

---

# AGING TODAY

---

Vol. XXVIII, No. 5

PAGES 3 & 4

September–October 2007

ISSN: 1043-1284

[www.agingtoday.org](http://www.agingtoday.org)

---

## HOW TO IMPROVE NURSING HOMES— ONE EXPERT'S 30-YEAR VIEW

*When this editor was starting to cover issues in healthcare and aging in 1982, one of the first lecturers I heard on long-term care policy was Charlene Harrington, who was as sharp-minded as the RN and PhD on her business card might suggest. Today, Harrington is a professor at the School of Nursing, University of California, San Francisco (UCSF), the associate director of UCSF's John A. Hartford Center of Geriatric Nursing Excellence, and the director of the university's Health Policy in Nursing Doctoral Nursing Program.*

*Sadly, Harrington continues to find no improvement in the quality of nursing home care more than three decades after she began to study long-term care, often for the federal government and state agencies. In the following article, based on her recent testimony before the U.S. Senate Special Committee on Aging, Harrington explains what's wrong with U.S. nursing homes and what can be done to improve them.*

---

By **CHARLENE HARRINGTON**

---

I first became aware of the serious quality problems in nursing homes in 1976, when I was director of the California Licensing and Certification program. At that time, about one-third of California nursing homes were providing substandard care. Today, more than 30 years later, the substandard care in many nursing homes results in harm, jeopardy and premature death for residents every year. Dozens of studies by researchers, the U.S. Government Accountability Office (GAO), the U.S. Department of Health and Human Services Office of Inspector General and others have documented the persistent quality problems in a sizable subset of the nation's nursing homes—20 years after the federal Nursing Home Reform Act was passed in 1987.

Three areas need to be improved to ensure high-quality nursing home care: the enforcement of existing laws, nurse staffing levels and financial accountability for government funding.

---

### ENFORCEMENT

---

The GAO should be commended for its 2007 report, "Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes From Repeatedly Harming Residents" (GAO-07-241). The report found that the number of serious deficiencies and sanctions declined in four states between 2000 and 2005, and that this decline was related to weaknesses in the survey system and inadequate use of sanctions. Often, quality problems are not detected—and when they are, the scope and severity of problems have been underrated. According to the report, nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm to residents.

The GAO report recommends that the federal Centers for Medicare and Medicaid Services (CMS) improve the policy for imposing immediate sanctions for violations, strengthen the deterrent effect of certain sanctions, enhance the enforcement of laws involving facilities with a history of noncompliance, and increase the effectiveness of the data reporting systems on enforcement.

At UCSF our studies of the wide variations in enforcement procedures have found that states with bet-

ter enforcement are those that receive higher allocations from CMS for the state agency that surveys facilities for compliance. State enforcement practices could be improved, in part, by increased funding for state survey agency activities.

---

### STAFFING ISSUES

Nursing home quality rests entirely in the hands of nurses, nursing assistants and other providers who deliver formal care and aid. Nursing homes are labor intensive and require well-educated, experienced nursing staff, who demonstrate compassion. Numerous studies reported by the Institute of Medicine (IOM) have shown the positive relationship between nurse staffing and quality of care. Higher levels of staffing hours per resident, particularly hours by registered nurses, have been consistently and significantly associated with overall quality of care, with outcomes ranging from improved resident survival rates to lower hospitalization rates. In addition, better staffing is associated with lower worker injury rates and less litigation. Studies have also found that gerontological nurse specialists and geriatric nurse practitioners contribute to improved quality outcomes in nursing homes and lower risk-adjusted hospitalization rates.

**Safe Staffing Levels:** A 2001 study by Abt Associates for CMS reported that a minimum of 4.1 hours per resident day (including 0.75 RN hours) were needed to prevent harm to residents with long stays in nursing homes. In 2003, an IOM committee report titled “Keeping Patients Safe” recommended that CMS adopt the minimum staffing levels recommended in the Abt study for all U.S. nursing homes, along with 24-hour RN coverage.

In spite of these recommendations, total nurse staffing levels have remained flat throughout the United States since 1997, at 3.6 to 3.7 hours per resident day (HPRD), well below the recommended levels—and these levels are dangerously low in some facilities.

Shockingly, RN staffing hours per patient day in U.S. nursing homes have fallen by 14% since 2000. That decline is directly related to the implementation of the Medicare prospective payment system (PPS) for skilled nursing homes, according to recent studies, and this change, in turn, has led to a reduction in nursing home quality. Under prospective payment, facilities receive a set amount of funds per resident rather than retrospective reimbursement for each individual’s care.

Under PPS, Medicare rates are based on each facility’s resident needs for nursing and therapy services, but skilled nursing homes do not need to provide the level of care for which Medicare rates pay. The declining quality of care and fewer RNs in nursing homes show the need for regulatory standards and incentives to improve staffing levels.

**State Minimum Licensed Staffing Standards:** Some states have begun to raise their minimum staffing levels: For example, Florida recently established a 3.9 HPRD total for licensed staff and a minimum for licensed nurses. Studies by our research team at UCSF and elsewhere have shown that increasing Medicaid reimbursement rates encourages higher staffing levels. I and my colleagues recently completed a study showing that high state minimum licensed staffing standards actually have a stronger positive effect on total nursing hours, including those for RNs, than better reimbursement rates. The most effective way to improve quality care is for states to increase average Medicaid reimbursement rates while also raising minimum RN staffing standards.

**Staff Turnover Rates:** Nursing home staff turnover rates continue to be high, reducing continuity and stability of care, leading to miscommunications and resulting in patient-safety problems, including worker injuries and poor morale. The consequences are decreased nursing home quality and increased costs. Turnover is directly related to heavy workloads, low wages and benefits, and poor working conditions.

---

### FINANCIAL ACCOUNTABILITY

Medicaid and Medicare programs pay for 61% of total U.S. nursing home expenditures. Government policies have primarily focused on cost containment rather than quality. The majority of states have adopted Medicaid PPS for nursing homes; the facilities tend to respond by cutting their staffing and quality. In 1998, a complex system was established for Medicare PPS payment rates, with little financial accountability. Nursing homes do not need to ensure that the amount of staff and therapy time is equal to the amount that is allocated in the Medicare rates.

One way to make nursing homes more financially accountable under Medicare and Medicaid PPS systems would be to establish four cost centers: direct-care services, such as nursing, activities and therapy services; indirect care, including housekeeping and dietary services; capital costs (building and land, for example); and administrative costs. After rates are determined for each cost center, nursing homes should be prevented from shifting funds away from nursing and direct care to pay for administra-

tive costs, meet capital costs and fatten profits.

Regulators should conduct retrospective audits to collect funds that facilities did not spend on direct and indirect care. Also, penalties should be issued for diverting funds from direct and indirect services. Furthermore, nursing homes should report nursing hours as a separate item on the Medicare cost reports to track their expenditures for nursing. Without reporting, nursing homes are not accountable for how they spend the Medicare funds they receive.

The most important measure of quality of care is the amount of nursing staff available. In nursing homes, the decline in the number of registered nurses and the failure to improve staffing shows the need for greater regulatory standards and incentive systems. To address nursing home quality, staff turnover rates must be addressed and wages and benefits must be improved. Greater financial accountability is needed to ensure that Medicare and Medicaid funds are spent only on direct and indirect care. We must invest in our nursing home workforce now so that high-quality providers will be available when our family members, our friends and ourselves need long-term care. ❖