in place to ensure the highest levels of well-being for residents. According to Zhang et al. there is a lack of specificity and adequacy in the federal requirements relating to nursing home staffing in that a facility with
fifty residents has the same staffing requirements as a facility with two hundred residents.

As part of the survey and certification process, state surveyors monitor nursing home staffing levels to ensure compliance with federal requirements. A nursing home must have a Registered Nurse (RN) on duty for eight consecutive hours per day, seven days a week. In nursing homes with less than sixty residents, the registered nurse can serve as the Director of Nursing for the facility and can also provide direct resident care. A nursing home must have a Licensed Practical Nurse (LPN) on duty twenty-four hours per day, seven days per week (in addition to the RN). This ensures a nurse will be on duty during the evening and overnight hours. The nurse must be licensed, and can be either a registered nurse, a vocational, or practical nurse. (Kaiser Commission on Medicaid and The Uninsured & Harrington, 2002).

While federal rules specify a minimum level of hours for registered and licensed nurses, federal regulations do not require a nursing home have a minimum level of non-licensed nursing staff, such as Certified Nurse Assistants (CNA). Though minimum levels of staffing for CNA’s are not federally required, Medicare and Medicaid statues do require certified nurse aides receive seventy-five hours of
training and pass a competency exam. (Kaiser Commission on Medicaid and The Uninsured & Harrington, 2002).

Nurse aides provide the majority of direct care for residents of nursing homes, assisting them with activities of daily living, such as dressing and undressing, eating, bathing, assisting to and from the bathroom, and providing oral and skin care. In addition to these skills, a CNA is taught to measure a resident’s basic body functions, such as vital signs, temperature, pulse and respiration rate, as well as looking for changes in a resident’s physical or emotional status, cognitive status, and appetite (Hernandez-Medina, Eaton, Hurd, & White, 2006).

As evidenced by the above job description, a CNA faces a challenging daily work environment. They routinely face “demanding workloads, unsafe working conditions, inadequate training, a lack of respect from supervisors, a lack of control over their jobs, and few opportunities for advancement” (Hernandez-Medina, Eaton, Hurd, & White, 2006, p. 2). Certified nursing assistants are frequently paid lower salaries and receive limited or no benefits. According to The United States Department of Labor Bureau of Labor Statistics, the median hourly wage for certified nurse aides in 2005 was $10.31.

Considering the low pay, lack of benefits and advancement opportunities, and demanding work environment,
it is easy to see why there is high voluntary turnover (Donoghue & Castle, 2006), among nurse staff within nursing homes. Using data collected from a 2002 AHCA report, Donoghue and Castle conducted an examination of turnover rates within the nursing home industry. The researchers found voluntary turnover rates for registered nurses was forty-seven percent; fifty-two percent for licensed practical nurses; and seventy-three percent for certified nurse aides. For-profit nursing homes were found to have higher rates of voluntary turnover.

Conclusion

As Americans continue to live longer, the likelihood of an individual requiring nursing home care increases. What steps can be taken to ensure residents receive the best care possible? Increases in regulation will continue to strain relationships between regulators and nursing home providers due to the deterrence oriented approach to regulation found within the nursing home industry. Addressing the survey process and providing state surveyors with better training is another potential approach however, as evidenced by the OIG report, the complaint tracking system implemented by CMS is only leading to more confusion between state agencies and the federal government. Staffing within nursing homes is another possible solution. Nursing homes are required to provide “sufficient staff” to ensure
the well-being of residents. However, there is a lack of specificity in federal regulations pertaining to staffing levels within nursing homes. As a result, a facility with fifty beds has the same staffing requirements as a facility with two hundred beds. A nursing home must ensure Registered Nurses and Licensed Practical Nurses are present to provide care to residents for a specified number of hours per day. There are no requirements for Certified Nurse Aides, though they provide the majority of care for residents. The staffs’ in nursing homes are over-worked and underpaid, which has led to a significantly high level of voluntary turnover within the industry.
CHAPTER VI

CONCLUSION: REALISTIC CHANGE

Over the next twenty years, American nursing homes will become inundated with members of the "baby-boomer" generation as they currently begin to retire. It will become increasingly important to ensure this significant portion of the American population receives the best long-term care possible. The nursing home industry is one in need of change. This change must not come from nursing home providers alone, but also from the Centers for Medicare and Medicaid Services (CMS).

What reform measures should be taken to ensure American citizens receive the highest level of nursing home care? The potential approaches outlined in the previous chapter are not feasible in the current state of the nursing home industry in The United States. In regards to an increase in regulation- it is not possible to increase regulation without consequences. In an industry of mutual distrust, an increase in regulation would only serve to inflict further damage on already strained relationships between regulators and providers. As for the second approach, involving change at CMS- CMS has not been successful in instituting effective process changes in the survey and complaint investigation, as evidenced by the General Accounting
Office (GAO) and Department of Health and Human Services Office of Inspector General (OIG) reports. A lack of communication has been the cause of these failures. In a federal agency the size of CMS, it is necessary to have effective communication channels in place to ensure policies are understood by employees at all levels. At this point, the organizational structure of CMS is not conducive to implementing improved methods of communication. In regards to an increase in staffing at the nursing home level—this is an unattainable goal, due in large part to the employment shortage in the nursing profession. In order to increase staffing, providers would have to increase salaries and benefit packages for employees. In an era of increasing insurance premiums and other exorbitant costs for nursing home providers, this is not likely to occur.

If the suggestions in the previous chapter are not viable options in today’s nursing home industry, what option, or options are feasible? In order to answer this question, I felt it necessary to gain first-hand insight into the daily operations of a nursing home. Therefore, I spoke with three nursing home administrators from the New England area; one from a corporate owned for-profit facility; one from a county-operated facility; and one from a single owner-for-profit facility. I chose to speak with these individuals on the condition of anonymity. Our
conversations touched upon topics such as how each viewed their role as a nursing home administrator; the benefits of working in the type of facility they are employed in, and what their definition of quality of care is.

One of the important areas covered in these interviews centered on the regulation process of nursing homes. When asked about their feelings on the current amount of regulation, each conditioned their responses by stating regulation serves an important role, and that government oversight is needed in the industry. With that said however, each respondent believed that currently, there was too much regulation within the industry and that it was a hindrance in their ability to provide quality care to their residents. The central reason for this pertains to the process itself. Each viewed the regulation process as punitive in nature; not allowing for the opportunity to develop a more effective system.

Due to the punitive nature of the regulation process, there was a feeling among respondents that prior to the commencement of a survey, they are presumed guilty and it is the responsibility of regulators to find evidence to support this presumption. This was a frustrating aspect of the survey process for each respondent. It was understood by each administrator there are pressures placed on each state by the federal government to carry out the survey
process in this fashion. Nevertheless, respondents expressed irritation, stating nursing home providers are not adversaries of surveyors; both groups are working toward the same goal of ensuring quality care for nursing home residents. Each respondent stated they would like to see more credit given to providers for successes regarding resident outcomes and facility accomplishments, rather than the current approach of ignoring successes and focusing on areas not meeting standard.

Another area respondents expressed frustration with was the lack of participation they, as an industry, have in the rule-making process. During the implementation of a new rule, there is a thirty day period of comment which allows industry representatives, as well as other stakeholders, the opportunity to voice concerns, or suggest improvements to the proposed rule. There was a commonly shared view among those interviewed that the thirty day period of comment was nothing more than "lip service;" that concerns or suggestions are not taken seriously by CMS. Respondents stated they would like to see the creation of a system where rule changes are implemented in a collaborative effort with industry representatives, because they, unlike regulators, have first-hand experience of the daily operations of nursing homes and would be able to provide a unique insight into the feasibility of proposed rules.
Therefore, considering the issues discussed in the preceding chapters, what approaches should be taken to improve the nursing home industry as a whole; not only in relation to care, but also from an operational aspect? CMS has been ineffective in following the survey and complaint investigation guidelines set forth in the 1987 Nursing Home Reform Act and the 1998 Nursing Home Initiative, and at providing the proper training for surveyors and complaint investigators to conduct their important work. CMS should not be the only entity faulted however. Culpability must also be placed with nursing home providers whose ultimate concern lies with making a profit, and are willing to sacrifice resident care in order to do so. Unethical providers are ultimately responsible for the current level of regulation within the industry and the negative perception of nursing homes in The United States today.

In order to bring successful change to the nursing home industry, it must transform into an industry operated and regulated on a collaborative basis. This transformation will lead to the type of improvements in care the American people expect and deserve. Both the federal government and nursing home providers must develop an effective partnership. An interesting point brought to light during one of the interviews conducted for this report was the revelation that while conducting a survey; a surveyor is
prohibited from suggesting potential solutions to assist a provider in improving an area of care which falls short of meeting established standards. Surveyors should be encouraged to work with providers, rather than distribute deficiency citations, and inflict further damage on already strained relationships. This is a prime example of why the deterrence model of regulation has not been effective in the nursing home industry, and why there is a drastic need for change to a collaborative form of regulation.

Nursing homes are not the final residence for all Americans. For those fortunate to have the financial resources, there are other options, such as full-time home care. However, with costs averaging $3,000 per week, few families are able afford these services for a prolonged period of time. There is also the option of assisted living. These facilities offer a level of independence while also providing support with a limited number of activities of daily living. As residents in these facilities continue to grow older, they may eventually require more care than assisted living facilities can provide. It is at this point that many people's worst fears become reality; it is time to enter a nursing home.

There are three reform efforts, which, if implemented, will influence real change throughout the nursing home industry and create facilities which people will welcome.
entering into. First, effective lines of communication must be established between CMS, its regional offices, and the state agencies responsible for conducting survey and complaint investigations, so issues such as the confusion over the implementation of the Aspen Complaint/Incident Tracking System (ACTS) and the uncertainty over the definition of what actions constitute "Actual Harm" no longer occur. Perhaps a solution to this problem could be found in conducting weekly teleconferences or video conferences where regional directors have the opportunity to discuss issues, or concerns with representatives from the central office in Washington D.C. This act would go a long way to strengthen lines of communication and put an end to the poor dissemination of information currently taking place within CMS.

Second, CMS should adopt the American Health Care Association's (AHCA) proposed training program for current and newly hired surveyors. This program would train surveyors, as well as nursing home operators in a facility for a period of five days. These steps would provide surveyors with "frontline" experience of the daily operations of a nursing home and view firsthand, the issues nursing home providers must address during the course of a given day. In addition to providing needed training for surveyors, the implementation of such a training program
would serve as the building block for the formation of effective relationships between surveyors and nursing home providers.

The final reform effort, arguably the most important, involves the inclusion of the nursing home industry in the policy-making process. Nursing home providers should be afforded the opportunity to have a voice in policy-making decisions within the industry. Providers are on the "frontlines" of daily operations of nursing homes. This provides them with a unique insight, which can in turn be conveyed to CMS when proposed rules are being discussed. Another benefit to this relationship can be found in the strength of both entities in addressing and removing unethical nursing home providers from the industry.

Accomplishing reform in these three areas will have a positive impact on the overall quality of the nursing home industry. Increased communication will improve CMS at every level. It will not only aide in addressing process issues which arise from the implementation of new programs, but also serve as a morale boost to state agencies who feel they do not receive the direction or support they need to meet the responsibilities of their positions. CMS and state agencies must also come to realize that nursing home providers are not the enemy; that both sides are working toward the same goal of ensuring nursing home residents
receive the best care possible. Achieving reform in these areas will benefit all parties involved in the nursing home industry; but most importantly, the residents of nursing homes.

The key to progress within any section of American society is the development of partnerships between groups with differing views. It is through discussions that common ground is discovered and ideas are formed into effective policies which ultimately benefit the public. The occurrence of this process is what makes American government effective. This view is supported by several competing theories of democracy. One such theory, known as Deliberative Democracy, argues that legitimate lawmaking can only arise from the public deliberation of the citizenry. An agency such as CMS, one responsible for the care of 1,600,000 residents in American nursing homes, should not make unilateral decisions without input from a group which plays a prominent role in the care process of residents, as nursing home providers do.

President John F. Kennedy once said the strength and durability of a society can be judged by how it treats its elderly. That quote holds significant importance today, because a considerable number of the American population will likely require nursing home care. There is no better way to honor this group’s contribution to American society
than by providing them with the quality nursing home care they so rightly deserve.
LIST OF REFERENCES


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APPENDIX A IRB APPROVAL FORM

University of New Hampshire

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21-Feb-2007

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IRB #: 3914
Study: An Examination of the Nursing Home Industry
Approval Date: 19-Feb-2006

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Exempt as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 101(b). Approval is granted to conduct your study as described in your protocol.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, Responsibilities of Directors of Research Studies Involving Human Subjects. (This document is also available at http://www.unh.edu/osr/compliance/irb.html.) Please read this document carefully before commencing your work involving human subjects.

Upon completion of your study, please complete the enclosed pink Exempt Study Final Report form and return it to this office along with a report of your findings.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.
For the IRB,

Julie F. Simpson
Manager

cc: File
Wirth. Clifford
APPENDIX B LETTER OF CONSENT

Letter of Consent

Dear Interviewee:

My name is Craig Lahore. I am a graduate student at the University of New Hampshire. In order to satisfy the thesis requirement to complete my Master of Arts Degree in Political Science, I am conducting a study of the nursing home industry in The United States. I would like to interview you to gain insight into the role of the administrator within the nursing home setting, and hear your opinions on topics such as regulation within the industry and steps which could be taken to better meet the needs of nursing home residents. The interview will take approximately 30 minutes to complete. I will discuss what I learn in our discussion with my thesis advisor, Prof. James Lewis from the Department of Health Policy and Management at the University of New Hampshire.

When I report my findings from our discussion, I will not identify you, or the facility for which you work for. Your participation in this project is voluntary and I appreciate your willingness to discuss your experiences within the nursing home industry with me. Should you have questions about this research project, you may contact my advisor, Prof. James Lewis at (603) 862-2733. Should you have questions about your rights as a subject in this research project you can speak with Julie Simpson in the Office of Sponsored Research at the University of New Hampshire at (603) 862-2003.

______________________________
Signature/Date
APPENDIX C ADDITIONAL RESOURCES


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