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Not Forgotten: Protecting Americans from Abuse and Neglect in Nursing Homes

Chairman Grassley, Ranking Member Wyden, and distinguished members of the Committee my name is David Grabowski and I am a Professor of Health Care Policy at Harvard Medical School. I want to thank you for inviting me to testify today on the important issue of protecting older Americans from abuse and neglect in nursing homes.

On a given day, roughly 1.5 million individuals receive care from approximately 16,000 nursing homes nationwide. These individuals have high levels of physical and cognitive impairment and often lack family support and financial resources. As such, these are among the frailest and most vulnerable individuals in our health care system. We spend roughly \$170 billion on nursing home care annually. This sector is heavily regulated. Yet, quality issues persist in many U.S. nursing homes.

Here is a section from a US Senate Special Committee on Aging report. In this report, the Committee identified the following nursing home abuses:

Lack of human dignity; lack of activities; untrained and inadequate numbers of staff; ineffective inspections and enforcement; profiteering; lack of control on drugs; poor care; unsanitary conditions; poor food; poor fire protection and other hazards to life; excessive charges in addition to the daily rate; unnecessary or unauthorized use of restraints; negligence leading to death or injury; theft; lack of psychiatric care; untrained administrators; discrimination against minority groups; reprisals against those who complain; lack of dental care; advance notice of state inspections; false advertising.¹

If this report does not sound familiar to the Senators and their staff, it's because it was published in 1974. I would acknowledge that the nursing home sector has made important improvements over the past 45 years. For example, the use of physical restraints in nursing homes has dropped. The rate of unnecessary hospital admissions and readmissions has also fallen. And, it is important to note certain nursing homes are providing innovative care. For example, a few nursing homes have begun to offer small house nursing home models that offer a less-institutional, more resident-focused living environment.

Some important changes have occurred in the nursing home sector since the 1974 report. First, today's residents have much greater acuity and medical complexity, suggesting their needs are much greater relative to residents even 10 or 20 years ago. Second,

nursing homes today still deliver chronic care services for long-stay residents but they also care for post-acute patients following a hospital stay. Post-acute Medicare payments keep facilities afloat financially, especially in the context of expanded home and community options, lowered occupancy rates, and parsimonious Medicaid payments. Third, nursing homes continue to be largely for-profit owned, but the sector has experienced a great deal of private investment entry and corporate restructuring.²⁻⁴ Fourth, the nursing home sector has become much more regulated over time. In particular, the Nursing Home Reform Act was passed as part of the Omnibus Reconciliation Act of 1987 (OBRA '87).⁵ The extensive standards established by OBRA '87 were resident-focused and outcome-oriented, emphasizing quality of care, resident assessment, residents' rights, and quality of life. Finally, many market-based approaches have been implemented to encourage better nursing home quality of care including report cards and value-based payment.

In spite of all these changes, many of the issues identified in the Senate report in 1974 persist today. In my testimony, I would like to take on two issues. First, I will review the state of nursing home quality today. Second, I will identify why we have been focusing on this issue for nearly five decades. What are the underlying issues that lead to persistent low nursing home quality?

The State of Nursing Home Quality

Nursing home quality of care continues to be an important public policy issue in spite of prolonged public outcry⁶⁻⁹ and government commissions¹⁰⁻¹². Often the number of nurses per resident is low and the staff turnover rate is high.¹³ Residents may develop new health problems after admission from physical restraints and missed medications.^{14,15} There are a number of studies documenting mistreatment of older adults in nursing homes.¹⁶ Amenities that are common within a nursing home – including the food, activities and public spaces – are too often sub-standard.¹⁷ The quality of life in many US nursing homes is inadequate and large numbers of residents suffer from isolation and loneliness.¹⁸

Staffing: Labor is the dominant input into the production of nursing home care, accounting for roughly two-thirds of nursing home expenditures. Nursing homes are predominantly staffed by registered nurses (RNs), licensed practical nurses (LPNs) and certified nurse aides (CNAs). Higher nursing home staffing has generally been found to be associated with better quality of care.^{13,19} Nursing homes with low staffing levels, especially low RN levels, tend to have higher rates of poor resident outcomes such as pressure ulcers, catheterization, lost ability to perform daily living activities, and depression. Staffing standards may also improve working conditions, which would increase job satisfaction and reduce nursing turnover and burnout. Nursing home staff, especially CNAs, have very high turnover.^{20,21} It is not uncommon for nursing homes to have their entire set of CNAs change multiple times within a calendar year. Research has found that nursing homes with higher staff turnover have worse quality.^{13,21-23}

Primary care physicians have been termed “missing in action” in the nursing home setting.²⁴ Some nursing homes have a nurse practitioner onsite,²⁵ but typically, a group

practice covers primary care in the nursing home.²⁶ These physicians are rarely onsite at the nursing home. For urgent issues, the physician may come visit the resident at the nursing home, but after hours and on weekends, this is often the exception rather than the rule. In these instances, it is more likely that the physician transfers the resident to the emergency room. Very few nursing homes have invested in innovative off-hour clinical delivery models like telemedicine.²⁷

Poor care practices: In the context of staff shortages, nursing homes often use labor-saving practices to deliver care.²⁸ These labor-saving practices are typically associated with a greater risk of morbidity and mortality. For example, managing incontinence may be labor-intensive, through regularly scheduled toileting and bladder rehabilitation, or labor-saving through urethral catheterization.²⁹ Urethral catheterization places the resident at greater risk for urinary tract infection and long-term complications including bladder and renal stones, abscesses, and renal failure. Nursing homes face similar decisions with respect to feeding residents (hand feeding versus feeding tubes), and in monitoring and controlling residents' behavior (monitoring by staff versus physical or chemical restraints). Although antipsychotics are not appropriate for the majority of nursing home residents with dementia, nursing homes often use antipsychotics to "manage" behavioral symptoms associated with dementia.^{30,31} Feeding tubes can result in complications including self-extubation, infections, aspiration, misplacement of the tube, and pain. Immobility resulting from physical restraints may increase the risk of pressure ulcers, depression, mental and physical deterioration, and mortality.²⁹ Inappropriate use of antipsychotic medications may also result in mental and physical deterioration.³²

Poor outcomes and adverse events: Researchers have identified a range of poor nursing home outcomes that could have been prevented such as falls and pressure ulcers or delayed such as functional decline and mortality. Many of these outcomes are reported as quality measures on the federal Nursing Home Compare website. The transfer of nursing home residents to the emergency room and hospital has emerged as an important area of interest for policymakers. These transfers are known to be frequent,^{33,34} costly,³⁵ often preventable³⁶ and potentially associated with negative health outcomes such as iatrogenic disease and delirium.³⁷ Although the rate of avoidable hospitalizations has declined in recent years, analyses by CMS suggested it was still 15.7% in 2015.³⁸

Safety: Many nursing homes are not safe environments to live. A large research literature documents both staff-on-resident^{39,40} and resident-on-resident⁴¹ abuse in nursing homes. Deficiency citations are given to nursing homes that are in violation of Medicare/Medicaid regulations in four specific areas (abuse; neglect by staff; criminal screening investigating and reporting; and, abuse prevention and policy development and implementation). 20% of facilities received one of these citations in 2007.⁴² Nursing homes can also be cited for deficiencies related to overall safety. In 2007, 33% of nursing homes were cited for environmental safety issues (e.g., "lighting levels"; "handrails"), 47% for care safety issues ("medication error rate"; "availability of physician for ER care"), and 60% for Life Safety Inspection issues (e.g., "fire alarm systems"). It should be noted that some of these deficiency citations can be for relatively minor events. Nevertheless, 16% of nursing homes were found to have at least one of the most severe

deficiency citations from 2000 through 2007. These deficiency citations are for actual or potential for death or serious injury.

One important nursing home safety issue involves emergency preparedness. This issue received increased scrutiny following the deaths of eight nursing home residents in Hollywood, Florida in September 2013 following Hurricane Irma.⁴³ A facility lost electricity during the hurricane and didn't have a generator capable of powering the air-conditioning. A Kaiser Health News investigation suggested many nursing homes fail to plan for even basic contingencies:

In one visit last May, inspectors found that an El Paso, Texas, nursing home had no plan for how to bring wheelchair-dependent people down the stairs in case of an evacuation. Inspectors in Colorado found a nursing home's courtyard gate was locked and employees did not know the combination, inspection records show. During a fire at a Chicago facility, residents were evacuated in the wrong order, starting with the people farthest from the blaze.⁴⁴

According to the article, nursing home inspectors issued 2,300 violations of emergency-planning rules over the prior four years, but they labeled only 20 as serious enough to place residents in danger. Although a third of nursing homes were cited for failing to inspect their generators each week or test them monthly, none of these violations was categorized as a major deficiency. This raises the important issue of whether current safety standards are being effectively enforced.

Low quality of life: Due to the fact that patients often spend long periods in nursing homes relative to most health institutions, quality of life is an important aspect of a resident's nursing home experience. Historically, there has been much greater emphasis on the "nursing" rather than "home" part of the nursing home experience. Quality of life may be thought of as generally corresponding to those characteristics of nursing home care that affect the resident's sense of well-being, self-worth, self-esteem, and life satisfaction. It's about how the resident is treated: for example, "having one's privacy respected by others' knocking before entering a bathroom, or having one's dignity maintained by not being wheeled down a hallway scantily covered en route to the shower."¹⁸

Measures such as resident or family satisfaction are important indicators of nursing home quality. Unfortunately, many nursing homes fall short on this domain. Nobody wants to go to a nursing home: In a survey of community-dwelling elders, almost one-third indicated they would rather die than enter a nursing home.⁴⁵ And once there, many individuals, especially family members, report low levels of satisfaction with the care delivered.^{46,47}

Traditional nursing homes fall short in several domains.¹⁸ Care is often directed by the facility rather than the resident. Ideally, residents should be offered choices about issues personally affecting them like what to wear and when to go to bed. Many nursing homes are quite institutional with long hallways with a nurse station at one end, linoleum floors

and two residents to a room. These nursing homes feel more like a hospital than a home. The staff structure at these facilities is often quite hierarchical with very little empowerment of direct caregivers. Nursing homes are not just suboptimal places to live, they are also often difficult places to work. CNAs tend to be paid at or near the minimum wage and many workers may view retail establishments and fast food restaurants as a better opportunity at that wage.⁴⁸ A more participatory management structure that engages CNAs in the decision-making process would help with staff turnover and performance.

Why is Nursing Home Quality such a Persistent Problem?

The U.S. nursing home market has a series of features that lead to persistent low quality. The way in which we regulate and oversee care quality, how we pay for nursing home services, how we regulate the supply of providers, and the inability of many residents to oversee and monitor their care all may contribute to low quality.

Payments are Often Low and Fragmented

When it comes to nursing home care, as the old saying goes, we get what we pay for. Due in part to the exclusion of long-stay nursing home services from the Medicare benefit, Medicaid is the dominant payer of nursing home services, accounting for 50% of revenues and 70% of bed-days. Medicaid payment rates are typically 70-80% of private-pay prices. In many states, the average “margins” for Medicaid residents are negative, suggesting the cost of treating Medicaid residents exceeds the amount that Medicaid reimburses for their care.⁴⁹

The nearly 15 percent of U.S. nonhospital-based nursing homes that serve predominantly Medicaid residents have fewer nurses, lower occupancy rates, and more health-related deficiencies.⁵⁰ They are more likely to be terminated from the Medicaid/Medicare program, are disproportionately located in the poorest counties, and are more likely to serve African-American residents than are other facilities. Low or negative margins for a substantial portion of a nursing home’s population strongly incentivizes facilities to prioritize the labor-saving care delivery approaches described previously in an effort to lower the costs of care. Moreover, a high-Medicaid census is likely to lead to nursing home closures, which can also put seniors at risk. A *New York Times* article from earlier this week suggested 440 rural nursing homes have merged or closed over the past decade.⁵¹ The article suggests many rural facilities are “losing money as their occupancy rates fall and more of their patients’ long-term care is covered by Medicaid, which in many states does not pay enough to keep the lights on.”

Another payment issue is the fragmentation in coverage of nursing home and medical services for long-stay nursing home residents.⁵² Many of these individuals are dually eligible in that Medicaid covers their nursing home care while Medicare covers all their health care including physician and hospital services. This “silo” based payment structure introduces strong incentives for nursing homes to transfer sicker patients to the emergency department and hospital in order to limit the burden on their staff and also

improve their potential standing with surveyors. As the saying goes in many US nursing homes, “when in doubt, ship them out.”

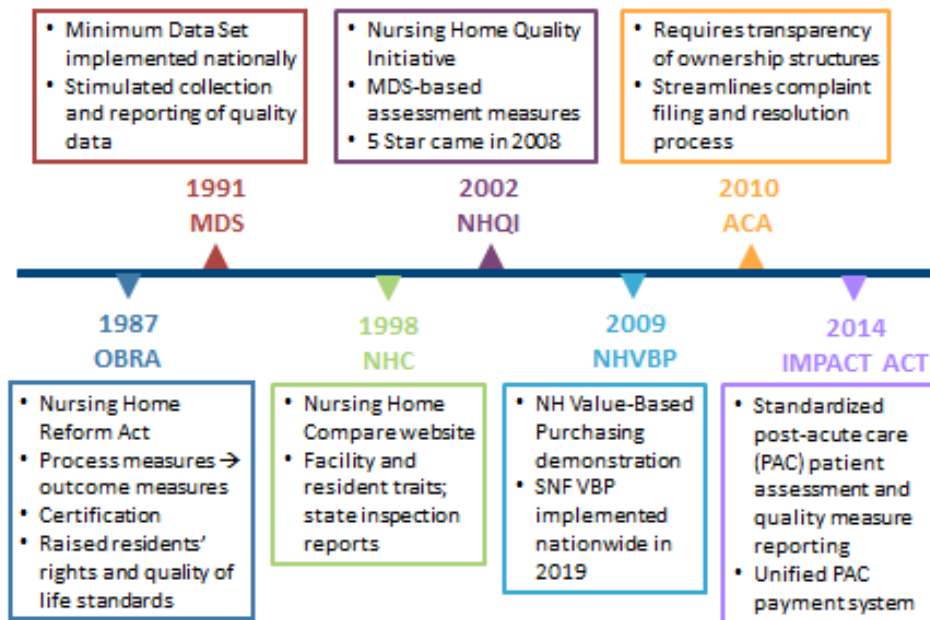
The fragmented Medicaid-Medicare coverage of long-stay nursing home residents also serves as a barrier to developing programs to prevent unnecessary transfers.⁵² Nursing homes that invest in models and staff to safely reduce the likelihood of hospital transfers predominantly generate savings for Medicare, while Medicaid often must pay for the increased cost of long-stay care in the nursing home. Thus, state Medicaid programs have little incentive to invest in policies to discourage transfers from the nursing home setting.

Quality Regulations are Extensive but Oversight Inconsistent

To date, the primary approach to addressing low quality has been regulation (see Figure 1). Regulations are extensive and the sanctions, when enforced, can be severe, ranging from fines to probation to closure. In particular, OBRA ‘87 has shaped oversight for the past 30+ years. The OBRA ‘87 standards overhauled nursing home regulation and sought to hold nursing homes to a higher standard. Specifically, it strengthened existing quality standards, elevated quality of life and residents’ rights to be of equal importance with traditional quality of care standards, required collection of detailed assessment data (Minimum Data Set), consolidated Medicare/Medicaid requirements, and expanded the range of available sanctions. OBRA ‘87 spurred many improvements in that it reduced physical restraints, catheter use, psychotropic medication use, and pressure ulcers. It also increased discussions between residents and care providers about care plans, end-of-life, etc., while increasing staffing levels overall. As noted in the prior section however, cracks are very clearly evident in the current quality assurance framework. Recent investigative reports have documented substantial lapses in oversight processes across multiple states.⁵³⁻⁵⁵ Importantly, states are largely responsible for implementation of oversight responsibilities and many of the identified gaps have been state specific.

The Trump Administration has proposed to scale back oversight and enforcement of nursing home rules as part of their broader movement to reduce bureaucracy, regulation and government intervention in business. In particular, new guidelines discourage regulators from levying fines in some situations, such as if an incident were a “one-time” event rather than evidence of a broader problem.⁵⁶ The new guidelines would also likely result in lower fines for many facilities. The administration has also proposed relaxing rules around emergency preparedness.⁵⁷

Figure 1: Nursing Home Quality Timeline



Certificate-of-need Regulation Impede Innovation

Certificate of need is an oft-used strategy to constrain health care spending.⁵⁸ It rests on what is termed “Roemer’s law,” which states “a built bed is a filled bed is a billed bed.” The logic goes something like this: if a state can hold the total number of nursing home beds down, then it will constrain the number of Medicaid beneficiaries in those beds, which ultimately lowers overall state Medicaid spending on nursing homes. 34 states still have nursing home certificate-of-need laws on the books.

Research has been fairly clear: nursing home certificate-of-need laws lower access and quality of care, while increasing private-pay prices.⁵⁹⁻⁶¹ Certificate of need has even distorted the size of nursing homes.⁶² The average number of beds in a nursing home is roughly 110 in states without a certificate-of-need law and 131 in states with a law.

Certificate-of-need laws also discourage innovation in a sector badly in need of modernization. Many recent culture change quality initiatives, such as the Green House and other small house models, have highlighted the importance of capital investment towards improving nursing home quality of care.⁶³ Although data on the capital stock in the nursing home industry are sparse, one estimate suggests the average age of nursing home structures is about 30 years.⁶⁴ Many older nursing homes lack private rooms and have an institutional, less home-like environment.

Lack of Quality Transparency

Although nursing home care is fairly non-technical in nature, monitoring of care can often be difficult for residents and their families. Given the high prevalence of dementia in the nursing home population, the resident is often neither the decision-maker nor able to easily evaluate quality or communicate concerns to family members and staff. Furthermore, the elderly who seek nursing home care are disproportionately the ones with no family support to help them with the decision process.⁶⁵ When residents did not have family member visit during the first month of care, one study found a greater likelihood of dehydration and urinary tract infection in for-profit nursing homes.⁶⁶

The Centers for Medicare and Medicaid Services produces the Nursing Home Compare tools on the Medicare.gov website to facilitate better consumer choice by providing data and summary rankings on the quality of care delivered by all eligible providers.⁶⁷ Although Nursing Home Compare was designed to facilitate easy comparisons across facilities on meaningful characteristics, evidence suggests that it is coming up short.

The Nursing Home Compare tool lacks information on many of the provider features that may be of the greatest importance to residents and their families. For example, the website gives no information about the amenities provided by a facility, the physical setting where care is delivered and a patient resides, the culture and care philosophy of the nursing home, the ability of the facility to coordinate with acute and primary care providers, and the availability of physicians and nurse practitioners on site. Accessing these “data” in the current environment likely requires an in-person visit to a facility, a time-consuming endeavor that requires a proactive family support system, or a word-of-mouth recommendation from a trusted source without competing incentives, which may not exist.

Staffing is an important quality measure used to profile nursing homes on the federal Nursing Home Compare website. Since staffing data were first reported on the website in 1998, Nursing Home Compare relied on data that were self-reported by facilities based on average levels over a two-week lookback period and rarely audited.^{68,69} Many researchers have questioned the completeness and accuracy of these facility-reported staffing data.^{68,70,71}

In October 2014, President Obama signed into law the Improving Medicare Post Acute Care Transformation Act of 2014 (IMPACT Act), which provided funding to implement Section 6106 of the Affordable Care Act requiring that nursing homes use the Payroll Based Journal (PBJ) system to submit auditable staffing and resident census data.⁷² Using the PBJ platform, nursing homes were required to begin submitting payroll-based staffing data in July 2016 on a quarterly basis. In April 2018, the Centers for Medicare and Medicaid Services (CMS) began using payroll data as the source for staffing information in Nursing Home Compare and the Five-Star Quality Rating System. Daily staffing data are now available for all U.S. nursing homes.

Policymakers are already beginning to use the payroll data in their oversight and monitoring of facilities. CMS used the payroll data to lower the quality star ratings at 1-in-11 facilities on Nursing Home Compare, both because of low RN staffing and failure to submit data.⁷³ In the wake of a New York Times story documenting discrepancies between payroll and administrative data,⁵⁵ Senator Wyden issued a letter demanding that CMS fully implement the transition to using payroll data and pursue increased protections for nursing home residents.⁷⁴ Similarly, the Office of the Inspector General has announced it will monitor CMS collection of the payroll data and enforcement of related staffing standards.⁷⁵

Beyond shortcomings in the Nursing Home Compare tool itself, more work is needed to actually get this information into the hands of consumers. We know that in its current form, Nursing Home Compare has had limited effects on patients' actual choices,⁷⁶ and available evidence indicates that a considerable portion of this limited impact could stem from a general lack of awareness, on the part of both patients and discharge planners, that the tool even exists.^{77,78} Furthermore, it appears that when hospital case managers are aware of the tool and its accompanying quality rankings, they are reluctant to share such information with patients for fear of violating patient choice regulations.⁷⁹ Patients and providers alike need to know that help is available, and barriers to accessing this website during the potentially stressful and hectic time of choosing a nursing home need to be minimized.

The lack of quality transparency makes it difficult for patients and their families to “vote with their feet” by choosing better quality facilities and avoiding the lowest quality ones. In turn, nursing homes may not face sufficient market pressure to improve care quality or develop new models of care that better match resident preferences. Even if residents and their families are unable to use report card information at times of crisis, greater quality transparency could still factor into government oversight activities and have a positive influence on care.

Summary

We have made important progress towards improving nursing home quality over the past few decades since the 1974 US Senate report.¹ I would assert, however, that the nursing home sector is *better but still not well*. We have a lot of work left to do. Significant quality of care problems persist at many US nursing homes. However, these problems are not isolated to particular facilities or patients. These problems are related to system level issues in how we pay for care, how we regulate providers, and the inability of residents and their advocates to monitor and oversee care. Unless we address these broader issues, we will be discussing poor nursing home quality for another fifty years.

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