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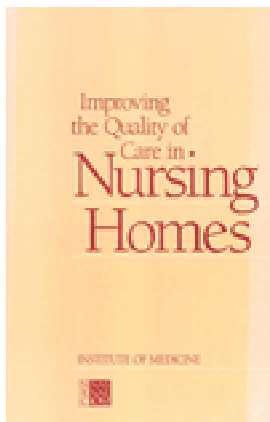

Improving the Quality of Care in Nursing Homes

Committee on Nursing Home Regulation
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Improving the Quality of Care in Nursing Homes

Committee on Nursing Home Regulation
Institute of Medicine

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This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an advisor to the federal government, and its own initiative in identifying issues of medical care, research, and education.

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Preface

The Institute of Medicine Committee on Nursing Home Regulation was given a complex and controversial task: to recommend ways to improve nursing home regulation. The regulation of nursing homes is a matter on which many knowledgeable people in all parts of the country have very strong and by no means unanimous views.

I was privileged to serve as chairman of the committee appointed by the president of the Institute of Medicine to conduct the study. The committee consisted of 20 individuals with substantial knowledge of and experience in nursing homes and with the perspectives of ownership, management, consumer advocacy, state regulation, and professional staff in both for-profit and not-for-profit nursing homes. Members of the committee have had substantial training and practical experience in medicine, health law, nursing, social work, public administration, public policy analysis, economics, statistics, sociology, health services research, and health care management. They come from 15 states and are familiar with the nursing homes in most parts of the country.

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The study was prompted by controversy over changes in nursing home certification procedures, proposed by the Health Care Financing Administration (HCFA) in 1982. When the committee commenced its work it agreed that a serious look at many factors bearing on nursing home regulation was necessary if the study was to contribute significantly toward enhancing the quality of care and of life in nursing homes by improving the regulatory system. The range of relevant issues is large and the relationships are complex. Not all could be addressed by the committee, but an effort was made to at least recognize and discuss them and to point some directional arrows for future policy development.

To address its charge properly, the committee decided that the study should collect and analyze data and other information as follows:

1. *Views of interested parties*. Knowledgeable, interested parties in various parts of the country—residents and their families, long-term-care ombudsmen, nursing home owners and administrators, professional and other staff who work in nursing homes, and state and federal regulatory agency officials—were asked to give their views of the problems.

   This information was obtained in several ways. First, the staff conducted semistructured interviews with state and federal regulatory officials, nursing home administrators, professional staff, and consumer advocates, and they visited nursing homes in several states. Second, they reviewed the voluminous hearings conducted by the HCFA in 1978 and the congressional hearings on, and the written responses to, the HCFA's proposed changes in the federal certification regulations (the action that led, ultimately, to this study). Third, the committee held five public meetings during September 1984, in Philadelphia, Atlanta, Dallas, Minneapolis, and Los Angeles. The meetings were announced and publicized well in advance and all interested parties were invited to offer oral and/or written statements to the committee. Over 200 persons spoke at the meetings and

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had informal discussions with committee members and staff. Many others submitted written statements. The discussions at the public meetings and the written materials were reviewed, analyzed, and summarized in a working paper used by the committee in shaping some parts of the study and as a basis for some statements made in this report. Finally, in the course of conducting the case studies in six states (discussed below), there was an opportunity to discuss in depth the perceptions of state regulatory officials, state agency staff, federal regional office staff, consumer advocates, nursing home operators, and professional staff.

2. *How states actually regulate nursing homes*. Information was obtained in four ways. First, case studies of nursing home regulation were conducted in six states. The states (Connecticut, Maryland, Georgia, Texas, Minnesota, and California) were chosen because they represented widely varying local circumstances, different regions of the country, and different approaches to regulating nursing homes. In each state, three staff members conducted semistructured interviews with state regulatory agency officials, with state surveyors and those who conducted inspection-of-care reviews in nursing homes, with representatives of the state nursing home operators' associations, with for-profit and nonprofit nursing home administrators and professional staff, with state and local ombudsmen and other consumer representatives, with state legislative committee staff, and with representatives of the attorney generals' and governors' offices. They also talked to federal regional office staff.

   Second, a mail survey of all 51 (including the District of Columbia) state licensure and certification directors was conducted. Its purpose was to get information on the resources being used by the states in carrying out their nursing home survey and certification responsibilities, on the intermediate sanctions they had available, the extent to which the sanctions were used, and the directors' opinions on several aspects of regulatory policy. Responses were received from 47 directors, although not all items were answered by all respondents.

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Third, staff reviewed and analyzed the contents of 15 state nursing home investigatory commission reports issued in the last 10 years, to determine the kinds of regulatory problems that prompted these investigations.

Fourth, a workshop was conducted to examine problems of enforcing the certification regulations and to formulate recommendations to improve enforcement. Several papers by experts were commissioned, and a group of over 30 enforcement experts from state and federal government agencies (including attorney generals' offices), lawyers who represented providers and their associations, and consumer advocacy (including legal service) groups, discussed the issues for 2 days.

3. *Quality and quality assessment*. The work consisted mainly of a review of the published literature, some unpublished studies including evaluations of HCFA-sponsored demonstration projects, plus commissioned papers. A great deal of research has been conducted and published on these subjects in the past 10 years or so, and this was digested by a subcommittee of the full committee.
4. *Medicaid reimbursement policies*. A conference was convened to explore what is known about the relationships between various types of state Medicaid reimbursement policies and both quality of care of, and access to nursing homes by, Medicaid-financed residents and those requiring extensive care. A paper was commissioned that reviewed the published literature on this subject, and extensive discussions were held by knowledgeable participants representing all pertinent perspectives. Additional literature was also reviewed by staff and committee members. The committee believes this to be an important subject that merits deeper exploration, but it was beyond the scope of this study.
5. *Demand for and supply of nursing home beds*. In addition to a literature review conducted by staff, two papers were commissioned to examine this question. One projected population and morbidity and disability trends by age category. The other reviewed the published and unpublished information and analyses on the effects of nursing home bed supply on regulation, enforcement, and quality of care.

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6. *Staffing*. A paper was commissioned to address the issues of training and accreditation (including licensure and/or certification) of four categories of nursing home staff: administrators, registered nurses, licensed practical nurses, and nurse's aides or nursing assistants. Another paper was commissioned on the role of physicians in nursing homes, and HCFA data on current staffing of nursing homes were analyzed.
7. *Consumer role and community relations*. A workshop was organized to explore the role of consumers (residents) and their advocates in quality assurance and to determine how this role should be enhanced by public policy changes. The same workshop also addressed the issue of nursing home/community relations. Several papers were commissioned that reviewed the ombudsman program, the development of nursing home residents' advocacy organizations, the development of residents' councils and family councils, and nursing home/community interactions.
8. *Management incentives*. The committee organized a workshop to explore the feasibility of introducing positive incentives into the regulatory system. The regulatory system now works almost entirely on negative incentives: There is punishment for inadequate performance, but no recognition or rewards for good or excellent performance. Nine papers were commissioned for the workshop.

I would like to call attention to two important considerations that affect the content of the report. First, although we used data and objective evidence as much as possible, many conclusions and recommendations rest largely on professional judgment. The committee was made up of people with diverse backgrounds and experience. Achieving consensus within this group after extensive discussion of the available evidence clearly is an appropriate and responsible way to recommend necessary adjustments in public policy. Of course, individual members did not agree in all cases with every conclusion and recommendation. But they all support the report as a whole.

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Second, for a number of reasons we did not address every issue that might be considered relevant. Two are of particular importance: Medicaid reimbursement policy and policy governing bed supply (that is, the administration of certificate-of-need for nursing homes). Both are state-administered policies and both clearly affect nursing home operations. Some members of the committee believed we should have addressed these issues directly, but the majority believed—for the reasons explained in Chapters 1 and 7 of the report—that we should not.

The results of our efforts are contained in this report. We hope they will contribute to achievement of the goals of improving the quality of care and the quality of life for nursing home residents and of producing a more efficient and effective regulatory environment.

SIDNEY KATZ, CHAIRMAN

COMMITTEE ON NURSING HOME REGULATION

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Acknowledgments

The committee wishes to express appreciation for the excellent cooperation and assistance it has received from hundreds of individuals and dozens of organizations throughout the country. The staffs of the Health Care Financing Administration, the American Health Care Association, the National Citizens' Coalition for Nursing Home Reform, the National Senior Citizens Law Center, the American Association of Homes for the Aging, the Association of Health Facility Licensure and Certification Directors, and the American College of Health Care Administrators were especially helpful. They received numerous requests from us for various types of information and documents. They always responded promptly and courteously. Other organizations, including the American Association of Retired Persons, the National Council of Senior Citizens, and the National Council on Aging, also were helpful.

Government officials in the six states in which we conducted case studies were generous in allotting time for interviews with our staff. The same was true of representatives of provider associations, consumer groups, ombudsmen, and staff in federal regional offices. We particularly appreciate the cooperation of the 47 state licensure and survey agencies who responded to our survey

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questionnaire. For many, a major effort was entailed to obtain the information needed to respond to our questions.

A study as complex and technically demanding as this requires competent professional staff. The committee was singularly fortunate in being supported by such a staff, effectively organized and directed by David Tilson. In addition to its deep appreciation for Mr. Tilson's leadership, the committee gratefully acknowledges the work of the other members of the professional staff: Robert Burke, Michael McGeary, Susan Sherman, Jane Takeuchi, and Peter Reinecke (who worked on the staff through January 1985). Don Tiller provided exceptionally effective administrative support. Staff members organized and coordinated conferences and workshops. They reviewed and abstracted hundreds of publications and technical documents. They carried out the survey of state licensure and certification agencies and analyzed the data. They prepared staff papers and drafted this report. In addition to long hours, the IOM professional staff displayed a sensitive commitment to nursing home residents. They never lost sight of the study's principal focus on residents as human beings with special needs for living and for care.

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1

Introduction and Summary

PURPOSE OF THE STUDY

This is the report of a study of government regulation of nursing homes (excluding intermediate care facilities for the mentally retarded). The study's purpose was to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care.

In May 1982, the Health Care Financing Administration (HCFA) announced a proposal to change some of the regulations governing the process of certifying the eligibility of nursing homes to receive payment under the Medicare and Medicaid programs. The changes were responsive to providers' complaints about the unreasonable rigidity of some of the requirements. The proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized states, if they so wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of state inspection as a basis for certifying that Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) are in compliance with

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the federal conditions of participation and operating standards.

The HCFA proposal was strongly opposed by consumer groups and most state regulatory agencies because the proposed changes were seen as a movement in the wrong direction—that is, towards easing the stringency of nursing home regulation—and because they did not deal with the fundamental weaknesses of the regulatory system. The controversy generated by the proposal caused Congress in the fall of 1982 to order the HCFA to defer implementing the proposed changes until August 1983 and ultimately resulted in a HCFA request to the Institute of Medicine (IOM) of the National Academy of Sciences to undertake this study. The contract between the HCFA and the IOM became effective on October 1, 1983. The charge to the IOM Committee on Nursing Home Regulation was to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible."[1]

THE PUBLIC POLICY CONTEXT OF THE STUDY

There is broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. The implicit goal of the regulatory system is to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. This happens in many nursing homes in all parts of the country. But in many other government-certified nursing homes, individuals who are admitted receive very inadequate—sometimes shockingly deficient—care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be

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subject to physical abuse. The apparent inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them is the underlying circumstance that prompted this study.

In the past 15 years many studies of nursing home care have identified both grossly inadequate care and abuse of residents.[2-23] Most of the studies revealing substantial evidence of appallingly bad care in most parts of the country have dealt with conditions during the 1970s. However, testimony in public meetings conducted by the committee in September 1984, news reports published during the past 2 years, recent state studies of nursing homes, and committee-conducted case studies of selected state programs have established that the problems identified earlier continue to exist in some facilities: neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the committee and of resident advocacy organizations, is that these disturbing practices now occur less frequently.

Residents and resident advocates, both in public hearings and in a study of resident attitudes conducted by the National Citizens' Coalition for Nursing Home Reform,[24] expressed particular concern about the poor quality of life in many nursing homes. Residents are often treated with disrespect; they are frequently denied any choices of food, of roommates, of the time they rise and go to sleep, of their activities, of the clothes they wear, and of when and where they may visit with family and friends. These problems may seem at first to be less urgent than outright neglect, but when considered in the context of a permanent and final living situation they are equally unacceptable.

The quality of medical and nursing care in many homes also leaves much to be desired. Geriatrics is becoming, in the mid-1980s, an area of concentration within internal

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medicine, family medicine, and psychiatry. (Both the American Academy of Family Practice and the Board of Internal Medicine have decided to establish certificates recognizing geriatric competence.) Many conditions that were once accepted as inevitable consequences of old age now can be treated or alleviated. Physicians and nurses in nursing homes are not always aware of advances in geriatrics so that even in pleasant and humane institutions examples may be found of residents whose disability could be reduced, whose pain could be controlled, or whose depression could be treated if they received proper medical care. A lower standard of medical and nursing practice should not be accepted for nursing home residents than is accepted for the elderly in the community. Given the fragility of nursing home residents and their dependence on medical care for a satisfactory life, practice standards should even be higher. Thus, physicians, as well as nurses, have substantial responsibility for quality of care in nursing homes.

These observations do not mean that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership. Such facilities serve both as evidence that overall performance can be improved and as markers for how that improvement can be accomplished.

The question asked by the committee was: How can the problems observed in nursing homes in the 1980s best be addressed? The current national tone is antiregulatory. Nursing homes are a service industry. Could not the observed problems be solved by decreasing regulation and allowing market forces to work? This viewpoint was advocated by some who spoke at public meetings or submitted ideas to the committee. Those who wished to see a freer market were particularly anxious to have restrictions on bed supply lifted.

A freer market was not considered by the committee to be a serious alternative to more effective government regulation for two reasons.

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First, under present circumstances, a free market for nursing home care will remain a theoretical concept until such time, if ever, that a major portion of the financing of long-term care services has shifted from public sources (primarily Medicaid) to private insurance. This is not likely to occur very soon. About half of current nursing home revenues come from appropriated state and federal funds through state-controlled Medicaid programs. Most people enter nursing homes as private-pay residents and soon "spend down" their income and assets until they become eligible for Medicaid. With few exceptions, community-based or home-based long-term care services—that might keep some people who require long-term care from entering nursing homes—are not eligible for Medicaid or other sources of public support. Most states maintain tight control on bed supply to control growth of their Medicaid budgets. They have learned that if they allow uncontrolled growth of nursing home beds, the additional beds would quickly be filled with residents now being cared for privately and informally in the community. Such residents would initially be private-pay, but would soon "spend down" to Medicaid eligibility.

Second, historical experience hardly supports an optimistic judgment about the effects on quality of care of allowing market forces, to exert the primary influence over nursing home behavior. Nursing homes were essentially unregulated in most states prior to the late 1960s. Their operations were governed almost entirely by market forces, and the quality of care was appalling. (See Appendix A.)

Persons needing nursing home care generally suffer from a large array of physical, functional, and mental disabilities. A significant proportion of all residents are mentally impaired. The average resident's ability to chose rationally among providers and to switch from one provider to another is therefore very limited even if bed occupancy rates are low enough to make such choices feasible. But they are not. In most communities, bed availability is the controlling factor because occupancy rates are very high. Moreover, some who reside in nursing homes lack close family to act as their advocates. Even

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if they have family, the choice of a nursing home is usually made relatively hastily in response to a new illness or disability level; once in an institution, the opportunities for transfer to another nursing home are very limited.[25]

The difficulties inherent in choosing among nursing homes are further exacerbated by the financial status of many residents. Because of the cost, few individuals or families can afford a prolonged nursing home stay.[26] As a result, government programs, primarily Medicaid, assist in paying for more than 60 percent of all care. In most states, Medicaid rates are lower than those paid by private residents. As a result the nursing home market is in fact two markets—a preferential one for those who can pay their way and a second, more restricted one, for those whose stays are paid by Medicaid.[27]

Regulation is essential to protect these vulnerable consumers. Although regulation alone is not sufficient to achieve high-quality care, easing or relaxing regulation is inappropriate under current circumstances.

The federal regulations now governing the certification of nursing homes under the Medicare and Medicaid programs have been in place, essentially unchanged, since the mid-1970s. Their central purpose is to assure that nursing home residents[28] receive adequate care in a safe facility and that they are not deprived of their civil rights. The regulations have a number of conceptual and technical weaknesses that were recognized almost from the time the regulations were promulgated. And, the regulations are administered and enforced very unevenly by the states. Yet there is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers, and state regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement.

Providers, consumer advocates, and government regulators all are dissatisfied with specific aspects of the

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regulations and the way they are administered.[29] Consumer advocates (nursing home residents, their families, and representatives of organizations concerned with protecting the interests of nursing home residents) contend that the standards are inadequate and their enforcement is too lax because too many nursing homes that pass inspection still provide unacceptably poor or only marginally adequate care. Moreover, they contend that violations of residents' rights occur in many homes and that often such violations either are not detected or are ignored by the regulatory authorities. The providers (nursing home operators, administrators, and professional staff) are concerned with the excessive attention to detailed documentation, the emphasis on structural specificity with the inherent (and sometimes irrational and costly) inflexibility that such specificity implies, and with the ambiguity of some of the standards (for example, the use of such words as "adequate") that result in inconsistent, subjective interpretations by state and federal surveyors. Some government regulators at both state and federal levels believe there is merit in both sets of contentions.

Since the present regulatory framework was set in place about 10 years ago, there have been developments that make possible a more effective regulatory system. There is deeper understanding of what is meant by high-quality care for nursing home residents and how to provide it, more knowledge of how to assess quality of care objectively, and better understanding of what it takes to operate a more effective quality assurance system. The nursing home industry itself has grown in managerial capability and professionalism. These developments make it possible now to redesign the regulatory system so that it will be much more likely to assure that all nursing homes provide care of acceptable quality.

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PERSPECTIVE ON THE ISSUES

The Role of Nursing Homes

In most places in this country, when an elderly (or disabled younger*) person requires more assistance in the activities of daily living[30] than can be provided by immediate family or friends, and especially if the individual is incontinent and/or mentally impaired, he or she may be placed in a nursing home. Also, when an elderly patient, after surgery or an acute medical episode in a hospital, requires rehabilitative/convalescent nursing care for several weeks or months, and neither a rehabilitation hospital bed nor home health services are available in the community, the patient may be discharged to a nursing home. Home health services, congregate housing, domiciliary care, day-care centers, and other professionally organized arrangements exist in some communities and provide long-term care services to elderly persons with disabilities comparable to those found among some residents in nursing homes. Although more of these types of long-term care arrangements are being developed, they still represent collectively only a small fraction of the total person-days of care provided by nursing homes.[31] In 1985, in most communities in this country, long-term care services for the physically frail and mentally impaired elderly are available only through informal support provided by family or friends or in nursing homes.

Nursing homes must provide care to a very heterogeneous resident population. Some require short-term, intense rehabilitation services. Many others are incontinent, mentally impaired, or so seriously disabled that they require extensive and continuous care for months or years. A small fraction are younger people who are severely disabled. A few are simply very old and very

* In 1980, 13 percent of nursing home residents were under 65 years of age. This figure is projected to drop to 9 percent by the year 2000. (See Appendix D, Table Q.)

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frail but are mentally competent and alert and require only moderate assistance in the activities of daily living and opportunities to participate in activities to satisfy their psychosocial needs.

It is not easy to provide high-quality care to meet such a broad spectrum of physical, medical, and psychosocial needs in one facility. Not all nursing homes admit all of these types of residents, but many do. If, in the future, alternate arrangements become available to provide proper care to some individuals requiring intensive short-term rehabilitation services (for example, stroke patients), and for those requiring on a long-term basis only moderate amounts of support services, nursing homes will not be expected to accommodate these kinds of residents. Nursing home beds are increasingly being filled with long-term, very disabled residents who cannot be cared for anywhere else. Pressures to admit a higher proportion of residents requiring "heavy care" (nursing home jargon referring to residents requiring at least 2-1/2 hours per day of personal and nursing care), many of whom are mentally impaired, has been experienced by nursing homes for some time. These pressures are certain to increase.[32]

There were about 15,000 nursing homes in operation in the United States in 1985, with a total of about 1.5 million beds, that are certified to receive patients/ residents under the Medicare and/or Medicaid programs.[33] About 1,000 nursing homes and perhaps 6,000-7,000 "board and care" homes (sometimes referred to as "domiciliary care" facilities) without nursing services are licensed by the states but are not certified to accept Medicare or Medicaid payments.[34]

There are two types of nursing homes recognized in federal regulations: Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). SNFs are required to be staffed and equipped to care for residents requiring skilled nursing care. ICFs are required to be staffed and equipped to care for residents requiring less nursing care and more personal service care. In practice, the states are not consistent in making distinctions between the two types of nursing homes: some states have almost no SNFs; others have almost no ICFs. Forty-three percent of all nursing homes are ICFs (Appendix D, Table C).

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The mix of characteristics and service needs of the residents found in SNFs in those states that have few ICFs do not appear to differ significantly from those found in ICFs in states that have few SNFs.

About 70 percent of the certified nursing homes, with 80 percent of the beds, are operated on a for-profit basis. Of the rest, 22 percent of the facilities are operated by nonprofit organizations and the other 8 percent are government-owned and -operated.[35] In almost every state, occupancy rates average well over 90 percent, an indication that the demand for nursing home beds is very high. [36] Demographic trends—the rapidly growing numbers of persons over 75 years old, about I in 10 of whom are now in nursing homes—make it certain that the demand for nursing home beds will continue to grow. A recent report projected the population aged 75 and over in the year 2000 to be 17.3 million, a 46 percent increase over the 1985 population of that age group. For people 85 years of age or older, one in five of whom is currently in a nursing home, the numbers are projected to increase from 2.85 million in 1985 to 5.1 million in 2000, an 80 percent increase.[37] In 1984, over $30 billion was spent on nursing home care.[38] According to Department of Labor estimates, "nursing and personal care" facilities employed over 1 million people in 1982.[39]

Quality of Care and Quality of Life

Providing consistently high quality care in nursing homes to a varied group of frail, very old residents, many of whom have mental impairments as well as physical disabilities, requires that the functional, medical, social, and psychological needs of residents be individually determined and met by careful assessment and care planning—steps that require professional skill and judgment. This process must be repeated periodically and the care plans adjusted appropriately. Not all nursing homes have enough professional staff who are trained and motivated to carry out these tasks competently, consistently, and periodically. Care is expensive because it is staff-intensive. To hold down costs, most of the

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care is provided by nurse's aides who, in many nursing homes, are paid very little, receive relatively little training, are inadequately supervised, and are required to care for more residents than they can serve properly. Not surprisingly, the turnover rate of nurse's aides is usually very high—from 70 percent to over 100 percent per year—a factor that causes stress in resident-staff interactions.

Quality of life is intimately related to the quality of resident-staff relationships. Kindness, courtesy, and opportunities to choose activities, food, and mealtimes are involved, as are factors such as privacy for intimate conversations with family or friends. This is difficult when most rooms are semiprivate—as is the case in most nursing homes. Making one's room as home-like as possible is important to many residents, but fire safety codes may limit the use of personal furniture or other belongings. And, it may not be possible to choose or change one's roommate.

Difficult as these problems may be, they can be handled satisfactorily by competent management and staff. In most regions of the country, very good homes can be found—places that are well-managed, where competent, caring staff provide services in a conscientious, sensitive manner; where the dignity, privacy, and human needs of the residents are respected and provided for in thoughtful, even imaginative ways. There are both for-profit and not-for-profit homes in this group. The exact number of very good homes is unknown because no objective, reliable methods exist for making interfacility comparisons of quality. The committee has the impression, obtained primarily from the Health Care Financing Administration's data collected from state reports on nursing home deficiencies, and from discussions with knowledgeable state and federal regulatory agency personnel, that the poor-quality homes outnumber the very good homes.

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The Regulatory System

Government regulation of nursing homes has two broad goals: (1) consumer protection, that is, to ensure the safety of residents, the adequacy of care they receive, and that their legal rights are protected; and (2) to control and account for the large public expenditures—mainly Medicaid—used to pay for nursing home care.

Regulation for quality assurance in nursing homes involves three main components, all of which are more or less embodied in both federal and state regulations and are, to some extent, intertwined with one another. They include

1. developing and promulgating explicit criteria (conditions of participation and standards) governing all aspects of the operation of nursing homes;
2. developing and applying standard procedures and criteria for monitoring the performance of nursing homes and for determining the extent to which nursing homes are complying with the performance criteria (monitoring procedures include periodic surveys of nursing homes, inspections of care, and investigations of complaints of poor care, neglect, or abuse of residents); and
3. enforcing compliance with the performance criteria in cases where unsatisfactory performance is found.

Both the federal and state governments are actively involved in regulating nursing homes, but the states' role is much larger. There is no American nursing home regulatory system; there are regulatory systems in 50 states and the District of Columbia with substantial differences in such things as organizational arrangements, resources committed to the licensure and certification process, the size and composition of the survey teams and the amount of time they spend inspecting nursing homes, the extent and nature of the training provided to surveyors, and in organizational ethos, that is, whether the agency is "enforcement-oriented" or "compliance-oriented." (This issue is discussed in Chapter 4.)

The federal government prescribes detailed standards that must be met by certified nursing homes, but it is the

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states that inspect (survey) the nursing homes to determine the extent of compliance with the certification standards. Although the federal government has the authority to "look behind" the states' survey and certification activities, it has never allocated much staff to this function. It conducts look-behind actions in about 3 percent of the facilities annually.

The states license nursing homes, but their licensure standards vary widely. About one-quarter have made them identical to the federal certification standards. About one-quarter have licensure standards that are less stringent than the federal certification standards. About half have more stringent licensure standards. (Appendix C contains a report of a survey of state licensure and certification agencies, conducted by the committee during 1984-1985, from which these data were obtained.)

The states also are responsible for enforcing the standards. The only federal sanction available, until recently, was decertification of a facility—that is, to make the facility ineligible to receive Medicaid or Medicare funds. In 1981 a federal intermediate sanction—suspension of payments for new admissions—was authorized by law. But regulations specifying how this authority should be used had not been issued as of February 1986. Since decertification is a very drastic measure when beds are in short supply, it is seldom invoked. Most states rely on a set of "intermediate" sanctions (fines, suspension of admissions, receiverships) available under their licensure authorities. But availability and use of intermediate sanctioning authority vary widely with states, as do enforcement attitudes and actions. Tolerance of inadequate care also appears to be widespread.

The history of nursing home regulation is relatively brief. Until the passage of the Medicare and Medicaid legislation in 1965, the regulation of nursing homes was entirely a state responsibility. (The history of the development of the federal role in nursing home regulation is summarized in Appendix A.) By 1965, there were hundreds of thousands of residents in nursing homes that did not meet Hill-Burton fire and health standards and were substandard in other respects as well—for example,

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with poorly trained or untrained staff and few of the necessary services.

The problems were described extensively by the U.S. Senate Special Committee on Aging that conducted several sets of hearings starting in 1963. (See Appendix A.) The initial efforts to set federal standards for both Medicare "extended care facilities" (ECFs) and for Medicaid SNFs quickly exposed the problems. Of 6,000 facilities that applied for certification as ECFs, only 740 could be certified the first year. More than 3,000 others were certified as being in "substantial compliance."

Initially, the federal government planned to use ECF standards for Medicaid SNFs, but this idea was dropped when it became evident that most homes could not qualify. The 1967 amendments to the Medicaid legislation authorized two categories of Medicaid nursing homes: SNFs and ICFs. Development of certification regulations for both categories proved to be very controversial. The Congress, prompted by consumer advocates and some professional groups, wanted stringent standards to protect the patients/residents. Some state governments and the nursing home industry were concerned about costs of stringent standards and the ability of many nursing homes to meet them.

The final Medicaid SNF regulations were issued in 1974 and the ICF regulations in 1976. There was substantial evidence made public throughout this period that very large numbers of nursing homes were not in compliance with federal standards and that most states were not enforcing them. In 1974, the Office of Nursing Home Affairs in the U.S. Department of Health, Education, and Welfare (HEW) began a study of the quality of care in nursing homes. The study found that "the extent to which nursing homes comply with the federal standards of care varies widely."[40] The study also found that the survey and certification regulations were concerned only with a facility's capacity to provide the required services, not with the quality of the services being provided. Substantial efforts were made to develop new, and to revise, strengthen, and clarify existing, standards in the late 1970s.

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In 1980 the HCFA published its proposed new regulations in the *Federal Register*. These would have, among other things,

1. combined the SNF and ICF regulations into a single set applicable to all nursing homes;
2. consolidated all resident care planning requirements into a single condition of participation requiring a resident care management system that called for interdisciplinary teams to assess residents and plan their care; and
3. elevated the residents' rights standard to a condition of participation.

Only one of the 1980 proposed changes was actually promulgated: the elevation of residents' rights from a standard to a condition. This was signed in January 1981 by the outgoing Secretary of the U.S. Department of Health and Human Services (HHS), but was promptly rescinded by the new Secretary. Thus, the regulations that were issued in the mid-1970s are still in place today despite widespread agreement that they are inadequate.

A recent legal development—the 1984 decision by the Tenth Circuit Court of Appeals in the *Smith v. Heckler* case[41]—requires the HCFA to modify the federal certification regulations so that they are more effective in assuring quality of care in nursing homes. This lawsuit (originally filed as *Smith v. O'Halloran*) was filed in 1975 on behalf of a group of nursing home residents in a Denver, Colorado, facility, alleging poor care, violation of residents' rights, and failures by government to monitor the nursing home. Plaintiffs sued the nursing home owners as well as the state health and Medicaid agencies and the Secretary of HEW. During the trial, residents proved a variety of violations of regulatory standards, including theft of personal funds, overuse of psychotropic drugs, inadequate care resulting in decubitus ulcers, inadequate skin and nail care, inadequate bowel assistance, and sanitation problems.

The case against the government agencies was based on the theory that the Medicaid statute requires a federal nursing home survey process that determines whether

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residents are receiving care they need, not merely whether facilities have the theoretical capacity to provide it. In 1978 the Colorado health and Medicaid agencies took the unprecedented step of agreeing with the nursing home plaintiffs and joining them in the case against HEW. The state's theory was that the federal survey system was both inadequate to determine whether residents received needed care and mandatory upon the state so that it could not develop a more appropriate system for Medicaid certification decisions.[42]

The case was nearly settled in 1980 when the HHS published proposed regulatory revisions that would have integrated a "patient care management system" into the survey system to evaluate actual resident care. But, these regulations were not promulgated, so the case was tried in 1982. The federal district court found that (1) serious deficiencies exist in some nursing homes, which it labeled "orphanages for the aged," (2) the current survey system is facility-oriented rather than resident-oriented, and (3) it is feasible for HHS to develop a survey system focusing on resident needs and care delivery. However, the court held that as a matter of law the Secretary of HHS had no duty to develop such a system under the Medicaid statute. The Federal Tenth Circuit Court of Appeals reversed the lower court's decision in 1984, holding that the Medicaid law does impose upon the Secretary a duty "to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act, including providing high quality patient care."[41]

The appeals court returned the case to the district court to determine what survey system would satisfy the Secretary's duty. The HCFA has indicated to the court that it will implement a resident-oriented survey system by January 1, 1986.

The recommendations contained in this report follow from the committee's conclusion that profound changes are needed in the regulatory system to make it substantially more effective. The changes thus far proposed by the HCFA in response to the court decision do not address all of the significant problems that limit the effectiveness of the current regulatory system.

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Other Factors Affecting Quality of Care in Nursing Homes

Other Regulatory Policies

Three areas of regulatory policy other than certification regulations that may affect the quality of care provided by nursing homes are Medicaid payment policies, control of bed supply, and information reporting requirements. Despite the importance of these policy areas, the committee did hot make recommendations on them for two reasons: (1) It was beyond the scope of its charge to address these issues seriously as part of its study effort, and (2) there is not enough clear evidence or other information now available to support specific recommendations for federal policy in these areas.

Nursing home care is paid for mainly from the private incomes or assets of the residents or their families and from Medicaid for those whose incomes and assets are low enough to qualify them for such support. There is almost no private health insurance coverage for long-term nursing home care. Half of the industry revenues, paying for part or all of the care of about two-thirds of the nursing home residents, comes from state Medicaid programs.[43] In most states Medicaid reimbursement rates are lower than the rates charged by the same nursing homes to private pay residents.[31] And because most states also have restricted the expansion of nursing home beds, the demand for beds exceeds the supply in all but a very few states. This supplier's market is advantageous to nursing home management because it allows nursing homes to be selective in their admissions and still keep their beds full. Administrators try to optimize (from their perspective) the mix of residents in their homes. In practice, this usually means they will favor admission of private-pay over public-pay residents, and—depending on the design of the state payment system—those who require less care over those who require a great deal. Demographic trends are likely to exacerbate the access problem, particularly for Medicaid and heavy-care residents, because the total number of people requiring long-term care is growing, and

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the proportion requiring a great deal of care also is growing.[44]

Each state establishes its own Medicaid eligibility rules, payment policies, and the amounts to be paid to nursing homes for allowable services to eligible residents. The federal law simply requires that the states' Medicaid payment rates be on a "reasonable cost-related basis," but an operational definition of this phrase has never been issued by the federal government. State payment methods and amounts vary widely. Although Medicaid payment policies contain powerful behavioral incentives for nursing home operators, not enough is now known about this complex question to make specific recommendations for federal policy.

Regulation of nursing home bed supply also is a state responsibility. Most states have maintained tight controls over the expansion of nursing home beds, despite strong evidence of excess demand, to constrain growth of their Medicaid budgets. The issue and the considerations affecting policy on controlling bed supply are discussed in Chapter 7.

Timely access to necessary data and other information is the life blood of effective regulation and of sound public policy development. But despite the importance of both federal and state government regulation in the nursing home industry, and the large proportion of public funds that flow into the nursing homes, there is a striking paucity of detailed information available about almost every aspect of nursing home operations. Information about the demographic characteristics of the residents, their medical, cognitive, and functional disabilities, from where they were admitted and, for those who are discharged, to where they are discharged, date back almost 10 years or are not available at all. Accurate, complete, and current information on the characteristics of nursing homes (their number, size, ownership, certification status, age) is not readily available.[45] Within state governments, the availability of information, and the way it is kept, varies widely.

Key financial information also is not available. What proportion of Medicaid-eligible residents contribute significantly to the cost of their care? How much? How

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does this vary by state? The federal government does not know. Very little is known about the effects of the "spend-down" requirement, the process by which private-pay nursing home residents "spend down" their assets to cover the cost of their care until they become eligible for Medicaid. How long does it take? What fraction of residents "spend down"? Data are fragmentary. Information on changing ownership patterns and on admission and discharge patterns are obtainable only from *ad hoc* studies conducted in limited areas for particular purposes. The last major survey (a sample survey) of nursing homes and residents was conducted by the National Center for Health Statistics in 1977. A new survey was started late in 1985, but the findings will not be available until late 1986 or 1987. Information on the outcomes of inspections and on enforcement actions also is incomplete and unreliable, both at the state and national levels.

By way of contrast, vast amounts of relatively current data and information are available about short-term hospitals, their patients, and finances. If more effective regulation and more rational public policy are to be developed in the long-term care area, serious efforts will have to be made to obtain the necessary data. The committee is firmly convinced that the federal government, particularly the cognizant committees of the Congress and the Department of Health and Human Services, should give this matter priority attention.

Consumers, the Community, and Nursing Home Management and Staff

Three other sets of factors affect quality of care and quality of life in nursing homes: (1) consumer involvement and consumer advocacy, (2) community interest and involvement in nursing homes, and (3) the motivation, attitudes and qualifications of nursing home management and staff. (All three are discussed in Chapter 6.)

Active participation by the residents in some aspects of management policy and care decisions can have important effects on quality of care and quality of life. Many

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important facility policy decisions rest on value judgments—they are not based entirely, or even primarily, on technical or managerial imperatives. Because resident quality of life is affected by such decisions, resident participation and preferences should be sought. Although the regulatory system can facilitate resident participation in decision-making, ultimately it depends on the residents themselves, their families, consumer advocates, and, most important, on the attitudes of the management and staff of the facilities.

Consumer advocacy plays an important role in quality assurance. Consumer advocates are essential because residents are a particularly vulnerable group and nursing home regulators are only occasional visitors to nursing homes. Advocates handle complaints and help individual residents in a variety of other ways. They represent residents as a group to management and government agencies. The Long-Term Care Ombudsman Program, authorized in the Older Americans Act in 1978, provides a statutory basis for the role of consumer advocacy. Unfortunately, the ombudsman program, as presently constituted and financed, is much less effective than it should—and could—be. Recommendations to strengthen it are contained in Chapter 6.

Outside visitors from the community in which the nursing home is set have an important positive effect on the quality of life of residents and on the quality of performance of the staff. It is thus very important to stimulate and facilitate community involvement in nursing homes.

Positive motivation and attitudes on the part of the owners and managers of nursing homes, and well-trained, well-supervised, and properly motivated staff are essential for high-quality care. Although pressures by regulators and consumers can have important positive effects on staff and management attitudes and behavior, they are not sufficient to produce the motivation and attitudes that will attract the kinds and quality of personnel needed to provide high quality of care and quality of life to nursing home residents. Such attitudes must be nurtured by sources within the industry and the educational and professional institutions associated with

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it. The regulatory system can encourage this process by recognizing and rewarding outstanding performance.

CONCLUSIONS

This report contains the following major conclusions derived in part from the prior experience and knowledge of the committee members and in part from the findings of this study.

1. *Quality of care and quality of life in many nursing homes are not satisfactory*. Despite extensive government regulation for more than 10 years, some nursing homes can be found in every state that provide seriously inadequate quality of care and quality of life. At the same time, examples of good and even excellent care can be found in other nursing homes in the same states. Because most nursing home residents live in nursing homes for many months or years, quality of life is as important as quality of care in these institutions. It is possible to define and assess quality of care and at least some aspects of quality of life. Furthermore, it is possible to develop and employ techniques for quality assurance that incorporate reasonably objective measures to judge the quality of care being provided by a facility. The concepts of quality, quality assessment, and quality assurance are discussed in Chapter 2, and specific recommendations to strengthen the quality assurance effectiveness of the survey and certification regulations are' discussed in Chapters 3, 4, and 5.
2. *More effective government regulation can substantially improve quality in nursing homes. A stronger federal role is essential.* Regulation of nursing homes both by state and federal governments is necessary to assure safety and acceptable quality of care for nursing home residents because of the vulnerability of the residents and the lack of institutional choices available to them. The committee is convinced that more effective government regulation can achieve substantial improvement in quality of care in many nursing homes in all states. A stronger federal leadership role is essential for

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improving nursing home regulation because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government. Chapters 3, 4, and 5 discuss these issues at length.

3. *Specific improvements are needed in the regulatory system*. A major reorientation of the regulatory system is needed to make it focus on the care being provided to residents and the effects of the care on their well-being. This will require revision of most aspects of the regulatory system, including the nursing home performance criteria and standards (the "conditions of participation" and "standards"), the surveillance (survey) process, compliance (enforcement) policies and procedures, and the systems for collecting and analyzing the data and other information needed for effective regulation. Chapter 3 discusses the problems with the current criteria and recommends some major changes. Chapter 4 discusses the problems with the survey process and recommends changes to strengthen it. Chapter 5 discusses enforcement problems and recommends ways to strengthen and improve the enforcement of performance standards.
4. *There are opportunities to improve quality of care in nursing homes that are independent of changes in the Medicaid payment policies or bed supply*. It is especially important to reorient and strengthen nursing homes to reduce or eliminate the many remediable weaknesses in the process of monitoring nursing home performance, and to strengthen compliance (enforcement) policies and procedures. Immediate steps to remedy current inadequacies in these three interrelated aspects of the regulatory system should be undertaken immediately. The committee recognizes that Medicaid payment policies clearly influence management decisions on admission and retention of residents; on the numbers, types, qualifications, and training of staff; and on the amount and quality of food. supplies, equipment and other resources to be purchased. All of these decisions affect quality of care. Unfortunately, the evidence of the effects on nursing home operations—and especially on quality of care—of different state approaches to Medicaid reimbursement policy is still not conclusive enough, nor

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is there sufficient professional consensus, to enable the committee to recommend adoption of a specific approach. For various reasons —including lack of precision in quality assessment—the complex relationships between costs, charges, reimbursement methods and amounts, and quality are not yet clear. There obviously must be a minimum reimbursement amount below which it is not possible to provide adequate care. But available evidence has not shown what that amount is. Since this is an issue of major importance, the HCFA should continue to support research and demonstration projects on the effects of Medicaid reimbursement policy on quality of care and quality of life in nursing homes. In this connection, one of the major recommendations discussed in Chapter 3—resident assessment—will make it feasible to arrive at objective methods of assessing quality of care that will be important for such studies. The issues are discussed more fully in Chapter 7.

Similarly, bed supply policy is a difficult issue. Although there clearly is excess demand for nursing home beds in most states, there also is evidence that some nursing home residents could be better cared for in alternative long-term-care settings if such were available. The main policy argument for constraining nursing home bed supply is that increasing bed supply would inhibit the development of more appropriate alternative long-term-care facilities and programs. But constraining the bed supply does not appear to have accelerated development of such programs because their development is probably tied closely to changes in payment policy. With only a few exceptions, the states control nursing home bed supply very tightly for a short-term political reason: to constrain growth of their Medicaid budgets. There is no federal policy either on bed supply or to facilitate development of alternatives to nursing home care. Some members of the committee favor policies that would encourage states to ease bed shortages. But the committee as a whole does not believe there is sufficient evidence or sufficient professional consensus to recommend either to the federal government or to the states a specific policy until the much larger

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issue of more appropriate financing of long-term-care services has been addressed.

5. *Regulation is necessary but not sufficient for high-quality care*. Skilled and properly motivated management, well-trained, well-supervised, and highly motivated staff, community involvement and support, and effective consumer involvement all are required. Although most of these factors are affected by regulation, they also contain important areas that are not. These issues are discussed, and recommendations are made, in Chapter 6.
6. *A system to obtain standardized data on residents is essential*. To reorient the regulatory system from its current "structural" and "facility-centered" orientation to a "resident-centered" and "outcome-oriented" approach will require development and introduction of a standard resident assessment data system that has multiple uses both for nursing home management and for government regulatory agencies. This concept is discussed in Chapters 2, 3, and 7.
7. *The regulatory system should be dynamic and evolutionary in outlook*. Specific regulatory standards should be modified to reflect changes in the art of long-term care, in experience with the regulatory system, and in the techniques of assessing outcomes more objectively.

The recommendations contained in this report collectively require many changes in all aspects of the regulatory system. These recommended changes should not be viewed as definitive and final. The effectiveness of the recommended modifications in the regulatory system should be followed closely. Experience is likely to expose the need for further changes. An effective regulatory system cannot be a static structure; it has to be conceived as being dynamic and evolutionary. The regulations will have to be modified periodically to keep pace as new knowledge becomes available about the changes in the domains of concern—the capabilities and performance of the facilities, the characteristics of the residents, and the knowledge of the effects of various care processes, techniques, and arrangements on the

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quality of care and quality of life of nursing home residents.

SUMMARY OF RECOMMENDATIONS

The committee's recommendations are contained in Chapters 3-7. They deal primarily with regulatory criteria, with the process of inspecting and certifying nursing homes, with the enforcement process, with the ombudsman program, and with issues requiring further study.

Regulatory Criteria

The following changes in the federal certification criteria are recommended:

1. The regulatory distinctions between SNFs and ICFs should be eliminated.

   Recommendation 3-1: The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards, with the modifications and additions recommended below, should become the bases for new certifying criteria.

   The reasons for making this recommendation are set forth in Chapter 3.
2. A new condition of participation on resident assessment is required. This is of fundamental importance because it has broad implications for both regulation and management (see Chapter 3, Resident Assessment).

   Recommendation 3-2: A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be

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responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

3. The existing SNF conditions of participation and standards should be rewritten in accordance with the following principles:

- Whenever appropriate, the criteria should address residents' needs and the effects of care on residents, and on the performance of a facility in providing care rather than on its capability to perform.
- The criteria should be based on the best professional standards for providing high quality of care and quality of life to nursing home residents.
- The criteria should be drafted clearly and with as much specificity as possible so that they can be understood by facilities, applied consistently by surveyors, and be legally enforceable.
- The criteria should be internally consistent, logical, and comprehensive.
- The criteria should include physical, mental, and social functioning; nursing care; nutritional status; social services; physician care; psychological care; pharmacy; dental care; environment; residents' rights; emotional well-being; personal choice; satisfaction; and community interaction.
- The criteria should be sensitive to each facility's case mix—that is, the variations in the services required and outcome expectations for residents with different needs found in one facility.
- The criteria should not be unnecessarily burdensome on facilities.

Recommendation 3-3: The existing SNF conditions and standards should be rewritten in accordance with the above principles and made applicable to all nursing homes.

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4. Because quality of life, in addition to quality of care, is particularly important in nursing homes, the committee believes that it should be incorporated as a condition of participation.

   Recommendation 3-4: A new condition of participation concerning quality of life should be added to the certification regulations. The condition should state that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents.

5. There is a need to reorient the approach to regulation of nursing homes to make it more resident-centered and outcome-oriented. This requires a new condition of participation on quality of care.

   Recommendation 3-5: A new condition of participation on quality of care should be added to the certification regulations. It should state that each resident is to receive high-quality care to meet individual physical, mental, and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being.

6. Residents' rights should be raised from a standard to a condition of participation and some new residents' rights standards should be added.

   Recommendation 3-6: The existing standard on residents' rights should be made into a condition of participation. The condition should state that every resident has certain civil and personal legal rights that must be honored by the staff of the facility. Rights specified in this condition, as they pertain to a resident who has been adjudicated incompetent in accordance with state law, shall devolve to the resident's guardian, or, if required by the state, a responsible party. In cases where the attending physician determines that a legally competent resident is incapable of exercising a right, the

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conditions and circumstances shall be fully documented in the medical record and the right shall devolve to a responsible party. The following standards should be added to the residents' rights condition:

a. *All residents admitted to the facility shall be told that there are legal rights for their protection during their stay at the facility and that these are described in an accompanying written statement. Reasonable arrangements shall be made for those who speak a language other than English. At such time as the rights set forth in this condition are revised, residents shall be given the updated information. Further explanation of the written statement of rights shall be available to residents and their visitors upon reasonable request to the administrator or other designated staff person*.
b. *Each resident has the right to know the name, address, and phone number of the state survey office, state or local nursing home ombudsman office, and state or local legal service office. The facility shall post such information in a location accessible to residents and visitors*.
c. *Each resident has a right to see written facility policies. Facilities shall make policies available on request. Facilities shall post state survey reports and plans of correction in a location accessible to residents*.
d. *Each resident may inspect his/her medical and social records upon request to the facility. The resident may request and receive copies of the records at a photocopying cost not exceeding the amount customarily charged in the facility's community for similar services*. (This overrides state law and/or regulations if they are in conflict.)
e. *Each resident must receive prior notice of transfer, discharge, and lapse of bed-hold periods. The facility must notify the resident, resident's representative, and attending physician in writing*

(1) *at least 3 days prior to the lapse of bed-hold periods*,
(2) *at least 3 days prior to intrafacility transfer*,

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(3) at least 4 days prior to discharge from the facility except as specified in documented emergencies.

The notice must contain the reason for the proposed transfer, the effective date, the location to which the facility proposes to transfer the resident, a statement that the resident may contest the proposed action, and the address and telephone number of the state or local nursing home ombudsman.

f. Each resident, along with his/her family has the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated responsible for providing this assistance and for responding to written requests that result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

g. Each resident has the right to meet with visitors and participate in social, religious, and political activities at their discretion so long as the activities do not infringe on the rights of other residents. This includes the right to join others within and outside the facility to work for improvement in long-term care. The facility must permit each resident to receive visitors and associate freely inside or outside of the facility with persons and groups on the resident's own initiative. Visitors must be granted access to residents. The residents, however, have the right to refuse or terminate any visit.

7. Seven of the current conditions of participation—governing body and management, utilization review, transfer agreement, disaster preparedness, medical direction, laboratory and radiological services, and medical records—should be consolidated into one new condition to be called "administration." New standards should be added on nurse's aide training, access, Medicaid discrimination, notification, and consumer participation.

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Recommendation 3-7: A new condition of participation entitled "Administration" should be established. The following current conditions of participation should be reclassified as standards under this new condition: governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records.

Recommendation 3-7, A: The current requirements for institutional planning and submission of quarterly staffing reports should be eliminated in drafting the new administration condition.

Recommendation 3-7B: A new standard, nurse's aide training, should be added to the administration condition. The standard should require that all nurse's aides complete a preservice state-approved training program in a state-accredited institution such as a community college.

Recommendation 3-7C: A new standard should be written under the administration condition that prohibits facilities that have signed a Medicaid Provider Agreement from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment.

Recommendation 3-7D: When the governing body and management condition is rewritten and incorporated in the new administration condition, the current standard "j" should be changed to require the facility to record at admission and periodically confirm or update the identity of a guardian, conservator, or resident's representative to be notified in the event of (1) care conferences: (2) changes in the resident's physical, mental, or emotional status; (3) an accident involving the resident; (4) change in billing: (5) change of room; (6) discharge from the facility; or (7) changes in federal or state residents' rights. Notification should be timely.

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Recommendation 3-7E: A new standard should be added to the administration condition that would require every facility to develop and implement a plan for regular resident participation in decision-making in the facility's operations and policies and for presentation of resident concerns. Forms of resident participation can include, but are not limited to, resident councils, regularly scheduled resident forums, resident issue or program committees, and grievance committees. Facilities should include existing resident councils and/or other resident representatives in developing this plan.

Recommendation 3-7F: Two new elements should be added to the governing body and management standard as follows:

a. *Certified nursing homes should be required to permit access to the homes by an ombudsman (whether volunteer or paid) who has been certified by the state. With permission of a resident or legal guardian, a certified ombudsman should be allowed to examine the resident's records maintained by the nursing home.*
b. *Any authorized employee or agent of a public agency, or any authorized representative of a community legal services organization, or any authorized member of a nonprofit community support agency that provides health or social services to nursing home residents should be permitted access at reasonable hours to any individual resident of any nursing home.*

8. Standards in the social services and physical environment conditions should be strengthened.

Recommendation 3-8: Standard 5, "Other Environmental Considerations" in the Physical Environment Condition currently reads ". . . provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature . . . ." It should be amended to add, at this point, "that is within acceptable ranges of operative temperature and humidity for persons clothed in typical summer or winter clothing at light, mainly sedentary activities, as specified in the ANSI-ASHRAE Standard

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55-1981." This is the standard prescribed by the nationally recognized American National Standards Institute. Waivers may be granted for existing facilities until such time as substantial renovation takes place.

Recommendation 3-9: The present social service condition should be changed to require that each facility with 100 beds or more be required to employ at least one full-time social worker. Qualifications for this position should be a bachelor's degree in social work, a master's degree in social work, or some equivalent degree in an applied human service field at the bachelor's level or higher as approved by the state. Facilities with fewer than 100 beds or those in rural areas that have made a good-faith effort and have been unable to recruit a qualified social worker with the required credentials may substitute a contractual arrangement with a community agency or with an independent social work consultant. However, the HCFA should establish a minimum level of effort for social services in exempted facilities—for example, one day of consultation per week.

Monitoring Nursing Home Performance

The following recommendations are made to strengthen the process of determining the extent to which nursing homes are complying with the conditions of participation:

1. Medicare and Medicaid survey and certification requirements should be consolidated.

   Recommendation 4-1: Medicare and Medicaid survey and certification process requirements should be consolidated in one place in the Code of Federal Regulations to promote consistency.

2. The timing of surveys should be adjusted to make them less predictable.

   Recommendation 4-2: The timing of surveys should maximize the element of surprise; the standard annual survey should

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be conducted somewhere between 9 and 15 months after the previous annual survey, with the average across all facilities within each state remaining at 12 months. Additional standard surveys also should take place whenever there are key events, such as a change in ownership. Independent of the survey cycle, all facilities should be required to pass rigorous life safety code and food inspections at regular intervals.

3. The following two survey instruments and protocols based on the new conditions and standards should be developed:

a. a standard, relatively short survey, that would be resident-centered and use key outcome indicators to determine quality of care, and
b. an extended survey that would entail a comprehensive examination of the nursing horne's operations. The extended survey would be used if the standard survey findings indicated that there were—or might be—evidence of inadequacies in the quality of care being provided to some or all of the residents. Good nursing homes would normally experience only the standard survey.

Recommendation 4-3: Two new survey protocols should be designed and tested to implement the new conditions and standards recommended in Chapter 3: a standard survey and an extended survey. Both must be based on the revised conditions of participation and standards.

4. The standard survey process would entail an audit of the resident assessment data maintained by the facility and would rely on a case-mix-referenced sample of residents to gather the information required by the standard survey instrument.

The extended survey would enlarge the sample of residents examined and increase the comprehensiveness of the standard protocol to look at compliance with all elements of all standards. It would further document poor resident outcomes and explore the extent to which structural and process factors may have contributed to these outcomes.

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Recommendation 4-4: Both standard and extended surveys should assess samples of residents stratified by standard case-mix categories. Case-mix definitions, and the procedures and sample sizes required to attain a prespecified level of precision, should be established by the HCFA.

Recommendation 4-5: The standard survey should rely on "key indicators" of quality of resident life and care that would be prescribed by the HCFA. These key indicators would measure poor resident outcomes and other resident and facility conditions that might be caused by noncompliance with the federal conditions and standards and should be investigated further by the survey agency.

Recommendation 4-6: Facilities that perform poorly on key indicators of quality of resident care or life should be subjected to a full or partial extended survey, depending on the range of problem areas discovered. The purpose of the extended survey is to determine the extent to which the facility is responsible for the poor outcomes due to noncompliance with the federal conditions and standards.

Recommendation 4-7: Quality assessment in the survey process should rely heavily on interviews with, and observation of, residents and staff, and only secondarily on "paper compliance," such as chart reviews, official policies and procedures manuals, and other indirect measures of actual care given and resident outcomes.

5. The survey process should be coordinated with the complaint-handling process, and the latter would be strengthened.

   Recommendation 4-8: The HCFA should require states to have a specific procedure and sufficient staff to properly investigate complaints.

6. The survey process should formally seek information directly from consumers (residents and their advocates).

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Recommendation 4-9: The HCFA should incorporate in its survey operations manual the following additional procedures to be followed by surveyors in addition to interviews with those residents sampled for the survey protocols:

- *At the beginning of the survey, surveyors should meet briefly with members of the facility's resident council or with a group of willing and capable residents to elicit general information about services and resident satisfaction as well as to identify any areas of particular concern.*
- *Resident representatives should participate in the part of the exit conference where deficiencies are cited and the plan of correction is discussed.*
- *At the close of the survey, the following notice should be posted in a location accessible to residents and visitors*:

The (state survey agency) completed its regular certification survey of (facility name) on (date).

Anyone wishing to provide additional information may contact the (state survey agency) before (date).

(address)
(phone)

7. Positive incentives for good performance should be incorporated into the survey and certification process.

   Recommendation 4-10: In addition to exempting good facilities from extended surveys, ways should be explored to commend superior performance.

8. The HCFA should require the state agencies to implement a program to develop and support consistent and reliable surveys.

   Recommendation 4-11: The new survey protocols, including the forms, procedures, and guidelines used by surveyors, should be designed in accordance with the revised and

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amended conditions and standards recommended in Chapter 3, and they should be revised as the conditions and standards are changed in the future.

Recommendation 4-12: All survey protocols (instruments and procedures) should be tested so that they are capable of yielding reliable and consistent results when used by properly trained surveyors anywhere.

Recommendation 4-13: A sample of facilities should be subject to an extended survey each year. Information from this sample should be used to validate and improve the standard survey.

Recommendation 4-14: The HCFA should require the state agencies to implement a program to develop and support consistent and reliable surveys. This program should be based on effective training and monitoring of surveyor performance to reduce inconsistency.

9. Several steps should be taken to strengthen the regulatory capacity of the states:

- Full federal funding should be provided for state survey and certification activities.
- State surveyor qualifications should be strengthened.
- Both federal and state surveyor training efforts should be increased.
- The results of research and evaluation studies should be analyzed and disseminated by the HCFA.

Recommendation 4-15: Title XIX of the Social Security Act should be amended to authorize 100 percent federal funding of costs of the nursing home survey and certification activities of the states. This authority should be extended for 3 years, after which time a federal-state matching ratio should be reestablished. The HCFA should develop a standard formula for distributing funds to the states under this authority so that each state is funded on an equal basis in proportion to its federal certification workload.

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Recommendation 4-16: The HCFA should revise its guidelines to make them more specific about the qualifications of surveyors and the composition and numbers of survey team staff necessary to conduct adequate resident-centered, outcome-oriented inspections of nursing homes. As a minimum, every survey team should include at least one nurse. For use on extended surveys, the survey agency should have specialists on staff (or, in small states, as consultants) in the disciplinary areas covered by the conditions and standards (for example, pharmacy, nutrition, social services, and activities).

Recommendation 4-17: Federal training efforts and support of state-level training programs should be increased, especially during the period of transition to the new survey process, and during the implementation of the new resident assessment condition of participation.

Recommendation 4-18: National data about survey operations and results, and from any experiments and demonstrations sponsored by the HCFA or the states, should be collected, analyzed, and disseminated by the federal government to facilitate continued improvement in survey methods.

10. Federal oversight capabilities vis-a-vis state survey operations should be strengthened and the HCFA should be given authority to withhold a portion of Medicaid matching funds from states that perform the survey and certification function inadequately.

Recommendation 4-19: The HCFA should increase its capabilities to oversee state survey and certification of nursing homes and to enforce federal requirements on states as well as facilities by

- *adding enough additional federal surveyors to each regional office to ensure that the random sample of nursing homes surveyed each year in each state is large enough to allow reasonable inferences about the adequacy of the state's survey and certification activities*;

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- *scheduling "look-behind" surveys so that valid comparisons can be made of the findings of federal and state surveys; and*
- *amending Title XIX of the Social Security Act to authorize the HCFA to withhold a portion of Medicaid matching funds from states that perform inadequately in their survey and certification of nursing homes.*

11. Inspection of care should be integrated with the certification survey.

    Recommendation 4-20: The inspection-of-care function should be carried out as part of the new resident-centered, outcome-oriented survey process. But individual resident reviews should be required for a sample of residents (private-pay as well as Medicaid) rather than for all residents (although individual states may elect to continue 100 percent reviews).

12. A realignment of federal and state certification role relationships vis-a-vis Medicare and state-owned facilities is necessary.

    Recommendation 4-21: The respective roles and responsibilities of the federal and state governments should be realigned as follows:

- *The states should be responsible for certifying all Medicare and Medicaid facilities (except state institutions) according to federal requirements.*
- *The HCFA should monitor state performance more actively and be responsible for conducting surveys of, and certifying, state-owned institutions directly.*

Enforcing Compliance with Federal Standards

The following improvements in enforcement are recommended:

1. The HCFA should revise its guidelines for the post-survey enforcement process.

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Recommendation 5-1: The HCFA should revise its guidelines for the post-survey process. Revisions should include

- *specifying that survey agency personnel not be used as consultants to providers with compliance problems*;
- *specifying how to evaluate plans of correction and what constitutes an acceptable plan of correction*;
- *specifying the circumstances under which onsite followup visits may be waived*;
- *specifying circumstances under which formal enforcement action should be initiated, and how actions should be taken; and*
- *requiring that states have formal enforcement procedures and mechanisms*.

2. The Medicaid authority should be amended to authorize a set of intermediate sanctions for use by the states and the federal government.

   Recommendation 5-2: The Medicaid authority should be amended to authorize a specified set of intermediate sanctions for use by states and by the federal government in enforcing compliance with nursing home conditions of participation and standards. The HCFA should then develop and issue detailed regulations and guidelines to be followed by the states and by the HCFA in using these sanctions. The sanctions should include

- *ban on admissions*,
- *civil fines*,
- *receivership*,
- *emergency authority to close facilities and transfer residents*.

3. The Medicaid statute should be amended to authorize sanctions for use against chronic or repeat violators of certification regulations.

   Recommendation 5-3: The Medicaid statute should be amended to provide authority to impose sanctions on chronic or repeat violators of certification regulations.

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The HCFA should develop detailed procedures to be followed by the states to deal with such facilities. Procedures should include, but not be limited to,

- *the authority to impose more severe sanctions,*
- *a requirement to consider a provider's previous record before certifying or recertifying, and*
- *the responsibility to obtain satisfactory assurances prior to recertifying, that the deficiencies that led to a termination will not recur.*

4. The Medicaid statute should be amended to strengthen the effectiveness of sanctions.

   Recommendation 5-4: The Medicaid statute should be amended to make the appeals process on sanctions, particularly decertification, less permissive. The HCFA should issue regulations and guidelines to implement this new authority.

5. The HCFA should strengthen state enforcement capabilities.

   Recommendation 5-5: The HCFA should strengthen state enforcement capabilities by

- *requiring states to commit adequate resources to enforcement activities, including legal and other enforcement-related staff;*
- *requiring survey and certification survey agency staffs to include enforcement-related specialists, such as lawyers, auditors, and investigators, to work as part of special survey teams for problem situations and to help support enforcement decision-making;*
- *including more training in investigatory techniques, witness preparation, and the legal system in the basic surveyor training course; and*
- *providing federal training support for state survey agency and welfare agency attorneys in nursing home enforcement matters.*

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Other Factors Affecting Quality of Care and Quality of Life in Nursing Homes

The following means to enhance the effectiveness of consumers and consumer advocates in quality assurance are recommended:

1. The HCFA should require states to make public all nursing home inspection and cost reports.

   Recommendation 6-1: The HCFA should require states to make public all nursing home inspection and cost reports. These documents should be required to be readily accessible at nominal cost to consumers and consumer advocates, including state and local ombudsmen.

2. The ombudsman program should be strengthened by amending the Older Americans Act.

   Recommendation 6-2: The Older Americans Act should be amended to:

- *establish the ombudsman program under a separate title in the Act*;
- *increase funds for state programs by authorizing federal-state matching formula grants for state ombudsman programs. The formula should provide each state with a minimum annual budget in the range of $100,000 (1985 dollars) plus an additional amount based on the number of elderly residents in the state. The federal-state matching ratio should be two-thirds federal to one-third state funds*. (Although the committee did not study in any depth the budget requirement, this minimum amount is intended to provide the ombudsman program with, for example, the capability to support, at a minimum, a full-time professional and secretary and sufficient travel and training funds to recruit, train, and certify volunteers as local ombudsmen.)
- *establish a statutory National Advisory Council composed of state ombudsmen, state and local aging agencies, provider and consumer representatives, state regulators, health care professionals (physicians, nurses*,

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administrators, social workers), and members of the general public to advise on administration, training, program priorities, development, research, and evaluation;

- *authorize state-certified substate and local ombudsmen, including trained, unpaid volunteers, access to nursing homes and, with the permission of the resident, to a resident's medical and social records;*
- *authorize public legal representation for ombudsman programs*;
- *exempt the ombudsman programs, including substate ombudsmen who are supported by funds from the state ombudsman program, from the antilobbying provisions of OMB Circular A-122*.

3. The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program.

   Recommendation 6-3: The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program. At a minimum the Commissioner of AoA should designate a senior full-time professional and some supporting staff to assume responsibility for administering the program. Priority should be given to establishing a national resource center for the program that would develop, in consultation with state programs, an information clearinghouse, training and other materials to assist states, and guidance to states on data collection and analysis. The center should advise on establishing program priorities, and sponsor research and evaluation studies.
4. The HCFA should require state long-term care regulatory agencies to develop written agreements with state ombudsman programs covering information-sharing, training, and case referral.

   Recommendation 6-4: The HCFA should require state long-term-care regulatory agencies to develop written agreements with state ombudsman programs covering information-sharing, training, and case referral.

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Issues Requiring Further Study

Information Systems

HHS should undertake a study to design a system for acquiring and using resident assessment data. A study also should be initiated to determine what other data about nursing homes are needed for regulatory, policy development, and other public purposes.

Recommendation 7-1: The Secretary of HHS should order a study to design a system for acquiring and using resident assessment data to meet the legitimate and continuing needs of state and federal government agencies. The Secretary also should order a study to determine the needs for other data about nursing homes that would facilitate regulation and policy development. This study should recommend specific ways to collect, analyze, and publish or otherwise make such data publicly available.

Medicaid Payment Policies

Further study is needed to determine optimal Medicaid payment policies.

Nursing Home Bed Supply

The policy on controlling the supply of nursing home beds is related to the issue of developing a broader array of interrelated long-term-care services. This, in turn hinges on the development of more appropriate private and public financing arrangements and policies. The federal government should undertake a systematic study of these interrelated issues to facilitate development of appropriate policies in these areas.

If the committee's major recommendations are carried out there may be some effect on the number of currently certified nursing homes that will continue to participate in the Medicaid program. It is likely that poorly managed marginal or substandard facilities will be forced either

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to improve their performance or go out of business. Most of those that go out of business are likely to be sold to other owners that will install more competent management and staff and continue in operation. It is possible, however, that some facilities may elect to withdraw from participation in the Medicaid program. There is no way of determining beforehand to what extent, if any, this is likely to occur. Or, if it does occur to a significant extent, whether states will respond by easing their restrictions on expansion of bed supply only for certified homes, or by making licensure contingent on participation in the Medicaid program.

Staffing of Nursing Homes

Based on the availability of systematic resident assessment data, two kinds of staffing studies should be undertaken: (1) studies to develop a minimum staffing algorithm relating staffing to case mix, and (2) studies on staff qualifications.

Single- Versus Multiple-Occupancy Rooms

The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes.

Recommendation 7-2: The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes. The study should be designed to obtain data about the effects of single rooms on the quality of life of various types of nursing home residents. It should be completed within 2 years after it has been authorized. It should contain recommendations for the desired proportions of single- and multiple-occupancy rooms in nursing homes. It also should recommend required proportions in future new construction and major remodeling of existing buildings.

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2

Concepts of Quality, Quality Assessment, and Quality Assurance

This chapter discusses three basic concepts: (1) what is meant by quality of care and quality of life in nursing homes; (2) what is known about the techniques available for quality assessment—that is, for determining how good the quality of care and quality of life are in a nursing home; and (3) how these concepts should affect the design of a regulatory system that would effectively ensure that nursing homes provide care of acceptable quality.

The discussions in the chapters that follow presume understanding of these concepts.

QUALITY OF CARE IN NURSING HOMES

The attributes of quality in nursing homes are very different from those in acute medical care settings such as hospitals. The differences stem from the characteristics of the residents of nursing homes, their care needs, the circumstances and settings in which the care is provided, the expected outcomes, and the fact that for many residents the nursing home is their *home*, not merely a temporary abode in which they are being treated for a medical problem. Thus, quality of life is very

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important for its own sake (that is, as an outcome goal) and because it is intimately related to quality of care in nursing homes.

Characteristics of the Residents

According to the 1977 National Nursing Home Survey,[1] 70 percent of nursing home residents were 75 years of age or older, about 70 percent were women, only 12 percent had a living spouse, and they had a wide range of physical, emotional, and cognitive disabilities. Nursing home residents differ in their social circumstances compared with noninstitutionalized persons of the same age group. Thirteen percent of residents had no visitors in the course of a year, but about 62 percent had visits from family or others on a daily or weekly basis. Nursing home residents are disproportionately single, widowed, and childless, and they are poorer than the elderly population in general.[2] These data are important because of the links that have been shown to exist between social support and health service needs and outcomes.[3-7]

Residents fall into two broad categories classified by length of stay. The largest group, the "long stayers," consists of those who are no longer able to live outside of institutions and who generally reside in the nursing home for many months or years, often until they die. The second group, the "short stayers," generally comes from hospitals and will be discharged home or will die in a fairly short period of time.[8]

Care Needs

Nursing home residents vary in the amount and types of care they require as well as in their lengths of stay. Many of the "short stayers" require intensive nursing and rehabilitative services. For these, the goal of nursing home care is rehabilitation and discharge home. Some are rehabilitated and discharged; some die either in the nursing home or shortly after discharge. The "long

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stayers" present a spectrum of care requirements, ranging from those who are relatively independent and require only modest amounts of care to those who are physically very disabled, mentally impaired, and incontinent and who require assistance in all activities of daily living (ADL). In a special study commissioned by the committee, longitudinal data derived from monthly assessments of all residents in 107 nursing homes in 11 states and the District of Columbia were analyzed.[9] In these nursing homes, about 63 percent of new residents either died or were discharged within 3 months of admission. That is, a substantial proportion of persons admitted to the nursing homes stayed for a relatively short period of time. But those who remain in the homes for long stays account for most of the resident bed-days. About 70 percent of all residents in bed on a particular day in all of these nursing homes were still alive and in the same nursing home 18 months later. On the basis of standard assessments of all residents and a standard way of estimating nursing time required per day, the residents on any day in this set of nursing homes fell into three broad categories: 10.8 percent required little care (40 to 60 minutes per day); 48.9 percent required "medium" care (61 to 134 minutes per day) and 40.3 percent required "heavy" care (135 to 268 minutes per day).

The Care Setting

Nursing home care is both a treatment and a living situation. It encompasses both the health care and social support services provided to individuals with chronic conditions or disabilities and the environment in which they live.[9] Nursing homes are "total institutions" in which care-givers, particularly nurse's aides, represent a large part of the social world of nursing home residents and control their daily schedules and activities.[10] This is the total environment for many nursing home residents for the duration of their stay, which may be several years. As a result, deficiencies in medical or nursing care or in housekeeping

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or dietary services, which could perhaps be tolerated during a brief hospital stay, become intolerable and harmful to well-being when they are part of an individual's day-to-day life over a longer period. The physical, psychosocial, and environmental circumstances and outcome expectations of nursing home residents distinguish the goals of nursing home care from those of acute medical care. In acute care, treatment goals are based on medical diagnosis. In nursing homes, the care goals are based on physical and psychosocial assessment. They focus on restoration, maintenance or slowing of the loss of function, and on alleviation of discomfort and pain.[11,12]

Requirements for High-Quality Care

The characteristics of nursing home residents, their care needs, and the care setting underlie the three central requirements for providing high-quality nursing home care: (1) a competently conducted, comprehensive assessment of each resident; (2) development of a treatment plan that integrates the contributions of all the relevant nursing home staff, based on the assessment findings; and (3) properly coordinated, competent, and conscientious execution of all aspects of the treatment plan. The assessments should be repeated periodically and the treatment plan adjusted accordingly.

Most nursing home residents suffer from various medical problems, and accurate, careful medical diagnosis and problem identification are very important. But a major determinant of care goals in nursing homes is functional status, that is, the ability of the individual to perform the activities of daily living (bathing, dressing, toileting, transfer, feeding, and continence).[11]

Functional status is a sociobiologic construct that can be used to indicate the existence of chronic conditions and to objectively measure their severity. It also can be used to determine service needs and outcomes resulting from service use among homogenous groups of patients. For example, the Index of Activities of Daily Living, or its variants, has been used to study chronically ill

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people, including those with hip fracture, cerebral infarction, multiple sclerosis, paraplegia, quadriplegia, rheumatoid arthritis, and other chronic conditions among institutionalized and noninstitutionalized people.[13-19]

The importance of functional status in predicting outcomes is also suggested by studies that were designed to measure the relationship between process and outcome measures of quality care. Those studies found residents' initial functional status to be the best predictor of health care outcomes.[20-22]

Mental status also predicts disability levels and service needs among nursing home residents.[23-25] An estimated 50 to 66 percent of nursing home residents have some type of mental or behavioral problem.[1,26] A substantial amount is attributable to senile dementia of various types, but depression and psychosis also are prevalent. In part, this is attributable to the massive discharges of patients from state mental hospitals during the 1970s. During that period, the number of elderly persons in mental hospitals decreased by about 40 percent, while the mentally ill in nursing homes increased by over 100 percent. [27]

Although the elderly suffer from disorders that affect younger persons (for example, neuroses, alcoholism, schizophrenia), the two most frequent diagnoses among those in nursing homes are depression and intellectual impairment (organic brain syndrome, confusional states, dementia, and so on).[28] Contrary to the beliefs of many health professionals, age *per se* is no bar to effective psychiatric treatment. This is particularly true for depression.[29]

Planning And Providing Care

The initial comprehensive assessment of a resident should include the resident's functional status, medical and dental conditions and needs, mental and emotional status, social interactions and support, personal activity preferences, and financial circumstances. This entails a team effort involving, at a minimum, a nurse, a physician, a social worker, and a physical therapist. The knowledge

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and specialized skills of other professionals, such as dentists, psychologists, audiologists, speech therapists, occupational therapists, and podiatrists, should be drawn on as needed. Assessments must be recorded in such a way in the resident's medical records that they can be understood and used by all staff responsible for providing care—including nurse's aides.

The plan of care developed to meet the resident's needs requires participation by all professional staff in the nursing home because there is almost no aspect of care that is the exclusive domain of one professional group or another. Physicians need to know from nursing staff the effectiveness of efforts to deal with depressed patients and whether drugs should be adjusted in dosage or the regimen altered; nurse's aides need to be instructed on specific rehabilitation efforts—such as range-of-motion exercises—that should be incorporated as part of the ADL support provided to residents; staff in the recreation department need to know that a close watch is being kept on certain residents for the side effects of drugs. Clear, easily understood records are essential to carry out such coordinated care because there is seldom time for meetings to share all of the necessary information. Moreover, staff on duty evenings and weekends have to rely on records to make critical decisions.

In sum, long-term care is directed primarily at relieving conditions that result from chronic physical or mental disorders or the chronic after-effects of acute disorders. Equally important is relief of pain and discomfort. Assessing functional competence or impairment gives direct information about these conditions, which is needed for care planning.

Chronic conditions generally require restorative or maintenance services with an emphasis on attaining small improvements or preventing undue decline, rather than the intensive efforts of acute medicine that usually aim for cures, remissions, or other substantial improvements.

Many residents in nursing homes will remain there for long periods, often until death. Their well-being is affected by the *environment,* by the quality of the medical/nursing and social support services they receive, and by the nature of their health problems.

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QUALITY OF LIFE

The quality of life experienced by anyone is related to that person's sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.[30,31] For nursing home residents this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishment of desired goals, and control over one's life.[32] For instance, a resident's quality of life is enhanced by close relationships and meaningful interchange with others, an environment supporting independence and incorporating personal belongings, and the opportunity to exercise reasonable control over life decisions. Opportunities for choice are necessarily somewhat limited in a nursing home, but they need not be as limited as they are in some nursing homes.[33] Participation in care planning is one important aspect of personal autonomy. But even such seemingly small choices as mealtimes, activities, clothing, or times to rise and retire greatly enhance the sense of personal control that leads to a sense of well-being. Lack of privacy for visits with family and friends, for medical treatment, and for personal solitude contributes to lack of self-esteem. Opportunities to engage in religious, political, civic, recreational, or other social activities foster a sense of worth. The quality and variety of food are often cited as some of the most important attributes of quality from the resident's perspective.[31,34] Quality of life also includes such life circumstances as personal assets, financial security, physical and mental health, personal safety, and security of one's possessions.[35-37]

Many aspects of nursing home life that affect a resident's perceptions of quality of life—and therefore, sense of well-being—are intimately intertwined with quality of care. This is evident in the findings of a study conducted during 1984-1985 by the National Citizens' Coalition for Nursing Home Reform.[34] The study was designed to obtain nursing home residents' views on quality of care. Its findings are based on a series of discussions held in 15 cities involving 455 residents from more than a hundred nursing homes. The sample of

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residents was drawn from a group who volunteered to be in the study, who were able to attend three meetings outside of their own facility, and who were able to participate actively in group discussions.

The highest importance was attached by residents to the qualifications, competence, attitudes, and feelings of staff, and the quality of the interactions among staff and residents. This follows from the circumstance that 80 to 90 percent of the care is provided by nurse's aides and the quality of their interactions with the residents—how helpful, how friendly, how competent, how cheerful they are and how much they treat each resident as a person worthy of dignity and respect—makes a big difference in the quality of a resident's life.

Success in improving function and greater independence are associated with enhanced sense of well-being.[8,38] A number of writers have stated that, because the major concern of quality of care is with improving or maintaining function, care should routinely incorporate rehabilitation exercises. This means reliance on nurse's aides to see that these exercises are done as prescribed. There are indications that some functional impairments in the elderly may be the result of inactivity and disuse and that even very elderly residents respond to rehabilitation exercises.[38-42]

Conflicts of values and ethics are inherent in nursing home care—for example, conflicts between care requirements, as judged by professionals, and the rights and preferences of the resident. Should a very old, perhaps mildly demented resident, who is not legally incompetent and who declines to eat, be fed by nasogastric tube even if he strongly objects to it? What about residents who decline to take medication or other treatments prescribed to manage their chronic disease? Should dietary preferences of a resident override adherence to a medically prescribed dietary regimen? Should a frail, unsteady resident with osteoporosis, who insists on walking by herself, be permitted to walk around unescorted even though there is a substantial risk that she will fall and suffer a hip fracture?

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The quality of medical and nursing care provided, the way it is provided, the quality of the interaction between staff and residents, the range of services and amenities available to residents and their ability to make personal choices and to influence the range of choices, and the facility's ambiance—all affect residents' functional, physical, and mental health status (objective well-being) and subjective well-being. Subjective well-being includes such factors as the extent of depression-demoralization, satisfaction-dissatisfaction, absence of discomfort-pain. For the very sick and disabled, the quality of the care and the way it is provided are probably the most significant contributors to well-being.

QUALITY ASSESSMENT CRITERIA

The widely accepted criteria used in assessing medical care quality can be used for assessing quality of nursing home care. They have structural, process, and outcome components.[43]

Structure

Structure refers to the health care facility's or provider's capacity to provide good-quality care. Structural criteria include the training, experience, and number of the care-givers; the organizational arrangements within which they function; the safety and appropriateness of the environment; and the adequacy and appropriateness of the equipment and other available technology. Structural factors are relatively easy to assess, although determining what technology, equipment, staff qualifications and numbers, and organizational arrangements are necessary to provide good medical care is a matter of professional judgment and subject to change as new knowledge is acquired and new technology developed. Moreover, structural factors have only a potential relationship to quality: the availability of the capacity to provide good

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care does not mean that good care is delivered.[43] The use of structural criteria to assess quality of care in nursing homes is based on the assumption that such criteria represent necessary, although minimal, conditions associated with acceptable levels of resident care services and outcomes.[44] The evidence to support this assumption is mixed. Studies on the linkages between structural measures and the process of care in nursing homes have not found them to be strong.[45-48] But there is evidence that environmental circumstances influence personal well-being.[32,49-51] Environments that foster autonomy, integration, and personalized care promote better morale, life satisfaction, and adjustment.[52-55] They also have positive effects on staff attitudes and behavior.

There also is evidence that, in some circumstances, structural criteria directly affect the process of care. One study that investigated the use of psychotropic drugs in nursing homes found that staff-to-resident ratios are associated with rates of use of such drugs. That is, understaffed facilities may make excessive use of antipsychotic drugs to substitute for inadequate numbers of nursing staff.[56] Moreover, in such areas as life safety codes, structural measures of quality clearly predict outcomes.[12] In general, however, structural capacity, the care actually provided, and the outcomes of care are not always associated. Although the capacity to provide care may exist, it may not be used appropriately, or not be applied in sufficient quantity or with adequate skill.

Process

Process criteria assume that quality is related to the services provided, how they are provided, and the resources used in doing so. Some studies conducted on relationships between process measures and resident outcomes in nursing homes have yielded mixed findings,[20,22,57] but a few have shown positive relationships under certain circumstances.[46,58-60] (The studies vary in scientific

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quality; many are descriptive rather than controlled.) These recent studies, and professional experience, suggest that process measures should not be ignored. If care related to improving function is neglected (for example, exercises to avoid contractures, bed positioning to avoid bed sores), residents' quality of life is affected adversely.[61]

Outcomes

Outcomes are changes in a resident's functional or psychosocial health that are associated with the care provided. Outcome measures of care have received a great deal of attention as the most direct way to approach the assurance of quality in long-term care. Proponents argue that a focus on outcomes avoids arguments about effectiveness of structure and process factors by letting the results, resident outcomes, speak for themselves. The use of outcomes allows providers flexibility in determining the most cost-effective means of achieving specific outcomes, an important consideration in "low-technology" care where substitution of personnel and technique seems possible.[31,49,62]

Two kinds of outcomes are measured: subjective and objective. For nursing home residents, the subjective components may include a basic sense of satisfaction with oneself and one's environment and the level of satisfaction with a range of aspects of nursing home care. The objective components of outcome include such things as changes in functional and mental status.

Some outcomes have been defined and measured in long-term care. For example, rehabilitation outcomes have been studied, as have patient discharge rates.[22,48,63] Studies also have associated particular attributes of individuals to ranges of outcomes. Social isolation and intellectual decline have been linked with premature death.[64,65] Health status has been tied to morale and to behavior.[57,66-70] And expected intermediate and final outcomes have been studied for a number of specific conditions such as stroke and hip fracture.[18,71-73]

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In sum, for quality assurance purposes, structural, process, and outcome criteria can contribute useful, complementary information for assessing the quality of care and the well-being of nursing home residents.

ASSESSING QUALITY OF CARE

The development and use of valid and reliable instruments to measure quality of care are critically important to quality assurance and to regulation. Moreover, good measurement has strong positive effects on the planning and provision of care. The practices of the regulatory system and of the nursing home industry in general have not been up to the state of the art for some time.

Much research has been devoted to this question in recent years. For example, about 15 years ago the Public Health Service supported research to develop a uniform terminology with which to describe residents' needs. An important result of this effort was the "Patient Classification for Long-Term Care," a collaborative effort of four research groups published in 1973.[74] In 1980 the Technical Consultant Panel on the Long-Term Health Care Data Set of the National Committee on Vital and Health Statistics recommended that all public and voluntary reporting systems for long-term health care clients and services collect a minimum set of information to establish standard measurements, definitions, and classifications for long-term care.

The information needs of the patient classification system and the minimum data set are similar and include sociodemographic items, functional competency/impairment, intellectual impairment/behavioral problems, and medical status. This and other information relevant to quality assurance, such as indicators of subjective well-being, must be obtained through valid and reliable data collection instruments.

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Functional Competency/Impairment

This is defined in terms of discrete task performance in independently transferring, ambulating or wheeling, dressing, toileting, bathing, eating, and grooming. Other tasks also can be tested and the details of performance and assistance added. There is now wide agreement that a number of relatively brief assessment instruments and procedures can be used reliably by trained professionals from various disciplines. These instruments have been tested extensively for validity and reliability. More importantly, they can be used reliably by trained nonprofessionals. The following are examples:

1. The Katz Index of Activities of Daily Living provides rating scales of six functions: bathing, dressing, going to the toilet, transferring from bed to chair, continence, and feeding.[18]
2. The Barthel Index provides scores on self-care abilities.[75]
3. The Kenny Self-Care Evaluation is used to measure functional ability in 17 activities that fall into 6 functional impairment categories: bed activities, transfers, locomotion, personal hygiene, dressing, and feeding.[76] The instrument has been found to successfully predict rehabilitation and the timing of discharge.[77]
4. Linn's Rapid Disability Scale includes 16 ADL and related items that are scored according to severity or frequency of occurrence. Predictive validity has been demonstrated for physicians' prognoses, length of stay, and 6-month mortality.[78] Interrater reliability and test/retest reliability are high.

A number of states are using resident classification instruments that predict service use and nursing home cost. West Virginia assesses residents for dependency in functional impairment on the basis of 15 categories of service need, and Ohio on the basis of 14 categories.[79] The Resource Utilization Groups (RUGS) classification system,[80] which will be used to establish Medicaid reimbursement rates in New York

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state, [81] categorizes residents into five clinically distinct and statistically different groups on the basis of the resources used to meet resident service needs. Each clinical group is further divided by an ADL index score into subgroups distinguished by level of physical functioning.

Instruments also have been developed by nursing home chains for purposes of rate setting and internal quality assurance. For example, the Patient Care Profile System assesses functional impairment in personal hygiene, bathing, dressing, mobility, eating, and positioning, as well as the presence of incontinence and decubitus ulcers, and the need for skilled procedures and restorative nursing. This system is being installed in over 300 Hillhaven Corporation nursing homes.[82] The National Health Corporation has developed the Patient Assessment Computerized system[83] to collect standardized information on functional impairment in the areas of walking, ADL, bladder and bowel continence, decubitus ulcers, special senses, communication, orientation, and behavior. Reliability is measured by quarterly audits of a 10 percent sample of residents' forms by nurse consultants. The state of Montana uses this instrument to obtain case-mix information for use in its Medicaid payment determinations.

These and other instruments (only a few have been mentioned) are useful for quality assurance because they make it possible to reliably identify residents who have similar characteristics—that is, similar levels of disability, need for personal assistance and nursing, likelihood of discharge, chance of recovery, and risk of mortality. By collecting the same assessment data on the same residents at regular intervals, longitudinal data on the distribution of outcomes for residents with similar characteristics can be obtained.

Intellectual Impairment/Behavioral Problems

Among nursing home residents, this debility usually occurs as dementia of the Alzheimer's or multi-infarct type. It can be assessed with brief interview techniques

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that are reliable in the hands of both trained professionals, such as nurses and social workers, and trained nonprofessionals. For example,

1. The Mental Status Questionnaire has been used widely in geriatric research and practice.[84,85] It consists of 10 short questions testing cognitive function that have been correlated with clinical diagnosis of organic brain syndrome. It has demonstrated high reliability and can be administered without extensive training. The Philadelphia Geriatric Center Mental Status Questionnaire is an extension of the Mental Status Questionnaire and includes items that are sensitive to the specific situation of nursing home residents.[86]
2. The Mini-Mental State Examination measures cognitive functioning using items similar to those of a clinical mental-state examination.[87] External validity has been demonstrated on the basis of clinical assessments of the presence/absence of cognitive disorder.
3. The Comprehensive Assessment and Referral Evaluation Instrument (CARE), which includes the Geriatric Mental Status Schedule, is designed to replicate clinical judgments among community and institutional populations.[88] Instrument reliability and validity have been tested in various ways.

The information obtained from these instruments and others makes it possible to place residents into comparable groups with defined characteristics such as probability of being intellectually incapacitated (demented), needing special investigations, having a behavior problem (such as wandering), requiring supervision, progressively deteriorating, and dying. The measurements are repeatable. Additional information, such as duration and course, increases the relevance to quality assurance.

Corresponding evidence exists for other key content areas. Subjective well-being (demoralization-depression; dissatisfaction-complaints) has been measured and associated with social functioning, physical health status, mental status, and activity levels.[50,89,90] Standardized instruments have been used to assess

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residents' satisfaction with nursing home care and relationships between satisfaction and nursing home characteristics.[63,91,92] Behavior problems have been described, measured, and associated with specific service interventions as a part of nursing home management systems (for example, the National Health Corporation's Patient Assessment Computerized system) and in research studies. [93-95]

PERSPECTIVE ON QUALITY ASSURANCE

At the most general level, quality assurance is a mechanism or process for promoting excellence in the performance of services or the production of goods. It entails

- specification of criteria and standards of performance quality,
- collection of accurate information about the quality of current performance,
- comparison with information on desired or acceptable standards of performance,
- analysis of the reasons for the differences between actual performance and desired standards of performance and determination of what needs to be done to eliminate these differences,
- adoption of the changes necessary to eliminate the differences between current performance and desired standards of performance,
- repeated collection of information to monitor the extent to which resolution of differences is taking place, and
- periodic iterations of these linked steps.

Quality assurance—or quality control—is generally practiced with varying degrees of formality by providers of services and producers of goods, by consumers and clients, and by government regulatory authorities. In the nursing home industry, the main reliance has been on government regulation, but a significant responsibility for quality assurance rests on the nursing homes themselves. Other factors affecting quality in nursing

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homes are important. They include the role of consumer advocacy groups (including ombudsmen), industry self-regulatory efforts (including accreditation), and efforts to increase the professional standards and training of administrators and other staff. These factors are discussed in Chapter 6.

INTERPRETING AND USING INFORMATION FOR QUALITY ASSURANCE

Measurement of Care Quality

In long-term care, there are areas where the medical needs of a subpopulation can be defined and the outcomes of care measured. Many measures used in general medical practice may be used in long-term-care settings: reduction in the blood pressure of hypertensives; reduction in pain and improvement in functional status of patients with angina; visual improvement for patients with cataracts; restoration of function and reduction of pain in patients requiring hip replacement.

Measures of effectiveness of care quality more specific to nursing homes include the level of restoration of function following such events as hip fractures and new strokes, infection rates in residents with indwelling catheters, skin breakdown in at-risk bedridden residents, and improvements in mood in depressed residents.

The choice of measure for evaluating quality of care depends not only on the innate value of that measure but on the context of its use as well. A measurement device that is satisfactory for a large-scale research project may be too expensive, too lengthy, or require too much training for regulatory purposes. Similarly, the nature and size of the target population must be considered. Restoration of function after hip replacement may be a very effective measurement of care quality when applied to an acute rehabilitation facility associated with an active orthopedic referral center, but it would be completely useless in measuring the effectiveness of rehabilitation services in a small nursing home in which only one or two hips are replaced per year. Many of the measuring devices described here have limited applicability for

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regulatory purposes because the numbers of residents with even a common condition will be small within a single nursing home.

Measurement for regulatory purposes must be clear-cut and reliable. Both the regulated and the regulators must be able to understand easily what is being measured and why it is being used for regulatory purposes. Disagreements about a particular measurement must be capable of arbitration. The application of regulatory quality measures must be satisfactory as legal evidence in court.

The kinds of outcomes that have been suggested for use as a part of the regulatory process are mostly avoidable events that can occur across a fairly large subset of the population if care is insufficient: decubitus ulcers in the bedridden and catheter-induced infections are two examples. Others are discussed in Appendix F.

Standards

Interpreting information on the structure, process, or outcome of care in order to evaluate quality of care and well-being requires comparison with some standards of reference. Relative quality is more readily assessed than absolute quality. The standards of reference are specific to a given condition or circumstance since the definition of good care or a good outcome may vary with the particular circumstance or condition. Thus, when comparing an observed level of care with a given standard (for example, from institutions performing at a level above an agreed percentile of performance), the comparison must be made between residents with comparable conditions, or, when making group comparisons, between groups with comparable conditions.

Standards may be constructed on the basis of professional experience and judgment, as reflected in professional practice norms or standards, or by comparison with information that can be collected under defined circumstances:

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- from institutions judged to be exemplary,
- from the same institution at an earlier point in time, or
- from the same or other institutions under varying conditions.

These standards (professional judgment and systematic comparisons) are not mutually exclusive. Professional judgment is informed by more systematic comparisons. It also may be necessary when systematic comparison data are not available. But systematic comparisons have the major advantage of objectivity and can be refined over time. Valid comparisons require that the information be collected uniformly and reliably and on a large scale. Also, the standards must be reviewed periodically and revised to keep them up to date.

Case Mix

Case-mix stratification entails grouping residents according to a select number of their characteristics (age, sex, functional status, mental status, and so on) and needs for services. Measurements of functional impairment, intellectual impairment, and subjective well-being, all of which predict needs for care, can be used to define case-mix reference groups. Thus the care given, as well as the changes in resident well-being associated with the care given, can be measured and evaluated for groups of residents with similar care needs.

Case mix is essential for measuring outcomes. The outcomes of care can be measured by changes in the health and functional status of residents. A study conducted by Jones and colleagues in Massachusetts in the early 1970s first demonstrated the feasibility of this approach to quality assessment in long-term care.[96] Outcomes also can be related to groups in which members have similar expected outcomes. A series of studies of residents of "high-quality" nursing homes has been undertaken by Kane in an attempt to link nursing home payment to resident outcomes and nursing home costs.[63] Data collected on residents included a

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broad set of functional aspects covering six domains: physical, functional (ADL), cognitive, affective, social, and satisfaction, with measurements made at 3-month intervals. The study introduced the concept of "prognostic adjustment factor" (PAF) as an outcome measurement of quality of care. The PAF reflects the extent to which the actual outcome of care exceeds or falls short of an expected level. The system is based on resident data that are used to generate a predicted course for the resident based on the experience of similar residents: the resident gets better, stays the same, or gets worse. Comparing the actual status of the resident with the predicted status after a suitable period of time gives the PAF for that resident over that time interval.

Morris and colleagues did a longitudinal analysis of a multi-year data set on the residents of 107 facilities located in 11 states and the District of Columbia. The data were obtained from the National Health Corporation and the state of Montana.[8] The authors developed a resident classification scheme differentiating among major categories of residents, classified by physical and mental functioning domains and care requirements. These characteristics were measured against a range of indicators that have quality-of-life implications, including ADL, communication, behavior, activities, outside contacts, family contacts, and decubitis ulcers. New admissions and current residents were studied over 1 year and the changes in these quality-of-life-related indicators, controlling for case mix, were shown. The study shows the powerful potential for monitoring outcomes and establishing standards that this type of data—collected regularly—can provide.

Standard Instruments

The use of standard instruments increases the power of interpreting and using information for quality assurance purposes. Standard information is necessary to make comparisons across institutions, which can lead to industrywide reference standards against which nursing homes can be evaluated for quality assurance purposes.

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Such instruments are currently being used by some nursing homes and nursing home chains, and by state regulatory bodies.

Nursing homes and nursing home chains are increasingly using standardized instruments to collect resident information for the purpose of service determination, internal quality assurance, and rate setting. As mentioned earlier, the National Health Corporation has used such an instrument in its Patient Assessment Computerized (PAC) system for about a dozen years. The PAC data include sociodemographic, medical, functional, and social components as well as service needs in determining case mix. The data are obtained from every resident each month and entered into a computer file. The instrument is used in conjunction with the Management Minutes System, an algorithm that uses resident assessment data to calculate daily nursing time requirements for each resident. [97] PAC data can be used to establish the costs of care, resident charges, and to budget nursing labor. The data also can be used for various longitudinal analyses, including outcome-based quality-of-care measures. The PAC system is being used by Montana for its Medicaid case-mix reimbursement system.

A similar effort has been undertaken by the Hillhaven Foundation in the development and implementation of the Patient Care Profile (PCP) system.[82] This instrument includes 19 variables related to functional status and service needs that form the lowest common denominator of need for nursing care, regardless of the resident's medical diagnosis. The PCP is used to help determine initial placement in the nursing home and to set rates for private-pay residents. On the basis of assessment findings, residents are grouped according to service need and mental status to promote resident satisfaction and effective use of human and material resources. The PCP is also used as an internal quality assurance tool to assess the effects of care on residents' physical performance over time.

A range of research and demonstration projects has standardized case-mix instruments to establish service needs and costs of care. For example, in 1983 the New York State Department of Health initiated a major study to

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develop a case-mix reimbursement system for long-term care facilities. [81] The major objective was to develop a reimbursement methodology that matches residents' needs to services and resources. The system will also provide incentives for rehabilitation, discharge, and better outcomes for residents. The system is based on Resource Utilization Groups (RUGS II).[82] It uses a classification instrument that categorizes residents into groups, each of which is different in clinical terms and different in resource use. The system will be implemented on a statewide basis in 1986.

National, Regional, and Local Uses

Interpretation of information for quality assurance is clearly critical to efficient regulation of nursing homes. Information collected through federal demonstration projects being conducted by state regulatory agencies is currently being used to categorize nursing home residents on the basis of service needs and costs of care.

Most state-level case-mix systems collect information for purposes of reimbursement. The same or similar information can be used for quality assurance by comparing the services actually received and resident outcomes with those expected for residents in comparable case-mix groups. The "expected" outcomes are determined empirically by collecting longitudinal assessment data on large numbers of residents.

The interpretation of information along the lines described here can also be of great value when practiced by the administrators and staff of the nursing homes themselves:

- to monitor the quality of their own performance in providing care
- to track gains in productivity
- to review unexpected outcomes
- for planning and monitoring resource use to meet changing case-mix requirements.

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As noted earlier, nursing homes and nursing home chains have interpreted and used information about residents' characteristics and service needs for one or more of these purposes.

Such comparative statistical information about nursing home performance, developed from local, regional, or national sources, can also be useful to consumers by helping them to become better informed and, therefore, able to play a more effective role in the process of quality assurance.

QUALITY ASSURANCE AND THE REGULATORY SYSTEM

The current goals of federal regulation of nursing homes for quality assurance purposes are to ensure the safety of residents and the adequacy of their care. In practice, as used by most states and the federal government, the term "adequate" has been interpreted to mean "minimum" acceptable standards. This grew out of the original circumstances prevailing when the Medicare and Medicaid programs began. At that time, strict application of higher-quality standards would have made most existing nursing homes ineligible for certification. So two things were done: the proposed standards were lowered and the concept of "substantial compliance" was introduced to allow many homes to participate in the Medicare and Medicaid programs while they undertook the necessary actions to bring them into compliance with the minimum standards. This established a tradition of allowing inadequate facilities to continue operating while the state regulatory agencies exerted varying amounts of pressure to bring them into compliance. (See Appendix A.)

In the last 10-15 years, however, there has been sufficient experience to enable the setting of more ambitious regulatory goals. It is now feasible for federal and state governments to strengthen their regulatory criteria, inspection processes, and enforcement procedures so that the regulatory system can be expected to reliably detect and quickly eliminate nursing home care

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of unacceptably poor quality that occurs anywhere in the country. It also is reasonable to expect that better quality assurance capabilities should result in improvement in the level of performance of facilities that are providing only marginally adequate care. Many of these facilities are continuously in and out of compliance. The strengthened quality assurance criteria and procedures also are likely to exert a positive effect on all other facilities so that the level of performance of "average" nursing homes can be expected to improve. This would increase overall levels of quality of care and quality of life provided to most residents in most nursing homes throughout the country.

To achieve these goals, the current regulatory system will have to make major changes in quality assessment criteria, inspection techniques and procedures, information systems, and enforcement policies and procedures. Chapters 3, 4, and 5 examine the current regulatory system and recommend changes that are designed to provide it with the increased capabilities that are now possible.

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3

Regulatory Criteria

THE ISSUES

Government regulation of nursing homes for quality assurance purposes has three components: (1) the criteria used to determine whether a nursing home is providing care of acceptable quality in a safe and clean environment, (2) the procedures used to determine the extent to which nursing homes comply with the criteria, and (3) the procedures used to enforce compliance. The three components are like the legs of a three-legged stool: All are equally important. This chapter deals only with quality criteria. Chapters 4 and 5 discuss the other components.

Two sets of federal certification criteria for nursing homes currently exist: one for skilled nursing facilities (SNFs) and one for intermediate care facilities (ICFs). SNFs and ICFs are defined as being capable of providing different "levels" of care. SNFs are required to be staffed and equipped to provide more skilled nursing and rehabilitation services than are ICFs. The SNF criteria consist of 18 "conditions of participation" each of which contains one or more standards that must be met to comply with the condition. There are 90 SNF standards contained in the 18 conditions. The regulations containing these

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criteria were issued in final form in 1974 and have remained in effect, essentially unchanged, since then. The ICF criteria do not have conditions of participation. Originally issued in 1974, they contained 15 standards comprising numerous elements. Later that year, the ICF standards—with three additional standards added, bringing the total to 18—were incorporated in a survey form. In 1978 the HCFA published a new set of ICF regulations containing 46 standards. The 1978 version was intended to be substantively the same as the 1974 standards, but better organized and worded more clearly. Most of the new standards were not new; they were elements in the 1974 version. However, the HCFA did not publish a new survey form based on the 1978 regulations. Surveyors continue to use the 1974 form that contains the 1974 version of the regulations. (Both the SNF and ICF criteria are contained in Appendix B.)

Dissatisfaction with both sets of criteria was expressed publicly and repeatedly almost from the time they were issued. In general, providers, consumer advocates, and many state and federal regulators agreed that

1. the regulations do not require assessment of the quality of care being delivered; rather, they require assessment of the facility's structural capacity to provide care;
2. the survey process emphasizes paper compliance rather than observation and interviews with nursing home residents;
3. many of the standards are vague and depend too much on unguided judgments by surveyors, many of whom are untrained. Surveyor judgments are frequently inconsistent: what is deemed acceptable by one surveyor may be unacceptable to another.

These views were publicly voiced on numerous occasions by many people —most recently at the public meetings held by the committee in September 1984.

The committee is convinced that it is not sound policy to maintain two levels of care subject to two sets of quality assurance criteria. This is the first of the issues discussed below.

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The second issue is the conceptual basis of the criteria. They rest on the implicit assumption that the presence of the potential capability and written intent on the part of the facility to provide appropriate care is sufficient to ensure —for regulatory purposes—that care of adequate quality is being provided. A major reorientation of the conditions and standards is necessary so that they require, whenever possible, assessment of the quality and appropriateness of care and the quality of life—a consideration not covered in current standards—being provided to residents, and the effects on residents' well-being.

A third issue is the excessive reliance the current standards place on unguided professional judgments by surveyors in three areas: (1) what constitutes good care for residents with differing service needs, (2) how to interpret survey findings, and (3) how to weight or score facility performance on individual standards, and how to aggregate performance on individual standards to determine whether a facility is in compliance with a condition of participation. Elimination of professional judgment—and the inconsistencies that are inescapably associated with it—will never be possible, but some steps to introduce more objectivity and reliability into the regulatory system are possible.

CONSOLIDATING THE TWO SETS OF CRITERIA

The two classes of nursing homes—SNFs and ICFs—are supposed to serve residents with different "levels" of nursing and rehabilitative care needs. The regulations differentiate between the two groups in their capacity to provide services (for example, in the professional staff required) and in the eligibility criteria (services needed by the residents) set by the states. Despite these regulatory distinctions, the actual distinctions between SNFs and ICFs— in the variety of services provided, and in the mix of residents they admit with different distributions of disability and nursing care needs—is blurred. Both types of facilities are nursing homes providing a range of services to residents with widely

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varying service needs. (The history of the development of federal regulation of nursing homes, including the establishment of the two classes of nursing homes, is contained in Appendix A.)

SNFs are considered more medically oriented, as implied, for example, by the use of the term "patients" throughout the SNF regulations. The ICF regulations refer to "residents." SNFs are required to provide more nurse staffing —SNFs must have a nurse on duty 24 hours a day, whereas ICFs must have a nurse on duty only during each day-shift. In addition, SNF standards for other staff and for services provided are also more detailed and stricter than ICF requirements. The minimal requirements for each type of facility describe a broad range of facilities and range of intensity of service in both levels of care that overlap. Most nursing homes provide both nursing care and assistance with activities of daily living. Furthermore, the definitions of each, and especially of the ICF, leave a large amount of discretion to the states as to which facilities they will call SNFs and which ICFs, and which residents they will consider eligible for SNF or ICF care. The number of SNFs in a jurisdiction ranges from as few as 3 in the District of Columbia to as many as 1,148 in California, and the proportion of facilities that are classified SNF from 2 percent in Oklahoma to 100 percent in Arizona. The number of ICFs ranges from none in Arizona to 770 in Texas, and accounts for 98 percent of Oklahoma's facilities.[1] The Medicaid reimbursement rates for SNFs must, by law, be higher than for ICFs. If the rate difference is large, there is an incentive for states to control costs by licensing more ICF beds than SNF beds, irrespective of the distribution of residents' needs.

States have different licensing criteria for nursing homes. They are allowed, under the Medicaid law, to set their own eligibility criteria for admission of residents to SNFs and ICFs. States can have more stringent requirements for licensure and eligibility for admission than the federal regulations require. Examples of different licensing requirements can be found in Connecticut and Iowa. The homes in each state serve residents with a wide range of service needs. In

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Connecticut, about 90 percent of nursing homes are certified as SNFs. In Iowa, nearly all of the nursing homes are certified as ICFs. It is highly improbable that the reason there are mostly SNFs in Connecticut and mostly ICFs in Iowa is that the residents' requirements for services differ that much—that is, that they require, on the average, more skilled nursing care in Connecticut than they do in Iowa. The differences are more likely to be due to other factors such as the availability of chronic hospitals, state judgments on appropriate nurse staffing for nursing homes, and state attitudes about Medicaid funding.

It is hardly appropriate to apply different quality assurance criteria to SNFs and ICFs that are, or should be, providing similar services to similar residents. This will become even more important as the rapid population growth of those over age 75 increases the number of seriously disabled residents requiring "heavy care." The main difference between the SNF and ICF standards is the requirement for minimum numbers of licensed practical nurses and RNs. To raise the ICF nursing standards to the SNF level will require an increase in nurses in many homes. Since most of the care in nursing homes is provided by nurse's aides who have had relatively little training, and who tend, on the average, not to remain in the same job very long, it is essential that all nursing homes employ a sufficient number of licensed practical and registered nurses to properly supervise the aides at all times. In addition, professional nurses are needed to supervise resident assessments and to monitor delivery of resident health care and treatment.

In sum, the administrative distinctions between SNFs and ICFs do not in practice display clear differences in the residents they serve. Both kinds of facilities are nursing homes that admit and care for residents with wide ranges of disabilities and service needs. They therefore should be subject to the same quality assurance criteria and procedures. Since most of the care in nursing homes is provided by unlicensed nurse's aides who require careful supervision by licensed nurses, the SNF minimum staffing standards should be applied to all nursing homes.

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Recommendation 3-1: The regulatory distinction between SNFs and ICFs should be abolished. A single set of conditions of participation and standards should be used to certify all nursing homes. The current SNF conditions and standards, with the modifications and additions recommended below, should become the bases for new certifying criteria.

This is a recommendation that requires a change in the law. It may lead to increases in Medicaid budgets in several states because it will require increased RN and LPN staffing in many nursing homes in those states. (This is discussed more fully in the last section of this chapter.) Some time will be needed to implement this change in states with many ICFs. But whatever the transition problems, applying one set of regulatory standards to all nursing homes is essential if the goal is to achieve overall improvement in the quality of care being provided to nursing home residents. The nursing home industry has matured in the past 15 years. The shortage of nurses—advanced as one of the important reasons for creating ICFs—that may have existed some years ago has eased, in part as a result of sharp drops in hospital bed occupancy rates, and the consequent reductions in hospital employment. Moreover, a better understanding of what is required to provide high-quality care in nursing homes exists today than existed 15 years ago.

RESIDENT ASSESSMENT

Providing high-quality care requires careful assessment of each resident's functional, medical, mental, and psychosocial status upon admission, and reassessment periodically thereafter, with the changes in status noted. Current regulations do not require a standardized assessment of any kind, although the development of individual plans of care clearly depend on resident assessments. The outcomes of care are defined by changes in functional, medical, mental, and psychosocial status. As discussed in Chapter 2, much research over many years

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has developed successful techniques and instruments that can produce valid, reliable assessment data that can be used for these purposes. Moreover, it has been demonstrated that these instruments can be used reliably by LPNs who have been trained to use them, as well as RNs.

The resident assessment data have several very important uses both for facility management and for government regulatory agencies. For the facility, standard resident assessment data, obtained on admission and periodically thereafter, are an essential tool for quality-of-care purposes and for other management uses. A careful assessment of every resident is needed to formulate a care plan for that resident. Typically, the resident care plan contains information on physical and mental function, health risk factors, diagnoses, prognoses, short- and long-term goals, as well as key social history items. Periodic reassessment—for example, every month for the first 2 months after admission, and quarterly thereafter—is essential for two reasons: (1) to check on the resident's status changes, and (2) to see what, if any, modifications in the care plan should be made. The data can be used by management for two other purposes: (1) to provide very precise information on case mix in the nursing home, how it is changing, and how appropriately residents, staff, and other resources are—or should be—distributed in the home; and (2) to conduct longitudinal studies on quality of care, controlled for case mix. For example, problems in particular bed sections—possibly attributable to inadequate nursing care—could be identified promptly and steps taken to remedy them. One nursing home chain has been using similar data for over 10 years for monitoring the case mix, staffing, and the quality-of-care performance in its 50 nursing homes from its central office.[4]

Standard, longitudinal assessment data are also essential for four state regulatory functions: (1) for obtaining case-mix information in each nursing home for use in sampling for survey purposes (see Chapter 4), (2) for obtaining outcome information by examining longitudinal assessment data in resident records, (3) for utilization review to assure that residents meet the eligibility requirements of Medicaid or Medicare, and (4)

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for case-mix information needed for Medicaid payment (reimbursement) calculations (in states where case mix is used as a factor in Medicaid payment policy).

The standards for this condition should specify the items to be used in making the assessment, the qualifications of the staff authorized to do the assessing (for example, licensed nurses), the training they should receive before being authorized to do the assessments, how often assessments of each resident are required—for example, on admission, once a month for the first 2 months, once every 3 months thereafter, and at discharge. The standards should specify that these assessment records should be retained in the resident's medical record. Auditing by the state regulatory agency also should be covered in a standard, and acceptable error rates specified. Once the system has been in operation for some time, unacceptably high error rates by facilities should be viewed as indicators of inferior performance and subject to sanctions by the survey agency.

Introducing and phasing in this new set of requirements will take time. Several major steps are necessary. The assessment items will have to be selected. The assessment data should include (but not be limited to) medical problem identification (diagnoses), measures of physical function such as activities of daily living and mobility, and measures of mental and psychosocial functioning such as appropriate behavior, cognitive ability and depression. An operations manual will have to be written for the ultimate users—licensed nurses. Training programs and training materials will have to be developed. A major training effort will have to be initiated by the HCFA and continued by the states, possibly with the help of the state provider associations. All state nurse surveyors will need to be trained in collecting this standard data in a consistent manner since they will be responsible for auditing the facilities. Federal regional office surveyors also will have to be trained in addition to the thousands of facility staff. Auditing procedures and standards for the kinds and amounts of acceptable discrepancies between auditor's findings and facility data should be based on the findings of careful empirical studies.

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The requirement for nursing homes to do standard assessments of all residents should not be immediately coupled to a requirement that the data be entered into a computer file. Eventually, computer access will be essential to be able to use the data for some of the important purposes noted above. But it will take at least 2-3 years to get the manual system installed and used with acceptable accuracy by most nursing homes.

During the period that this system is being developed and installed, there will be an opportunity to undertake simultaneously a careful study of the policy and technical problems involved in computerizing resident assessment data, and to agree on the use of such data by state and federal governments. The product of such a study should be a specific plan for doing so. This is discussed in Chapter 7.

Recommendation 3-2: A new condition of participation on resident assessment should be added. It should require that in every certified facility a registered nurse who has received appropriate training for the purpose shall be responsible for seeing that accurate assessments of each resident are done upon admission, periodically, and whenever there is a change in resident status. The results should be recorded and retained in a standard format in the resident's medical record.

REVISING AND STRENGTHENING THE CONDITIONS AND STANDARDS

The conditions of participation were introduced by the Medicare law in 1965. SNFs must comply with them to be eligible for certification under Medicaid or Medicare. There are 18 SNF conditions governing the following areas: state licensing, governing body, medical direction, physician care, nursing, dietary, specialized rehabilitation, pharmacy, lab and x-ray, dental, social services, patient activities, medical records, transfer agreement, physical environment, infection control, disaster preparedness, and utilization review. If a

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skilled nursing facility is found to be out of compliance with one or more conditions, it is subject to decertification. This means the SNF is not eligible to receive payment for care provided to Medicaid- or Medicare-eligible residents.

The current SNF conditions and standards—which would, under our recommendation, become applicable to all nursing homes—need to be rewritten in accordance with the following principles:

1. Whenever appropriate, the criteria should address residents' needs and the effects of care on residents, and the performance of a facility in providing care rather than its capability to perform.
2. The criteria should be based on the best professional standards for providing high quality of care and quality of life to nursing home residents.
3. The criteria should be drafted clearly and with as much specificity as possible so that they can be understood by facilities, applied consistently by trained surveyors, and be legally enforceable.
4. The criteria should be internally consistent, logical, and comprehensive.
5. They should include physical, mental, and social functioning; nursing care; nutritional status; social services; physician care; psychological care; pharmacy; dental care; environment; residents' rights; emotional well-being; personal choice; satisfaction; and community interaction.
6. The criteria should be sensitive to each facility's case mix, that is, to the variations in the services required and outcome expectations for residents with different needs found in one facility.
7. The criteria should not be unnecessarily burdensome on facilities.

An examination of the conditions of participation using the above principles reveals the areas where improvements are needed.

First, the current conditions and standards focus on the facility's capacity to provide services rather than on the quality of services received by the residents and their

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effects on the residents. Most conditions and standards begin by stating "facilities will provide ... or facilities have policies to...." The conditions and standards need to be rewritten to state, "residents will receive ... appropriate to their needs (as documented in the resident's care plan)." The facility will still be held accountable for providing the services, but the surveyor should be concerned with how adequately the services were provided to the residents in accordance with their needs. That is, the emphasis should shift from facility capability to facility performance.

Second, the conditions do not consistently reflect current professional standards for long-term care in at least two respects: (1) they do not explicitly recognize the importance of quality of life, and (2) they do not require facilities to apply the state of the art in assessment and care planning. This is remediable by adding a new condition on quality of life and one requiring regular assessment of all residents. By use of longitudinal resident assessment data to develop statistics on outcomes of care controlled for case mix, objective outcome standards for assessing the quality of long-term care can be developed.

Third, a consistent criticism of the conditions is the vagueness of their language and lack of specificity compared to the licensing regulations in some states. The concept of the conditions—statements of broad requirements supported by detailed standards—is appropriate. The standards must be as precise and detailed as possible to be understandable to facilities, consistently applied, and enforceable by survey agencies. Terms such as "adequate" or "sufficient" are not precise, but they may not be entirely avoidable when there are no quantitative guidelines available. For example, the nursing condition requires "an organized nursing service with a sufficient number of qualified personnel to meet the total nursing needs" of the residents. Such a standard can be met through the exercise of professional judgment by facility staff. The facility's judgment may not be congruent with a surveyor's judgment, but the latter's judgment should rest in part on outcome assessments as well as observation of the workload of

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available staff. Until such time as quantitative standards become available—for example, a standard that relates residents' service needs to nurse staffing by mathematical algorithm—professional judgment will have to remain. Vague, unmodified terms should be eliminated from the regulations, but professional judgment, guided by general standards, must remain where quantification is not currently feasible. The results of these modifications should allow surveyors to apply the criteria with greater consistency.

Fourth, the criteria should be sensitive to all major domains of resident care as well as to differences in residents' characteristics and service needs (case mix). For example, among residents who are bed-bound, the extent to which decubitus ulcers are found is a strong indicator of quality of care. Bed-bound residents have other important service needs that should be checked by surveyors, for example, bedside activities programs. Bedside activities would be inappropriate for ambulatory residents who require different services.

Standards that require facilities to use large amounts of staff time for purposes that do not contribute significantly to resident safety or the quality of care or quality of life should be minimized. Requirements that may disrupt resident care services also should be limited or avoided. Providers have reported during public meetings that the survey process requires such extensive maintenance, review, and abstracting of medical records and other documents that they are sometimes forced to assign resident care staff to these clerical tasks even though it interferes with the facility's ability to provide provision of necessary care to residents.

Recommendation 3-3: The existing SNF conditions and standards should be rewritten in accordance with the above principles and made applicable to all nursing homes.

In addition to rewriting the current criteria in accordance with the above principles, some new conditions and standards are needed and some of the current conditions and standards should be restructured. Specifically,

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1. Two new conditions of participation should be added that deal with quality of life and quality of care.
2. Residents' rights should be raised from a standard to a condition of participation and some new residents' rights standards added.
3. Seven existing conditions of participation—governing body and management, utilization review, transfer agreement, disaster preparedness, medical direction, laboratory and radiological services, and medical records—should become standards in a new condition to be called "administration."
4. Five new standards should be added to the administration condition: one on training for nurse's aides and one banning discrimination on admission or retention of residents on the basis of source of payment, access, notification, and consumer participation.
5. Standards in the social service and physical environment conditions should be strengthened.

These recommendations are summarized in Table 3-1 and discussed separately below. Other existing criteria that address structural components remain as conditions of participation.

Quality of Life

A major weakness of the current regulations is that they do not address quality of life, despite its importance to the majority of nursing home residents (as discussed in Chapter 2). Certain key aspects of quality of life can be specified as regulatory standards, although there are difficult measurement problems. The importance of quality of life merits its being incorporated into the regulations as a condition of participation.

Recommendation 3-4: A new condition of participation concerning quality of life should be added to the certification regulations. The condition should state that residents shall be cared for in such a manner and in such an environment as will promote maintenance or enhancement of their quality of life without abridging the safety and rights of other residents.

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TABLE 3-1 Recommended Changes in Conditions of Participation

1. Resident Assessment (new)
2. Quality of Care (new)
3. Quality of Life (new)
4. Residents' Rights (new)
5. Administration (new). This would involve reducing the following conditions to standards and adding five new standards:
   - Governing body and management (II)*
   - Utilization review (XVIII)
   - Transfer agreement (XIV)
   - Disaster preparedness (XVII)
   - Medical direction (III)
   - Laboratory and radiological services (IX)
   - Medical records (XIII)
   - Nurse's aide training (new)
   - Access (new)
   - Medicaid discrimination (new)
   - Notification (new)
   - Consumer participation (new)

The following would remain as conditions but require modification:

6. Nursing services (V)
7. Dietetic services (VI)
8. Physician services (IV)
9. Specialized rehabilitative services (VII)
10. Resident activities (XII)
11. Social services (XI) (strengthen)
12. Dental services (X)
13. Pharmaceutical services (VIII)
14. Infection control (XVI)
15. Physical environment (XV) (strengthen)
16. Compliance with federal, state, and local laws (I)

* Roman numerals refer to the number of the condition of participation in the current federal regulations.

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Some standards that should be included under this condition are—

1. Residents should have a supportive, comfortable, home-like environment.
2. Residents should have choice over their surroundings, schedules, health care, and activities.
3. Residents should be treated with dignity and respect.
4. Residents should have opportunities to interact with members of the community inside and outside the nursing home.

Quality of Care

At present, the conditions of participation relating to care are disciplinary: there is a nursing condition, a social service condition, dietary condition, and so on. But much of the care actually provided has multidisciplinary involvement. Thus, in reorienting the approach of regulation to give more emphasis to the care being provided and its effects on the residents, a new quality-of-care condition is needed that has both process and outcome standards.

The standards for the quality-of-care condition should identify desirable resident outcomes of care processes in functional status, physical well-being and safety, emotional well-being, social involvement and participation, cognitive functioning, and resident satisfaction. Examples of outcome standards are: each resident is clean, dressed, has well-trimmed nails, and is well-groomed; each resident maintains physical functioning. Examples of process standards are: each resident is protected from accidents, injury, and infection; each resident has daily activities and exercise; each resident has social interactions throughout each day with staff members and other residents; each resident has mental stimulation, reality orientation, emotional support, and other psychological supports.

Specifying desired processes and outcomes is important because it focuses on the purpose of nursing home care.

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Assessing the relationship between the quality of care provided and a particular outcome is not always easy in the absence of case-mix-controlled outcome data. Until such data become available, continued reliance on professional judgment will be necessary. Introduction of the resident assessment data system recommended below will make it possible to produce, in a few years, the data required for defining the ranges of outcomes. As quantitative outcome data become available, the standards in this condition should be updated.

Outcomes can be negative or positive. Negative outcomes are those that should not occur except in circumstances where a resident's medical and physical condition makes the outcome difficult or impossible to avoid. Negative outcomes include cognitive impairment or other side effects from overmedication; decubitus ulcers; upper respiratory, urinary tract, or other infections; urinary incontinence; dehydration; malnutrition; contractures; unnecessary physical restraints and immobility; social isolation; and physical inactivity. The standards should specify the negative outcomes to be avoided. For example: "Each resident should receive skin care that promotes health and prevents decubitus ulcers and skin breakdown due to pressure and/or friction." This standard is based upon the principle that good skin care can prevent skin breakdown except in unusual circumstances where a preexisting medical condition such as diabetes causes circulatory problems that make skin breakdowns a common occurrence. Decubitus ulcers (bedsores) are generally considered an indicator of poor-quality care.[2,3] Protocols have been developed for identifying and measuring the severity of such skin breakdowns, and it can be determined whether care by the facility is improving the problem, maintaining an existing condition, or allowing the resident's condition to deteriorate. Positive outcomes are, for the most part, the obverse of the negative outcomes—for example, no decubitus ulcers among bed-bound residents, resident satisfaction with food and care, and so on. The importance of resident outcomes and process of care merits their inclusion in a new condition of participation.

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Recommendation 3-5: A new condition of participation on quality of care should be added to the certification regulations. It should state that each resident is to receive high-quality care to meet individual physical, mental, and psychosocial needs. The care should be designed to maintain or improve the residents' physical, mental, and emotional well-being.

Residents' Rights

As discussed in Chapter 2, residents who receive good personalized care and opportunities for choice have higher morale, greater life satisfaction, and better adjustment. Research has shown that morale and activity are linked to physical health, and perception of social isolation is associated with premature death. Residents who have the information necessary to solve problems are better able to cooperate with both nursing home staff and state surveyors.[5] These factors underly the importance of ensuring every resident's right to receive necessary information, to be given reasonable choices, and to be treated with dignity.

Although residents' rights are incorporated in a standard in the current regulations, at the committee's public meetings and at its special workshop on consumer issues (December 1984), the testimony of consumers, consumer advocates, and regulators cited numerous instances and patterns of serious rights violations. Many agreed that the ambiguity of elements in the current residents' rights standard is such that both residents' entitlements and facilities' obligations are unclear. The ambiguity hampers enforcement. The likelihood of improving facility performance and also of improving enforcement by the state regulatory agencies will be increased by (1) raising residents' rights to a condition of participation from its current status as 1 of 13 standards under the "governing body and management" condition of participation, and (2) clarifying the language of several enumerated rights and adding some that experience has demonstrated to be necessary.

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Testimony at the public meetings and consumer issues workshop identified the particular topic areas where clarified, expanded, or additional standards are warranted. These are the rights to information (about community services, about one's medical condition, and about one's medical records), rights to notice and assistance in transfer or discharge, and rights of association. The enumerated rights set forth below are reasonable to expect all facilities to honor. They have been observed in many high-quality facilities for some time.

Recommendation 3-6: The existing standard on residents' rights should be made into a condition of participation. The condition should state that every resident has certain civil and personal legal rights that must be honored by the staff of the facility. Rights specified in this condition, as they pertain to a resident who has been adjudicated incompetent in accordance with state law, shall devolve to the resident's guardian, or, if required by the state, a responsible party. In cases where the attending physician determines that a legally competent resident is incapable of exercising a right, the conditions and circumstances shall be fully documented in the medical record and shall devolve to a responsible party. The following standards should be added to the residents rights' condition:

- *a.* *All residents admitted to the facility shall be told that there are legal rights for their protection during their stay at the facility and that these are described in an accompanying written statement. Reasonable arrangements shall be made for those who speak a language other than English. At such time as the rights set forth in this condition are revised, residents shall be given the updated information. Further explanation of the written statement of rights shall be available to residents and their visitors upon reasonable request to the administrator or other designated staff person.*
- *b.* *Each resident has the right to know the name, address, and phone number of the state survey office, state or local nursing home ombudsman office, and state or*

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local legal service office. The facility shall post such information in a location accessible to residents and visitors.

c. *Each resident has a right to see written facility policies. Facilities shall make policies available on request. Facilities shall post state survey reports and plans of correction in a location accessible to residents.*

d. *Each resident may inspect his/her medical and social records upon request to the facility. The resident may request and receive copies of the records at a photocopying cost not exceeding the amount customarily charged in the facility's community for similar services.* (This overrides state law and/or regulations if they are in conflict.)

e. *Each resident must receive prior notice of transfer, discharge, and lapse of bed-hold periods. The facility must notify the resident, resident's representative, and attending physician in writing*

(1) *at least 3 clays prior to the lapse of bed-hold periods*,
(2) *at least 3 days prior to intrafacility transfer*,
(3) *at least 4 clays prior to discharge from the facility except as specified in documented emergencies.*

The notice must contain the reason for the proposed transfer, the effective date, the location to which the facility proposes to transfer the resident, a statement that the resident may contest the proposed action, and the address and telephone number of the state or local nursing home ombudsman.

f. *Each resident, along with his/her family has the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated responsible for providing this assistance and for responding to written requests that result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.*

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g. *Each resident has the right to meet with visitors and participate in social, religious, and political activities at their discretion so long as the activities do not infringe on the rights of other residents. This includes the right to join others within and outside the facility to work for improvement in long-term care. The facility must permit each resident to receive visitors and associate freely inside or outside of the facility with persons and groups on the resident's own initiative. Visitors must be granted access to residents. The residents, however, have the right to refuse or terminate any visit.*

Administration

According to the HCFA, the following seven conditions of participation are rarely cited as the reason for a nursing home being out of compliance:

- Governing body and management
- Utilization review
- Transfer agreements
- Disaster preparedness
- Medical direction
- Laboratory and radiological services
- Medical records

Determining whether a facility is in compliance with these conditions involves review of documents such as organization charts, contracts, disaster plans, and medical records. To simplify the survey process, these seven conditions should be grouped together under a new condition of participation entitled, "Administration."

Recommendation 3-7: A new condition of participation entitled "Administration" should be established. The following current conditions of participation should be reclassified as standards under this new condition: governing body and management, utilization review, transfer agreements, disaster preparedness, medical

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direction, laboratory and radiological services, and medical records.

Consolidating seven existing conditions into one administration condition will give more relative emphasis to resident quality-of-life and quality-of-care issues. In the process of rewriting the seven conditions as standards, two items should be eliminated because they are examples of paperwork requirements that do not seem to serve any regulatory function: the standard on institutional planning and the requirement for routine submission of quarterly staffing reports. Staffing records may be examined if resident care problems suggest insufficient numbers of staff, but submission every 3 months to survey agencies is unnecessarily burdensome to facilities, and the reports are almost never used by the regulatory agencies.

Recommendation 3-7 A: The current requirements for institutional planning and submission of quarterly staffing reports should be eliminated in drafting the new administration condition.

Several new standards should be added to the administration condition to strengthen it. These specify requirements for training nurse's aides, discrimination, legal access to facilities by ombudsmen, and resident participation in facility decision-making. In addition, the current standard (notification of changes in patient status) under the governing body and management condition should be modified to deal more clearly with the problem of the incompetent resident who has not been legally adjudicated as being incompetent.

Training of Nurse's Aides

There are now no federal requirements concerning qualifications of nurse's aides. In most states, nurse's aides occupy entry-level positions that have no experience or formal educational or training requirements. Over 70

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percent of the nursing personnel in long-term care facilities are nurse's aides[6] and as much as 90 percent of the resident care in nursing homes is delivered by them. Current federal regulations allow nurse's aides to deliver all resident care in ICFs without the supervision of a registered, licensed, or vocational nurse from 3 p.m. to 7 a.m. every day.

Nurse's aides usually are not experienced or adequately trained for their jobs, in some places many speak English poorly, and they often are new to the job as well. A Minnesota study found that 45 percent of the nurse's aides left their jobs within the first 3 months of employment and another 30 percent left within the first year.[7] Another study found that 70 percent left within the first 6 months.[6] Studies of the causes of the high attrition rate of nurse's aides have mentioned lack of respect from management, lack of autonomy, lack of job mobility, and low pay.[6-11]

Seventeen states have mandated training programs for nurse's aides. Other training models have been developed by consultants to the federal government, by universities, and by facilities.[6] States' training requirements range from as much as 50 classroom hours and 100 clinical hours of training for aides in California, to as few as 20 total hours in Nebraska. A majority of the states have no specific training requirements. Existing state programs follow no consistent educational model in content, goal, or organization. In many, the essential relationship between perceived training needs and on-the-job experience is riot present. Given the number of nurse's aides, and the importance of their role, training of nurse's aides prior to employment in the long-term facility should be federally mandated.

Nursing homes or other potential employers could arrange and pay for the training program for a newly hired aide. This would not put undue financial burden on the potential aide and may in fact screen out potentially unsatisfactory aides prior to their being given resident care responsibilities. There is no clear evidence at present of the amount of time and the content of the most effective nurse's aide training programs. This an important issue on which the HCFA should sponsor study.

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In addition to preservice training, continuing on-the-job training by qualified supervisors is essential. A nurse-supervisor should be in all facilities on all shifts. Nurse's aides should be able to consult with a professional nurse while on the job. Considering the current trend of increasing numbers of residents who require substantial amounts of nursing care, aides must be trained and supervised. Improvements in aide training and job responsibility will help to improve nursing aide skills, elevate their self-esteem, improve resident care and, perhaps, decrease nurse's aide attrition rates as well.

Recommendation 3-7 B: A new standard, nurse's aide training, should be added to the administration condition. The standard should require that all nurse's aides complete a preservice state-approved training program in a state-accredited institution such as a community college.

Discrimination

There is widespread evidence that nursing homes actively discriminate against certain types of individuals. The two groups most at risk appear to be those individuals with "heavy care" needs and those whose primary source of payment is Medicaid. The evidence of this discrimination is very strong. As the U.S. Senate Special Committee on Aging[12] reported,

> Findings of a recent committee investigation show that in some areas of this country, up to 80 percent of what are called federally certified nursing homes (that is, those that voluntarily participate in the Medicare and/or Medicaid programs) are reported to actively discriminate against Medicaid beneficiaries in their admission practices.

In addition, several other studies demonstrate that discrimination and limited access to nursing home services are particularly acute problems for Medicaid patients and

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those individuals with heavy-care needs.[13-19] The National Summary of State Nursing Home Ombudsman Reports for the United States (FY 1982) stated that discrimination against Medicaid recipients or potential Medicaid recipients was identified as a major problem in 21 states and was the fourth most frequently mentioned problem out of 74 problems cited by the ombudsmen programs. The General Accounting Office[20] summarized 11 studies conducted since 1979 and concluded that severe access problems and discrimination were occurring on the basis of resident "handicap." Individuals who required especially heavy care or substantial hands-on care, such as those suffering from Alzheimer's disease and other related disorders, experienced access problems and were often in hospitals awaiting nursing home placement even when there were empty nursing home beds in the community. The nursing homes simply refused to admit these residents. The U.S. Senate Special Committee on Aging reports similar problems—as well as a variety of illegal discriminatory practices—by nursing homes.[12]

The committee also heard about such practices in testimony at the public meetings it held around the country in 1984. State reports and empirical studies substantiate this finding of discrimination against Medicaid beneficiaries and against those with heavy-care needs. Nearly all observers agree that in almost every state there are more people seeking admission to nursing homes than there are beds available. This circumstance allows a nursing home administrator to select those applicants in the queue he or she prefers to admit. Nursing homes prefer to admit private-pay residents over public-pay residents because the Medicaid reimbursement rates are lower than charges to private-pay residents. Further, except in states that have ease-mix reimbursement systems, homes have an incentive to select residents with relatively low levels of need over the heavy-care residents because those requiring less service are less costly to care for. This is of particular concern because of the expected growth in heavy-care residents and because

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the vast majority of individuals needing long-term care will rely on Medicaid for assistance in paying for that care. Currently, two-thirds of all middle-income residents in nursing homes spend their life savings within 2 years of admission and become Medicaid-eligible.

It is recognized that there are many complex and interrelated factors at work in the nursing home market that may contribute to discrimination. The committee's concern is to identify policies that may reduce or eliminate discrimination that strikes at those most vulnerable—the poorest and most disabled.

Congress intended that the disabled should be protected from discrimination in admission practices. The 1974 amendments to section 504 of the Rehabilitation Act makes such discrimination illegal. It is also recognized that a nursing home administrator cannot responsibly admit more heavy-care residents than can be cared for properly. The incentive to discriminate against heavy-care residents is strengthened by reimbursement systems that set Medicaid rates without taking into account the differences in amounts of services required by individual residents to meet their care needs. In some cases, the Medicaid rate may be too low for nursing homes to provide adequate care for certain individuals, but in all cases a rate that is the same for light-care residents as for heavy-care residents provides nursing homes with a strong incentive to discriminate.

Discrimination against individuals who receive assistance from Medicaid in paying for care poses complex questions. Such discrimination appears in several forms. Some nursing homes maintain separate waiting lists—one for private-pay residents and another for Medicaid residents—and give preference in admission to those individuals on the private-pay list. Another discriminatory practice is to require residents to remain in private-pay status for a specified period of time before the home will allow them to apply for Medicaid support. Still another practice followed by some nursing homes is to evict residents once they have exhausted their private funds and become eligible for Medicaid. Some residents have successfully challenged transfers out of facilities, but this is a time-consuming and inefficient

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way to enforce such rights, and it has not led to widespread changes in facility practices.[15]

The problem of discrimination against Medicaid recipients is further complicated by the phenomenon of residents spending down to Medicaid eligibility. Most nursing home residents whose care is covered by Medicaid will have originally entered the facility as private-pay residents. Conversely, most private-pay residents can be expected to spend down to Medicaid eligibility.

There is no simple solution to this problem. Because a seller's market exists in most states, increasing the Medicaid rate probably also would increase the private-pay rate. Increasing Medicaid rates also increases the speed with which private-pay residents spend down to Medicaid eligibility. Nor would increasing the bed supply necessarily eliminate the problem of Medicaid discrimination in its various forms. Increased bed supply would make more nursing home beds available to Medicaid residents, but it would not ensure their ability to enter the facility of their choice on an equal basis with private-pay residents. Separate waiting lists, forced discharges, and contracts stipulating a fixed period of private-pay status could still occur. Such discrimination should not occur in facilities that have chosen to participate in government programs. Discrimination against Medicaid recipients should not be permitted in certified facilities.

A few states have adopted laws to reduce or eliminate discrimination on the basis of source of payment. These states include Minnesota, Ohio, Washington, and New York. New Jersey requires a certified nursing home to allow up to a specified percent of its beds to be occupied by Medicaid residents. There is no known evidence of the effectiveness of these laws. The HCFA should analyze the experience in these states and develop federal criteria based on one or more of these state laws.

In developing antidiscrimination legislation, care should be taken to ensure that facilities are not permitted to avoid compliance by certifying different segments of the same institutions in different ways ("distinct part" certification).

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Recommendation 3-7 C: A new standard should be written under the administration condition that prohibits facilities that have signed a Medicaid Provider Agreement from having different standards of admission, transfer, discharge, and service for individuals on the basis of sources of payment.

Notification

Many nursing home residents have strong feelings of personal isolation despite the group-living situation.[5] These feelings are reinforced by the failure of facilities to notify residents' families about significant changes in a resident's status, failure to provide residents with a way to express opinions about aspects of the home's operation, and obstacles to community access. These problems should be addressed in specific standards in the administration condition.

Notification of those who might assist the resident when changes occur is now required by standard (j) under the governing body and management condition. It reads as follows:

> (j) Standard: Notification of changes in patient status. The facility has appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of an accident involving the patient, or other significant change in the patient's physical, mental, or emotional status, or patient charges, billings, and related administrative matters. Except in a medical emergency, a patient is not transferred or discharged, nor is treatment altered radically, without consultation with the patient or, if he is incompetent, without prior notification of next of kin or sponsor.

Recommendation 3-7 D: When the governing body and management condition is rewritten and incorporated in the

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new administration condition, the current standard "j" should be changed to require the facility to record at admission and periodically confirm or update the identity of a guardian, conservator, or resident's representative to be notified in the event of (1) care conferences; (2) changes in the resident's physical, mental, or emotional status; (3) an accident involving the resident; (4) change in billing; (5) change of room; (6) discharge from the facility; or (7) changes in federal or state residents' rights. Notification should be timely.

Participation

Residents' rights to associate and express concerns should have an analog in the administration condition, one that obligates the nursing home to be receptive to regular, reasonable expression of views. The recommendation below recognizes the diversity of resident capabilities and administrative styles while fostering communication. It reflects current policy and practice in many facilities and is encouraged by the national nursing home trade associations and consumer organizations.

Recommendation 3-7 E: A new standard should be added to the administration condition that would require every facility to develop and implement a plan for regular resident participation in decision-making in the facility's operations and policies and for presentation of resident concerns. Forms of resident participation can include, but are not limited to, resident councils, regularly scheduled resident forums, resident issue or program committees, and grievance committees. Facilities should include existing resident councils and/or other resident representatives in developing this plan.

Access

Local area ombudsmen and other community volunteers are denied access to some nursing homes in some areas despite

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the demonstrated benefits of community presence in nursing homes.[21,22] Some local nursing home ombudsmen have been hampered in their response to residents' requests for assistance because they have been refused entry to the facility and/or access to the residents' records that are germane to the problem.[23] Given the long-term-care ombudsman's statutory role in handling complaints and serving as an advocate on behalf of residents (see Chapter 6), and in the process complementing the work of the state survey agency, it is essential that local ombudsmen have legal access to nursing homes. This authority should be clear both in the Older Americans Act (see Chapter 6) and in the HCFA's certification standards. It also is unreasonable to permit some facilities to isolate residents from contacts with community volunteers who can provide legal or social services to them.

Recommendation 3-7 F: Two new elements should be added to the governing body and management standard as follows:

a. *Certified nursing homes should be required to permit access to the homes by an ombudsman (whether volunteer or paid) who has been certified by the state. With permission of a resident or legal guardian, a certified ombudsman should be allowed to examine the resident's records maintained by the nursing home.*
b. *Any authorized employee or agent of a public agency, or any authorized representative of a community legal services organization, or any authorized member of a nonprofit community support agency that provides health or social services to nursing home residents should be permitted access at reasonable hours to any individual resident of any nursing home.*

Physical Environment

Older individuals are much more sensitive to changes in temperature. They have a lower tolerance for cold and heat and easily suffer from hypothermia and hyperthermia. Thus, nursing home temperatures should be carefully monitored. The comfort of staff also is important because

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it affects quality of care. The current standards are too vague to assure that the temperatures are carefully controlled; they should be strengthened. But since retrofitting changes in the heating, ventilation, and air-conditioning systems in a nursing home can be very expensive, the recommended standard could be waived for older facilities if it would result in undue hardship.

Recommendation 3-8: Standard 5, "Other Environmental Considerations" in the Physical Environment Condition currently reads "...provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature ...." It should be amended to add, at this point, "that is within acceptable ranges of operative temperature and humidity for persons clothed in typical summer or winter clothing at light, mainly sedentary activities, as specified in the ANSI-ASHRAE Standard 55-1981." This is the standard prescribed by the nationally recognized American National Standards Institute. Waivers may be granted for existing facilities until such time as substantial renovation takes place.

NOTE ON STAFFING STANDARDS

General

Many types of professional services are required to formulate care plans and to provide high-quality care to meet the needs of the nursing home population. Physicians, dentists, podiatrists, speech therapists, physical therapists, occupational therapists, dietitians, and activities directors are needed in addition to nurses, social workers, and administrators. The heterogeneity of the residents and their service needs makes it inappropriate to prescribe detailed staffing standards for each of these disciplines. The major recommendations earlier in this chapter to shift the regulatory emphasis from structural to outcome orientation has an implication for staffing; namely, that every nursing home should be obligated to provide its residents with the full range of

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services they need to meet the standards in the new quality-of-care and quality-of-life conditions. This will require sufficient staff—both numbers and types of professionals—to meet the needs of the residents in each home. All professionals should be trained in geriatrics and gerontology. Special efforts are needed to ensure that adequate physician services are provided to residents even though physicians—except for a part-time medical director—are not on the staff of nursing homes.

The committee did not examine the staffing standards pertaining to all types of staff and for most does not recommend any changes. However, it did look at social services and nursing.

Social Services

The current social services condition of participation is weak. It requires a designated person to be responsible for social services in each nursing home, and consultation from a social worker with an MSW degree when the designee is not so qualified. Reliance on this weak requirement has produced uneven results at best. Studies in various parts of the country show that many facilities have a bare minimum of social services—that is, they hire an MSW for 4 hours per month of consultation and appoint designees who are less than full-time and have little professional or even general education. Studies of the consultant role have shown how difficult it is for a nursing home consultant to design a social work program, develop procedures for a socially and psychologically sensitive environment, train and supervise social service designees, and design and conduct in-service training for all nursing home staff, given the minimal time allotted to their role and their negligible authority as a consultant.[24-26]

A full-time social worker with at least minimum professional credentials will be needed to help implement several of the recommendations contained earlier in this chapter, especially the new quality-of-life condition and the emphasis on resident outcomes. The latter implies that facilities will be held responsible for residents'

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well-being, including social and emotional aspects as well as physical.

Social services in nursing homes can be effective in promoting a satisfactory quality of life and in improving social and psychological outcomes.[27-30] Such programs develop interventions directed at the well-being of individual residents or subgroups of residents (for example, individual counseling to alleviate depression, counseling with the terminally ill, individual or group life review projects, orientation programs for new residents and their families). A social service program should be designed in collaboration with an activities program so that the social worker's knowledge of community resources can help residents take advantage of agencies and programs in the community that offer social, mental health, legal, educational, recreational, and spiritual affiliations. The social worker's function in a nursing home also should include training and assisting staff to positively influence residents' psychological and social states. One model program in a number of nursing homes also encouraged social workers to assist nursing staff in dealing with their own stress-induced family and personal problems, which in turn allowed those staff to be more comforting and supportive of residents.[29]

Recommendation 3-9: The present social services condition should be changed to require that each facility with 100 beds or more be required to employ at least one full-time social worker. Qualifications for this position should be a bachelor's degree in social work, a master's degree in social work, or some equivalent degree in an applied human service field at the bachelor's level or higher as approved by the state. Facilities with fewer than 100 beds or those in rural areas that have made a good-faith effort and have been unable to recruit a qualified social worker with the required credentials may substitute a contractual arrangement with a community agency or with an independent social work consultant. However, the HCFA should establish a minimum level of effort for social services in exempted facilities—for example, one day of consultation per week.

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Licensed and Registered Nurses

One of the major factors affecting quality of care and quality of life in nursing homes is the number and quality of nursing staff in relation to the facility's requirements. Greater numbers of nurses have been associated with improved resident outcomes in research studies. But many nursing homes still rely largely on untrained and unlicensed nursing personnel to provide most of the care, with very few professional or licensed practical nurses to supervise them.[31-33] Moreover, most professional nurses in nursing homes have had little or no formal training in gerontology and long-term care. Staffing patterns vary across facilities, regions, and states, but for the most part there are inadequate numbers of nurses to provide the minimum care needed. Further, the wages for nurses and nurse's aides are substantially below wages for comparable positions in hospitals. Poor working conditions combined with heavy resident workloads and inadequate training are all factors that contribute to poor quality of care and high turnover rates in some facilities. Although there has not been extensive research on staffing patterns, there is little doubt that qualified nursing personnel are one of the most important factors affecting high quality of care.

Federal SNF certification regulations require registered nurses to act as directors of nursing. Licensed practical or registered nurses may act as charge nurses. Nursing homes currently have roughly equal numbers of registered nurses and licensed practical or vocational nurses working in long-term care facilities. About 15 percent of the nursing personnel in the nation's nursing homes are registered nurses, 14 percent are licensed practical nurses, and 71 percent are nurse's aides. "Aides ... provide six times as much care in nursing homes as do registered nurses, and five times as much care as do licensed practical nurses."[6]

On the assumption that adequate staffing improves quality of care, many states have adopted stricter nursing requirements, in the form of nurse-to-resident ratios, to supplement the federal regulations. These ratios range

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from as little as 0.4 nursing hour per resident-day to as many as 4.0 hours.

There is a 4-fold variation in beds per licensed nurse, from 4.5 in Alaska to 18.8 in Oklahoma. The variation in RN/LPN ratio among the states is 9-fold, from 0.2 in Texas to 1.9 in New Hampshire.

Some states also set more specific duties for the director of nursing, such as planning staff development, setting nurse practice standards and resident care policies, assessing resident needs, and recommending staff ratios. Facilities in each of these states must meet the state's staffing requirements to be licensed. And homes must be licensed in order to be certified. Most state standards do not distinguish between professional and nonprofessional nursing. However, they do set a measurable standard for the amount of nursing care required in homes according to the number of residents.

There is evidence that many homes staff above minimal state requirements where requirements are low.[34] Some individual homes and chains of nursing homes have also adopted methods for determining necessary nurse staffing that exceed state standards.[4,35]

Because of the complexities of case mix—that is, the widely differing needs of individual residents in the same facility—prescribing simple staffing ratios clearly is inappropriate. Although algorithms have been developed to estimate amounts of nursing time needed by residents that are based on functional assessment scores and requirements for special care needs, insufficient evidence of the validity and reliability of the algorithms is available. Until standardized resident assessment data become generally available, and some careful empirical studies have been completed, prescribing sophisticated staffing standards in the regulations will not be possible. However, the committee is convinced that minimums for professional supervision of the nurse's aides who provide most of the care are too low, not only in ICFs, but also in SNFs. Most good nursing homes now exceed these minimums, often by a considerable margin. If the case mix in a given nursing home, or a given bed section in a nursing home, is such that more licensed nurses are required to provide proper care to the residents, the

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nursing home should be required to provide it. Further, the committee believes that as the case mix moves toward a larger proportion of heavy-care residents, the minimum requirements should be raised to increasingly higher levels.

Increasing staffing may cause some problems initially, but the committee believes that the benefits to the residents of increasing the ratio of better-trained staff far outweigh the costs of increased staffing. *To this extent, nursing homes should place their highest priority on the recruitment, retention, and support of adequate numbers of professional nurses who are trained in gerontology and geriatrics to ensure an adequate number and appropriate mix of professional and nonprofessional nursing personnel to meet the needs of all types of residents in each facility*.

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4

Monitoring Nursing Home Performance

THE ISSUES

The federal and state governments share responsibility for quality assurance in nursing homes. The performance criteria are federal, but the federal government has delegated to the states responsibility to inspect nursing homes using these criteria and to certify their eligibility to participate in the Medicaid program. For the Medicare program, state governments inspect the facilities on behalf of the federal government and make certification recommendations to the federal government; the certification decisions are made by the HCFA. The federal government has authority in both the Medicaid and Medicare programs to conduct independent inspections of certified nursing homes to audit the states' certification activities. The federal government also can decertify substandard facilities.

The federal conditions and standards were designed for use by state surveyors in inspecting nursing homes. The survey process is supposed to identify and measure performance deficiencies that result in poor-quality care and should produce documentation of the deficiencies that will support the government's case in contested enforcement actions.

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State monitoring of the performance of nursing homes now includes three types of activities:

1. Nursing home inspections (surveys) are conducted at least once a year by staff of the state health facilities licensure and certification agency to determine the extent of compliance of facilities with federal conditions and standards.
2. "Inspection of care" (IOC) is conducted either by the state Medicaid agency, the state health facilities licensure and certification agency, or a professional review organization. By law, inspection of the 'care provided to every Medicaid recipient must be done annually. It is conducted for two purposes: (1) utilization review, to be certain that the resident is eligible for nursing home care and is placed in the right level of care; and (2) quality of care, to be sure each resident is receiving appropriate care of adequate quality.
3. *Ad hoc* complaints submitted by residents, their families, or ombudsmen or other third parties are also investigated. Complaints frequently concern possible violations of federal conditions and standards or other regulatory requirements.

Monitoring the performance of thousands of nursing homes for quality assurance purposes has been difficult to carry out effectively and reliably. The first set of problems stems from the inadequacies of the criteria and of the survey process used to determine the quality of care being provided. The problems with the current criteria are discussed in Chapter 3 and major changes are recommended to make them more resident-centered and outcome-oriented. The first set of issues discussed in this chapter covers the inadequacies of the current survey process. Changes are recommended that follow from the new conditions and standards recommended in Chapter 3.

A second set of issues concerns federal-state and intrastate role relationships. Four specific issues are discussed: the relationship of inspection of care to the survey process, the relationships of the survey process to

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the long-term-care ombudsman program, the elimination of the differences in federal and state certification responsibilities for Medicare and Medicaid facilities, and shifts in the responsibility for surveying state-owned facilities.

The third set of issues deals with both state and federal capacity for effectively carrying out their quality assurance responsibilities. These issues include funding of federal and state survey units and the numbers, qualifications, and training of surveyors.

PROBLEMS WITH THE SURVEY PROCESS

The survey process has several problems that should be addressed to make it more effective: predictability, inefficiency, emphasis on paper compliance, insensitivity to resident needs, inconsistency, isolation from related monitoring processes, and variable state regulatory capacity.

Predictability

If the operators of a substandard facility know when it will be surveyed, they not only can clean it up and bring the records up to date, but they also may stock up, improve the menus, bring in additional personnel, and take other actions to bring the facility into temporary compliance. The committee heard anecdotal accounts in the public meetings and in case-study interviews of facilities being notified about impending survey visits. Prior notice, either formal or informal, was the policy in some states because it made the visit easier by ensuring the presence of key personnel in the facility. Prior notice was prohibited by the HCFA several years ago, but a few states apparently still follow this policy.

Even without direct notice, however, providers often can predict the timing of an annual survey visit within several weeks because certification lasts exactly 12 months and an annual survey is required by the regulations

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at least 90 days before certification expires. The case studies found that some states routinely schedule visits during the same week each year. Others send in a team of auditors or the state fire marshal a specified number of weeks before the survey visit.

Inefficiency

All nursing homes are subjected to the same survey intensity regardless of their past record of compliance. Most state survey agencies have very limited budgets. They barely have enough staff to complete the round of annual required surveys and do not always have enough surveyors to follow up adequately on the major problem facilities. A more efficient survey process would permit them to spend more time in poor facilities and less time in good facilities.

Paper Compliance

Not only are the current standards focused on theoretical facility capability rather than actual performance, but compliance is often determined on the basis of record reviews rather than direct observation.[1,2]

Insensitivity to Resident Needs

Nursing home residents have widely varying needs and some facilities specialize, either formally or informally, by accepting residents only of a particular type. The severely demented and those requiring active rehabilitation are two groups of residents often cared for in separate facilities or on separate floors. The existing survey process makes no allowance for the observed diversity among patients and across facilities. At present, all SNFs are surveyed in the same manner; the same is true for all ICFs with the exception of

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intermediate care facilities for the mentally retarded, which are subject to a different set of standards.

Inconsistency

The case studies and survey of state licensure and certification agencies conducted by the committee revealed great variations among the states in the way they carry out the survey process. HCFA data show wide variations in the numbers and types of deficiencies typically cited from state to state. For example, the proportion of a state's SNFs having more than 25 deficiencies in 1983 ranged from 0 in Delaware to 100 percent in Washington, D.C. (mean = 24 percent).[3] Another study found that the most common deficiencies in SNFs were very different from state to state.[4] Part of the variation in findings may reflect real differences in facility characteristics from state to state, but much of the variation is probably due to differences in state agency interpretation of conditions and standards and in survey processes.

In addition to state-level variations, numerous anecdotes of inconsistencies from one surveyor to the next were cited in the public meetings and case-study interviews. These inconsistencies in surveyor judgments are evidently random and appear as "noise" in national survey statistics, but they are extremely annoying to providers and confound state agency efforts to manage the survey process effectively.

Isolation from Related Monitoring Processes

In some states, there is little or no sharing of information or coordinated effort between the survey process and the processes for monitoring and investigating complaints, even though complaints can be an important source of information about quality problems in nursing homes. Relationships between the state survey agencies and ombudsman programs are often undeveloped or even adversarial. In addition, only 17 states combine or

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coordinate the inspection-of-care reviews with the survey process even though both involve annual inspections of resident care.

Variable State Regulatory Capacity

The survey results and case studies of the state survey and certification agencies revealed large differences in the level of funding and staffing and in the types and deployment of personnel relative to the number of facilities. These differences result in part from the absence of a federal formula for distributing survey and certification funds and the absence of guidelines for organizing and staffing the state agencies, but they also reflect differences in state budgeting contributions and inspection policies and practices. There also are differences in state regulatory standards, due-process rules, court interpretations, and availability of intermediate sanctions.

REDESIGNING THE SURVEY PROCESS

These problems can be dealt with effectively by redesigning the survey process to implement the resident-centered, outcome-oriented conditions and standards recommended in Chapter 3. The new conditions and standards will require surveyors to scrutinize the care being provided and its effects on residents, rather than emphasize reviews of records, forms, and written policies as is now the case. In conjunction with new survey protocols and scoring procedures based on empirical resident-outcome standards developed from standardized resident assessment data, the new conditions and standards should improve consistency of decision-making on deficiencies, although surveyor judgment will still play an important role. Development and use of a shorter inspection procedure and use of an outcome-oriented survey protocol will permit surveyors to identify and concentrate their efforts on facilities with problems. Also, the

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inspection-of-care reviews should be incorporated into the survey process, permitting more efficient use of regulatory capacity. Other problems, such as predictability, could be solved by making minor changes in standard operating procedures.

The revised survey process should be resident-centered and outcome-oriented where appropriate, although it should not eliminate all concern for certain facility characteristics that relate to life safety, cleanliness, sanitary food service, basic capacity to provide proper care, or the process standards for therapeutic diets or drug administration. It should take into account the different mixes of resident characteristics and service needs (case mix) found in different facilities, spend less survey time in the better facilities and more in the poorer facilities, and decrease the predictability of survey timing.

The new process outlined in this chapter would be more efficient because it would use a shorter standard survey that would permit survey agencies to spend less time on good facilities and more time on substandard providers. It would also relieve good providers from being subjected to unnecessarily intensive inspections. More important, the new survey process would be more effective because it would rely on more appropriate indicators of compliance with federal quality-of-care and quality-of-life conditions and standards than the structurally focused survey in use today.

The main features of the new survey process are discussed in detail in the remainder of this chapter. The following points are covered:

- consolidation of Medicaid and Medicare survey procedures,
- two-stage survey approach,
- case-mix referencing,
- key indicators of quality,
- scoring and decision-making,
- survey data sources,
- coordination with complaint programs,
- consumer involvement,

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- positive incentives, and
- continuous improvement of the survey process.

Consolidation of Medicare and Medicaid Survey Procedures

The procedures for certifying Medicaid and Medicare facilities are virtually identical. They should be consolidated.

Recommendation 4-1: Medicare and Medicaid survey and certification process requirements should be consolidated in one place in the Code of Federal Regulations to promote consistency.

Timing and Frequency of Surveys

Although some states have experimented with flexible survey cycles, there is still no valid information on the optimum periodicity of inspections for detecting violations before they become serious. Even excellent facilities may fall out of compliance very quickly after key staff, ownership, or resident mix changes. The consensus among consumer, regulator, and provider groups is that annual surveys of nursing homes are both reasonable and necessary.

The frequency and timing of standard surveys should be determined by each facility's performance history and should maximize the element of surprise. The objective is to encourage continuing compliance with the federal regulations. To ensure scheduling uncertainty, the actual interval between surveys for a particular facility might range from 9 to 15 months, depending upon past performance and its latest survey findings. Some facilities may need to be surveyed even more frequently if their performance has been exceptionally poor.

This increased flexibility in the timing of surveys should not, however, lead to an effective lengthening of the average time between routine surveys across all

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facilities in each state. That should remain constant at 12 months.

As a general principle, surveys should be unannounced and unanticipated by facilities, with the exception of followup visits to determine whether satisfactory corrections have been made. Whatever their record, all facilities should be at risk for a random, full-scale extended survey at any time.

Facilities also should be surveyed within a specified period of time after key events occur that are likely to affect the quality of care and quality of life in a facility, for example, change in ownership, administrator, or director of nursing. (Surveys after changes in ownership are already required by current regulations.) A high rate of nursing staff turnover or extensive use of nursing pools also might trigger an inspection. Similarly, multiple validated complaints about a facility should warrant an immediate survey.

The introduction into the survey cycle of flexibility that is tied to performance and key events should enable survey resources to be targeted to those facilities most in need of attention: problem or marginal facilities and facilities where new circumstances could adversely affect residents. Facilities that are performing well would be rewarded for their good behavior by less-intense monitoring. That will allow survey agency staff to be used for more urgent tasks. The time-limited agreement requirement that was dropped in 1981 legislation, but is still required by regulation, should be eliminated to allow the annual survey to take place as late as 15 months after the previous annual survey. In practice, the time-limited agreement provisions have not made it easier to terminate facilities, because the courts have imposed the same due-process prior hearing requirements for terminating facilities with expired agreements as apply to facilities with agreements in force. For this reason, a group of providers, consumers, and regulators convened by the HCFA in 1983 to develop a consensus on regulatory changes recommended elimination of mandatory time-limited agreements.

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Recommendation 4-2: The timing of surveys should maximize the element of surprise; the standard annual survey should be conducted somewhere between 9 and 15 months after the previous annual survey, with the average across all facilities within each state remaining at 12 months. Additional standard surveys also should take place whenever there are key events, such as a change in ownership. Independent of the survey cycle, all facilities should be required to pass rigorous life safety code and food inspections at regular intervals.

Two-Stage Survey Approach

After an initial audit of a sample of resident assessment records, each annual survey would begin with a short standard survey protocol. The standard survey would be designed to use "key indicators" of performance to identify facilities with poor resident outcomes that might have resulted from substandard nursing home performance. If a facility had problems on the key indicators (discussed below), it would be subjected to an extended survey protocol entailing observation and interview of additional residents to determine the extent to which staffing and other structural features of the facility, and the way care is being provided, may have caused the poor resident outcomes. The main purposes of the two-stage process are to relieve good facilities from the burden of a lengthy regular survey and to permit survey agencies to concentrate their efforts on poor and marginal facilities.

The Resident Assessment Audit

Surveyors would audit, by using the same resident assessment protocol the facilities are required to use, a sample of all residents to test the accuracy of the facility's assessment reports. A determination would then be made of whether the facility's resident assessment reports meet acceptable standards of accuracy. If

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surveyors find that a facility's assessments of resident status differ from their own by more than a predetermined rate, they would conclude that the facility's misclassification of residents reflects either professional incompetence or deliberate inaccuracy. In either case, a complete extended survey of the facility would be called for.

For facilities that pass the audit, a standard survey would be conducted.

The Standard Survey

The standard survey would use a statistically valid, case-mix-stratified sample of the residents in a nursing home. (The case-mix definitions, sampling issues, and the key indicators are discussed more fully below.) It also would measure overall facility performance through such environmental indicators as the personal grooming of residents, cleanliness, and so on. To the extent possible, the standard survey would use a short protocol that would rely on "key indicators" of performance. Among the key indicators that may be used, depending on the availability of empirical evidence, are those elements in a standard that have been shown to be highly predictive of compliance with the other elements in that standard. Key indicators also may be specific negative (although sometimes unavoidable) or positive outcomes appropriate to case-mix groupings.

Use of the standard survey should enable surveyors to sort facilities into one of three categories: those that are superior or clearly adequate, those that are clearly inadequate or deficient in one or more areas of performance, and those whose performance is ambiguous. Facilities in the superior/adequate group would normally be exempt from further review at that time, except for life safety code and sanitation inspections that will be required for all facilities and scheduled independently of the survey cycle. All other facilities will be required to undergo a partial or complete extended survey.

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The Extended Survey

The extended survey would enlarge the sample of residents examined and increase the comprehensiveness of the standard protocol to look at compliance with all elements and all standards. It would further document poor resident outcomes and explore the extent to which structural and process features of the facility may have contributed to these outcomes.

Partial extended surveys would be conducted in facilities where performance is questionable or clearly below par in particular areas, but where performance in other areas is not suspected of being substandard. Complete extended surveys would be conducted in facilities where serious or persistent questions about overall performance have been raised. For "ambiguous" facilities, a partial or complete extended survey would be conducted, depending on the nature of the ambiguity found during the standard survey.

Recommendation 4-3: Two new survey protocols should be designed and tested to implement the new conditions and standards recommended in Chapter 3: a standard survey and an extended survey. Both must be based on the revised conditions of participation and standards.

Case-Mix Referencing

The survey protocols should take into account the differing characteristics of residents in a facility, because some key indicators of quality are more relevant to residents with certain characteristics than to others. Accordingly, it is necessary to classify residents into defined case-mix groupings, using specified criteria. A simple stratification approach using key variables important in dealing with nursing home residents is proposed in this section for initial use in the revised survey process. Eventually, however, case-mix categories should be defined on the basis of resident groupings that emerge from the resident assessment scores and on empirical evidence from the resident assessment data that

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residents in a particular case-mix grouping should have a statistically predictable distribution of outcomes (changes in status) over defined periods of time after admission. The numbers of residents in different case-mix groupings could then become the denominators in determining the prevalence of poor outcomes among relevant groups of residents (for example, the percentage of decubitus ulcers among bed-bound and chair-bound residents, the percentage of mentally confused residents under physical or chemical restraint, the percentage of residents with. urinary incontinence who have indwelling catheters, and so forth).

The purpose of both the standard and the extended surveys is to evaluate the appropriateness of the care and the quality of life provided to the various types of residents found in a nursing home. Ideally, one would like to include the alert and oriented residents, short-and long-stayers, the physically and mentally dependent, younger and older residents, the well- and lesser-educated, and public- and private-pay residents, to name a few categories. However, it is not feasible to stratify nursing home residents by a large number of variables for survey purposes.

Initially, the case-mix categories would be based on measurements of physical and cognitive functioning and, if indicated, levels of mental depression. Most nursing home residents have either mental or physical impairments, or both. A few have neither. Residents in each of these categories have very different medical and social needs. The committee believes that the survey instruments and survey process can and should be organized to take into account these differences in resident need in different facility populations. It is time-consuming and therefore costly to have surveyors assess all residents in a nursing home. Moreover, it is not necessary to do so, because it is possible to assess a carefully selected sample of residents and obtain generalizable results.[5]

The survey instrument can be designed so that different sets of standards and elements may be used for different compositions of facility populations. The survey process can be referenced to resident case mix so that, for

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example, different sets of criteria will be applied to evaluate quality of care and life for a bed-bound population than for a mostly physically independent population. It is important to measure the incidence of bed sores only among individuals at risk of skin breakdown because they are bed-bound or chair-fast rather than to measure the incidence of bed sores among all residents in a facility if a significant number are not at risk of acquiring bed sores. Otherwise, a facility with almost all ambulatory care residents and a 1 percent incidence of decubitus ulcers would be rated as superior to a facility with a totally bed-bound population and a 3 percent incidence of decubiti. Yet the comparison would not be valid.

Accordingly, the case-mix referencing system should center around two parameters of resident condition that are central to the special care needs and vulnerabilities of nursing home residents: mental status and physical dependency. For survey purposes, there would be four major case-mix groups, each of which should be defined by scores on the resident assessment instrument. In addition, of the two mentally competent groups, subsets of interest are those residents who are also clinically depressed. The process for sorting and stratifying residents into these categories would be as follows:

1. The facility would give the survey team a list of the residents and the case-mix categories to which they are assigned.
2. The survey protocol would then draw samples according to a prescribed sampling algorithm from each of the case-mix groupings. The sampling algorithm, which would specify the sampling methodology (for example, randomized within case-mix grouping) and sample size (perhaps to take account of overall facility population size), would have to be specified by the HCFA.

The resident assessment protocols applied to the sample residents by surveyors would require obtaining somewhat different information about sampled residents depending on their functional and mental status.

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- Mentally competent residents would be interviewed to determine their level of satisfaction with the care they are receiving and to provide concrete information about matters such as the availability of activities, the flexibility of meal and bedtime hours, and so on.
- Mentally confused residents would be observed to determine whether there is excessive use of physical or chemical restraints. Audited institutional data should be used to define the numbers of residents at risk so that negative outcomes could be evaluated by the ratio of such occurrences to the numbers of at-risk patients.
- For physically independent residents, the standard survey would seek information on the availability of appropriate activities.
- For the physically dependent residents, the survey would place particular emphasis on specific, measurable results of poor care, such as decubitus ulcers, urinary tract infections, contractures, malnutrition, and dehydration. Audited institutional data should be used to define the numbers of residents at risk so that negative outcomes could be evaluated using the ratio of such occurrences to the numbers of at-risk residents.

Recommendation 4-4: Both standard and extended surveys should assess samples of residents stratified by standard case-mix categories. Case-mix definitions, and the procedures and sample sizes required to attain a prespecified level of precision, should be established by the HCFA.

Key Indicators

The standard survey would consist of a number of key indicators, that is, outcome and process measures of quality of care and quality of life that are mostly resident-centered, although some relate to facility characteristics. Many of these indicators could be drawn from existing protocols. Examples of negative indicators include excessive use of psychotropic drugs, excessive rate of adverse drug reactions, high incidence of urinary tract infections among catheterized residents,

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development of avoidable decubitus ulcers among physically dependent residents while in the nursing home, dehydration, contractures, avoidable declines in functional status, and unexplained weight changes. Examples of positive indicators are pain control and increased functioning in residents with angina, lowering of blood pressure in hypertensives, residents wearing street clothes, and service of palatable food.

Some of the key indicators would come directly from the resident assessment data, especially those resident outcomes based on change over time, as shown in medical and other types of facility records. But most would be measured by the inspectors through direct observation, interviewing, and assessment of the case-mix-referenced sample of residents and of the facility environment.

Several states have attempted to refine the federal certification process to save money and concentrate scarce regulatory resources on facilities demonstrating poor care.[6] These states include New York,[7] Massachusetts,[8] Wisconsin,[9] Colorado,[10] and Illinois.[11] Ohio has a resident assessment system for reimbursement purposes that focuses on resident needs and service provision,[12,13] and Iowa has developed an outcome-oriented licensure survey that focuses on selected domains of quality.[14-16]

Evaluations of some of these survey systems that focus on key indicators of quality of care and quality of life, such as New York's sentinal health events, indicate they are at least as successful in detecting serious deficiencies in the quality of nursing home care as the current certification surveys.[17,18] Thus it seems possible to develop key indicators, many of them drawn from or modifications of existing protocols, that are resident-centered and oriented toward appropriate—and away from inappropriate—resident outcomes and care processes and that can differentiate between facilities on the quality of resident care and quality of life they provide.

An example of a key indicator of potentially poor nursing and dietary care would be considerable weight loss (for example, 5 or more pounds) within 30 days (as determined from medical records and observations of

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residents). If a given percentage of residents experience such weight loss, the extended survey would examine records for acceptable reasons for weight loss (diagnosis of cancer, treatment of obesity, recent physical activity level changes, and so on). The surveyors also would examine the current dietary program (caloric intake); observe residents for treatable conditions (poor or missing teeth, depression); observe meal presentation (temperature and taste of food); observe and interview residents regarding eating habits, need for assistance devices or staff assistance, and food preferences; and investigate nursing staff levels and policies regarding food supplementation and nursing assistance in eating. Appendix F contains other examples of key indicators and followup procedures in the extended survey.

Recommendation 4-5: The standard survey should rely on "key indicators" of quality of resident life and care that would be prescribed by the HCFA. These key indicators would measure poor resident outcomes and other resident and facility conditions that might be caused by noncompliance with the federal conditions and standards and should be investigated further by the survey agency.

Triggering an Extended Survey: Scoring and Decision-Making

After the number of poor outcomes or inadequate care procedures involving each key indicator is determined, the survey team would have to decide whether there are enough poor cases to warrant an extended survey. For the time being, these essentially normative decisions would have to be based on the judgment of the survey team or the policies of each state agency. In the long run, however, it should be possible to have data on national or regional norms, controlled for case mix, for each key indicator, that can be used as the bases for these decisions.

For each category of resident sampled in the standard survey, facility performance would be evaluated using key indicators. The contents of the particular instruments

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and protocols used should differ for the four categories of residents and should be tailored to those aspects of care and quality of life that are most relevant and appropriate for each group. The proportion of the protocols for these different classes of residents that are based on interview, observation, and record reviews will also vary with the functional and mental status of the resident being evaluated.

For the sample of mentally competent residents, for instance, the standard survey should include an interview protocol that is designed to determine their level of satisfaction with the quality of care they receive and with their quality of life. Also, their views of the facility's performance, including such things as its flexibility in matters of rising and retiring, its arrangements for privacy, and consideration of food preferences in meal planning. The interview might also include the residents' perception of staff attitudes toward and treatment of the mentally impaired residents.

For the subset of mentally competent residents who are clinically depressed, the protocols will be designed to determine the adequacy of the facility's diagnosis and treatment of the condition.

For mentally impaired residents, the protocols will involve more observation and will focus on the appropriateness of their care and the nature of the activities program provided. The incidence of such undesirable practices as excessive use of physical or chemical restraints would be checked relative to the number of facility residents at risk for such practices. Cases of neglect and of verbal and physical abuse should be determined. (The complaint files may be a source of such data.)

For physically dependent residents, protocols will include a review of the presence of potentially avoidable negative outcomes such as decubitus ulcers, urinary tract infections, contractures, malnutrition, and dehydration.

Surveyors will use the audited data supplied by the facility to estimate the incidence of these and other such undesirable outcomes in relation to the numbers of residents at risk for such outcomes. These incidence data, as well as findings about the care provided to

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sampled residents, will be used by surveyors to reach decisions about the adequacy of facility performance.

The number of physically independent and mentally unimpaired residents should be small in most nursing homes. The focus of the survey protocols for them should be on issues relevant to their functional and mental or emotional status, the availability of activities, alleviation of pain, and maintenance of or slowing of deterioration of function in their activities of daily living.

Pass/fail and other scoring criteria for facility performance in each area, and for each category of resident sampled, should be established in advance. At the beginning, however, scoring will have to be more discretionary until analyses of the data base from the residents' assessments reveal the population-based outcome norms for each key indicator. When the data become available, policy-level normative decisions on cutoff or pass/fail scores can be made. Facilities that score below the cutoff point in any area will then receive an extended survey for those areas in which their performance appears to be questionable or deficient.

Whenever there are doubts or ambiguities about the adequacy of a facility's performance on the standard survey, a partial or complete extended survey will be conducted to clarify the situation. Citations for noncompliance will be made only after completion of an extended survey. A facility that required no extended survey following the standard survey would thus pass inspection and be exempt from routine review for a certain period of time.

Careful consideration will have to be given to deciding how many instances of poor care or negative but avoidable outcomes should constitute failure and trigger an extended survey or citation for noncompliance. A single instance of resident abuse or serious neglect might constitute grounds for an extended survey and citation. For other undesirable outcomes the absolute number or percentage of residents manifesting the condition that should constitute "failure" will need to be determined.

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Recommendation 4-6: Facilities that perform poorly on key indicators of quality of resident care or life should be subjected to a full or partial extended survey, depending on the range of problem areas discovered. The purpose of the extended survey is to determine the extent to which the facility is responsible for the poor outcomes due to noncompliance with the federal conditions and standards.

Survey Data Sources

As already noted, the standard survey would rely primarily (but not exclusively) on outcome and process indicators of facility performance. Extended surveys, whether partial or complete, would sample more residents and include more structural and process indicators than the standard survey.

Both the standard survey and extended surveys should be based primarily on observation of and interviews with residents and staff. Examination of facility records and written procedures would be secondary. Information may also be solicited from sources outside the facility, such as ombudsmen, community organizations, and residents' families and friends.

Instruments used for the extended survey, whether partial or complete, will be designed to elicit information that is more detailed, comprehensive, and intrusive in nature. In keeping with the committee's view that the residents themselves should be the focus of attention, and that resident status is best determined by direct contact between the surveyor and the resident, facility records will be used to validate observations, to check the accuracy and thoroughness of professional evaluations and facility tracking of resident needs and interventions, and to help locate the source of problems or weaknesses in facility performance.

There are potential difficulties in interviewing nursing home residents. First, there are questions as to the reliability and validity of the findings based on such

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interviews, given the nature of the population being interviewed (the frail elderly) and their circumstances (as a somewhat "captive" population in an institutional setting). In addition, there may be scheduling and logistical problems, as well as ethical issues, associated with interviewing a physically and psychologically vulnerable population.

Despite these difficulties, there is evidence that such interviews are useful and produce valid information. The Iowa licensure surveyors, for example, routinely interview residents about feelings of comfort and social adjustment, sense of freedom, perception of fairness in terms of their treatment by staff, feeling of security, and enjoyment of food. They are convinced of its usefulness. Interviews with a sample of nursing home residents who are mentally competent, willing, and able to be interviewed without undue physical or psychological strain, can yield important information about the day-to-day performance of the facilities and the residents' satisfaction with the quality of care and life they experience.[19,20]

Recommendation 4-7: Quality assessment in the survey process should rely heavily on interviews with, and observation of, residents and staff, and only secondarily on "paper compliance," such as chart reviews, official policies and procedures manuals, and other indirect measures of actual care given and resident outcomes.

Coordination with Complaint Programs

Although complaints can be an important source of information about substandard conditions and form the basis for potential enforcement actions, federal guidelines about complaint handling are general (State Operations Manual, Section 3500), and sufficient staff for adequate complaint handling is not always available to state licensure and certification agencies. Each state agency has its own way of handling complaints. The committee's survey found that 46 (of 47) state agencies conduct complaint investigations. Forty-one reported that their state had a statutory complaint and abuse reporting

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system, 34 operated by the survey agency and 7 by another agency. Of the survey agencies, 10 had separately staffed complaint units; the others used regular surveyors.

Complaints are a potentially important source of information about compliance between annual certification inspection visits. There should be HCFA guidelines for analyzing and reporting complaints. The complaint procedure should include criteria for deciding whether to conduct an investigation, whether to conduct an onsite visit, how to schedule followup visits, and when to cite deficiencies. Complaint histories might also be used to decide whether to initiate an earlier survey or go directly to an extended survey or both.

State licensure and certification agencies should be required to work out cooperative agreements for the reporting and handling of complaints with their state ombudsman program and the Medicaid fraud unit as well as with any state-mandated patient abuse or complaint programs. (The Medicaid fraud unit often obtains information relevant to a facility's compliance with licensure and certification standards.)

Recommendation 4-8: The HCFA should require states to have a specific procedure and sufficient staff to properly investigate complaints.

Consumer Involvement

The principle of resident-centered standards is furthered by direct resident interviews. Testimony at the public meetings and at the consumer issues workshop conducted by the committee in December 1984 noted that in most states current survey procedures do not require communication with residents before, during, or after the survey. Residents are an important source of information to surveyors. If surveyors seek information directly from residents and inform them at the conclusion of a survey of deficiencies and plans of correction, survey objectives are more likely to be achieved. Information provided to residents at the conclusion of a survey should not abridge the confidentiality of individual residents' care or

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records. The recommendation below also provides a means for inviting further information without compromising the unannounced survey. It is intended to facilitate effective communication between residents and surveyors.

Recommendation 4-9: The HCFA should incorporate in its survey operations manual the following additional procedures to be followed by surveyors in addition to interviews with those residents sampled for the survey protocols:

- *At the beginning of the survey, surveyors should meet briefly with members of the facility's resident council or with a group of willing and capable residents to elicit general information about services and resident satisfaction as well as to identify any areas of particular concern.*
- *Resident representatives should participate in the part of the exit conference where deficiencies are cited and the plan of correction is discussed.*
- *At the close of the survey, the following notice should be posted in a location accessible to residents and visitors*:

The (state survey agency) completed its regular certification survey of (facility name) on (date).
Anyone wishing to provide additional information may contact the (state survey agency) before (date).
(Address)
(Phone)

Positive Incentives

Facilities that pass the abbreviated survey will receive regulatory relief by not having to submit to further inspections until the next annual survey except for being subject to a random extended survey (and unless there is an ownership or other change requiring a new survey or a pattern of complaints triggers a new survey).

Surveyors and state agencies should be encouraged not to limit their comments to noting deficiencies, but to praise good or outstanding performance when they see it, both

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privately and publicly. The use of letters of recommendation for outstanding performance (perhaps for no deficiencies for two or more consecutive inspections) should be explored. If surveyors find some good or outstanding aspects of a facility along with some deficiencies, they should not fail to note both at the exit conference. The effect on staff and management attitudes and morale is certain to be positive. The HCFA should introduce these concepts into its manuals and its training program.

Recommendation 4-10: In addition to exempting good facilities from extended surveys, ways should be explored to commend superior performance.

Continuing Improvement of the Survey Process

An effective and efficient survey process, like the conditions and standards it applies, cannot remain static. Survey procedures must be adapted to changes in the characteristics of residents (for example, increasing age and disability) and of nursing homes (size, staffing). More important, they must be updated as knowledge increases about the conditions and problems of nursing home residents, and with improvements in care techniques.

Administration of the survey process also must be monitored and evaluated to improve consistency and efficiency.

The development of new and better methods to assess quality of care and nursing home performance should be encouraged.

Reliability and Validity of Instruments and Procedures

The survey procedures should be designed to implement the new resident-centered, outcome-oriented conditions and standards and should be revised regularly as the conditions and standards evolve in the light of new knowledge and other changes (in resident, facility,

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or staff characteristics, and so on). Such changes will be especially common in the early years as the new system is implemented and the resident assessment data base develops.

Recommendation 4-11: The new survey protocols, including the forms, procedures, and guidelines used by surveyors, should be designed in accordance with the revised and amended conditions and standards recommended in Chapter 3, and they should be revised as the conditions and standards are changed in the future.

It is important that the survey instruments and procedures be tested so that when used by properly trained surveyors they produce consistent and reliable findings.

Recommendation 4-12: All survey protocols (instruments and procedures) should be tested so that they are capable of yielding reliable and consistent results when used by properly trained surveyors anywhere.

Survey findings must be valid and reliable as well as consistent—they should be capable of determining the extent to which a facility is in compliance with the conditions and standards of participation. This is particularly important for the standard survey which relies upon obtaining data from a sample of residents. To assure the validity of the standard survey, extended surveys should be taken in a random sample of facilities each year and the results compared with the findings of standard surveys of the same facilities. In addition to providing data for improving the conditions and standards, these surveys would provide a check on how well the two-stage survey process is working and should induce facilities to stay in compliance with all regulatory requirements, not just those that might be checked by the standard survey.

Recommendation 4-13: A sample of facilities should be subject to an extended survey each year. Information from this sample should be used to validate and improve the standard survey.

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Consistency of Survey Results

A major criticism of the survey process by providers of long-term care has been the inconsistency of surveyors' interpretations of their findings on what constitutes acceptable or deficient performance. The results of a survey are likely to be dependent on the professional and personal values and biases of the individual surveyors. It is therefore essential that state survey agencies make a serious effort to increase consistency of interpretation and decision-making by surveyors. It should be possible to improve surveyor consistency by means of better training, monitoring, and evaluation of surveyor performance as well as better design of survey instruments and procedures. Such monitoring and training are done only in a few states, but such activities are essential to ensure consistency in translating survey findings into judgments of nursing home compliance with conditions and standards.

The importance of adequate training for surveyors to achieve consistency cannot be overemphasized. Such training should focus on the development among surveyors of a common language for describing what is observed during the course of a survey and the conclusions that are reached, techniques of eliciting relevant and useful information while surveying a facility, and methods and common points of departure for discussing a facility's performance and problems with its management, among other things. This training should not only increase the reliability and consistency of surveys, but also enhance the credibility of surveyors as a group with facility managers.

Recommendation 4-14: The HCFA should require the state agencies to implement a program to develop and support consistent and reliable surveys. This program should be based on effective training and monitoring of surveyor performance to reduce inconsistency.

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PACS: A NEW HCFA SURVEY PROTOCOL

In 1984, the HCFA began to test a new resident-centered survey process that focuses on the provision of services and resident outcomes. It was named PaCS (for Patient Care and Services). The HCFA developed PaCS to redirect the survey process from emphasizing facility structure and theoretical care-giving capacity toward evaluating the actual delivery of care and its outcomes. The PaCS process was based on the preliminary results of a series of state experiments with demonstrations of modified survey processes (for example, the final evaluations of experiments and demonstrations in New York, Wisconsin, and Massachusetts, is Washington,[21] and Iowa.[21,22]).

A PaCS survey encompasses—

1. evaluation through direct observation of certain aspects of the physical environment, including cleanliness, space, equipment, infection control, and disaster preparedness;
2. detailed review of care provided to a sample of residents, through observation, interviews, and medical record reviews;
3. evaluation of meals, dining, and eating assistance by observing meal service; and
4. observation of drug administration for a sample of residents.

Currently, PaCS is being evaluated experimentally in three states—Connecticut, Rhode Island, and Tennessee. In addition, all other states have been asked by the HCFA to administer PaCS in a small number of SNFs with good compliance histories.

More recently, the PaCS survey process has become the HCFA's response to the court's decision in *Smith v. Heckler* that the HCFA produce a more effective regulatory process for assuring adequate quality of care in nursing homes. The HCFA plans to evaluate the PaCS experiments, make any needed modifications in the process, and implement it as early as April 1986.

The committee has reviewed the PaCS forms and

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accompanying guidelines and has heard from state survey agency officials who have used the new survey process. There is general agreement that PaCS is a significant improvement over the traditional survey process, primarily because it focuses on resident outcomes rather than facility capacity and record reviews. In concept, it resembles the recommendation for a standard survey protocol made earlier in this chapter. It is a step in the right direction, but much additional work remains to be done before PaCS could become a valid and reliable resident-outcome-oriented survey protocol.

Five major problems exist with its present form. First, PaCS is being implemented without changing the conditions and standards, which remain oriented toward facility and capability and do not include quality-of-life factors. The conceptual problems of reliably relating findings from resident-centered data to compliance with structural standards have not been addressed. Major changes are necessary in the conditions and standards to make them more resident-centered and outcome-oriented before an effective survey process can be designed and implemented.

Second, PaCS has not designed a formal protocol for sampling of residents for detailed reviews of care-giving. There is no requirement to stratify by case mix, for example, nor recognition of the requirements of valid sampling. The PaCS process leaves it to the surveyors to select a sample of residents and to decide, relying exclusively on surveyor judgment, on the proportion of undesirable outcomes that are beyond the facility's control, those being appropriately handled, and those that are due to oversight or neglect. It is essential to incorporate statistically defensible sampling procedures to achieve valid, consistent, and reliable findings that can be sustained in enforcement proceedings.

Third, the PaCS survey process still relies on unguided surveyor judgment to make the important decisions of whether care problems demonstrated by a facility constitute deficiencies. PaCS does not have guidelines with criteria for making these decisions, but leaves them to unguided surveyor judgment. The PaCS experiments should therefore be carefully analyzed for interrater reliability in use of the instrument. As noted earlier in

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this chapter, although many key decisions must continue to be left to the professional judgment of surveyors, many aids to guide such judgment must be built into the survey system.

Fourth, current PaCS procedures do not require the facilities to maintain standard resident assessment data. A sound quality assurance system for nursing homes has to rely on standard resident assessment data both for reliable case-mix groupings and for tracking changes in resident outcomes. This was the reason for recommending that a standard resident assessment procedure be added as a condition of participation.

Fifth, PaCS does not integrate the PaCS survey with the inspection-of-care (IOC) function. The committee has recommended that IOC be combined with a resident-centered, outcome-oriented survey process to make it more efficient by preventing duplication. This depends on implementing the resident assessment program.

The recommendations made in Chapter 3 and those made in this chapter constitute an integral package. PaCS, properly developed to take account of the problems enumerated above, could become the standard survey protocol discussed earlier. But as currently envisioned, it is not conceptually or operationally part of a comprehensive revision of the nursing home regulatory system. It does not incorporate many of the other key changes in the nursing home performance criteria, in the survey process, and in the enforcement process that are necessary to make significant improvements in the regulatory system.

INCREASING STATE REGULATORY CAPACITY

To facilitate the attainment of regulatory goals, the federal government should help the states to increase their capacity to conduct effective, reliable surveys of nursing homes by providing the state survey agencies with enough resources (funds, training programs, and research results) to help achieve more adequate and consistent application and enforcement of federal standards.

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Federal Funding of Certification Activities

Funding for Medicare certification activities comes from the Medicare trust funds. Historically, although states have submitted estimated budgets each year to their regional offices, they have received Medicare allocations incrementally larger than their previous year's budget. In 1981 the Medicare certification budget was cut from $30 million to $25 million and, in 1982 it was cut to less than $14 million (see Table 4-1). When Congress restored the funding in 1983, the HCFA tried to reallocate the funding among states more in accordance with workload. The costs of average long-term care and other health facility surveys are estimated on the basis of 1980 expenditures, and are updated annually with an inflation factor. The figure is multiplied by the number of facilities in each region to determine its allocation. But each regional office uses a different allocation method to distribute the funds among its states.

For Medicaid, Title XIX authorizes the HCFA to match whatever the state spends in certain approved categories. From 1965 to 1972 the matching ratio was 75 percent federal to 25 percent state funds. In 1972 the law was changed to authorize 100 percent federal funding of the salaries, travel, and training of state surveyors. In 1980, Congress reduced the matching ratio back to 75 percent federal.

Federal funding of the survey and certification program is modest in total amount—less than $70 million in fiscal year 1984—or about 0.6 percent of total federal Medicare and Medicaid expenditures for nursing home services. It is not distributed entirely according to a formula based on consistent criteria. The states are still feeling the effects of major cuts in the funding of Medicare surveys imposed in 1981-1982. The amount the states themselves contribute for the licensure part of the survey process varies greatly. As a result, the number of surveyors and the number of inspections (and their intensity as shown by average person-days of surveyor time in a facility) vary significantly from state to state.

The committee's survey of state licensure and certification agencies found that the average expenditures

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TABLE 4-1 HCFA Expenditures for State Survey Agency Activities (in millions of dollars)

Fiscal Year	Medicare	Medicaid	Total
1977	$23.6	$33.2	$56.8
1978	24.9	36.2	61.1
1979	25.3	34.4	59.7
1980	27.4	38.4	65.8
1981	24.6	34.2*	58.8
1982	13.6	31.8	45.4
1984	35.6	32.2	67.8

SOURCE: The Health Care Financing Administration. 1984.
* Federal (Medicaid) matching for surveyor salaries, travel, and training was cut from 100 to 75 percent in 1980.

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for nursing home licensure and certification surveys vary from $1,296 to $13,018 per nursing home (median = $4,700). This variation apparently has more to do with the historical funding base provided by the HCFA and the willingness of a state to add state funds than to the current workload level (total number of facilities, adjusted by bed size), or mix (mostly skilled vs. mostly intermediate facilities, mostly large size vs. small, high vs. low Medicaid admission criteria, and so on).

The recommendations made earlier in this report for a resident assessment system and a new survey process and procedures will require extensive training for all surveyors, training of nursing home staff, and improved and better supervision of surveyors by state licensure and certification agencies. This will require larger budgets for the state licensure and certification agencies. To facilitate cooperation by the states in introducing the new survey process and the resident assessment system and enhancing their survey staff supervisory capabilities, the Congress should once again authorize 100 percent federal support for state survey and certification activities (in nursing homes). This authority should be extended for 3 years to facilitate installation of the new system. After 3 years, the matching ratio should be reviewed and a permanent ratio involving some state participation reinstated.

Recommendation 4-15: Title XIX of the Social Security Act should be amended to authorize 100 percent federal funding of costs of the nursing home survey and certification activities of the states. This authority should be extended for 3 years, after which time a federal-state matching ratio should be reestablished. The HCFA should develop a standard formula for distributing funds to the states under this authority so that each state is funded on an equal basis in proportion to its federal certification workload.

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State Surveyor Qualifications

Federal regulations and the State Operations Manual are very general regarding survey agency staffing levels and qualifications. In practice, there arc significant variations in the experience and educational backgrounds of the surveyors and the composition of the survey teams in each state, for example, how many nurses, generalists or sanitarians, and other specialists such as pharmacists, nutritionists, physicians are on the teams. Nationally, about half are nurses, a fifth are sanitarians, and most of the rest are engineers, administrators, and generalists.[23,24]

Surveyors come from a variety of backgrounds, and few have previous nursing home or long-term-care experience.

Federal guidelines for survey staff composition permit states a great deal of latitude, and the HCFA's data on surveyors indicate that some states are not staffed adequately to conduct surveys that are more oriented to resident care. For example, at least one state had no nurses on its survey staff in 1982.[23] In 1983, eight states had only one or two licensed nurses on staff.[24]

Recommendation 4-16: The HCFA should revise its guidelines to make them more specific about the qualifications of surveyors and the composition and numbers of survey team staff necessary to conduct adequate resident-centered, outcome-oriented inspections of nursing homes. At a minimum, every survey team should include at least one nurse. For use on extended surveys, the survey agency should have specialists on staff (or, in small states, as consultants) in the disciplinary areas covered by the conditions and standards (for example, pharmacy, nutrition, social services, and activities).

Federal Training Support

Federal training requirements are minimal and federal training programs were cut back substantially in 1980-1981 because of budget constraints. According to the case

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studies, the states vary greatly in the scope of their training efforts. Three-quarters of the surveyors had at least 10 hours of in-service training in 1982, but one-quarter had less than 10 hours and, of those, a third had none.[24]

Recommendation 4-17: Federal training efforts and support of state-level training programs should be increased, especially during the period of transition to the new survey process, and during the implementation of the new resident assessment condition of participation.

Dissemination of Research and Evaluation Results

Information about survey operations and their results are inadequate at the state and federal levels.[4] Evaluation of the new survey system will depend on the availability of performance data. At the same time, the federal government should continue to sponsor experiments in improving the survey process.[18,21,22,25] The federal government should disseminate the results of experiments sponsored by it or the states to the other states.

Recommendation 4-18: National data about survey operations and results, and from any experiments and demonstrations sponsored by the HCFA or the states, should be collected, analyzed, and disseminated by the federal government to facilitate continued improvement in survey methods.

Federal Oversight and Sanctioning Responsibilities

The HCFA regional offices have not been able to carry out their monitoring responsibilities effectively in part because of inadequate resources and procedures. Regional office personnel devoted to certification work totals about 300, or about 30 per regional office.

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The HCFA has three ways to judge state survey agency performance, other than paper reviews of survey documents. They are—

1. *Validation surveys*. Theoretically, the federal surveyors are supposed to conduct validation surveys of a 5 percent sample of nursing homes assess state survey performance. In practice, this goal rarely has been attained. After the number of federal surveyors was cut from 100 to 70 in 1981, the sample size was reduced to 3 percent. Moreover, the validation surveys are often not performed until several months after the state survey, making it difficult to prove that the state overlooked or misinterpreted deficiencies found by federal surveyors. The new outcome-oriented conditions and standards and the new survey process should make it possible to judge state performance in a more reliable and consistent way. This will undoubtedly require an increase in the number of federal surveyors.
2. *Complaint investigations*. Complaints pertaining to possible violations of federal requirements are usually referred to the appropriate state survey agency for investigation but they may be conducted directly by federal surveyors. In some cases, this should stimulate a "look behind" survey.
3. *Look behind*. The HCFA has long had the authority to review state survey and certification decisions and to deny federal Medicaid reimbursement to a facility that is improperly certified by a state survey agency. Technically, under this "old look-behind" provision, the HCFA did not have the authority to decertify Medicaid-only facilities, only the authority to recover from a state any federal funds paid to a certified facility on the grounds that the state had not followed correct procedures.

In 1981 the Omnibus Budget Reconciliation Act gave the HCFA direct authority to cancel the agreement between the Medicaid agency and the facility for not meeting federal standards, as determined by an onsite survey by a federal team. This is called "new look-behind." However, it requires a full evidentiary hearing before an administrative law judge before the effective date of

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termination (if the deficiencies do not pose an immediate and serious threat to patient health and safety). Termination can be further delayed pending appeal to an appeals council, and judicial review. This requirement for a prior hearing before an administrative law judge, except in cases of immediate and serious threats to residents, is not now required for other termination procedures under Medicare and Medicaid law. In the view of HCFA officials, it lessens the effectiveness of the new procedure.

There have been several problems with federal oversight. First, in recent years, insufficient numbers of federal surveyors have precluded surveys of 5 percent of nursing homes as called for in federal procedures.

Second, the nursing homes surveyed in each state are not for the most part randomly selected; most are selected because there has been a complaint or a pattern of complaints about care in the homes.

Third, the lack of timeliness of these surveys further reduces their value for evaluating state survey performance. They often take place weeks or months after the state visit and thus do not constitute a limited check on the reliability of the state's results.

Fourth, the HCFA is very limited in what it can do to states that do not carry out their federal surveying responsibilities. It does not have effective sanctions, short of terminating its agreement with the state (which has never been done), to use against states that underenforce or wrongly interpret federal standards. An intermediate sanction, such as reducing the amount of Medicaid matching funds, is needed.

Recommendation 4-19: The HCFA should increase its capabilities to oversee state survey and certification of nursing homes and to enforce federal requirements on states as well as facilities by

- *adding enough additional federal surveyors to each regional office to ensure that the random sample of nursing homes surveyed each year in each state is large enough to allow reasonable inferences about the adequacy of the state's survey and certification activities*;

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- *scheduling "look-behind" surveys so that valid comparisons can be made of the findings of federal and state surveys; and*
- *amending Title XIX of the Social Security Act to authorize the HCFA to withhold a portion of Medicaid matching funds from states that perform inadequately in their survey and certification of nursing homes.*

ORGANIZATIONAL CHANGES

Incorporation of Inspection of Care in the Survey Process

Federal law and regulations currently require each state Medicaid agency to conduct at least one "inspection-of-care" (IOC) review of all patients annually to determine the appropriateness and quality of care given to recipients. The inspection of care involves a look at the care given to every Medicaid resident. It is done by a team of nurses and social workers, often with access to physician consultants. Traditionally, this inspection-of-care process has been performed independently of the facility surveys in all but a few states.

Federal guidelines for IOC are general, and inspection-of-care programs differ widely in the way they are conducted, the size and qualifications of the inspection teams, and the scope of the review. Many focus on level-of-care determinations rather than quality-of-care problems and do not have resident assessment tools and techniques adequate to determine quality of care for regulatory purposes.

In the past few years, some states have combined their inspection-of-care and survey staffs, usually for budgetary reasons. In some states, the processes are fully integrated—done by the same team on the same visit. In others, they are done separately, but the information derived from the two processes is shared. The responsible agencies regularly take joint action in some states. In most states, however, the two processes operate in isolation from each other.[26,27]

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In the 47 states responding to the committee's survey, 17 licensure and certification agencies were also responsible for inspection-of-care reviews. In nine of the states, the same team conducted both IOC and the certification surveys on the same visit; in the other eight states, IOC was conducted by a different team or on a different visit, or both. Of the 46 states answering the question of whether IOC should be integrated with the survey process, 32 said they should be done by the same team or at the same visit or both. Another seven thought they should be separate functions under the same supervisor. Only seven advocated keeping them as separately administered functions.

Inspection of care, as it is currently conducted in most states, provides resident-centered quality-of-care information that is not always available to or used by the certification surveyors. The survey and IOC should be combined because they are somewhat duplicative and IOC findings would help in the assessment of compliance with resident care standards.

Combining IOC with the recommended new survey process would require a statutory change to permit reviews of a sample rather than of all residents. The transfer of IOC also will affect utilization review and control responsibilities. Currently, the regulations governing IOC are included under the general subject of utilization control. These regulations require each state Medicaid program to have a surveillance and utilization control program to (1) guard against unnecessary or inappropriate use of services, (2) minimize excess payments, and (3) assess the quality of those services. Utilization control must include for each recipient a physician's certification and periodic recertification of the need for nursing home care, a medical evaluation and a rehabilitation plan for admission, and a discharge plan. In addition, there must be a utilization review (UR) plan for each facility that includes periodic reviews of each recipient's need for continuing stay in a nursing home, medical care evaluation studies, and discharge plan reviews. The state cannot receive the full federal share of payments for Medicaid services provided in a facility that does not have a proper utilization review program.

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In most states, utilization reviews, including the continuing stay reviews, are done by facility-based UR committees. The annual IOC visit, with its 100 percent review of Medicaid recipients, is the means by which the Medicaid agency monitors the performance of the UR committees. With consolidation of ICFs and SNFs, UR committees will be required to determine the need for continued nursing home care. The annual IOC has been used for this purpose. Accordingly, if IOC is transferred, the survey agency would need to perform this audit function for the Medicaid agency. The effort should be directed at a sample of residents most likely to be discharged. This function would be greatly facilitated by the availability of the standard resident assessment data. The placement of residents in the nursing home could be checked at the time of the standard survey and reported to the Medicaid agency. If the placement decisions for the sample are wrong in too many cases, a review of all residents could be triggered.

Recommendation 4-20: The inspection-of-care function should be carried out as part of the new resident-centered, outcome-oriented survey process. But individual resident reviews should be required for a sample of residents (private-pay as well as Medicaid) rather than for all residents (although individual states may elect to continue 100 percent reviews).

Restructuring of State and Federal Roles and Responsibilities

The federal and state role relationships in nursing home regulation must be clear and workable, because the two levels of government share the responsibility for maintaining the federal quality standards in nursing homes participating in the Medicare and Medicaid programs. In the past, federal statutes have given principal responsibility to the states for determining whether participating nursing homes comply with federal health and safety standards. The states do this by conducting onsite inspections and complaint investigations in all facilities

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participating in Medicare and Medicaid. They certify the compliance or noncompliance of these facilities.

In the case of Medicaid-only facilities, which account for 61 percent of the participating facilities and 53 percent of the beds,[28] the state Medicaid agency makes the final decision to enter into a provider agreement with a certified facility. In the case of Medicare-only or Medicare and Medicaid facilities, however, it is the HCFA regional offices that make this decision. In both instances, the federal government's primary responsibility should be to monitor and assist the states in the performance of their jobs. One result of this difference in certification responsibilities for Medicare and Medicaid facilities has been federal preoccupation with Medicare SNFs and relative state autonomy over Medicaid-only facilities. Another result is state Medicaid certification of state-owned nursing homes and hospitals. It is a potential conflict of interest for a state to survey its own institutions. It puts the survey agency in the position of criticizing the performance of a sister agency (often in the same department) and, if it requires major state expenditures, it may come under pressure from the governor's office to modify its findings. Moreover, the survey agency is put at a disadvantage in taking a tough line with private facilities when it is widely believed that state facilities are borderline or worse.

The respective roles of the federal and state governments would be clarified and strengthened if the states assumed responsibility for approving certification of all (Medicare as well as Medicaid) facilities except state-owned institutions. The latter should be certified by the federal regional offices on the basis of inspections by federal surveyors. The primary role of the regional offices would still be to monitor the activities of the state survey agencies and to take steps, including the use of the sanctions referred to in the previous recommendation, to ensure adequate performance.

This recommendation concerning certification authority should be implemented by overhauling the so-called "1864 agreement"—the contract between the Secretary of Health and Human Services and each state health department to

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carry out Medicare surveys—assuming the following other recommendations of the committee are implemented: (1) the development and adoption of more outcome-oriented conditions and standards and of a new survey process to implement them, (2) provision of adequate resources and training to the states to carry out their certification responsibilities, (3) increased and improved federal monitoring of state survey performance, and (4) the adoption of federal sanctions to use against states that do not adequately apply or enforce federal requirements.

Section 1864 of the Social Security Act directs the Secretary of Health and Human Services to make agreements with any "able and willing" state under which the state health department or other appropriate state agency surveys health facilities wishing to participate in Medicare and certifies whether or not they meet federal definitions, standards of care, and other requirements. In return, the secretary agrees to pay for the reasonable costs of the survey and certification activities of the state agency. Currently, 1864 agreements are open-ended in duration, but they may be terminated under certain conditions by either party.

Although the HCFA has been dissatisfied with the performance of some states from time to time, it has never terminated an 1864 agreement. Because section 1864 compels the secretary to enter into agreement with any state that wants to, and does not provide for alternative sponsorship of survey activities, the HCFA has not had much leverage with states that do not strictly comply with federal requirements.

The HCFA implemented a revised 1864 agreement on July 1, 1985, in an attempt to hold the states more accountable. It should continue this effort to clarify the respective roles of the federal and state levels in conjunction with the other major recommendations cited above, that is, implementation of a resident-centered, outcome-oriented standards and survey process and increased resources at the federal and state levels.

It should be noted that the federal cost savings resulting from the elimination of the paper reviews of the certification packages in the regional offices should

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offset in part the higher costs of the expanded federal oversight function called for in the last recommendation.

Recommendation 4-21: The respective roles and responsibilities of the federal and state governments should be realigned as follows:

- *The states should be responsible for certifying all Medicare and Medicaid facilities (except state institutions) according to federal requirements.*
- *The HCFA should monitor state performance more actively and be responsible for conducting surveys of, and certifying, state-owned institutions directly.*

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5

Enforcing Compliance with Federal Standards

THE ISSUES

Even with improved regulatory standards and a more effective survey process, it is unlikely that quality of care and quality of life for residents in marginal or substandard nursing homes will improve unless compliance with the standards is effectively enforced. The committee was made aware—at its public meetings, by many letters from individuals, from interviews conducted during its case studies, and by stories that appeared in the press and on television in several states during the course of this study—of the serious, even shocking, inadequacies of enforcement in many states. The problem appears to be national in scope. Although public attention is focused on the relatively few scandalous cases, a more serious issue appears to be the large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed, may or may not be subject to mild sanctions, temporarily correct their deficiencies under a plan of correction, and then quickly lapse into noncompliance until the next annual survey. In one large city, the committee's staff was told by a federal regional official that the federal surveyors in that office estimated that about one-third of the nursing homes in

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that city were of marginal or less-than-marginal quality. This estimate was considered reasonable by a state regulatory official in the agency responsible for inspecting the nursing homes in that city. The extent of the problem undoubtedly varies widely among the states and within states. Although data on the nature and extent of the problems are not available, the anecdotal evidence is very persuasive: inadequate enforcement is a major problem.

Enforcement issues can be grouped into four areas: (1) federal and state orientation and attitudes toward enforcement; (2) the federal rules and procedures; (3) state variations in enforcement authority, policies, and procedures; and (4) inadequate federal and state resources committed to enforcement.

ENFORCEMENT ATTITUDES

Federal procedures for dealing with facilities found to be out of compliance are oriented toward helping facilities to improve rather than enforcing the certification standards. This posture may be reasonable and beneficial in many cases, but it allows states to continue certifying facilities that provide poor or marginal care. Some poor facilities remain in operation over long periods to correct deficiencies, then meet standards for only short periods following the resurveys, and then repeat the same pattern of behavior.[1] In other cases, facilities may be decertified, but then quickly correct the deficiencies and promptly be recertified.[2]

When the federal government became directly involved in nursing home regulation after 1965, few nursing homes could meet federal standards. Strict enforcement of federal standards would have barred most nursing homes from participating in the Medicare program and therefore would have prevented many Medicare patients from receiving needed services. The Department of Health, Education, and Welfare then decided to certify nursing homes that were only in "substantial compliance" with Medicare standards.

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Although nearly 6,000 facilities had applied for participation in Medicare by December 1966, only 740 were able to achieve compliance by July 1967. Another 3,210 were certified as being in "substantial compliance."[3] From the beginning, then, the goal of enforcement in federal nursing home regulation was to allow some substandard facilities to participate in the program while encouraging them to achieve compliance, rather than to bar such facilities until they were in compliance. The emphasis of federal and state regulatory efforts was, and in many states still is, on upgrading substandard facilities rather than keeping them out of the program.

The current survey policies and procedures encourage states to consult and coerce facilities into compliance, not to punish them. The state agency does not have the authority under federal regulations to punish a violation immediately. The survey agency must issue a notice to the operator of a substandard nursing home, giving the facility a period of time (usually 30 to 60 days) in which to correct deficiencies. The survey agency is instructed to try to resolve cases before referring them to the formal administrative or law enforcement system.[4] The agency may apply formal sanctions only if the facility remains in violation beyond the deadline set for compliance. Consequently, the facility is not punished for violations directly, but rather for failing to carry out an administrative order to correct violations by a certain date. Resort to formal sanctions by a compliance-oriented agency therefore becomes the last step in a long series of follow-up visits and plans of correction designed to induce conformity on the part of substandard facilities.

In practice, in the interest of eliminating the hazard as quickly as possible, nursing home regulators typically continue their efforts to gain compliance well after the point at which they could resort to formal sanctions.[4] Substandard nursing homes apparently come into compliance long enough to be recertified, without penalty, but are again found out of compliance with the same or similar standards in one or more subsequent annual inspections.[1] Regulators in the

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six states in which the committee did case studies reported having chronic problems with 10 to 15 percent of their nursing homes, which they called "roller-coaster," "yo-yo," "in-and-out," or "borderline" nursing homes. The HCFA has estimated that 5 percent of SNFs will fail to meet one or more conditions on their current and next two certification surveys, and 14.6 percent of ICFs will fail the same test. One condition out of compliance is grounds for starting decertification procedures.[4] But the number of decertifications taking place does not match these estimates of numbers of facilities with conditions out of compliance.

Even when the state licensure and certification agencies and the HCFA regional offices do decertify facilities, facilities still reenter the program easily. The federal Medicare regulations call for "reasonable assurance" that the deficiencies which led to termination will not recur. (The HCFA has proposed more specific reinstatement rules.[5])

Although it may have been necessary to work with facilities to bring them into compliance when federal regulations were new, the certification regulations have been in use for more than 10 years and the nursing home industry is much more sophisticated than it was. There is no longer a valid reason for facilities to operate with numerous and repeated deficiencies. The committee believes that current federal policies requiring consultation undermine state agency efforts to eliminate substandard providers and deter marginal facilities from repeating violations. Federal and state procedures for enforcement should be modified to reorient the program toward enforcement rather than consultation and to encourage states to adopt a stronger enforcement posture. This can be done by (1) separating the consultant and surveyor roles, (2) making survey follow-up procedures more specific, (3) making federal and state sanctions more comprehensive and applying them more rigorously, and (4) increasing both federal oversight and federal support of state enforcement activities. Each of these remedies implies changes in federal policy and a stronger federal role in the enforcement system. Some require statutory changes.

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FEDERAL RULES AND PROCEDURES

Consultation

The law and regulations now require survey agencies to advise facilities on how to improve their performance. The state survey agencies organize the consultation work in several ways: In some states, surveyors are the consultants; in others, separate units are staffed with various professionals who serve as consultants to nursing homes.[1]

There is potential conflict between the consulting and regulatory roles of a survey agency.[6] The compliance-oriented consulting role, combined with professional attitudes of surveyors trained in the helping professions such as nursing and social work, can lead surveyors to be too understanding and lenient toward substandard providers. Compliance-oriented enforcement may allow surveyors to work with a facility for long-range improvements, but the dilemma of compliance-oriented enforcement is that threats of punishment are not credible if they are not used predictably under specified circumstances.[7] Without a credible threat of sanctions, many marginal or poor facilities never improve. In many states, surveyors are responsible both for consulting with and disciplining providers, despite the potential conflict in these roles. Some states, notably Washington, New York, and Connecticut, use separate consultant teams. They consider this procedure successful.[8]

Survey Follow-up Procedures

Current federal guidelines for survey follow-up procedures are inadequate because they do not specify how plans of correction should be evaluated, how correction actions should be measured, or when more stringent enforcement actions should be initiated. Guidelines on consultation do not specify methods or extent of consultation to be given. Guidelines on plans of correction, follow-up visits, and the initiation of enforcement

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are procedurally precise, but do not discuss content of plans or circumstances of visits and what specific circumstances should prompt imposition of sanctions.[4] Most states lack internal guidelines on these matters.[9]

Plans of Correction

The post-survey phase of nursing home certification has been much less studied and is far less sophisticated than the annual survey process, but detecting deficiencies—as difficult as that may be—is only the first step in achieving compliance.[8] State post-survey procedures vary widely. States may be more or less stringent in accepting plans of correction and in agreeing that adequate corrections have been made. They may give the facilities more or less time to make the corrections.[1,9]

Under federal guidelines, the survey agency has 10 days after a nursing home inspection visit to issue its statement of deficiencies. These are listed and documented on a HCFA form. The provider is supposed to respond within 10 days with a plan of correction for every deficiency that is written on the statement of deficiencies. The plan of correction is supposed to list the actions the provider proposes to take, including expected dates of correction or completion dates for deficiencies already corrected, or to outline any disagreements the provider may have with the survey findings.[4]

Plans of correction are obviously crucial because they specify the actions to be taken by the facility to remedy the specific deficiencies for which it was cited. The state survey agency must decide if the proposed corrective actions are appropriate to remedy the deficiencies and the proposed correction dates are reasonable. An internal HCFA study showed that the failure to follow post-survey procedures is related to the survival of poor providers. The study found that in 126 problem facilities identified by the regional offices (most of them repeat violators) 60 had incidents of improper actions, including unmet deadlines, deviations from plan of correction procedures, and improper use of automatic cancellation clauses.[5]

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The HCFA also determined that in the cases reviewed, formal enforcement was regularly not taken when warranted. Despite the importance of survey follow-up and plans of correction, the federal criteria for acceptable plans of correction are general. According to the State Operations Manual (Section 2340), "the plan must be specific (stating exactly how the provider or supplier intends to effect corrective action), and realistic. It should include expected completion dates and be signed by the Administrator or other authorized official of the health care entity." Although the procedures for obtaining a plan of correction are specific, the directions concerning the actual content of the plan are quite vague.[4]

States have different procedures for reviewing correction plans. In some, survey agency supervisors conduct the review; in others, plans are reviewed by surveyors. In some states, it is not uncommon. to send correction plans back for revision; in most, this is rarely done. In the case of Medicare or Medicare/ Medicaid facilities, the HCFA's regional office staff also reviews the acceptability of correction plans.[1,9] Follow-up visits and procedures also vary by state. The number of follow-up visits made by state agencies in 1983 ranged from none to 2,280. Follow-up visits average about one per facility survey, lasting about 1-1/2 to 2 days. Most (30) survey agency directors think that a single onsite follow-up visit is sufficient.[9] Given the range in facility size, numbers of deficiencies cited, and variation in scope and duration of correction plans, a broader range in the numbers of follow-up visits to facilities, and in their duration, is warranted.

Only a few survey agencies have explicit guidelines for evaluating the correction plans submitted by the facilities, although sanctions may be imposed. Also, higher-level sanctions are usually based on a finding of noncompliance with a correction plan. Specific guidelines on evaluating a correction plan should be available to surveyors. Surveyors also must be trained to document deficiencies and evaluate plans to make the guidelines effective.

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Initiation of Formal Enforcement

A major finding in the IOM case studies is that state survey agencies lack formal enforcement procedures and guidelines. They also lack explicit criteria for making decisions at important stages in the enforcement process. The survey of state agencies found that only 20 of the 47 states reporting have written guidelines for when and how to take formal enforcement actions.[9]

Generally, onsite post-survey revisits are made to facilities to check the progress of the correction plan. If the deficiency is a minor paper compliance item, such as amended bylaws or written policies, the facility may be allowed to mail the corrected documents for verification in lieu of an onsite visit.[4] In most cases, however, onsite revisits are made to verify correction of deficiencies, generally within 60 to 90 days of the initial survey.[9] Revisits must be made by a qualified surveyor or agency consultant.

Some states have a practice of making more than one revisit to verify immediate correction of acute situations and later to verify correction of the remaining deficiencies. Thirty states believe that one onsite follow-up visit is adequate in most cases, 13 think there should be more than one visit if there are multiple deadlines for corrections, and 3 said none were needed in most cases because corrections could be adequately verified by telephone or mail. (One did not reply.) [9]

If all deficiencies are corrected at the time of the revisit, the surveyor is required to complete a post-certification revisit report that indicates to the HCFA or the state Medicaid agency or both that the facility is in full compliance.[4]

If there are still uncorrected deficiencies, the surveyor fills out a summary of the uncorrected deficiencies on a HCFA form that reports whether the provider made acceptable progress or showed effort or made inadequate or no progress, and provides details. In the last-mentioned case, the surveyor is urged by the State Operations Manual (Section 3306) to find out why and, if possible, through consultation, to work out a new plan of

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correction. If the provider continues to fail or refuses to correct a deficiency, the surveyor must determine if the deficiency poses a clear hazard to resident health and safety. If so, the surveyor is supposed to recommend termination of the Medicaid agreement, the only federal sanction.[4]

Although the federal regulations outline the procedures for following up on a survey, they do not specify what constitutes a clear hazard to health and safety. Nor do the regulations set limits on the duration and number of plans of correction. Without federal guidelines on these matters, it can be difficult for a surveyor to judge when initiation of decertification is warranted. In the six states studied by the committee, those active in enforcement were more likely to have detailed enforcement procedures. Specific procedures were developed in Texas because the survey and Medicaid agencies found themselves losing too many court cases on the grounds of inconsistent procedures.[1]

Guidelines on when to initiate sanctions are necessary for effective state enforcement. Surveyors need specific guidelines on when deficiencies found in the standard survey warrant further investigation, when violations should be cited, and what findings in the extended survey should be followed by sanctions. Specified enforcement procedures would encourage states to be less tolerant of substandard providers, and to be more consistent in initiating enforcement activity and in setting precedents for future activities. Written procedures are needed for both federal and state sanctions. Guidelines for use should accompany any new sanctions that are put into place. States also should have legal and administrative staff who specialize in nursing home enforcement issues to assist them in applying sanctions.

More-specific guidelines on consultation, plans of correction, follow-up visits, and initiation of enforcement are needed to direct state agencies to be less tolerant of substandard homes that are chronic or repeat violators. Stronger and more specific federal guidelines would facilitate stricter state enforcement. More intensive reviews of correction plans would not only ensure that plans are reasonable and carried out properly,

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but that standardized documentation on progress of corrections is completed. This would permit prompt penalization of facilities that do not correct deficiencies.

Recommendation 5-1: The HCFA should revise its guidelines for the post-survey process. Revisions should include

- *specifying that survey agency personnel not be used as consultants to providers with compliance problems*;
- *specifying how to evaluate plans of correction and what constitutes an acceptable plan of correction*;
- *specifying the circumstances under which onsite follow-up visits may be waived*;
- *specifying circumstances under which formal enforcement action should be initiated, and how actions should be taken; and*
- *requiring that states have formal enforcement procedures and mechanisms.*

Sanctions

Current federal sanctions are inadequate. Until very recently, if a state found a facility out of compliance with regulations, its only option under the federal program was to threaten to terminate the provider's Medicaid contract.[4] Termination of a contract essentially puts a provider out of business. Because of the undesirability of closing facilities and relocating residents, states rarely terminate contracts.[1]

Federal survey and enforcement criteria do not take historical offenses into account. Facilities are recertified on the basis of evidence of facility compliance collected at the time of the survey or on follow-up visits. Records of owners and operators and administrators are not considered. Sanctions are not applied for repeat deficiencies. Each of the case study states reported that 10 to 15 percent of their providers are constantly found to be out of compliance; they file and comply with correction plans, then are found to be out of compliance at the following survey. Even facilities

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with repeated major deficiencies are recertified if they meet their correction plans within 60 to 90 days. Recertification of decertified facilities or providers is done without regard to a history of noncompliance. Most terminated providers reenter the certification program a short time after decertification.[1]

The available federal sanctions are decertification and termination of the provider contract. Facilities also may be issued a temporary certification with an automatic cancellation clause. Early in 1985, the HCFA proposed additional federal rules allowing suspension of payments for new admissions, but (as of October 1985) this regulation has not been put into effect.

Decertification and Termination of the Provider Agreement

If the survey agency finds that a provider is out of compliance with one or more conditions of participation, is jeopardizing the health and safety of its residents, or has "limited capacity . . . to furnish adequate level or quality of care," it begins the process of decertification. Furthermore, if the provider has a Medicare contract, the state survey agency recommends to the federal regional office that the provider's Medicare contract be terminated. If the provider holds only a Medicaid contract, the state agency recommends to the state Medicaid agency that the provider's contract be terminated, and provides supporting documentation. The decision to terminate Medicare contracts rests with the federal office. The decision to terminate Medicaid contracts rests with the state Medicaid agency.

Decertification of providers is rare. It is an action of last resort, to be taken only when a provider demonstrates no intention of coming into compliance or the inability to do so. A facility has many opportunities during the lengthy process of decertification to come into compliance, however briefly, and thus be recertified.

From 1980 to 1984, the HCFA recorded the termination of 159 nursing home Medicare and Medicaid contracts.[10] Thirteen of the state agency directors report that their state decertified facilities in 1983. [9] The number of

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decertifications in those states ranged from I to 55 and totaled 129.

Voluntary Decertification

Facilities also may voluntarily terminate their Medicare or Medicaid contracts. This is usually done because the facility is unable or unwilling to correct deficiencies, or the facility is dissatisfied with reimbursement, or there is a change of ownership and the new owner does not wish to participate, or because the facility closes. [5]

According to the HCFA data, there were 967 voluntary Medicare contract cancellations between 1980 and 1984. In many of the cases recorded by the HCFA, the facility may have voluntarily terminated its Medicare contract while retaining its Medicaid contract. National data on the number of voluntary Medicaid contract cancellations are not available.

Termination Without Decertification

The federal regulations provide a number of grounds for terminating a provider contract in addition to failure to comply with the federal health and safety standards (42 CFR Part 489, Subpart E, in the case of Medicare providers; 42 CFR Part 442, Subpart B, in the case of Medicaid providers). These include failure to meet civil rights requirements, failure to provide financial information needed to determine payments, submission of false information, nondisclosure of ownership or of information on an individual convicted of a program-related crime (for example, Medicaid fraud).

Automatic Cancellation Clause

If a state agency determines that a provider has any deficiencies, the agency must issue a certification with an automatic cancellation date upon which the provider's certification will expire if the facility fails to correct the deficiencies by the given date. The date of automatic

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cancellation can be up to 60 days following the final date given in the provider's plan of correction. If the provider has corrected the facility's deficiencies, or if the provider "can document effort and progress to correct" the deficiencies by the date of the automatic cancellation clause, the cancellation is rescinded and the provider is given a routine 12-month certification. If the provider does not correct or make progress on correcting the deficiencies by the given date, the agency must initiate termination proceedings.

Of the 28 state certification agency directors who responded to questions regarding the cancellation clause, 7 states said they used the procedure often and 21 said they seldom or never used it. Twelve respondents said they thought the provision is an effective enforcement tool; 16 said it was ineffective. Several said that the ability to issue the clause is useful as a threat, whether or not they actually use it.[9] According to HCFA guidelines, cancellation clauses should accompany all certifications to providers in which a plan of correction is requested. States, however, either use the cancellation clause as a sort of intermediate sanction or do not use it at all. Only a few states reported that they used the automatic cancellation clause as routinely as instructed.

Suspension of Payment

The Omnibus Budget Reconciliation Act of 1981 provided authority to the Secretary of Health and Human Services to deny Medicare payments for new admissions to providers who are out of compliance with conditions of participation, as long as the deficiencies do not pose an immediate threat to the health and safety of the residents in the facility. The act assigns similar authority over Medicaid-only facilities to state agencies.

On February 21, 1985, the HCFA proposed regulations to implement the law and published them for review and comment.[11] The proposed regulations would allow the HCFA or the state Medicaid agencies to suspend Medicare or

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Medicaid payments for new admissions to a facility. If a state agency finds that a facility has deficiencies on the condition level that do not pose immediate threats to the residents' health and safety, but "are serious enough to require more emphasis than just a plan of correction," it may recommend suspension of payments for new Medicare and Medicaid admissions to the facility for a period of up to 11 months.[12] During a period of suspension of payments, the facility continues to receive payments for existing Medicare and Medicaid residents. The HCFA's New York regional office has, on the basis of a federal court order, used the federal authority to ban admissions to facilities. It reported that this mechanism is effective in coercing compliance with certification regulations. However, the statute and the proposed HCFA regulation on suspension of admission require that a formal hearing take place before the sanction takes effect, making the proposed sanction more difficult and slower to implement than decertification.

Until these regulations become final, a surveyor finding that a facility is consistently or repeatedly violating the certification standards may only decertify the facility and recommend termination of the provider's contract. For reasons previously cited, surveyors and state agencies hesitate to do this. Clearly, effective intermediate sanctions are needed.

Enforcement also could be more effective if the HCFA changed its procedures for hearings and appeals. It should develop regulations that would allow states to implement sanctions prior to hearings and appeals. The appeals process on sanctions should be made less permissive. This will require statutory change. Frivolous appeals could be discouraged by (1) clarifying the lack of a facility's right to a stay, pending judicial review of decertification decisions; (2) not making states prove that the violation is still outstanding at the time of the hearing in order to continue applying the sanctions; and (3) not reimbursing provider legal fees for unsuccessful appeals of survey-related cases. Currently, agencies cannot implement sanctions until the appeals process is exhausted. And many courts grant stays on decertification actions to facilities that have appealed

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the action, until the close of the appeal hearing. Thus a facility that the HCFA or the state agency has recommended for decertification may continue to operate for months or even years. Furthermore, if the facility has come into compliance by the time the appeal hearing is held, courts often reverse the decertification decision.[1,7] This practice has the effect of greatly extending the time a facility has to correct violations.

Because decertification proceedings only take place in the most severe situations, facilities should not be allowed to use this tactic to extend the time they are allowed to eliminate deficiencies. Appeals initiated for the purpose of delaying correction of deficiencies should be discouraged by making it clear that serious violations do not merit stays, that sanctions will be based on the deficiency in performance found at the time of the survey and not on later events, and that reimbursement for legal and other costs of unsuccessful appeals will be denied.

Finally, federal regulations should allow states to take into account prior years' survey findings as well as the most recent survey findings in applying sanctions. This is necessary to solve the problem of the chronically substandard facility. States also must have a method of weighting offenses as to seriousness, defining repeat violations, matching sanctions to violations, and determining liability for offenses to effectively sanction repeat offenders. Statutory authority will be necessary to enable the HCFA to prescribe procedures to be followed by the states in dealing with chronic or repeat violators of the regulations.

A repeat violation is defined as any major violation of a standard under a resident-care-related condition of participation if any other standard under the same condition was found out of compliance on the previous visit. The repeat violation may be found at either the follow-up visit, a complaint investigation, or at the subsequent annual survey visit. (If the latter, the facility's correction of the violation following the first visit should not prohibit the state agency from counting the first violation as an initial offense.) Any

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conditions that deal directly with the health and safety of residents should be included in this definition. Major violations of standards under a resident-care-related condition could include, for example, a facility's failure to employ a qualified dietetic supervisor one year, and then a failure to prepare and serve prescribed therapeutic diets the following year. Or a facility could be cited for poor resident care planning under the nursing services condition on an annual survey, correct the problem, and then be cited for poor administration of drugs on a follow-up or complaint visit. Procedures for punishing repeat offenses should include (1) the authority to apply stricter sanctions, such as more-severe fines, based on repeat offenses; (2) requiring states to consider the past record of an owner, administrator, or operator in their own and in other states prior to granting Medicaid certification; and (3) requiring states to obtain satisfactory assurances prior to granting a recertification that violations that led to a termination will not recur.

In determining the past record of owners for consideration in certification decisions, states should use the definition of ownership applied under current Medicaid fraud statutes: any party having 5 percent or more interest in the facility, land, or deed. The current Minnesota statutes covering nursing homes are a good example. The Minnesota statute states that a controlling person means (1) any public body, governmental agency, business entity, officer, nursing home administrator, or director whose responsibilities include the direction of the management or policies of the home; and (2) any person who, directly or indirectly, beneficially owns any interest in any corporation, partnership or other business association which is a controlling person, any interest in the land or structure, interest in any mortgage, contract for deed, or other obligation secured in whole or part by the land or structure, or interest in any lease or sublease of the land, structure, or facilities.[13]

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STATE RULES AND PROCEDURES

State Sanctions

Many states have authority to use various intermediate sanctions under their state licensing laws. States license nursing homes under their police power to protect the health, safety, and welfare of the public. The federal courts have upheld state authority to sanction nursing homes under state licensing regulations.[2,14]

The availability and use of intermediate sanctions vary widely by state. Although the median state has eight sanctions available, each state tends to use a subset of those sanctions, usually in a particular sequence that is graduated in severity.[9] Since intermediate sanctions are authorized by state legislatures, the sanctions differ from state to state. There are no nationally consistent intermediate sanctions or enforcement procedures. The intermediate sanctions available to states, and their use in 1983, are shown in Table 5-1.

Although regulators interviewed by the committee in about 10 states estimate that at least 10 or 15 percent of the facilities they regulate are marginal or constantly going in and out of compliance, the number of sanctions reported is relatively small. In 1983, a total of 2,000 actions were taken against some 15,000 facilities. Most of the actions (85%) were taken in 13 states. (This statistic probably means that some states are more enforcement-oriented than others, not that facilities in the 13 states are consistently poorer providers than facilities in the other 37.)

The survey of state licensure and certification agencies found that the use of sanctions in a state is associated with (1) higher state appropriations for the survey agency, presence of special enforcement training for surveyors, more available sanctions, and higher state licensure nursing standards; and (2) survey procedures that required greater numbers of facility visits a year.[9] It may be that increased resources available to a state survey agency lead to the increased detection of deficiencies, and this, in turn leads to more sanctions. Or it may be that states in which the

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TABLE 5-1 State Sanctions and Use in 1983

Sanction	Number of States With	Number of States Reporting Use of Sanctions in 1983	Total Number of Actions Taken
Civil or administrative fines	26	13	900
Court-appointed receiver	21	8	12
State-appointed monitor	7	3	3
Suspension of all admissions	32	15	96
Consideration of past record in CON approval	25	10	105
Court injunctions against substandard operation	37	9	13
State-initiated relocation of residents	36	14	27
Reduced Medicaid rates for interior performance	9	1	10
Conditional/ provisional licensing	35	14	268
Probationary license	15	5	154
Criminal penalties for patient abuse	30	5	376
License revocation	44	15	59
Involuntary decertification	40	13	129
Withholding of payments	19	3	272

SOURCE: Survey of State Licensure and Certification Agencies (see Appendix C).

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enforcement climate is favorable are more likely to provide their regulators with more resources and legal authority.

Directors of state survey agencies tended to give favorable ratings to the sanctions they use. Thirty-seven stated that particular sanctions seemed to be effective because they

- affect the income of the provider (20),
- can be implemented quickly (7),
- give the provider unwanted publicity (5), and
- can be used to remove the operator (4).

Nineteen states listed obstacles to the successful use of sanctions. These included

- administrative and legal time delays in implementation (11),
- administrative problems (3),
- fear of harm to residents (transfer trauma, service cutbacks to pay fines, and so on) (4), and
- insufficient impact on the provider's income (2).

Because current state sanctions are operated under state licensure programs, no two states impose the same sanctions or follow the same procedures. If the states are to conduct an effective and uniform enforcement program, it will be necessary for all states (and the federal government) to have the same set of intermediate sanctions and apply them in the same way. This change in enforcement policy and procedures will require federal statutory authority.

Intermediate sanctions must be available to the federal government as well as to the states. The HCFA needs sanctions to apply to facilities it certifies directly (state-owned facilities) and facilities it finds out of compliance in look-behind surveys. States need uniform sanctions to be applied in the same way to all facilities and to maintain consistency and credibility in the regulatory process. At a minimum, both the federal and the state governments should have the authority to ban admissions to facilities, to impose civil fines upon facilities, to put a facility into receivership, and, in

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the case of an emergency, to close a facility and transfer its residents to other facilities.

Intermediate sanctions should be authorized under the Medicaid program (as well as under state licensure authority) and implemented under a set of federal guidelines. This change would increase uniformity in enforcement activity and link intermediate sanctions directly to certification. Authorizing the same sanctions for both the federal government and the states will ensure that states have the same sanction to use in enforcing adherence to Medicare arid Medicaid nursing home standards. With appropriate federal guidelines on the use of sanctions, consistency among states will be increased and precedents within and among states will be set.

Procedures for implementing the sanctions should be specified by the HCFA. Intermediate sanctions adopted by the federal government and the states should operate so that they can be invoked promptly and be serious enough to the provider to deter violations as well as encourage immediate response. Procedures for *implementing* sanctions should include explanations of what sorts of deficiencies trigger the sanction, a method for ranking the seriousness of violations and corresponding punishment, timing of sanctions and appeals, and specific rules for designating responsibility for the violation and liability for punishment. For example, violations of residents' rights could be related to specific fines, increasing in amount based on the number of residents affected, the seriousness of the violation, the duration, and whether other rights have previously been violated. The fines could be implementable within a specified number of days, and applied to the controlling operator of the facility.

The particular sanctions recommended below are in use by a number of states as licensing sanctions. In the 32 states that currently have authority to suspend admissions to facilities, some have authority to suspend all admissions, and some can suspend only Medicaid admissions or payments for new Medicaid admissions. Suspension of admissions can work well because it combines a loss of new funds with adverse publicity. The sanction is also useful because it continues as long as the violation continues, but does not adversely affect current residents. The economic impact accumulates, but the loss of funds does

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not include current residents. Additionally, with the exception of truly life-threatening situations, allowing current residents to remain in the facility recognizes that the injury of substandard care may be outweighed by the injury of being uprooted and transferred. Most suspensions of admissions last only 2 to 4 weeks.[1,14] For a suspension of admissions to be effective, it should include admissions for all residents, and it should be implementable prior to hearings and appeals.

Civil fines are used by 26 states, 19 of which consider their fining system effective. In some states, civil penalty systems have performed up to expectations; in others, fines have rarely been used, or have been plagued by administrative problems.[14] Fines are a valuable enforcement tool because they can be applied to minor violations early and often, thus deterring facilities from making more serious transgressions. They also can be used for serious but isolated incidents.[7,14] Such desirable versatility requires that violations be ranked according to seriousness and duration, and fines of appropriate size matched appropriately. It is sometimes argued that fines are inappropriate sanctions since they may come from resident care funds. Any sanction, however, may have that effect. It is possible to monitor quality of care through financial audits and the survey process, to guard against this problem.

For a fining system to be effective, it is essential that the administrative and legal delays be avoided by prompt, short hearings, that the fines be graduated according to seriousness, duration, and repetition of the violations, and that fines be used to deter further violations. All fines should be large enough to be more costly than the money saved by the violation. Fining systems should be versatile enough to allow correction of less-serious violations, but immediately punish life-threatening violations.

Receivership is used by 17 states. Six of the states considered it effective. Receivership can be a useful enforcement tool. It enables the state to prevent an owner or administrator from continuing to operate a seriously deficient facility but does not force the

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facility to close and relocate residents. Receivership allows states to force dramatic upgrading of very poor quality facilities. Receivership can also be implemented quickly.[14]

An effective receivership program requires that the state licensure agency maintain a list of potential receivers, and a fund for paying them. Receivers should be experienced private parties who are assigned to operate the facility for a limited time. They should be paid for their services from an independent fund, and allowed reimbursement sufficient to cover required improvements in the facility.[14]

Additionally, residents, friends, families, interested community groups, and employees must be kept fully informed of the conditions leading to the receivership, and the scope and terms of the receivership order, including, for example, whether the receiver will transfer the residents or maintain the facility for possible purchase. If the receiver has indicated that he or she will not consider becoming the permanent operator of the facility, that should be clearly established. Coordination with the community is essential to successful receivership. If the purpose of receivership is to transfer residents, the receiver and the state should have a concrete and detailed transfer plan in place at the inception of the receivership, and residents, families, advocates, and the community should be consulted in developing this plan. Honest and full information to employees—and, as appropriate, their unions—also is essential. Fully informed employees are better able to assist in supporting the residents' needs. Although the facility may be reducing the number of employees over the receivership period, it would be harmful if employees left en masse. The receiver should develop a specific plan for relocation or job assistance for the employees. The employees' unions should be involved in this plan.

Receivership arrangements should be of short duration. Most state receivership statutes establish a time limit for operation of a receivership. The receiver should establish intermediate deadlines to accomplish particular objectives.

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Authority to close a nursing home and relocate residents in an emergency situation should be available to all state survey agencies. In extreme situations, such as fire, closing and relocation are clearly necessary, and should be a state-assisted effort. Thirty-six state agencies now have this authority.

Recommendation 5-2: The Medicaid authority should be amended to authorize a specified set of intermediate sanctions for use by states and by the federal government in enforcing compliance with nursing home conditions of participation and standards. The HCFA should then develop and issue detailed regulations and guidelines to be followed by the states and by the HCFA in using these sanctions. The sanctions should include

- *ban on admissions,*
- *civil fines,*
- *receivership,*
- *emergency authority to close facilities and transfer residents.*

Recommendation 5-3: The Medicaid statute should be amended to provide authority to impose sanctions on chronic or repeat violators of certification regulations. The HCFA should develop detailed procedures to be followed by the states to deal with such facilities. Procedures should include, but not be limited to,

- *the authority to impose more severe sanctions,*
- *a requirement to consider a provider's previous record before certifying or recertifying and*
- *the responsibility to obtain satisfactory assurances prior to recertifying, that the deficiencies that led to a termination will not recur.*

Recommendation 5-4: The Medicaid statute should be amended to make the appeals process on sanctions, particularly decertification, less permissive. The HCFA should issue regulations and guidelines to implement this new authority.

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ENFORCEMENT RESOURCES

Federal funds allocated to federal and state enforcement activities are inadequate. The federal role in improving the enforcement of nursing home standards should include not only developing new guidelines, procedures, and sanctions, but increasing federal enforcement activities, federal support for state enforcement resources, and federal oversight and support of state enforcement activities. The HCFA should have its own financial and legal resources for enforcement. Support of state programs should include both money and training. The HCFA also should increase data collection on enforcement resources and activities.

Enforcement is not currently recognized as a legitimate category of certification expenditures. Special funds are not set aside at the federal level for regional legal staff or legal actions. Regional offices have not allowed states to hire lawyers or other enforcement personnel or pursue hearings and appeals with certification funds.[1] Survey agency staffs rarely include specialists trained in investigation and enforcement, although some states use separate teams of special investigators. Only 15 states have staff attorneys in their licensure agencies who are specifically designated to deal with enforcement issues. Only three have special investigators. When states take court action, 13 have staff attorneys to represent them: 31 have departmental attorneys available; 3 have none.[9]

Surveyor training in enforcement is important. Health professionals are helpers by nature and training, and they are reluctant to invoke sanctions against violators except in extreme cases.[6] Federal training of surveyors in enforcement is minimal. The 1-week federal training course devotes only part of 1 day to documentation and witness preparation.[5] Thirty-three states conduct their own enforcement training. Programs vary from 1 to 96 hours, and average around 7.5 hours. Those who conduct specialized enforcement training find it to be effective. Without enforcement training, surveyors may not be able to

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document deficiencies in ways that will hold up in formal enforcement proceedings or act as effective witnesses.

There is no federal training support for state officials involved in nursing home certification other than surveyors. Officials involved in nursing home regulatory enforcement outside the licensure and certification agency often are ill-prepared to handle intricacies of nursing home law.[2]

Finally, data on surveyor decision-making, the imposition of sanctions, and the duration of sanctions are not kept by most states or by the HCFA. Thirteen states apparently did not have the information to respond to questions in the committee's survey of state health facility licensing and certification agency directors on actions taken in 1980. A few agencies could not give *information on* actions taken in 1983. The availability of national data on enforcement is necessary to maintain consistent and fair enforcement among the states, to allow states to compare and evaluate enforcement activities, and to allow states to trace the compliance histories of multistate providers—information that is essential to deal effectively with repeat offenders.

Recommendation 5-5: The HCFA should strengthen state enforcement capabilities by

- *requiring states to commit adequate resources to enforcement activities, including legal and other enforcement-related staff*:
- *requiring survey and certification survey agency staffs to include enforcement-related specialists, such as lawyers, auditors, and investigators, to work as part of special survey teams for problem situations and to help support enforcement decision-making*;
- *including more training in investigatory techniques, witness preparation, and the legal system in the basic surveyor training course; and*
- *providing federal training support for state survey agency and welfare agency attorneys in nursing home enforcement matters.*

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Other Factors Affecting Quality of Care and Quality of Life in Nursing Homes

Effective regulation is essential, but regulation is not sufficient to ensure high quality of care and quality of life in nursing homes. Three other factors are important: (1) active consumer involvement and effective consumer advocacy, (2) active community interest and involvement in nursing homes, and (3) positive motivation on the part of the owners and managers of nursing homes, and well-trained, well-supervised, and properly motivated staff. The first two are needed to help improve quality of life for residents and influence the attitudes and performance of the government regulators and elected officials as well as the attitudes and behavior of the management and staff of nursing homes. The third is essential for high-quality care. Pressures by regulators and consumers certainly can influence management and staff attitudes and behavior, but such pressures are not sufficient to produce the management and staff attitudes and to attract the quality of personnel needed to provide high quality of care and quality of life to nursing home residents. The desire for excellent performance and the ability to create the climate that will attract highly motivated and well-qualified professionals to work in nursing homes must be nurtured by sources within the industry and the educational and professional institutions

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that train and foster professional values, attitudes, and ethical standards.

INVOLVEMENT OF CONSUMERS AND CONSUMER ADVOCATES

Participation by residents and consumer advocates in some aspects of resident care policy-making in nursing homes is essential for achieving high quality of care and quality of life. Many important decisions on care policy rest on implicit value choices—that is, they are not based entirely on technical or managerial imperatives. Because quality-of-life considerations are so important in nursing homes, systematic arrangements should be made to determine the value preferences of the residents or those most concerned about their well-being, both at the individual and facility-wide levels.[1]

Consumer Involvement

Whenever possible, facility staff and management should honor consumer preferences. An authoritarian style of decision-making is not appropriate in nursing homes, but many nursing homes appear to operate in this style because it is administratively more convenient for staff and management. It is not appropriate for two reasons: (1) Long-term care requires explicit recognition of the deep psychological need of all adults to be able to exercise some personal choice on matters involving the quality of their daily lives—food, clothing, recreation; (2) staff in a long-term-care facility need to obtain systematic feedback on the care needs and desires of individual residents to ensure that their plans of care fit the residents' perceptions—as well as those of the staff—of their physical and psychosocial needs. Several recommendations in Chapter 3 address the issue of ensuring resident participation in nursing home decision-making.

Another important aspect of resident and consumer advocate participation is discussed in Chapter 4: participation in the survey process.

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The Role of Consumer Advocacy

Although improving state and federal regulatory attention to residents' opinions is a fundamental requirement for improving nursing home quality, broader consumer protection measures are warranted for the following reasons:

- Regulatory agencies are constrained by their limited resources to inspecting nursing homes only once—or at most a few times—each year, and these agencies have no capacity to monitor the process of care or staff/resident interactions between their infrequent inspections.
- In many nursing homes some of the care-giving staff are undertrained, overworked, and unable to provide sufficient attention to very dependent residents. Moreover, there is considerable staff turnover. Under these circumstances, staff/resident interactions may be less than satisfactory, residents' rights may be violated by staff, by management, or by other residents, and there is an ever-present risk of neglect and even of abuse of residents by staff or other residents.[2]
- Physical, mental, cognitive, and financial infirmities (see data in Chapter 2) render many residents incapable of assertion and self-protection.[2] Thus, many nursing home residents are too frail and too vulnerable to effectively influence the attitudes and behavior of nursing home staff in homes that are not very sensitive to residents' needs. Without the assistance of effective consumer advocates, such residents usually cannot communicate complaints to outside agencies that could help them. There is abundant evidence that the need for strong consumer protection in nursing homes is still essential.

Access to Information

Consumer advocates require access to certain information to be effective in their roles of advising and helping consumers. In the case of individual residents, access to a resident's medical records (with the resident's

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permission) may be necessary for an ombudsman concerned with investigating a complaint about an individual's care. Recommendation 3-7F in Chapter 3 addresses this issue. More broadly, it is important for local and other substate ombudsmen, as well as other consumer advocacy organizations, to have access routinely and easily to government inspection and cost reports on individual nursing homes. Although these are public documents, many states do not routinely make the information publicly available and it is often difficult for consumer advocates to obtain copies.[3] The HCFA has no explicit policy on this matter. In the survey of state licensure and certification agencies conducted by the committee, 30 of 47 state agencies expressed support for the policy of making the results of nursing home inspections public.[3] A few states already do so. The committee is convinced it would be desirable to make this practice universal.

Recommendation 6-1: The HCFA should require states to make public all nursing home inspection and cost reports. These documents should be required to be readily accessible at nominal cost to consumers and consumer advocates, including state and local ombudsmen.

The Ombudsman Program

The ombudsman program emerged in the early 1970s in response to growing public awareness of the need for stronger consumer protection activities in nursing homes to supplement government regulation. Eight pilot programs were funded by HEW in 1972 and 1973. In a program instruction dated May 1975, and issued to all state agencies on aging, the Commissioner of the Administration on Aging (AoA) explained the necessity for establishing the ombudsman program:

> Our nation has been conducting investigations, passing new laws, and issuing new regulations relative to nursing homes at a rapid rate during the past few years. All of this activity will be of

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> little avail unless our communities are organized in such a manner that new laws and regulations are utilized to deal with the individual complaints of older people who are living in nursing homes. The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued.[4]

The statutory authority for the ombudsman program dates from 1978 (minor amendments were added in 1984) when the Older Americans Act was amended to require that every state agency on aging include in its multiyear plan of proposed activities assurances that each state plan will

(A) establish and operate, either directly or by contract or other arrangement with any public agency or other appropriate private non-profit organization not responsible for licensing or certifying long-term care services in the State or which is an association (or an affiliate of such an association) of long-term facilities (including any other residential facility for other individuals), a long-term-care ombudsman program which provides an individual who will, on a full-time basis:

(i) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare, and rights of such residents;

(ii) monitor the development and implementation of Federal, State and local laws, regulations, and policies with respect to long-term care facilities in that state;

(iii) provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities;

(iv) provide for the training of staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program; and

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(v) carry out such other activities as the Commissioner deems appropriate;

(B) establish procedures for appropriate access by the ombudsman to long-term care facilities and patients' records, including procedures to protect the confidentiality of such records and ensure that the identity of any complainant or resident will not be disclosed without the written consent of such complainant or resident, or upon court order;

(C) establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems, with provision or submission of such data to the agency of the State responsible for licensing or certifying long-term care facilities in the State and to the Commissioner on a regular basis;

(D) establish procedures to assure that any files maintained by the ombudsman program shall be disclosed only at the discretion of the ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long-term care facility shall not be disclosed by such ombudsman unless

(i) such complainant or resident, or his legal representative, consents in writing to such disclosure; or

(ii) such disclosure is required by court order;

(E) in planning and operating the ombudsman program, consider the views of area agencies on aging, older individuals and provider agencies. [5]

Several aspects of this authority are particularly significant:

- The responsibilities of the state ombudsman programs are defined in very broad and general terms. Their interpretation and implementation are left entirely to

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the states. (The implementing regulations issued by AoA do not eliminate the vagueness.)

- The ombudsmen are to be available to help *all* residents of nursing homes and other long-term-care facilities, not only those funded by Medicare and Medicaid.
- The ombudsman program was evidently conceived as a bridge between the state government and the nongovernmental consumer advocacy groups. An ombudsman (according to *Webster's New Collegiate Dictionary*) is a government official appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials; also one who investigates reported complaints from consumers and helps to achieve equitable settlements. But the ombudsman's role, as defined in the Older Americans Act, goes beyond the dictionary definition in that it mandates a *consumer advocacy* role for the ombudsman programs. It also explicitly authorizes contracting with "appropriate non-profit" organizations. In practice, most such organizations are consumer advocacy organizations concerned with nursing home residents because the local or area-wide ombudsman role fits comfortably within the purposes and capabilities of such organizations. Many, though by no means all, states have thus merged the ombudsman and the voluntary consumer advocacy functions at the local level.
- The law makes state ombudsmen responsible for the collection and analysis of data and other information about complaints, about conditions in long-term-care facilities, and about other matters required to carry out their statutory responsibilities, and makes them responsible for submitting such data to the state licensure and certification agencies.
- The statute does not refer to substate ombudsmen—only to "the ombudsman" who is, presumably, the state ombudsman. Thus, for example, in paragraph B concerning access to facilities and patients' records, the reference is to "the ombudsman," although it is the local ombudsman program representatives (who may be volunteers) who do most of the complaint investigations.

There are ombudsman programs in virtually every state and territory, with more than 1,000 paid staff and more

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than 5,000 volunteers,[6] but the programs vary widely in their effectiveness. Moreover, there are many communities that are not adequately served. Successful programs tend to have the following factors in common: budget continuity, some professional staff, a qualified supervisor, organizational sponsorship but independence in operation, standard methods of intervening and representing residents, consistent documentation of findings and actions, and standard methods of correcting problems and coordinating with regulatory and community services agencies. [2,6-9]

Ombudsmen help individual residents and their families negotiate with nursing homes and regulatory agencies. They deal with individuals and their orientation is problem-solving rather than regulatory. They frequently deal with problems that are beyond the scope of regulation. And they are available to help all residents of long-term-care facilities, not just those supported by Medicare or Medicaid.[7]

Because of their orientation, the scope of their responsibilities, and because they see residents regularly and are acquainted with individual resident views and difficulties, ombudsmen in the effective programs have demonstrated their ability to serve as consumer representatives in dealing with nursing home staff and management and with government agencies. They can aid individuals and they can help residents obtain more formal assistance when it is needed.

Ombudsmen have a range of legitimate and necessary roles in consumer protection. They can serve as a resident's ally in a negotiation or serve as a third-party mediator. They can educate family groups in self-advocacy or help a community planning group develop a service for the elderly and handicapped. They can be a conduit of consumer information to nursing home professionals and to regulatory agencies. Whereas state government surveyors are responsible only for determining whether facilities are in compliance with licensure and certification regulations, an ombudsman addresses any problems faced by residents, ranging from unsatisfactory food to unexplained extra charges to personal worries. Because ombudsmen are not regulators, they can mediate between and among consumers, providers, and regulators.[7-9]

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Despite the breadth of the statutory authority provided to the ombudsman program, Congress implicitly accorded the program low priority within the Older Americans Act because (1) it is authorized in Title III, where it is juxtaposed with the service programs for the non-institutionalized elderly, that is, with AoA's major program responsibilities; and (2) each state program is authorized to use not more than 1 percent of its AoA Title III federal funding or $20,000, whichever is larger, and to match federal funding at 15 percent of the total.[7,10] States may opt to fund their programs at higher levels, but few do.[3,11] The scope and responsibilities of the state ombudsman programs are defined by the act in very broad and general terms. Interpretation and implementation are left entirely to the states.

Local programs vary widely within and among states in their organizational arrangements and the training and qualifications of ombudsmen. Most ombudsman programs rely heavily upon volunteers to carry out the day-to-day work in nursing homes. Volunteers vary in background, experience, and aptitude. Local programs lack resources, staff, legal support, and training.[7,8] Yet between FY 1982 and FY 1984, there was a 56 percent increase (29,699 to 46,325) in the complaints processed by these offices.[6] Increased service requests are expected.

Concern has been expressed by state and substate ombudsmen about the lack of adequate professional staff support at the federal level for the ombudsman program.[6] Concern has also been expressed about the adequacy of federal guidelines for structuring state ombudsman programs. There needs to be stronger national leadership to foster development of effective training and other necessary materials to assist state programs. No national clearinghouse has been established to facilitate exchange of information and experience among state programs. Inadequate information is being collected on the comparative effectiveness of different programs.[8] The complex issue of standardizing data collection and analysis in the various state programs has not been solved.

Consistency and accountability would be enhanced by the statutory establishment of a National Advisory Council

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whose members are appointed by the Secretary of HHS and who would not only advise the Secretary on the development and operation of the program but would submit an annual report to Congress on the status, progress, problems, and future plans of the ombudsman program.

Vague statutory language is responsible in part for problems of access to nursing homes experienced by local ombudsmen in some states. The law specifies that only "the ombudsman" has authorized access to facilities, residents, and documents. In many states, this is interpreted to mean that only the state ombudsman has this authority. Yet it is the local ombudsman who is most likely to visit residents and assist in resolving their individual problems. Substate and volunteer ombudsmen, who deal directly with the majority of residents, do not always have official access to residents and facilities. Some states have statutes addressing this issue. Many do not.[8]

Further, the ombudsman programs need legal advice and support to ensure careful interpretation of laws and regulations, and to withstand the occasional legal challenges with which they are confronted as a result of actions taken in carrying out their authorized responsibilities. Statutory language should authorize such support.

Another pressure constraining ombudsmen Stems from a recent circular of the Office of Management and Budget. In April 1984 the Office of Management and Budget issued a revision of OMB Circular A-122, "Cost Principles for Non-Profit Organizations." Among other provisions, the circular prohibits federally funded programs from lobbying.[12] The Older Americans Act makes ombudsmen responsible for monitoring legislative and regulatory events to advise public officials on the perceived effects of particular laws and regulations on nursing home residents. This statutory responsibility can be interpreted as conflicting with Circular A-22. Federal funds are usually the major portion of an ombudsman's budget. If federal auditors were to disallow use of ombudsman program funds on the ground that ombudsmen were violating the lobbying provisions of Circular A-122, they could destroy the program. To safeguard the continuance

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of individual client services, many programs have ceased speaking publicly about nursing home issues. Although requested to do so, the OMB has declined to exempt the ombudsman program from compliance with the relevant portions of this circular. Most substate ombudsmen believe that advocacy involving such activities as testimony before state legislative committees will be challenged by federal auditors because of OMB Circular A-122, despite their statutory authority to act as advocates for long-term-care residents at the state policy level.[7,8] Congress should resolve this conflict by statutory action that confirms the legislative and regulatory advisory roles of ombudsmen. With the increases in resources and authorities recommended below, state and local programs should be obligated to screen, train, and monitor their professional and volunteer staff; set service standards and evaluate results; and coordinate services with other community and professional groups and with regulatory agencies.

The successful ombudsman programs have demonstrated the considerable value these programs have for nursing home residents, but there are too few successful programs. These circumstances are not likely to change without increased funding and stronger federal direction for the program.

Recommendation 6-2: The Older Americans Act should be amended to

- *establish the ombudsman program under a separate title in the Act*;
- *increase funds for state programs by authorizing federal-state matching formula grants for state ombudsman programs. The formula should provide each state with a minimum annual budget in the range of $100,000 (1985 dollars) plus an additional amount based on the number of elderly residents in the state. The federal-state matching ratio should be two-thirds federal to one-third state funds*. (Although the committee did not study in any depth the budget requirement, this minimum amount is intended to provide the ombudsman program with, for example, the capability to support, at a minimum, a

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full-time professional and secretary and sufficient travel and training funds to recruit, train, and certify volunteers as local ombudsmen.)

- *establish a statutory National Advisory Council composed of state ombudsmen, state and local aging agencies, provider and consumer representatives, state regulators, health care professionals (physicians, nurses, administrators, social workers), and members of the general public to advise on administration, training, program priorities, development, research, and evaluation*;
- *authorize state-certified substate and local ombudsmen, including trained, unpaid volunteers, access to nursing homes and, with the permission of the resident, to a resident's medical and social records*;
- *authorize public legal representation for ombudsman programs*;
- *exempt the ombudsman programs, including substate ombudsmen who are supported by funds from the state ombudsman program, from the antilobbying provisions of OMB Circular A-122.*

Recommendation 6-3: The Secretary of HHS should direct the Administration on Aging (AoA) to take steps to provide effective national leadership for the Ombudsman Program. At a minimum the Commissioner of AoA should designate a senior full-time professional and some supporting staff to assume responsibility for administering the program. Priority should be given to establishing a national resource center for the program that would develop, in consultation with state programs, an information clearinghouse, training and other materials to assist states, and guidance to states on data collection and analysis. The center should advise on establishing program priorities, and sponsor research and evaluation studies.

One other major issue requires attention: the relationships between state licensure and certification agencies and ombudsmen. Although reasonably good working relationships exist in some states, relationships are unfriendly in many states. The key issues are mutual

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understanding of, and agreement on, roles, operational relationships, and access to information. These can be complex issues, and there are few states where they have been worked out fully. Obtaining copies of state nursing home survey reports is sometimes difficult and expensive for ombudsmen. In many states, surveyors seldom make an effort to contact local ombudsmen either before or after they survey a facility.[7,8] About one-quarter of the states regularly inform ombudsmen of survey findings; less than half receive information from ombudsmen.[3] Survey agencies are often concerned that ombudsmen are assuming a quasi-regulatory role, or that they are ill-equipped to render beneficial services to nursing home residents. Only a few state regulatory agencies routinely share information with ombudsmen and receive and refer cases to ombudsmen.[8,10] On the other side, ombudsmen often are suspicious of regulators and their findings.[7]

Conceptually, of course, the two roles are complementary: the state surveyor is concerned with legal compliance with regulatory standards by the nursing home, the ombudsman with ensuring that the individual residents' rights are observed and that they receive reasonable treatment by facility staff and management. In places where ombudsmen and state surveyors understand each others' roles, seek and offer each other advice and services, and cooperate on problems of mutual concern (whether the problem is a specific facility or a state policy), nursing home residents and their families benefit. A few states have developed formal, written agreements between state regulatory agencies and the state ombudsman program that cover information-sharing, training, and case referral between surveyors and ombudsmen. The committee is convinced that this is a desirable arrangement that all states should follow.

Recommendation 6-4: The HCFA should require state long-term-care regulatory agencies to develop written agreements with state ombudsman programs covering information-sharing, training, and case referral.

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COMMUNITY INVOLVEMENT

In the last 20 years or so, research studies have explored issues of the effects on nursing home residents and staff of varying degrees of involvement with community groups. These studies have found that residents benefit and the quality of nursing home performance is likely to be higher than in homes with few outside visitors.[1,13-15] Residents who were able to maintain family relationships or create new relationships with others from the community were more likely to have more amenities for living, including favorite foods to supplement the institutional diet. Clothing and toiletries, which are difficult to obtain because most nursing home residents have a very small monthly personal allowance and are unable to shop outside the home, may be supplied by visitors. Moreover, the frequent presence of visitors encourages staff attention to the resident, and often roommates and others in the unit.

There are many examples of the involvement and commitment of local community groups such as churches and service organizations to some nursing homes in their communities, but—although data are not available—such involvement appears to be much less common than would be desirable.

Many nursing homes, despite their status as public facilities, generally receive little or no community support or attention. Increasing community involvement with nursing homes on a regular, sustained basis is important for three reasons: (1) to enhance the quality of life of nursing home residents by reducing their sense of isolation from the community and providing opportunities for stimulating social interactions, (2) to help improve the quality of care in nursing homes by making staff-resident interactions more visible to members of the community, (3) to increase the level of understanding in the community about the issues and complexities of long-term care so as to facilitate the development of more appropriate public policies in this area.

Serious exploration of ways to stimulate and foster such community involvement merits the attention of the

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Administration on Aging. The possibility of enlisting the interest of one or more national service organizations to undertake a demonstration project should be considered.

MANAGEMENT AND STAFF MOTIVATION

The motivation, attitudes, qualifications, and skills of management and staff in nursing homes are among the most critical factors affecting quality of care and quality of life in nursing homes. Professionals in all fields are responsive to peer judgment. A professional's ethical and performance standards and associated values and attitudes are acquired as a concomitant of his/her education and training. They are sustained through interactions with peers in various settings and circumstances, both formal and informal.

Development of Professionalism

The emergence of professionalism in the nursing home industry is a recent phenomenon. There was very little professionalism in this field 30 to 35 years ago, but this has been changing. A number of professional organizations and institutions have contributed to this growth of professionalism.

Although the committee does not believe it would be sound public policy to allow JCAH accreditation to serve—in lieu of a state survey—as a basis for certifying a nursing home, it does believe that the accreditation process is an important and very desirable way for the industry to raise its own standards of performance using the techniques of peer judgment and consultation.

The Joint Commission on Accreditation of Hospitals (JCAH) has had an accreditation program for nursing homes since 1966. Voluntary accreditation by JCAH has been the standard form of quality assurance used by hospitals for many years. The JCAH accreditation process emphasizes voluntary participation, independent peer review, and professional responsibility. Individualized and ongoing

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educational and consultation activities are key aspects of the program. About 1,400 nursing homes are now accredited. The JCAH publishes a Long-Term Care Standards Manual that is revised and updated periodically.[16]

The health professional schools, particularly schools of nursing and schools of medicine, have begun to develop active research and educational ties with nursing homes. Both the Robert Wood Johnson Foundation and the National Institute on Aging sponsor teaching nursing home programs.[17,18] These are recent developments—the programs have been under way for a few years—but in the long run they are likely to exert a powerful effect on professional values, on care practices, on training, and on quality of care in nursing homes.

The professionalism of nursing home administrators also is being strengthened. All states license nursing home administrators, although requirements for state licensure vary widely. Nursing home administrators have formed an active professional association—the American College of Health Care Administrators—to raise qualifications and to enhance the professionalism and skills of its members.

Although physicians' roles in nursing homes are much more limited than they are in hospitals, there is substantial concern that in many nursing homes physicians perform in only a perfunctory or *pro forma* manner. But this may be changing. There is growing interest in geriatric medicine among physicians and in medical schools. This has been stimulated by the programs of the National Institute on Aging, the Veterans Administration, and the Bureau of Health Professions in the U.S. Public Health Service. It seems probable that the growing numbers of elderly and the rapid growth in the number of practicing physicians in the 1980s also may be contributing.[17,19] In the long run, these trends are likely to result in better-motivated physicians, with some formal training in geriatric medicine, providing better medical care to nursing home residents.

The leadership of organized nursing has recognized for almost 20 years a specialty of "gerontological nursing." It emphasizes health promotion, health maintenance, disease prevention, self-care, and self-help. Gerontological nurses are expected to help older patients

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reach their maximum potential level of physical, mental, and social functioning. Both the National League for Nursing and the American Nurses Association Division of Gerontological nursing have been promulgating national standards for long-term nursing care. As the regulatory system becomes more sensitive to the presence and importance of directors of nursing in nursing homes, the professional nursing organizations are responding by formulating standards, career development courses, and facility-based procedures that support the nursing director's role in the organization and management of care in nursing homes. [12,18] Facilities should recruit and employ specialty-trained gerontological nurses and encourage currently employed nurses to seek training in gerontological nursing.

Another step toward professionalism is indicated by the large interstate proprietary nursing home chains that have started internal corporate quality assurance programs. For example, the National Health Corporation introduced a computerized resident assessment system about 12 years ago in its eight-state chain of 50 nursing homes.[20] The system has multiple purposes, but among them is outcome-oriented quality assurance by means of longitudinal analysis of changes in resident status. The availability of the data makes it possible for corporate headquarters to determine whether specific nursing homes are having quality problems and to take steps to deal with them promptly. The Hillhaven Corporation, one of the largest chains, is in the process of installing a similar system. Beverly Enterprises, the largest of the chains, has developed an internal quality assurance program with a full-time executive in charge of it.

It is clear that both private efforts and government regulation are needed to improve quality of care for and well-being of nursing home residents. Private efforts to increase knowledge, to improve training, to enhance professionalism in the industry, to increase efficiency and effectiveness in providing care, and to strengthen commitments to self-regulation are essential. But the vulnerability of the residents and the widespread perceptions that current levels of performance still leave

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much to be desired also make effective government regulation essential.

Incentive Systems for High-Quality Care

Modern management theory holds that excellent results are more likely to be achieved when the members of an organization are motivated not by fear of sanctions for inadequate performance, but by pride, accountability, cooperation, and loyalty.[21,22] The HCFA and state governments can apply this concept in their dealings with nursing homes. The current federal regulatory system is structured only to punish poor behavior. Good behavior goes unrecognized. Only a few states have developed systems for rewarding good or outstanding facilities.[3] In part, this is attributable to the crudeness of the survey instruments. After the HCFA has implemented the new survey process recommended in Chapter 4, and after some statistically derived outcome standards are developed, it should be possible to reliably distinguish the very good from the poor or merely acceptable performers. It will then be possible to reward facilities for excellent performance and thus to encourage continued excellent performance.

The new survey process recommended in Chapter 4 ultimately can facilitate development of an incentive system. Facilities with proven records of good behavior would be praised by surveyors and would be surveyed in full less frequently. Extended surveys would be applied only to facilities whose outcomes of care indicate that further investigation is warranted. More reliance on outcome-oriented standards would enable the survey agency to allow facilities with records of good care to experiment with better procedures for delivering care. Methods that continue to produce good results, even though not strictly in keeping with structural or process regulations, such as the use of a geriatric nurse practitioner for a medical director, should be allowed in facilities that consistently demonstrate excellent performance on the standard survey.

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The certificate-of-need (CON) process also can be used as part of an incentive system. Certificates of need are documents issued by the state to authorize health facilities to build or expand. States set criteria by which they judge whether the services proposed by a provider are needed, and whether the provider is qualified to provide services in the state. Currently, 46 states require nursing homes to obtain certificates of need before expanding services.[23] In 25 states, the agency granting a CON first reviews the facility's licensure and certification record. These states use the procedure as a sanction against poor providers, denying certificates of need to providers with records of poor care. (Ten states refused certificates of need to poor providers in 1983.[3]) Awarding a certificate of need also could be used as an incentive to provide superior care. Only facilities with records of providing superior care should be eligible to receive CONs.

Systematic use of rewards for superior performance would not only motivate providers who currently give superior care to continue to do so, but would encourage above-average and average facilities to try to improve so as to reap the benefits of this status.

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Issues Requiring Further Study

There are five sets of issues that need study before federal policy positions on these issues can be developed and prescribed: (1) the scope and design of information systems needed to regulate nursing homes effectively and to facilitate development of sound policies for long-term care; (2) policies governing the methods and amounts of payments to nursing homes for care of residents eligible for support under the Medicaid program; (3) policies affecting the supply of nursing home beds in the context of the growing demand for all types of long-term-care services; (4) regulatory policies concerning (a) the training and qualifications of all staff in nursing homes and (b) minimum staffing patterns needed to provide adequate care to mixes of residents with varying needs; and (5) policies governing construction of new nursing homes, specifically, the proportion of single rooms that should be required.

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INFORMATION SYSTEMS

Data About Residents

The introduction of the requirement (recommended in Chapter 3) for standard assessment data on every resident will produce a vast body of data about the characteristics of nursing home residents and how they change while in nursing homes. These data have potentially major significance for three purposes: (1) for improving nursing home management, (2) for improving the effectiveness of regulation, and (3) for obtaining essential information with which to develop more effective and efficient nursing home regulatory policies, and for facilitating development of more appropriate long-term-care policies.

It is a large undertaking to install a national standard resident assessment system in 15,000 nursing homes that has the capability of allowing needed information to be retrieved readily. It involves, among other things, determining the standard data to be collected and designing and testing techniques for Collecting it reliably, developing instruction manuals, and training thousands of people to conduct the assessment routinely and with reasonable integrity and reliability.

It also involves developing case-mix groupings based on definitions related primarily to assessment scores, and developing auditing procedures and the standards to be used by state auditors to determine whether the error rates they find are acceptable. With good planning, adequate resources, and strong, competent leadership, this set of tasks could be accomplished in 2 or 3 years.

Complex technical and policy decisions are involved in designing a sound system for gaining access to these data by computer. The decisions will require careful study and will take time. Introducing a manual resident assessment system should not be delayed until this study is completed. A great many nursing homes now have their own computers. Some—perhaps many—are likely to enter resident assessment data into their own computer files so that they can use it for their own management purposes.[1]

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But a great deal of work would have to be done to determine how best to use these data to meet both state and federal government (as well as resident care) needs. Some questions occur, such as whether all data on all residents should be acquired by the state regularly or whether the data should be sampled, and, if so, how, and how often. These questions can be answered largely by determining the priority uses to which the data are to be put—for example, for developing case-mix-controlled outcome standards for quality assurance purposes, for use in Medicaid payment decisions, for developing staffing and other resource algorithms tied to case mix, or for utilization review. There also are questions of cost, technical feasibility, privacy, authorized access to and uses of the data, and a number of other technically and legally complex and politically sensitive matters.

These questions can and should be resolved. The rapid advances and decreasing costs of computer technology make a computerized system for handling resident assessment data feasible from technical and economic standpoints. A study should be commissioned by the Department of Health and Human Services to design the system. Responsibility for conducting the study should be assigned to a group of technically competent and broadly knowledgeable people who are sensitive to the concerns and needs of all interested parties—the residents, the nursing home operators, state governments, and the federal government.

Such a study will have implications for the future role and contents of the National Nursing Home Survey conducted by the National Center for Health Statistics. This survey has been the most important source of information on nursing home residents and care resources. However, its utility has been limited by its small sample size, long intervals between surveys (almost 10 years since the last completed survey), the modest amount of data on the health and functional status of residents, and absence of longitudinal data. The recommended study could lead to a new strategy that would resolve these problems. In this process, consideration needs to be given to relevant recommendations of the National Committee on Vital and Health Statistics for a minimum data set on long-term care.

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Other Data About Nursing Homes

As mentioned in Chapter 1, the committee was impressed by the paucity of information about nursing homes and their operations, as well as about regulatory activities available on both national and state levels. With more than half of all nursing home revenues coming from public funds, and with growing demand for nursing homes and other types of long-term-care services, the need for more information seems clear. But moving from that general conclusion to specific decisions on what information should be collected, how frequently, how it should be done, how it should be aggregated, analyzed, and made publicly available, and who should be responsible, is quite another matter. A study by a technically competent and broadly knowledgeable group—possibly the same group that is responsible for studying the resident assessment data system—should be asked to study the requirements and make recommendations on how they should be handled.

Recommendation 7-1: The Secretary of HHS should order a study to design a system for acquiring and using resident assessment data to meet the legitimate and continuing needs of state and federal government agencies. The Secretary also should order a study to determine the needs for other data about nursing homes that would facilitate regulation and policy development. This study should recommend specific ways to collect, analyze, and publish or otherwise make such data publicly available.

MEDICAID PAYMENT POLICIES

The Medicaid program was originally designed to pay for health care services for those on welfare and selected others whose incomes were low and who were "medically needy" because they had no health insurance. Medicaid was—and is—perceived at the state and federal levels as a component of the welfare system. As is true of the other components of the welfare system, the states are responsible for administering it under broad federal guidelines. This means that each state determines who

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shall be eligible for Medicaid, what services it will pay for, and how (and how much) it will pay the health professionals and the institutions who provide authorized services to eligible patients. Medicaid funds are appropriated annually (or biennially) by state legislatures as are the matching federal funds. The federal contribution to state Medicaid budgets ranges from 50 to 78 percent. In most states, Medicaid is the second largest budget item after education and in recent years has been the fastest growing.[2] About 50 percent of nursing home revenues come from Medicaid. The funds pay for some or all of the costs of about two-thirds of the residents.[3] In 1984, Medicaid expenditures for nursing home care totaled about $14 billion.[4]

Medicaid payment policies—both the methods used to calculate how much to pay, and the actual rates of payment—provide strong incentives to nursing home operators. (Eighty percent of the beds are operated on a for-profit basis.) Nursing home operators adjust their operations so that the revenues they receive cover all of their costs (including capital costs) plus a profit. Nursing homes can control costs by controlling admissions (choosing a mix of residents whose needs for care can be paid for by the revenues they bring in), and by controlling such variable operating expenses as staffing, food, laundry, housekeeping, and plant maintenance. Because Medicaid rates are as much as 30 percent lower than private rates for comparable residents in some states, there is a clear incentive to try to attract and keep as many private-pay residents as possible.

At least six goals have been suggested (or implied) as appropriate for state Medicaid payment policy. It should

1. control public expenditures for Medicaid;
2. ensure adequate provider participation and access to care by those eligible—or likely to become eligible—for Medicaid, irrespective of degree of disability;
3. encourage appropriate and high-quality care;
4. deliver service efficiently (provide the maximum appropriate service per dollar);
5. be administratively simple to implement; and
6. minimize the potential for fraud and abuse.

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The committee commissioned a review of the research literature to ascertain what is known about the effects of different Medicaid payment policies both on access and quality of care in nursing homes.[5] The findings suggest that the relationship between quality and payment policy is highly variable and somewhat unpredictable. Some facilities provide excellent care at the same payment rate, and with the same resident mix, as other facilities in the same geographic area that provide substandard care. Some rates or payment levels may be insufficient to provide desirable quality of care and quality of life, but the distribution of the payment into cost line items within a facility may have a greater impact on quality than the amount of the total payment. Furthermore, such aspects of facility performance as the quality, motivation, and efficiency of the care-giving staff, and managerial skill, are not price-sensitive. These performance characteristics vary greatly across facilities. Since the relationships among costs, charges, and quality of care are very complex, simply paying more is no guarantee of improved quality. In some cases, paying less (up to a point) need not lower quality. No studies, however, have adequately investigated the complex relationships among costs, charges, reimbursement, and quality.

The fact that the current literature does not show strong relationships among cost, charges, payment policy, and quality does not imply that there are no relationships. Available ways to measure are neither valid nor reliable. Most studies have measured structure or process because they were the only known proxies for quality. It would be desirable to know how the quality of life (as perceived by the resident) and the quality of the care (as determined by case-mix-controlled outcomes compared to national norms) are related to costs.

In sum, there is now no evidence to establish the superiority of any Medicaid payment policy with respect to its effects on quality of care. There has been little systematic evaluation of the impact of different systems, in part because many have been implemented recently. Ideally, if a particular approach to Medicaid reimbursement policy proves to be more successful than

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others in having the desired effects on nursing home behavior, it should be adopted by all states. Thus, it is an important area for further federal policy development. But much additional research is needed and it merits continued high-priority attention by the HCFA. Research and demonstrations to test innovative payment systems should be encouraged. They should include, for example, all-payer rate setting, to assess its effects on quality of care and access for heavy care and Medicaid residents. The research opportunities in these questions will be enhanced considerably once the standardized resident assessment data system is in place. It will then become possible to control for case mix and apply outcome measures of quality.

DEMAND FOR AND SUPPLY OF NURSING HOME BEDS

Demand

In most states[6] there is evidence of excess demand for nursing home beds: occupancy rates are well over 90 percent and there are waiting lists at many facilities. The demographic trends suggest that the demand for the kinds of long-term care services now being provided mainly by nursing homes is certain to increase. The number of persons over 65 is projected to increase from 25.7 million in 1980 to 36.3 million in 2000, a 41.2 percent increase. For the over-85 group, the projected increase is 108 percent during this period, from 2.6 to 5.4 million.[7]

The rapid growth of the population aged 85 and over is likely to have a significant impact on the size and structure of the nursing home population.[8] If current age and sex-specific institutionalization rates hold, the proportion of the residents in nursing homes who are age 85 and over can be expected to rise from 31 percent in 1980 to 43 percent in 2000. This increase in the mean age of the nursing home population implies a greater proportion of heavy-care residents.

Two additional factors may affect demand for nursing home beds. One is the rate and direction of change in health status at advanced ages. That is, in addition to

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the effects of health status on survival, changes in health status may directly affect the risk of institutionalization for the elderly. For example, with increasing numbers of persons over 85 there may be an increase in the prevalence of chronic diseases if the increases in survival are concentrated among chronically morbid and impaired people. This would increase the demand for intensive nursing home care. (Alternately, it may be that the future survivors will be proportionately healthier than those in the same age group today, and that projecting current rates will overestimate future morbidity rates. But there is no evidence to suggest this is happening.)

Another factor affecting future demand will be increases in the availability of alternative long-term care services, perhaps stimulated by the, emergence of alternative financing patterns, for example, the growth of private, long-term-care insurance.

Irrespective of the nature and extent of such developments, the need for nursing home care will not diminish during the next 15 years. There is no evidence that either the population's health status (physical, functional, and mental) will so improve that nursing home care requirements will decrease, or that other long-term-care services could be substituted for nursing home care for the majority of individuals now found in nursing homes. The population in nursing homes is likely to be more aged and more disabled, and some form of mental disability (particularly Alzheimer's disease) is likely to be more common. But the current pattern of a mix of residents with different treatment and service needs (that is, a fairly heterogeneous population) is likely to continue.

Bed Supply

In most states there are more people seeking admission to nursing homes than there are beds available. This excess demand results from three interrelated factors: (1) There are many individuals now living in the community who are just as disabled as nursing home residents, and some of them would enter a nursing home if a bed were

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available; (2) to control the costs of the Medicaid program, some states have sharply constrained or completely stopped construction of new nursing homes or expansions of existing nursing homes; (3) in some states Medicaid reimbursement rates are so low that at current rates, the marginal cost of treating some (heavy-care) residents may exceed the reimbursement rate.

The supplier's market for nursing home beds that exists in most states allows nursing home operators to select among applicants for beds. Business logic suggests that they will try to optimize net income by favoring private-pay over Medicaid-eligible and, generally, the easier-to-care-for resident over those who are more difficult (and, therefore, more costly) to care for properly. However, the latter judgment is affected by payment policy: if payment for heavier-care residents is more than sufficient to offset higher costs so that it is more profitable to admit them than lighter-care residents, and if adequate staffing to care for such residents is feasible, heavier-care residents may be given preference for admission. But there are still likely to be some types of residents who will be hard to place. A recent study was done on patients in Massachusetts hospitals who were "backed-up"; that is, they were in hospital beds for administrative necessity."[8] Although they no longer needed hospital care, they could not be discharged to their homes because they needed nursing home care. The hospitals could not find nursing homes willing to admit them, so they were allowed to remain in more costly hospital beds pending availability of nursing home beds. The study found that the backup population consisted of two groups of patients: one group spent a short time in the queue before being admitted to nursing homes; the second group spent a long time in the queue. The second group of patients was sicker and often had severe mental problems. The findings of this study support the judgment that, other things being equal, nursing homes will select the easier-to-care-for patients from the queue.

Another important factor about which there is currently insufficient information is the influence of hospital prospective payment systems and other cost-containment

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measures on demand for, and availability of, nursing home beds. A special effort is needed to study these relationships.

Regardless of the payment system, however, the supplier's market also places heavier demands on the regulatory system to assure quality because the market pressure to maintain high quality to attract residents does not exist. And the business logic that tempts nursing home administrators to cut operating costs to minimum levels or even below is hard for many to resist.

The question of what constitutes the best policy with respect to bed supply has no simple answer. The variation among states in the number of nursing home beds per thousand is very large: the national average is about 1 bed per 20 persons aged 65 or over. Minnesota has more than twice the national average; Florida has about half the national average. Thus, there is a fourfold variation. But bed occupancy rates—and excess demand—appear to exist in most states. [6]

The uncharted policy areas that are related to bed supply are (1) alternative ways of financing long-term care—particularly the possibility of private insurance arrangements for financing long-term-care services that are not primarily health-related and are not limited to payment for services provided in nursing homes; and (2) the development and greater availability in most communities of a much larger number of alternative long-term-care arrangements such as home health care, homemaker services, congregate housing (including domiciliary care), meals-on-wheels, special transportation facilities, adult day-care, and respite care.

If good alternatives to nursing homes were readily available and could be paid for from third-party insurance, a fraction—the exact number is not now known—of residents could be cared for more appropriately in alternative service arrangements or facilities. If this were to occur, then a certain number of nursing home beds now occupied by residents requiring lesser levels of care would become available to help cope with the growing numbers of older heavy-care residents who must be in nursing homes. The development of alternative long-term

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care arrangements on a large scale is not likely to occur until alternative financing arrangements become available.

Exploration of some alternative care arrangements—on a small scale—is proceeding. The HCFA has sponsored some innovative long-term-care demonstration projects during the past 10 years. More recently, under statutory authority contained in the 1981 budget legislation, states have been granted waivers to permit them to use Medicaid funds to finance services in community-based, long-term projects designed to prevent unnecessary institutionalization for individuals who otherwise could receive Medicaid support only in nursing homes.[9] Systematic evaluation of these programs has just begun.

In sum, the policy issue concerning supply of nursing home beds is related to the broader policy issue of developing a more appropriate array of long-term-care services. This, in turn, hinges on the development of more appropriate private and public financing arrangements and policies. A systematic study of these issues is necessary to design sound public policies to facilitate development of both the new financing mechanisms and of the array of long-term-care services needed. This study should be viewed as a matter of high priority by both the Congress and the executive branch of the federal government.

STAFFING OF NURSING HOMES

Once a data base derived from systematic, periodic resident assessments becomes available, two kinds of staffing studies will become possible that have not yet been done satisfactorily. The first will be studies to develop an algorithm for relating minimum nursing staff requirements to case mix. Perhaps something analogous to the "management minutes" concept[10] could be developed. (Management minutes is an empirically derived algorithm used to estimate the daily nursing time requirements for a resident based on his/her assessment scores and service needs.) This is a complex study that will require considerable sophistication in study design and execution to produce valid and reliable results. If

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completed successfully, it could provide the basis for a regulatory tool of considerable power.

The second kind of study deals with the issue of staff qualifications and training. At present, only professional judgment is used to define the requirements. But with outcome measures that can be derived from resident assessment data, studies to compare the effectiveness of different staffing patterns, types of staff, and training requirements will be possible. The HCFA should support well-designed studies within this area. If convincing evidence becomes available that some approaches to staffing and training are distinctly superior (in quality of care/life and cost) to others, the HCFA will be in a position to incorporate the desirable approaches into its regulatory standards.

SINGLE- VERSUS MULTIPLE-OCCUPANCY ROOMS

Most nursing homes have been constructed with either all or most of their rooms designed for double occupancy. Because beds in most places are in short supply, residents seldom can choose either private rooms or their roommates. The nursing home population is heterogeneous, so this is a thorny issue. It is clear that quality of life for an undemented resident can be seriously affected by the functional, mental, and behavioral status and service needs of a roommate. Moreover, the issues of privacy and of choice—for example, whether or not to watch TV or listen to music, and which programs—loom very high in the quality-of-life values of most residents. Most mentally alert residents probably would prefer private rooms if they could have one. The question is: Should the HCFA require that all new construction, or additions to existing nursing homes, be required to have a specified fraction of private rooms? If so, what should that fraction be? Not enough is known to answer this question with confidence. The effects on construction costs or on operating costs of requiring a specific proportion of single rooms are not known. Moreover, not enough is now known either about the preferences of residents for private rooms and of the desirability of

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having certain residents—particularly some who are demented—share a room, and whether four-bed rooms might be better than two-bed rooms.

In the next 10 to 20 years there may be a substantial amount of new construction or major remodeling of nursing homes. The committee believes that the HCFA should commission a study of this issue to determine the proper balance between single- and multiple-occupancy rooms that should be required in newly constructed nursing homes and in additions to—or major remodelings of—existing homes.

Recommendation 7-2: The HCFA should commission a study of the costs and benefits of single-occupancy rooms compared to multiple-occupancy rooms in nursing homes. The study should be designed to obtain data about the effects of single rooms on the quality of life of various types of nursing home residents. The study should be completed within 2 years after it has been authorized. It should contain recommendations for the desired proportions of single- and multiple-occupancy rooms in nursing homes. It should recommend required proportions in future new construction and major remodeling of existing buildings.

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8

Actions Required and Cost Implications of the Recommendations

The recommendations contained in Chapters 3, 4, 5, and 6 will require the following major implementing actions: (1) amending the Social Security Act and the Older Americans Act, (2) promulgating new survey and certification regulations and major revisions of existing regulations, (3) designing and testing a standard procedure for resident assessment to be done by nursing home staff and then developing training materials and launching a major program to train all RNs and LPNs (LVNs) in nursing homes to conduct such assessments properly, and (4) designing and testing new survey and certification instruments and procedures and training state and federal regulatory personnel to conduct the new standard and extended surveys. The recommendations are likely to affect both the costs of regulation and the costs of resident care. Although insufficient information is available to make quantitative estimates, the implications of the recommendations for both types of costs are discussed in general terms in the last section of this chapter.

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LEGISLATIVE ACTIONS REQUIRED

Amendments to the Social Security Act

The Social Security Act will have to be amended to implement the following recommendations:

1. *Recommendation 3-1*. Consolidate the two levels of care into one and have current SNF standards (with the other changes recommended) apply to all nursing homes. The two levels of care are now specified in Title XIX of the Social Security Act. Since the two levels of care are embedded in current state and federal policy, eliminating the distinctions between ICFs and SNFs will require changes in language in many sections of the law and also will require numerous changes in both federal and state regulations.
2. *Recommendations 3-2 through 3-7*. These recommendations involve major revisions in the language and structure of the existing regulations, including promulgating new conditions of participation covering quality of life, quality of care, resident assessment, residents' rights, and administration. The following current conditions would be reclassified as standards under the administration condition: governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records. Ten of-the current conditions of participation have statutory authorization either in Title XVIII or Title XIX of the Social Security Act. These are

I. Compliance with Federal, State, and Local Laws
II. Governing Body
IV. Physician Services
V. Nursing Services
VII. Rehabilitation Services
VIII. Pharmaceutical Services
XIII. Medical Records
XIV. Transfer Agreements
XV. Physical Environment
XVIII. Utilization Review

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It will be necessary to modify the statutory language in some cases to authorize the recommended revisions in the language and structure of the conditions and standards of participation.

3. *Recommendation 4-7*. The HCFA should increase the federal share of funding of state survey and certification activities from 75 percent to 10.0 percent.

   Between 1965 and 1972, Title XIX authorized federal funding of 75 percent of the states' costs of surveyor salaries, travel, and training for survey and certification of Medicaid facilities. This was increased to 100 percent between 1972 and 1980. In 1980, Congress reduced federal participation to 75 percent. Restoration of 100 percent federal funding will require an amendment to Title XIX.
4. *Recommendation 4-11*. This recommends that HHS be given authority to withhold a portion of a state's federal matching funds for Medicaid as a sanction to be used against any state that does not carry out its survey and certification responsibilities properly. Since this is a politically sensitive matter, statutory authority specifying the circumstances under which the sanction may be used seems necessary because the current law is not clear on this point.
5. *Recommendation 4-14*. The HCFA should use federal surveyors to inspect and certify state-owned institutions.
6. *Recommendations 5-2 and 5-4*. The HCFA should require states to have a standard, federally prescribed set of intermediate sanctions to be used in specified circumstances to improve enforcement of the conditions and standards. The HCFA also will need statutory authority to authorize states to decertify facilities that have a record of chronic or repeated violations of important conditions and standards, rather than accept another plan of correction.
7. *Recommendation 5-3*. The HCFA should have intermediate sanctions comparable to those available to the states. At present, the only federal intermediate sanction authorized by law (in 1981) is a ban on admissions, but, as of February 1986, the regulation for implementing this authority had not yet been promulgated.

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8. *Recommendation 5-5*. The HCFA should develop guidelines to make legal appeals of the decertification process less permissive. Although this may not require statutory action, it probably would be more effective if explicitly authorized by law.

Amendments to the Older Americans Act

The following recommendation will require amendments to the Older Americans Act:

Recommendation 6-2. The ombudsman program should be strengthened by the following statutory actions:

- authorizing the ombudsman program as a separate title in the Older Americans Act;
- authorizing federal-state matching formula grants for the ombudsman program;
- authorizing a statutory national advisory council;
- authorizing access to nursing homes and to residents' records (with the residents' permission) by certified substate and local ombudsmen;
- authorizing state legal assistance for ombudsmen; and
- exempting ombudsmen from lobbying restrictions in OMB Circular A-122.

REVISION AND ADDITION OF SURVEY AND CERTIFICATION REGULATIONS

With acceptance of most of the recommendations, the process of revising the current regulations governing the survey and certification process would have to be done in three phases: (1) Drafting of the new conditions of participation covering quality of life, quality of care, resident assessment, and residents' rights, and revision of some of the existing conditions and standards could be started immediately, although they could not be formally proposed for issuance until the statutory changes have been enacted; (2) after the amendments to the Social Security Act have been enacted, their detailed

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requirements will have to be reflected in the regulations; and (3) detailed specifications of the standards governing survey procedures and facility-administered resident assessment procedures will have to be deferred until completion of the design and testing of the instruments and procedures and training of thousands of state regulatory and nursing home personnel. This development phase may require 2 or 3 years to complete.

Preliminary work on developing and testing the two new survey instruments and procedures—the standard survey and the extended survey—could begin promptly. Design of these instruments has to be based on the revised conditions of participation and standards. Policy decisions on the latter must be made before the scope of the instruments can be finally set. The survey procedures depend on access to standard resident assessment data, so that high priority should be given to developing the resident assessment data set, the procedures for collecting it, recording the data, prescribing standard case-mix definitions for survey purposes, specifying sampling procedures, and developing training programs and materials for nursing home staff who will be required to conduct resident assessments.

DESIGN AND TESTING ACTIVITIES

Resident Assessment Data

Design, testing, and installation of a standard facility-administered resident assessment system is a large and complex undertaking. It involves several tasks, each of which requires considerable technical knowledge and skill. The main tasks are—

1. Standard assessment elements must be selected for recording in a prescribed way. A standard approach to resident assessment will be necessary to get comparable information on all residents in nursing homes. Fortunately, so much research has been done on resident assessment that this task can be accomplished quickly. The data probably will be a hybrid of several of the

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instruments that already have been designed and tested and that have been shown to be effective and reliable. It is very important that the required standard data be viewed by facility professional staff as a subset of that considered to be essential for sound resident-care planning and facility management. (The amount of data on each resident needed by the facility for developing an individual's plan of care usually will be much more extensive than that needed for regulatory purposes.)

2. Standard assessment procedures must be designed for use by nursing home staff in assessing residents, scoring, and recording the data. Guidelines, an instruction manual, and problem resolution techniques will have to be developed and tested.
3. Methods must be developed to ensure the reliability of the data collectors. A training program and training materials for RNs and LPNs (LVNs) will have to be prescribed. Auditing procedures (including sampling procedures) will have to be developed and pass/fail criteria specified that are based on the results of interrater reliability tests. (The standards may vary for various aspects of the data—higher consistency of scoring might be required for functional status assessments than for mental or behavioral status.) Instruction manuals will then have to be developed and the surveyors in every state will have to be trained to audit the accuracy of facility resident assessments as part of the new survey process.
4. Policy decisions must be made on how frequently assessments are to be conducted on each resident. For example, the first assessment should be done on admission, then reassessments might be required once a month for the next 2 months, and once every 3 months thereafter. The frequency of regular assessments is a major issue and the decision should be based, ideally, on empirical evidence.
5. Case-mix groupings must be defined on the basis of resident assessment scores. The groupings will be needed for survey sampling purposes. The initial groupings are likely to be based on limited data and will need to be revised as empirical evidence from longitudinal assessment data become available and analysis reveals that alternate

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case-mix groupings would be more appropriate for sampling purposes.

6. Sampling algorithms must be developed for auditing the accuracy of the facility's resident assessment data and for conducting the standard survey. Statistically sound sampling is essential to establish both public and provider confidence in the validity of a somewhat abbreviated standard survey process.

Once this manual system for resident assessment data has been introduced and implemented in nursing homes, the steps needed to gain ready access to the data for regulatory purposes should be studied. Many nursing homes are likely to enter the data into their own computers to take full advantage of it for their own management purposes. But many others—probably most—are unlikely to do so at first. A study of the important regulatory and other government uses for the data, and ways to obtain access to it, will be needed. The study will have to examine and propose methods for dealing with numerous technical and policy questions inherent in handling large data sets about individuals. The product should be a proposed plan that would permit access to and analysis of the data on a regular basis to improve the precision and objectivity of the new regulatory system.

Survey Instruments and Procedures

The development of a short, resident-centered, outcome-oriented standard survey procedure and a complementary extended survey procedure must reflect the requirements of the new and revised conditions of participation and standards if the findings are to be enforceable. Although development of the survey instruments, the scoring criteria and pass/fail standards, and the procedures for conducting the surveys can be tested on the assumption that the revised conditions and standards will in fact be promulgated, they cannot be introduced until the proposed new and revised conditions and standards become official. Moreover, the new standard survey is tied to the

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availability of data from the assessment system—a system that will have to be developed and tested. The time required to complete each of the three sets of activities—(l) enactment of amendments to the Social Security Act and promulgation of new and revised conditions, (2) development and introduction of the resident assessment system, and (3) development and introduction of the new survey and certification procedures—is likely to be 2 to 3 years. It therefore would be desirable to proceed simultaneously with all three activities, making scheduling and substantive adjustments necessary to fit the policy decisions as they are made. If all goes well, the entire system could be in place and functioning in 3 years.

COST IMPLICATIONS OF THE RECOMMENDATIONS

The effects of the recommendations on the costs of regulation and on the costs of providing care to residents are not easily calculated for two reasons: (1) The quantitative and qualitative changes in behavior of the various actors in the system, and the effects on efficiency of the regulatory agencies and nursing homes, cannot be predicted on the basis of current data; (2) current data about staffing and costs in nursing homes and in state regulatory agencies are not available in sufficient detail; and (3) some immediate costs are likely to produce long-term savings that cannot be estimated.

Given these uncertainties, any estimates made—even with the assistance of a very elaborate cost model—would have to present a wide range of costs to account for interactions of varying assumptions. For this reason, the committee chose not to divert any of its limited time and resources to this purpose. It concentrated on developing recommendations that will improve the regulatory system's ability to ensure better quality of care and quality of life for nursing home residents.

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Regulatory Costs

The combined effects on state regulatory agency staffing requirements of (1) the integration of inspection of care with the survey process, (2) the resident assessment system, (3) the use of the standard and extended survey system, and (4) increased enforcement capabilities is by no means clear.

Most states now use, and are funded for, separate staff to conduct inspections of care (IOC). In those states, integrating the functions of surveying nursing homes with IOC would eliminate the requirements for separate staff and the additional travel, training, and overhead costs. However, the new system will require well-qualified and well-trained survey staff and this may, in some states, require larger survey agency budgets. How much larger will depend on the performance of the nursing homes. If the introduction of the resident assessment system and the standard survey improve performance of the poor and marginal facilities so that fewer extended surveys are necessary, there may be no significant requirement for additional staff. On the other hand, if many extended surveys should be necessary, this could lead to requirements for staff increases. The experience is likely to vary widely among the states. Similar uncertainties pertain to the costs of strengthening enforcement capabilities.

There will be costs for developing, testing, and conducting the training necessary to install the resident assessment system and the new survey instruments and procedures. These costs will have to be borne largely by the HCFA, both in its own operating budget and in larger federal grants to the states to carry out state survey and certification responsibilities.

The federal regional offices will need more staff to strengthen their look-behind capabilities and to conduct surveys of state-owned facilities. On the other hand, they will be relieved of the responsibility for certifying Medicare facilities, so some of the staff devoted to those time-consuming activities could be shifted to the increased oversight activities.

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The cost effects of strengthening the ombudsman program are not entirely clear. The federal and state contributions to the ombudsman program are now too small; they will have to be increased if the program is to become more effective. But the effects of an improved ombudsman program on state survey agency costs are not clear. One possibility is that it could increase the number of complaints that have to be investigated by the survey agency. But another is that it could have the opposite effect: The volume of complaints could go down as ombudsmen work more effectively in resolving problems within nursing homes. Probably both types of effects will occur, but it is clearly impossible to make any quantitative forecasts of the net effect on costs.

Program Costs

The recommendation to eliminate ICFs will increase the costs of care in some states more than in others, but it is not clear by how much. In many states that have mainly ICF facilities, the actual average staffing is already well above the minimum federal requirements because the homes have had to accommodate a growing proportion of heavy-care residents. Nevertheless, requiring compliance with SNF standards almost certainly will increase costs in some nursing homes in some states. This may lead to increases in Medicaid budgets in some states.

The costs to the nursing homes of the resident assessment system are not likely to be significant. All nursing homes should be doing resident assessments as a basis for care planning anyway. The good nursing homes have been conducting very comprehensive assessments of their residents as part of their normal resident care activities. The federal requirement to do so in a standard way should not add significantly to resident care costs.

In sum, the regulatory changes recommended in this report will increase both regulatory and program costs in the short term, but the benefits to society and to the nursing home residents will be well worth the additional costs.

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Notes

Chapter 1

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supply which have resulted in a nursing home bed shortage in most parts of the country. Unfortunately, good recent data to demonstrate the increasing proportion of heavy-care residents are not available. The last national nursing home survey was conducted in 1977. The National Center for Health Statistics now plans to conduct its next national survey of nursing homes in 1986. The most recent analysis of the available data is contained in: U.S. General Accounting Office. 1983. Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly. Report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives. GAO/IPE-84-1, October 21, 1983.

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Chapter 7

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Appendix A

History of Federal Nursing Home Regulation

The federal government first became involved in nursing homes with the passage of the Social Security Act of 1935.[1,2] The Act established a federal-state public assistance program for the elderly called Old Age Assistance (OAA). Because the drafters of the legislation opposed the use of the public poorhouse to care for the poor elderly, the act prohibited the payment of OAA funds to residents of public institutions. This stimulated the growth of voluntary and proprietary nursing homes. By the time of the first national survey of nursing homes in 1954, there were 9,000 homes classified as skilled nursing or personal care homes with skilled nursing facilities; 86 percent were proprietary, 10 percent were voluntary, and 4 percent were public.[3]

In 1950, amendments to the Social Security Act authorized payments to beneficiaries in public institutions and enabled direct payments to health care providers. The 1950 legislation also required that participating states establish programs for licensing nursing homes, but it did not specify what the standards or enforcement procedures should be. Although most states licensed hospitals (it was a requirement of the 1946 Hill-Burton hospital construction program), few of them licensed nursing homes until after 1950.

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Federal involvement in nursing homes accelerated after that. Studies showed that there were few nursing homes providing skilled nursing services,[4,5] and a consensus began to develop that the federal government should promote their development. In 1954 the Hill-Burton Act was amended to provide funds to nonprofit organizations for the construction of skilled nursing facilities that met certain definitions and hospital-like building standards. In 1956, amendments to the Social Security Act increased the level of federal funding of OAA payments and created a separate, matching program for medical services to public assistance recipients, including nursing home services; payments for OAA jumped from $35.9 million in 1950 to $280.3 million in 1960.[6] In 1960 the latter program was replaced by the Kerr-Mills Act with a more extensive program called Medical Assistance for the Aged (MAA). This covered the "medically needy" for the first time. By 1965, 47 states had MAA programs, with a total outlay of $1.3 billion a year. There were about 300,000 recipients.

In the meantime, legislation in 1958 and 1959 authorized the Small Business and Federal Housing administrations to aid proprietary nursing home construction and operation.[7]

Various studies in the 1950s found that between 30 and 60 percent of the residents in private nursing homes were public assistance recipients.[8] A Public Health Service survey of nursing home residents in 13 states during 1953-1954 found that 51.3 percent were public assistance recipients.[5] Another study of expenditures for nursing and convalescent homes found that, in 1957, even before the 1956 amendments took effect, 53 percent of the expenditures for nursing and convalescent homes were from federal, state, and local governments.[9] In 1965, 60 percent of the residents of nursing and convalescent homes were supported by welfare.[10]

With this increasing federal financial involvement in nursing home services and construction, federal attention began to focus on quality issues. In 1956, the Commission on Chronic Illness called attention to problems with the quality of care in nursing homes.[11] The states themselves began to report problems.[12] A 1955 study

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by the Council of State Governments reported that the majority of nursing homes were functioning with low standards of service and relatively untrained personnel.[13]

There were concerns about the adequacy of state licensing standards and the variability of state enforcement efforts throughout the period leading up to the passage of the Medicare and Medicaid acts in 1965. The 1950 "standard-setting amendment" to the Social Security Act did not specify minimum state licensure standards or procedures, and there was no mechanism for assuring that states enforced licensure standards. The Public Health Service found in 1958 that few states had adequate numbers of survey staff and that the qualifications of survey personnel varied widely.[14] About 44 percent of 308,000 skilled nursing beds did not meet Hill-Burton fire and health standards in 1960.[15]

A special Senate Subcommittee on Problems of the Aged and Aging was established in 1959. It reported that only a few nursing homes were of high quality. Most facilities were substandard, had poorly trained or untrained staff, and provided few services. But, the subcommittee concluded, "because of the shortage of nursing home beds, many states have not fully enforced the existing regulations, failure to do so reflecting the policy of the states to give ample time to the nursing home owners and operators to bring the facilities up to the standards. Many states report that strict enforcement of the regulations would close the majority of the homes."[16]

As a result of concerns about the quality of care and safety of conditions in nursing homes, the chronic disease program of the Public Health Service began to study state licensing programs in 1957. The program began to work with the states and the industry to develop federal -guidelines for nursing home licensure programs.[17] The final product, the *Nursing Home Standards Guide*, was issued in 1963. It was mostly concerned with standards, but also made some recommendations for regulatory organization and procedures.[18]

The Senate created the Special Committee on Aging in 1961, and began to hold hearings on nursing home problems in 1963, chaired by Senator Frank Moss. The Moss

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Committee hearings in 1965 documented great variations in state nursing home standards and enforcement efforts on the eve of the Medicare and Medicaid programs. The 1974 report of the Moss Committee restated the reasons for these variations:[19]

1. Enforcement meant the closure of facilities, already in short supply, with no place to put the dispossessed patients.
2. States have few weapons other than the threat of license revocation to bring a home into compliance.
3. The license revocation itself was of very little use because of protracted administrative or legal procedures required.
4. Even if the revocation procedure was implemented, judges were reluctant to close a facility when the operator claimed that the deficiencies were being corrected.
5. Nursing home inspections were geared to surveying the physical plant rather than assessing the quality of care.

THE ADVENT OF MEDICARE AND MEDICAID

The next major event was the enactment of the Medicare and Medicaid programs in 1965. This greatly expanded federal funding of nursing home services and gave the U.S. Department of Health, Education, and Welfare (HEW) the authority to set standards for nursing homes choosing to participate. The Medicare Act provided funding for beneficiaries needing post-hospital convalescence in what was called an "extended care facility" (ECF). Medicaid paid for skilled nursing services.

The Medicare ECF program had immediate problems. Few nursing homes could meet the health and safety standards or provide the level of services envisioned under the program. Of 6,000 applicants, only 740 could be fully certified the first year. More than 3,000 nursing homes that could not otherwise comply were certified as being in "substantial compliance."[20]

Meanwhile, given the fact that thousands of Kerr-Mills

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recipients were in nursing homes that could not meet Medicare standards, the Medicaid program had to give up the idea of using ECF standards for its skilled nursing facilities and essentially left it to the states to decide on nursing home participation. Amendments made in 1967 to the Medicaid program included those sponsored by Senator Moss authorizing HEW to develop standards and regulations to be applied uniformly by the states. The Moss amendments included a statutory definition of a skilled nursing facility (SNF) and specified standards for participating homes. They also provided HEW with the authority to withhold federal funds from nursing homes not meeting the standards.

The new Medicaid SNF regulations were supposed to be implemented at the beginning of 1969, but a lengthy battle over their scope and substance ensued. The outgoing Johnson administration went through several drafts, and interim regulations were finally issued by the Nixon administration later in the year.

The 1967 amendments also resulted in the establishment of intermediate care facilities (ICFs). They were intended to care for residents who did not need the 24-hour nursing services provided in skilled nursing homes, but who needed more than custodial care.[2] The committee report said that ICFs would lower the overall costs of long-term care and allow many nursing homes to participate that could not meet SNF or ECF requirements. ICFs were established under Title XVI (OAA). This left federal standard-setting authority ambiguous. HEW withdrew proposed ICF regulations in 1969 when states protested.

Pressure to increase the standards for nursing homes participating in Medicare and, especially, Medicaid, and to improve their enforcement, began to build in the early 1970s. The Moss Committee began a series of hearings in 1969 that lasted until 1973 and resulted in 3,000 pages of testimony and, in 1974, a series of well-publicized reports critical of federal regulatory efforts. In 1970 and 1971, nursing home problems became front-page news with a fire that killed 32 residents in Ohio, a case of food-poisoning in Maryland that killed 36, and Congressman

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David Pryor reporting on the floor of the House his experiences as a nursing home orderly.[2]

Meanwhile, a Senate Finance Committee staff study found that some states were reclassifying nursing homes as ICFs "wholesale."[20] (ICFs were not brought into the Medicaid program, where they would be subject to federal regulation, until 1971.) HEW discovered that the states were certifying Medicaid SNFs merely on the basis of licensure requirements and that Medicaid was making vendor payments to homes that did not comply with federal standards.[21] The U.S. General Accounting Office (GAO) audited skilled nursing homes in three states and found that half were in violation of Medicaid standards for nurse staffing, physician visits, or fire safety.[22]

The Senate Finance Committee staff study of Medicare and Medicaid in 1970 was very critical of Medicare certification.[20] Congress forced HEW to stop using "substantial compliance" as a basis for certifying nursing homes. The department instead adopted the procedure of certifying nursing homes with deficiencies that were not considered an immediate hazard to patient health or safety. The undersecretary of HEW testified at a Moss Committee hearing in 1971 that 74 percent of the nursing homes participating in Medicare were certified with deficiencies and more than 70 percent of them had had deficiencies from 1968 through 1971. He concluded that "reliance on state enforcement machinery had led to widespread nonenforcement of federal standards."[23] Secretary of Health, Education, and Welfare Elliot Richardson told the White House Conference on Aging that 39 states had not been complying with federal procedural requirements.

In June 1971, with the White House Conference on Aging pending, President Nixon made a major speech deploring conditions in nursing homes and pledging to end federal payments to substandard facilities. In a second speech 2 months later, Nixon announced an eight-point plan to improve nursing home regulation. Among the points were initiatives to centralize Medicare and Medicaid enforcement activities and to expand HEW's enforcement

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staff, to increase funding for training state surveyors, to provide full federal reimbursement for the costs of state nursing home inspection programs, and a promise to decertify substandard facilities. The president also proposed training programs for nursing home staff, experimental funding of state nursing home ombudsmen, and the creation of an Office of Nursing Home Affairs in HEW to coordinate the new enforcement efforts and conduct a "comprehensive study" of federal long-term-care policies.

During 1972 Congress passed the remnants of Nixon's comprehensive welfare reform bill, which still contained many changes in the social security, Medicare, and Medicaid programs. The law included full federal funding of state survey and certification activities, redefined Medicare ECFs and Medicaid skilled facilities as "skilled nursing facilities" (SNFs), and directed HEW to develop a single set of standards for Medicare and Medicaid SNFs. Although the Senate Finance Committee's report said the provision to unify Medicare and Medicaid standards for SNFs was "not intended to result in any dilution or weakening of standards for skilled nursing facilities," the law itself reduced some Medicare provisions, such as eliminating social workers in SNFs, reducing RN coverage in rural SNFs from 7 to 5 days a week, and extending indefinitely the grandfathering from state licensure requirements of nursing home administrators with 3 years of practical experience.

Work began in earnest to develop the regulations for SNFs and ICFs in 1972. But interim regulations were not issued until 1973 and the final regulations were promulgated in January 1974. Senator Moss criticized the interim SNF regulations as being significantly weaker than those for ECFs, and some requirements, such as those for medical direction, residents' rights, and 7-day RN staffing were reinstated later in 1974. But the final ICF regulations were less stringent than the interim regulations in several areas, such as nurse staffing requirements, and waivers for life safety code provisions were allowed. The department defended the increased generality of some of the requirements on the ground that they were "performance standards," which could be more flexibly applied by skilled health professional surveyors.[24]

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Meanwhile, until 1974, states were able to use their discretion in allocating Medicaid funds to support residents in facilities not meeting the ICF level of care or that could not meet new requirements for federal reimbursement, such as the most recent life safety code (LSC).[25] The 1974 regulations made official the inclusion of ICFs in the Medicaid program and applied to them SNF certification procedures (but not the standards) and left approvals of LSC and RN staffing waivers to the states. A study by the Office of, Nursing Home Affairs (ONHA) in January 1974, just prior to the promulgation of the ICF standards, found that 59 percent of SNFs were being certified with life safety code deficiencies.[26] The new standards triggered another wave of conversions from SNF to ICF.[25]

Finally, in 1974, "as a result of an increasing awareness on the part of the federal government that many nursing home facilities which were receiving Medicare (Title XVIII) and Medicaid (Title XIX) funds were not meeting standards," HEW established offices of long-term care standards enforcement in the federal regional offices.[25] Its regional directors were delegated the authority to approve provider agreements with Medicare and Medicare/Medicaid SNFs and to monitor state agency certifications and agreements with Medicaid-only providers.

POST-1974 EFFORTS TO REVISE FEDERAL REGULATIONS

Since 1974 there has been a series of attempts to revise the federal nursing home certification regulations.[27] In 1974 the Office of Nursing Home Affairs began a study of the quality of care in nursing homes. Teams of health professionals made surprise visits to 288 SNFs to assess their management, structural, and staffing characteristics. They also investigated the quality of patient care by looking at a sample of 3,454 residents with a standardized patient assessment form. The study found that "the extent to which nursing homes comply with the federal standards of care and safety varies widely."[28] The ONHA also found that the

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surveys and certification regulations only looked at whether facilities had the capacity to deliver required services, not whether services of adequate quality were actually being delivered.

This finding, that the certification process focused on the institutional framework within which care is provided, rather than on the patient, led to an effort to develop a patient assessment instrument based on outcome measures, called Patient Appraisal and Care Evaluation, or PACE. The ONHA's original intention was to test PACE and, after evaluation and modification, to use it in a national study of nursing homes. The ONHA then planned to use it to develop a survey process based on the quality of care and, ultimately, as the basis for reimbursement.[25,29] As it turned out, the PACE form and process became too unwieldy and complex for use as a regulatory instrument. In the end, the Health Care Financing Administration (HCFA) merely published it for voluntary use by nursing homes in patient assessment.

The ONHA, now called the Office of Long-Term Care, was overseeing a substantial revision of the SNF standards by an interagency work group as early as 1976. HEW began another effort to revise the nursing home survey program as part of President Carter's regulatory reform effort, "Operation Common Sense." The HCFA announced plans to revise the SNF conditions of participation and ICF standards.[30] The announcement was followed by public hearings in five cities[31] and numerous written comments and meetings with interested parties. Commentators criticized certain features of the regulations: their medical orientation, focus on input and process rather than outcomes, costs imposed on providers not related to better outcomes, and emphasis on paperwork and paper review.

While most of the comments focused on quality-of-care issues, it was evident that there were enforcement problems in the survey process. From this came the idea of elevating certain requirements to the condition level, to make them more enforceable. The HCFA also concluded that revisions of the certification procedures contained in Subpart S of the regulations were necessary (42 CFR

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Part 405), and began work on them in 1980 (internal HCFA documents).

After 2 years of work and three drafts, the HCFA published its proposed new rules in 1980.[32] From the beginning, and in line with the PACE effort, the HCFA had planned to shift the focus of the regulations from paper reviews of facility capability to an evaluation of patients and the care they were actually receiving. The new regulations would have[33]

1. consolidated all patient care planning requirements into a single condition, and required a patient care management system that called for interdisciplinary teams to assess patients and plan their care;
2. deemphasized the medical model by increasing the minimum time required between attending physician visits, reducing the medical director requirements, and making consultant services discretionary after I year;
3. elevated the residents' rights standard to the status of a condition of participation; and
4. combined the SNF and ICF regulations into a single set in the *Code of Federal Regulations*.

The nursing home industry disputed the HCFA's estimates of the costs the new regulations would impose. The HCFA said, in its regulatory impact analysis, that the changes would cost about $80 million a year (revised in 1981 to $135 million), but consultants engaged by the industry estimated first-year costs of $586 million and annual costs thereafter of $435 million.[34,35] The proposed rules stayed in limbo until the final hours of the Carter administration, when the rule elevating residents' rights to the condition level was published.

The new regulation was immediately rescinded by the new administration, which began a new regulatory reform effort. The HCFA established a Task Force on Regulatory Reform that reevaluated the regulations according to a detailed protocol. Although the task force decided to retain major elements of the 1980 proposed regulations,

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including the patient care management system and the elevation of residents' rights to a condition, it also proposed the deletion or revision of many other conditions and standards or made them effective only if there were no applicable state laws. The reaction from consumer groups, state regulators, the Congress, and providers was so strong that Secretary of Health and Human Services Richard Schweiker announced that the draft regulations would be dropped, leaving the 1974 rules in effect.

Finding it impossible to change the standards, the HCFA turned to an attempt to change the procedures for applying the standards. Many of the changes proposed had long been considered desirable within the HCFA, such as combining Medicare and Medicaid procedural requirements (Subpart S of 42 CFR Part 405 and Subpart C of 42 CFR Part 442), allowing more flexible survey cycles, and eliminating a number of requirements that had proved unworkable or ineffective. But the proposed regulations also would have permitted states to accept accreditation of a nursing home by the Joint Commission on Accreditation of Hospitals (JCAH) as sufficient evidence that facilities met federal requirements for Medicare and Medicaid participation. Taken together, these changes were viewed as another attempt to reduce federal protection of the health and safety of nursing home residents by Congress, which promptly imposed a moratorium on them.

In the summer of 1983, the HCFA and Congress agreed to postpone virtually all changes in the regulations until a committee appointed by the Institute of Medicine studied the issues and reported its recommendations for changes, except for certain minor changes agreed to by all members of a group of consumer, provider, and state regulatory representatives. The latter group, called the Subpart S Consensus Group, met until January 1984, and agreed to some of the 1982 procedural changes (consolidation of Medicare and Medicaid rules, elimination of the 90-day resurvey rule but requiring 120-day resurveys of significant deficiencies, and elimination of quarterly staffing reports except for problem facilities (internal HCFA documents). It rejected some of the proposals ("deemed status" for JCAH-accredited nursing homes and less-than-annual surveys), and suggested that others be

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optional, at the discretion of the state in the case of a Medicaid-only facility or according to a joint federal-state agreement in the case of a Medicare or a Medicare/ Medicaid facility (elimination of time-limited agreements, automatic cancellation clauses, and the repeat deficiency requirements). But the Consensus Group changes have not been implemented.

In the meantime, the HCFA has begun to develop a modified survey instrument, called Patient Care and Services (PaCS), that is based primarily on direct patient assessments and outcome-oriented indicators of care. Conceptually, PaCS is a lineal descendant of PACE. It is also based in part on the results of a series of HCFA-sponsored demonstrations and experiments with modified survey instruments and processes. Currently (1985), the new instrument is being tested extensively in three states and every state is experimenting with it in a few facilities.

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Appendix B

Existing Snf Conditions of Participation and Icf Standards

A. SNF CONDITIONS OF PARTICIPATION (42 CFR 405.1120 THROUGH 405.1137 (1974))

1. Condition Of Participation—Compliance With Federal, State, And Local Laws.

The skilled nursing facility is in compliance with applicable Federal, State, and local laws and regulations.

(a) *Standard: Licensure*. The facility, in any State in which State or applicable local law provides for licensing of facilities of this nature:

(1) Is licensed pursuant to such law; or
(2) If not subject to licensure, is approved by the agency of the State or locality responsible for licensing skilled nursing facilities as meeting fully the standards established for such licensing, and
(3) Except that a facility which formerly met fully such licensure requirements, but is currently determined not to meet fully all such requirements, may be recognized for a period specified by the State standard-setting authority.

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(b) *Standard: Licensure or registration of personnel*. Staff of the facility are licensed or registered in accordance with applicable laws.

(c) *Standard: Conformity with other Federal, State, and local laws*. The facility is in conformity with all Federal, State, and local laws relating to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, and other relevant health and safety requirements.

2. Condition Of Participation—Governing Body And Management.

The skilled nursing facility has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility. The governing body adopts and enforces rules and regulations relative to health care and safety of patients, to the protection of their personal and property rights, and to the general operation of the facility.

(a) *Standard: Disclosure of ownership*. The facility complies with the disclosure requirements of 42 CFR 420.206

(b) *Standard: Staffing patterns*. The facility furnishes to the State survey agency information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least 1 week of each quarter. Such week will be selected by the survey agency.

(c) *Standard: Bylaws*. The governing body adopts effective patient care policies and administrative policies and bylaws governing the operation of the facility, in accordance with legal requirements. Such policies and bylaws are in writing, dated, and made available to all members of the governing body which ensures that they are operational, and reviews and revises them as necessary.

(d) *Standard: Independent medical evaluation (medical review)*. The governing body adopts policies to ensure that the facility cooperates in an effective program which provides for a regular program of

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independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including, at least annually, medical evaluation of each patient's need for skilled nursing facility care).

(e) *Standard: Administrator*. The governing body appoints a qualified administrator who is responsible for the overall management of the facility, enforces the rules and regulations relative to the level of health care and safety of patients, and to the protection of their personal rights, and plans, organizes, and directs those responsibilities delegated to him by the governing body. Through meetings and periodic reports, the administrator maintains ongoing liaison among the governing body, medical and nursing staffs, and other professional and supervisory staff of the facility, and studies and acts upon recommendations made by the utilization review and other committees. In the absence of the administrator, an employee is authorized, in writing, to act on his behalf.

(f) *Standard: Institutional planning*. The skilled nursing facility, under the direction of the governing body, prepares an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

(1) Annual operating budget. There is an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense).

(2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period (including the year to which the operating budget described in paragraph (f)(1) of this section is applicable), which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 for items which would, under generally

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accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $100,000, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions which are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of such financing is, in any part, the anticipated reimbursement from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Health Insurance for the Aged and Disabled) or title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, the plan states: (a) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed pursuant to the Public Health Service Act of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, to meet the need for adequate health care facilities in the area covered by the plan or plans so developed; (b) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval pursuant to section 1122 of the Social Security Act (42 U.S.C. 1320a-1) and implementing regulations; (c) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it has been so presented.

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(3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the skilled nursing facility by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (or chief medical officer, or patient care policies advisory group as described in 405.1122(a)) of the skilled nursing facility.

(4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (f)(3) of this section under the direction of the governing body of the skilled nursing facility.

(g) *Standard: Personnel policies and procedures*. The governing body, through the administrator, is responsible for implementing and maintaining written personnel policies and procedures that support sound patient care and personnel practices. Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable disease are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work, and that a safe and sanitary environment for patients and personnel exists and incidents and accidents to patients and personnel are reviewed to identify health and safety hazards. Employees are provided, or referred for, periodic health examinations, to ensure freedom from communicable disease.

(h) *Standard: Staff development*. An ongoing educational program is planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Each employee receives appropriate orientation to the facility and its policies, and to his position and duties. Inservice training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of patient information, and preservation of patient dignity,

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including protection of his privacy and personal and property rights. Records are maintained which indicate the content of, and attendance at, such staff development programs.

(i) *Standard: Use of outside resources*. If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, it makes arrangements to have such a service provided by an outside resource—a person or agency that will render direct service to patients or act as a consultant to the facility. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or agency providing the service. Agreements pertaining to services must specify that the facility assumes professional and administrative responsibility for the services rendered. The outside resource, when acting as a consultant, appraises the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for followup action and evaluation of performance. (See requirement under each service—405.1125 through 405.1132.)

(j) *Standard: Notification of changes in patient status*. The facility has appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the · event of an accident involving the patient, or other significant change in the patient's physical, mental, or emotional status, or patient charges, billings, and related administrative matters. Except in a medical emergency, a patient is not transferred or discharged, nor is treatment altered radically, without consultation with the patient or, if he is incompetent, without prior notification of next of kin or sponsor.

(k) *Standard: Patients' rights*. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for

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development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205(j) of the Social Security Act, and Subpart Q of 20 CFR Part 404, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:

(1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

(2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;

(3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

(4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment of his stay (except as prohibited by titles XVIII or XIX or the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

(5) Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

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(6) May manage his or her personal financial affairs, may designate another person to manage them, or may authorize the facility, in writing, to hold, safeguard, and account for his or her personal funds in accordance with paragraph (m) of this section. In the event that the Social Security Administration has determined that a Title II or Title XVI (SSI) benefit to which the patient is entitled should be paid through a representative payee, the provisions in 20 CFR 404.1601 through 404.1610 (for OASDI benefits) and 20 CFR 416.601 through 416.690 (for SSI benefits) apply;

(7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

(8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

(9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

(10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

(11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

(12) May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

(13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless

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medically contraindicated (as documented by his physician in his medical record); and

(14) If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

All rights and responsibilities specified in paragraphs (k)(1) through (4) of this section—as they pertain to (i) a patient adjudicated incompetent in accordance with State law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who exhibits a communication barrier—devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of 20 CFR Part 404.

(l) *Standard: Patient care policies*. The skilled nursing facility has written patient care policies to govern the continuing skilled nursing care and related medical or other services provided.

(1) The facility has policies, which are developed by the medical director or the organized medical staff (see 405.1122), with the advice of (and with provision for review of such policies from time to time, but at least annually, by a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients

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admitted. These policies also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

(2) The medical director or a registered nurse is designated, in writing, to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the medical director serves as the advisory physician from whom she receives medical guidance. (See 405.1122(b).)

(m) *Standard protection of patients' funds.*

(1) Definition: Representative. "Representative" as used in this paragraph is a patient's legal guardian, conservator, or representative payee as designated by the Social Security Administration, or person designated in writing by the patient to manage his or her personal funds.

(2) Statement provided at time of administration. The facility must provide each patient and representative with a written statement, at the time of admission, that: (i) Lists all services provided by the facility, distinguishing between those services included in the facility's basic rate and those services not included in the facility's basic rate, that can be charged to the patient's personal funds; (ii) States that there is no obligation for the patient to deposit funds with the facility; (iii) Describes the patient's right to select how personal funds will be handled. The following alternatives must be included: (A) The patient's right to receive, retain and manage his or her personal funds or have this done by a legal guardian, if any; (B) The patient's right to apply to the Social Security Administration to have a representative payee designated for purposes of Federal or State benefits to which he or she may be entitled; (C) Except when

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paragraph (B) of this section applies, the patient's right to designate, in writing, another person to act for the purpose of managing his or her personal funds; and (D) The facility's obligation, upon written authorization by the patient, to hold, safeguard, and account for the patient's personal funds in accordance with this paragraph. (iv) States that any charge for this service is included in the facility's basic rate. (v) States that the facility is permitted to accept a patient's funds to hold, safeguard, and account for, only upon the written authorization of the patient or representative, or if the facility is appointed as the patient's representative payee; (vi) States that, if the patient becomes incapable of managing his or her personal funds and does not have a representative, the facility is required to arrange for the management of his or her personal funds in accordance with paragraph (m)(14) of this section.

(3) Basic requirements. The facility must, upon written authorization by the patient, accept responsibility for holding, safeguarding and accounting for the patient's personal funds. The facility may make arrangements with a Federally or State insured banking institution to provide these services but the responsibility for the quality and accuracy of compliance with the requirements of paragraph (m)(4) through (m)(13) of this section remains with the facility.

The facility may not charge the patient for these services, but must include any charges in the facility's basic daily rate.

(4) Individual records. The facility must maintain current, written, individual records of all financial transactions involving patients' personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must keep these records in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Standards, and the records must include at least the following: (i) Patient's name; (ii) Identification of patient's representative, if

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any; (iii) Admission date; (iv) Date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction; (v) Receipts indicating the purpose for which any withdrawn funds were spent; and (vi) Patient's earned interest, if any.

(5) Access to records. The facility must provide each patient reasonable access to his or her own financial records.

(6) Quarterly statements. The facility must provide a written statement, at least quarterly, to each patient or representative. The quarterly statement must reflect any patient funds which the facility has deposited in an interest bearing or a non-interest bearing account as well as any patient funds held by the facility in a petty cash account. The statement must include at least the following: (i) Balance at the beginning of the statement period; (ii) Total deposits and withdrawals; (iii) Interest earned, if any; (iv) Identification number and location of any account in which that patient's personal funds have been deposited; (v) Ending balance; and (vi) For patients eligible for Supplemental Security Income or Medical Assistance, the difference between the ending balance and the applicable benefits eligibility level.

(7) Commingling prohibited. The facility must keep any funds received from a patient for holding, safeguarding, and accounting separate from the facility's funds, and from the funds of any person other than another patient in that facility.

(8) Types of accounts; distribution of interest—(i) Petty cash. The facility may keep up to $150.00 of a patient's money in a non-interest bearing account or petty cash fund. If a patient's monthly personal needs allowance increases after October 22, 1980, the facility may increase the threshold amount by an amount equal to the increase in the personal needs allowance. (ii) Interest-bearing accounts. Unless precluded by State law, the facility must, within 15 days of receipt of the money, deposit in an interest bearing account any

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funds in excess of $150.00 from an individual patient. The account may be individual to the patient or pooled with other patients in the facility. If a pooled account is used, each patient must be individually identified. The account must be in a form that clearly indicates that the facility does not have an ownership interest in the funds. The account must be insured under Federal or State law. (iii) Distribution of interest. The interest earned on any pooled interest bearing account must be distributed in one of the following ways, at the election of the facility: (A) Pro-rated to each patient on an actual interest-earned basis; or (B) Pro-rated to each patient on the basis of his or her end-of-quarter balance.

(9) Access to funds—(i) Funds held in the facility. The patient must have access to funds daily, at least two hours during normal business hours and for some reasonable time on Saturdays and Sundays. The facility must, upon request or upon the patient's transfer or discharge, return to the patient, the legal guardian, or the representative payee all or any part of the patient's personal funds that the facility has received for holding, safeguarding, and accounting, and that are maintained in a petty cash fund. (ii) Funds held outside the facility. For a patient's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request or upon the patient's transfer or discharge must, within 5 business days, return to the patient, the legal guardian, or the representative payee, all or any part of those funds.

(10) Handling of monthly benefits. When a facility is a patient's representative payee and directly receives monthly benefits to which the patient is entitled, it must fulfill its duties as representative payee in accordance with 20 CFR 416.620 and 404.1603, that define those duties.

(11) Accounting upon change of ownership. (i) Duties to new owner. Upon sale of the facility or other transfer of ownership, the facility must

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provide the new owner with a written accounting, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Auditing Procedures, of all patient funds being transferred, and obtain a written receipt for those funds from the new owner. (ii) Duties to patient. The facility must give each patient or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs. (iii) Rights of patients. In the event of a disagreement with the accounting provided by the facility, the patient retains all rights and remedies provided under State law.

(12) Accounting upon death of patient. Unless precluded by State law, the facility must provide the executor or administrator of a patient's estate with a written accounting of the patient's personal funds within 10 business days of a patient's death. If the deceased patient's estate has no executor or administrator, the facility must provide the accounting to: (i) The patient's next of kin; (ii) The patient's representative; and (iii) The Clerk of the probate court of the county in which the patient died.

(13) Surety bond. The facility must purchase a surety bond to guarantee the security of a patient's funds retained in the facility. Facilities of less than 60 beds must purchase a surety bond only when the amount of patients' money it is holding in the facility exceeds $5,000.00.

(14) Patient incapable of managing funds. If a patient is incapable of managing personal funds and has no representative, the facility must refer the patient to the Area Agency on Aging, to the State protective agency with appropriate jurisdiction, or to the State Guardian's Office, if one exists. If there is no such office, the facility must: (i) In the case of a patient who is eligible for Medical Assistance (Title XIX), or SSI (Title XVI), notify the local office of the Social Security Administration (SSA) and request that a representative payee

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be appointed. Whoever is appointed must fulfill the duties of representative payee in accordance with 20 CFR 416.620 and 404.1603 that defines those duties. (ii) In the case of a patient who is not eligible for Medical Assistance (Title XIX), or SSI (Title XVI), institute a proceeding in accordance with State law for the appointment of a guardian, conservator, or committee. Unless precluded by State law, the costs of instituting the proceeding and administering the patient's estate may be charged against the patient's estate; or, (iii) In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, or notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the patient. During this period, the facility must fulfill its duties in accordance with 20 CFR 416.620 and 404.1603.

(15) Substitution of existing system. (i) If a State has adopted requirements for the protection of patients' funds, those requirements may be substituted for the provisions of this section: Provided, That (A) The State has first incorporated this substitution into its State Plan, and (B) It has been approved by HCFA as part of that Plan on the grounds that the State's requirements for each of these sections are equivalent or superior to those contained in this paragraph. (ii) If an individual facility has independently implemented a system for the protection of patients' funds, the facility's system may be substituted for the provisions of this section: Provided (A) This system is incorporated in the facility's provider agreement with the State, and (B) The State has incorporated this substitution into its State Plan, and (C) It has been approved by HCFA as part of that Plan on the grounds that the facility's system provides safeguards that are equivalent or superior to those contained in this paragraph.

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(16) Resident property records. (i) The facility must maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the facility by the resident. (ii) The property record must be available to the resident and resident representative (as defined by 405.1121(m)(1)).

3. Condition of Participation—Medical Direction.

The facility retains, effective not later than 12 full calendar months from December 2, 1974, pursuant to a written agreement, a physician, licensed under State law to practice medicine or osteopathy, to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the patients and the facility. If the facility has an organized medical staff, the medical director is designated by the medical staff with approval of the governing body. A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement. The medical director is responsible for the over-all coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees. (See 405.1911(b) regarding waiver of the requirement for a medical director.)

(a) *Standard: Coordination of medical care*. Medical direction and coordination of medical care in the facility are provided by a medical director. The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(b) *Standard: Responsibilities to the facility*. The medical director is responsible for surveillance of

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the health status of the facility's employees. Incidents and accidents that occur on the premises are reviewed by the medical director to identify hazards to health and safety. The administrator is given appropriate information to help ensure a safe and sanitary environment for patients and personnel. The medical director is responsible for the execution of patient care policies in accordance with 405.1121(1).

4. Condition of Participation—Physician Services.

Patients in need of skilled nursing or rehabilitative care are admitted to the facility only upon the recommendation of and remain under the care of a physician. To the extent feasible, each patient or his sponsor designates a personal physician.

(a) *Standard: Medical findings and physicians' orders at time of admission*. There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the patient. Information about the rehabilitation potential of the patient and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

(b) *Standard: Patient supervision by physician*. The facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care. Each attending physician is required to make arrangements for the medical care of his patients in his absence. The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time

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of each visit, and he signs all his orders. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with 405.1126(b). At no time may the alternate schedule exceed 60 days between visits. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient, in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid agency of the change in schedule, including justification, and the utilization review committee or the medical review team (see 405.1121(d)) promptly evaluates the patient's need for monthly physician visits as well as his continued need for skilled nursing facility services (see 405.1137(d)). If the utilization review committee or the medical review team does not concur in the schedule of visits at intervals of more than 30 days, the alternate schedule is not acceptable.

(c) *Standard: Availability of physicians for emergency patient care*. The facility has written procedures, available at each nurses station, that provide for having a physician available to furnish necessary medical care in case of emergency.

5. Condition of Participation—Nursing Services.

The skilled nursing facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty 7 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all patients in the facility. (See 405.1911(a) regarding waiver of the 7-day registered nurse requirement.)

(a) *Standard: Director of nursing services*. The director of nursing services is a qualified registered nurse employed full-time who has, in writing, administrative authority, responsibility, and accountability for

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the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as her assistant so that there is the equivalent of a full-time director of nursing services on duty. The director of nursing services is responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedures manuals, written job descriptions for each level of nursing personnel, scheduling of daily rounds to see all patients, methods for coordination of nursing services with other patient services, for recommending the number and levels of nursing personnel to be employed, and nursing staff development (see 405.1121(h)).

(b) *Standard: Charge nurse*. A registered nurse, or a qualified licensed practical (vocational) nurse, is designated as charge nurse by the director of nursing services for each tour of duty, and is responsible for supervision of the total nursing activities in the facility during each tour of duty. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more patients. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty, on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.

(c) *Standard: Twenty-four-hour nursing service*. The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient care policies developed as provided in 405.1121(I). The policies are designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from

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accident, injury, and infection, and encouraged, assisted, and trained in self-care and group activities. Nursing personnel, including at least one registered nurse on the day tour of duty 7 days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience and based on the characteristics of the patient load. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel, including relief personnel, who worked on each unit for each tour of duty.

(d) *Standard: Patient care plan*. In coordination with the other patient care services to be provided, a written patient care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission. The plan indicates care to be given and goals to be accomplished and which professional service is responsible for each element of care. The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient.

(e) *Standard: Rehabilitative nursing care*. Nursing personnel are trained in rehabilitative nursing, and the facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.

(f) *Standard: Supervision of patient nutrition*. Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist promptly where necessary in the feeding of patients. A procedure is established to inform the dietetic service of physicians' diet orders and of patients' dietetic problems. Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and the physician.

(g) *Standard: Administration of drugs*. Drugs and biologicals are administered only by physicians,

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licensed nursing personnel, or by other personnel who have completed a State-approved training program in medication administration. Procedures are established by the pharmaceutical services committee (see 405.1127(d)) to ensure that drugs to be administered are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administered the drug. Drugs and biologicals are administered as soon as possible after doses are prepared, and are administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems. (See 405.1101 (h).)

(h) *Standard: Conformance with physicians' drug orders*. Drugs are administered in accordance with written orders of the attending physician. Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. Physicians' verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.) Such orders are countersigned by the attending physician within 48 hours. The attending physician is notified of an automatic stop order prior to the last dose so that he may decide if the administration of the drug or biological is to be continued or altered.

(i) *Standard: Storage of drugs and biologicals*. Procedures for storing and disposing of drugs and biologicals are established by the pharmaceutical services committee. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention &

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Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.

6. Condition of Participation—Dietetic Services.

The skilled nursing facility provides a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this condition provided the facility and/or company meets the standards listed herein.

(a) *Standard: Staffing*. Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor. If the dietetic service supervisor is not a qualified dietitian he functions with frequent, regularly scheduled consultation from a person so qualified. (See 405.1121(i).) In addition, the facility employs sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel are on duty daily over a period of 12 or more hours. If consultant dietetic services are used, the consultant's visits are at appropriate times, and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus, and participation in development or revision of dietetic policies and procedures and in planning and conducting inservice education programs (see 405.1121(h)).

(b) *Standard: Menus and nutritional adequacy*. Menus are planned and followed to meet nutritional needs of patients in accordance with physicians' orders and, to the extent medically possible, in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences.

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(c) *Standard: Therapeutic diets*. Therapeutic diets are prescribed by the attending physician. Therapeutic menus are planned in writing, and prepared and served as ordered, with supervision or consultation from the dietitian and advice from the physician whenever necessary. A current therapeutic diet manual approved by the dietitian is readily available to attending physicians and nursing and dietetic service personnel.

(d) *Standard: Frequency of meals*. At least three meals or their equivalent are served daily, at regular hours, with not more than a 14-hour span between substantial evening meal and breakfast. To the extent medically possible, bedtime nourishments are offered routinely to all patients.

(e) *Standard: Preparation and service of food*. Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. If a patient refuses food served, appropriate substitutes of similar nutritive value are offered.

(f) *Standard: Hygiene of staff*. Dietetic service personnel are free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties do not interfere with the sanitation, safety, or time required for dietetic work assignments. (See 405.1121(g).)

(g) *Standard: Sanitary conditions*. Food is procured from sources approved or considered satisfactory by Federal, State, or local authorities, and stored, prepared, distributed, and served under sanitary conditions. Waste is disposed of properly. Written reports of inspections by State and local health authorities are on file at the facility, with notation made of action taken by the facility to comply with any recommendations.

7. Condition of Participation—Specialized Rehabilitative Services.

In addition to rehabilitative nursing (405.1124(e)), the skilled nursing facility

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provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional responsibilities for the services rendered. (See 450.1121(i).)

(a) *Standard: Organization and staffing*. Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists. Other rehabilitative services may also be provided, but must be in a facility where all rehabilitative services are provided through an organized rehabilitative service under the supervision of a physician qualified in physical medicine who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those providing such services. Written administrative and patient care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.

(b) *Standard: Plan of care*. Rehabilitative services are provided under a written plan of care initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy is provided only upon written orders of the attending physician. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but

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at least every 30 days, by the physician and the therapist(s).

(c) *Standard: Documentation of services*. The physician's orders, the plan of rehabilitative care, services rendered, evaluations of progress, and other pertinent information are recorded in the patient's medical record, and are dated and signed by the physician ordering the service and the person who provided the service.

(d) *Standard: Qualifying to provide outpatient physical therapy services*. If the facility provides outpatient physical therapy services, it meets the applicable health and safety regulations pertaining to such services as are included in Subpart Q of these regulations.

8. Condition of Participation—Pharmaceutical Services.

The skilled nursing facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws. (See 405.1124(g), (h), and (i).)

(a) *Standard: Supervision of services*. The pharmaceutical services are under the general supervision of a qualified pharmacist who is responsible to the administrative staff for developing, coordinating, and supervising all pharmaceutical services. The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities. The pharmacist reviews the drug regimen of each patient at least monthly, and reports any irregularities to the medical director and administrator. The pharmacist submits a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.

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(b) *Standard: Control and accountability*. The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Only approved drugs and biologicals are used in the facility, and are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

(c) *Standard: Labeling of drugs and biologicals*. The labeling of drugs and biologicals is based on currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

(d) *Standard: Pharmaceutical services committee*. A pharmaceutical services committee (or its equivalent) develops written policies and procedures for safe and effective drug therapy, distribution, control, and use. The committee is composed of at least the pharmacist, the director of nursing services, the administrator, and one physician. The committee oversees pharmaceutical service in the facility, makes recommendations for improvement, and monitors the service to ensure its accuracy and adequacy. The committee meets at least quarterly and documents its activities, findings, and recommendations.

9. Condition of Participation—Laboratory and Radiologic Services.

The skilled nursing facility has provision for promptly obtaining required laboratory, X-ray, and other diagnostic services.

(a) *Standard: Provision for services*. If the facility provides its own laboratory and X-ray services, these meet the applicable conditions established for certification of hospitals that are contained in 405.1028 and 405.1029, respectively. If the facility itself does not provide such services, arrangements are made for obtaining these services from a physician's office, a participating hospital or skilled nursing

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facility, or a portable X-ray supplier or independent laboratory which is approved to provide these services under the program. All such services are provided only on the orders of the attending physician, who is notified promptly of the findings. The facility assists the patient, if necessary, in arranging for transportation to and from the source of service. Signed and dated reports of a clinical laboratory, X-ray, and other diagnostic services are filed with the patient's medical record.

(b) *Standard: Blood and blood products*. Blood handling and storage facilities are safe, adequate, and properly supervised. If the facility provides for maintaining and transfusing blood and blood products, it meets the conditions established for certification of hospitals that are contained in 405.1028(j). If the facility does not provide its own facilities but does provide transfusion services alone, it meets at least the requirements of 405.1028(j)(1), (3), (4), (6), and (9).

10. Condition of Participation—Dental Services.

The skilled nursing facility has satisfactory arrangements to assist patients to obtain routine and emergency dental care. (See 405.1121(i).) (The basic Hospital Insurance Program does not cover the services of a dentist in a skilled nursing facility in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth; and only certain oral surgery is included in the Supplemental Medical insurance Program.)

(a) *Standard: Advisory dentist*. An advisory dentist participates in the staff development program for nursing and other appropriate personnel (see 405.1121(h)), and recommends oral hygiene policies and practices for the care of patients.

(b) *Standard: Arrangements for outside services*. The facility has a cooperative agreement with a dental service, and maintains a list of dentists in the community for patients who do not have a private dentist. The facility assists the patient, if necessary, in arranging for transportation to and from the dentist's office.

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11. Condition of Participation—Social Services.

The skilled nursing facility has satisfactory arrangements for identifying the medically related social and emotional needs of the patient. It is not mandatory that the skilled nursing facility itself provide social services in order to participate in the program. If the facility does not provide social services, it has written procedures for referring patients in need of social services to appropriate social agencies. If social services are offered by the facility, they are provided under a clearly defined plan, by qualified persons, to assist each patient to adjust to the social and emotional aspects of his illness, treatment, and stay in the facility.

(a) *Standard: Social service functions*. The medically related social and emotional needs of the patient are identified and services provided to meet them, either by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency. The patient and his family or responsible person are fully informed of the patient's personal and property rights.

(b) *Standard: Staffing*. If the facility offers social services, a member of the staff of the facility is designated as responsible for social services. If the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. (See 405.1121(i).) The social service also has sufficient supportive personnel to meet patient needs. Facilities are adequate for social service personnel, easily accessible to patients and medical and other staff, and ensure privacy for interviews.

(c) *Standard: Records and confidentiality of social data*. Records of pertinent social data about personal and family problems medically related to the patient's illness and care, and of action taken to meet his needs, are maintained in the patient's medical record. If social services are provided by an outside

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resource, a record is maintained of each referral to such resource. Policies and procedures are established for ensuring the confidentiality of all patients' social information.

12. Condition of Participation—Patient Activities.

The skilled nursing facility provides for an activities program, appropriate to the needs and interests of each patient, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning.

(a) *Standard: Responsibility for patient activities*. A member of the facility's staff is designated as responsible for the patient activities program. If he is not a qualified patient activities coordinator, he functions with frequent, regularly scheduled consultation from a person so qualified. (See 405.1121(i).)

(b) *Standard: Patient activities program*. Provision is made for an ongoing program of meaningful activities appropriate to the needs and interests of patients, designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. Each patient's activities program is approved by the patient's attending physician as not in conflict with the treatment plan. The activities are designed to promote the physical, social, and mental well-being of the patients. The facility makes available adequate space and a variety of supplies and equipment to satisfy the individual interests of patients. (See 405.1134(g).)

13. Condition of Participation—Medical Records.

The facility maintains clinical (medical) records on all patients in accordance with accepted professional standards and practices. The medical record service has sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) *Standard: Staffing*. Overall supervisory responsibility for the medical record service is

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assigned to a full-time employee of the facility. The facility also employs sufficient supportive personnel competent to carry out the functions of the medical record service. If the medical record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified. (See 405.1121(i).)

(b) *Standard: Protection of medical record information*. The facility safeguards medical record information against loss, destruction, or unauthorized use.

(c) *Standard: Content*. The medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. All medical records contain the following general categories of data: Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of treatment, and of the care and services provided; authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form), identification data and consent forms, medical and nursing history of patient, report of physical examination(s), diagnostic and therapeutic orders, observations and progress notes, reports of treatments and clinical findings, and discharge summary including final diagnosis and prognosis.

(d) *Standard: Physician documentation*. Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable). Each physician signs his entries into the medical record.

(e) *Standard: Completion of records and centralization of reports*. Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient's stay is centralized in the patient's medical record.

(f) *Standard: Retention and preservation*. Medical records are retained for a period of time not less than that determined by the respective State statute, the

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statute of limitations in the State, or 5 years from the date of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the patient becomes of age under State law.

(g) *Standard: Indexes*. Patients' medical records are indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(h) *Standard: Location and facilities*. The facility maintains adequate facilities and equipment, conveniently located, to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

14. Condition of Participation—Transfer Agreement.

The skilled nursing facility has in effect a transfer agreement with one or more hospitals approved for participation under the programs, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's patients when needed. (A facility that has been unable to establish a transfer agreement with the hospital(s) in the community or service area after documented attempts to do so is considered to have such an agreement in effect.)

(a) *Standard: Patient transfer*. A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that:

(1) Transfer of patients will be effected between the hospital and the skilled nursing facility, ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician, and

(2) There will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such

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individuals can be adequately cared for otherwise than in either of such institutions, and

(3) Security and accountability for patients' personal effects are provided on transfer. Any skilled nursing facility which does not have such agreement in effect, but which is found by a State agency (of the State in which such facility is located) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (a)(2) of this section, shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to ensuring skilled nursing facility services for persons in the community who are eligible for payments with respect to such services under the programs.

15. Condition of Participation—Physical Environment.

The skilled nursing facility is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public.

(a) *Standard: Life safety from fire*. The skilled nursing facility meets such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that, in consideration of a recommendation by the State survey agency, the Secretary may waive, for such periods as deemed appropriate, specific provisions of such Code which, if rigidly applied, would result in unreasonable hardship upon a skilled nursing facility, but only if such waiver will not adversely affect the health and safety of the patients; and except that the provisions of such Code shall not apply in any State if the Secretary finds, in accordance with applicable provisions of section 1861(j)(13) of the Social Security Act, that in such

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State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in skilled nursing facilities. Where waiver permits the participation of an existing facility of two or more stories which is not of at least 2-hour fire resistive construction, blind, nonambulatory, or physically handicapped patients are not housed above the street level floor unless the facility is of 1-hour protected noncombustible construction (as defined in National Fire Protection Association Standard No. 220), fully sprinklered 1-hour protected ordinary construction, or fully sprinklered 1-hour protected wood-frame construction. Nonflammable medical gas systems, such as oxygen and nitrous oxide, installed in the facility comply with applicable provisions of National Fire Protection Association Standard No. 56B (Standard for the Use of Inhalation Therapy) 1968 and National Fire Protection Association Standard No. 56F (Nonflammable Medical Gas Systems) 1970.

(b) *Standard: Emergency power*. The facility provides an emergency source of electrical power necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system must supply power adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems. Where life support systems are used, emergency electrical service is provided by an emergency generator located on the premises.

(c) *Standard: Facilities for physically handicapped*. The facility is accessible to, and functional for, patients, personnel, and the public. All necessary accommodations are made to meet the needs of persons with semiambulatory disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities, in accordance with the American National Standards Institute (ANSI) Standard No. Al 17.1, American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by,

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the Physically Handicapped. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency—see 42 CFR 449.33(a)(1)(i)) may waive in existing buildings, for such periods as deemed appropriate, specific provisions of ANSI Standard No. Al 17.1 which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not adversely affect the health and safety of patients.

(d) *Standard: Nursing unit*. Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well-lighted to facilitate staff functioning. The nurses station is equipped to register patients' calls through a communication system from patient areas, including patient rooms and toilet and bathing facilities.

(e) *Standard: Patient rooms and toilet facilities*. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients, and have no more than four beds, except in facilities primarily for the care of the mentally ill and/or retarded where there shall be no more than 12 beds per room. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.) Single patient rooms measure at least 100 square feet, and multipatient rooms provide a minimum of 80 square feet per bed. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency—see 42 CFR 449.33(a)(1)(i)) may permit variations in individual cases where the facility demonstrates in writing that such variations are in accordance with the particular needs of the patients and will not adversely affect their health and safety. Each room is equipped with, or is conveniently located near, adequate toilet and bathing facilities.

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Each room has direct access to a corridor and outside exposure, with the floor at or above grade level.

(f) *Standard: Facilities for special care*. Provision is made for isolating patients as necessary in single rooms ventilated to the outside, with private toilet and handwashing facilities. Procedures in aseptic and isolation techniques are established in writing and followed by all personnel. Such areas are identified by appropriate precautionary signs.

(g) *Standard: Dining and patient activities rooms*. The facility provides one or more clean, orderly, and appropriately furnished rooms of adequate size designated for patient dining and for patient activities. These areas are well-lighted and well-ventilated. If a multipurpose room is used for dining and patient activities, there is sufficient space to accommodate all activities and prevent their interference with each other.

(h) *Standard: Kitchen and dietetic service areas*. The facility has kitchen and dietetic service areas adequate to meet food service needs. These areas are properly ventilated, and arranged and equipped for sanitary refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal.

(i) *Standard: Maintenance of equipment, building, and grounds*. The facility establishes a written preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.

(j) *Standard: Other environmental considerations*. The facility provides a functional, sanitary, and comfortable environment for patients, personnel, and the public. Provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature, procedures to ensure water to all essential areas in the event of loss of normal water supply, and

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adequate ventilation through windows or mechanical means or a combination of both. Corridors are equipped with firmly secured handrails on each side.

16. Condition of Participation—Infection Control.

The skilled nursing facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.

(a) *Standard: Infection control committee*. The infection control committee is composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services. The committee establishes policies and procedures for investigating, controlling, and preventing infections in the facility, and monitors staff performance to ensure that the policies and procedures are executed.

(b) *Standard: Aseptic and isolation techniques*. Written effective procedures in aseptic and isolation techniques are followed by all personnel. Procedures are reviewed and revised annually for effectiveness and improvement.

(c) *Standard: Housekeeping*. The facility employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee is responsible for the services and for supervision and training of personnel. Nursing personnel are not assigned housekeeping duties. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility and/or outside resource meets the requirements of the standard.

(d) *Standard: Linen*. The facility has available at all times a quantity of linen essential for proper

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care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(e) *Standard: Pest control*. The facility is maintained free from insects and rodents through operation of a pest control program.

17. Condition of Participation—Disaster Preparedness.

The skilled nursing facility has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(a) *Standard: Disaster plan*. The facility has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other · appropriate experts, and includes procedures for prompt transfer of casualties and records, instructions regarding the location and use of alarm systems and signals and of fire-fighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons, and specifications of evacuation routes and procedures.

(b) *Standard: Staff training and drills*. All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his specific role in case of disaster.

18. Condition of Participation—Utilization Review.

The skilled nursing facility carries out utilization review of the services provided in the facility at least to inpatients who are entitled to benefits under the program(s). Utilization review has as its overall objectives both the maintenance of high quality patient care and assurance of appropriate and efficient utilization of facility services. There are two elements to utilization review: medical care evaluation studies that identify and examine patterns of care

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provided in the facility, and review of extended duration cases which is concerned with efficiency, appropriateness, and cost effectiveness of care.

(a) *Standard: Written plan of utilization review activity*. The skilled nursing facility has a currently applicable written description of its utilization review plan. Such description includes:

(1) The organization and composition of the committee or group which will be responsible for the utilization review function;
(2) Frequency of meetings;
(3) The type of records to be kept;
(4) The methods and criteria (including norms where available) to be used to define periods of continuous extended duration and to assign or select subsequent dates for continued stay review;
(5) Methods for selection and conduct of medical care evaluation studies;
(6) The relationship of the utilization review plan to claims administration by a third party;
(7) Arrangements of committee reports and their dissemination;
(8) Responsibilities of the skilled nursing facility's administrative staff.
(b) *Standard: Composition and organization of utilization review committee*.

(1) The utilization review function is conducted by a staff committee of the skilled nursing facility composed of two or more physicians, with participation of other professional personnel, or by a group outside the facility which is similarly composed and which is established by the local medical or osteopathic society and some or all of the hospitals and skilled nursing facilities in the locality, or by a group established and organized in a manner approved by the Secretary that is capable of performing such a function.
(2) The medical care evaluation studies, as described in paragraph (c) of this section, and educational duties of the review program, and the review of admissions and long-stay cases need not be performed by the same committee or group and they

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need not be performed by a specially established group.

(3) Review by the committee or group may not be conducted by any person who is employed by or who is financially interested in any skilled nursing facility or by any person who was professionally involved in the care of the patient whose case is being reviewed.

(c) *Standard: Medical care evaluation studies*. Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care. Studies emphasize identification and analysis of patterns of patient care, and suggest, where appropriate, possible changes for maintaining consistently high quality patient care and effective and efficient use of services. Each medical care evaluation study (whether medical or administrative in emphasis) identifies and analyzes factors related to the patient care rendered in the facility, and where indicated, results in recommendations for change beneficial to patients, staff, the facility and the community. Studies on a sample or other basis include, but need not be limited to: admissions, durations of stay, ancillary services furnished (including drugs and biologicals) and professional services performed on facility premises. At least one study must be in progress at any given time, and at least one study must be completed each year. The study will be accomplished by considering and analyzing data obtained from any one or a combination of the following sources:

(1) Medical records or other appropriate data;

(2) External organizations which compile statistics, design profiles, and produce other comparative data; and

(3) By cooperative endeavor with the PSRO, fiscal intermediary(ies), providers of services, or appropriate agencies. The committee or group shall document the results of each medical care evaluation study and how such results have, where appropriate, been used to institute changes to improve the quality

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of care and promote more effective and efficient use of facilities and services.

(d) *Standard: Extended stay review*.

(1) Periodic review is made of each current inpatient skilled nursing facility beneficiary case of continuous extended duration, the length of which is defined in the utilization review plan, to determine whether further inpatient stay is necessary. The plan may specify a different number of days for different diagnostic classes of cases, or may use the same number of days for all cases. In any event the period(s) specified bears a reasonable relationship to current average length-of-stay statistics and does not exceed 30 days after admission. An exception to this 30-day limit may be made where the extended stay review date is based on: (i) The average, or some other appropriate point (e.g., median) of current length of stay data for diagnostic classes of cases selected by the committee or group in accordance with guidelines established by the Secretary, when the average (or other length of stay review point) for the individual's specific diagnostic class or category, based on functional capability, exceeds 30 days; or (ii) A period, established pursuant to section 1814(h)(1) of the Act, which exceeds 20 days.

(2) The initial extended stay review takes place prior to or at the end of the period of extended duration specified pursuant to paragraph (d)(1) of this section. The review is based on the attending physician's reasons for and plan for continued stay and any other documentation the committee or group deems appropriate. Cases may be screened by a qualified nonphysician representative of the committee or group who uses criteria established by the physician members of the committee, provided that cases are referred to a physician member for further review when it appears that the patient no longer requires further inpatient care. Where the committee or group selects a nonphysician representative to screen extended stay review cases, it will select an individual with experience in such screening or

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appropriate training in the application of the screening criteria used, or both. The Secretary may grant an additional period of time, beyond July 1, 1975, the effective date of this paragraph, for a committee or group of a skilled nursing facility to select or develop the written criteria and standards required by this paragraph: (i) Where the committee or group documents that it made every effort to comply by July 1, 1975, and that it is currently making substantial progress in developing the criteria and standards; and (ii) where the committee or group establishes a timetable for meeting the requirements which is acceptable to the Secretary.

(3) Where a finding is made that the individual continues to need inpatient skilled nursing care, an additional stay is approved for a period the committee or group deems appropriate, provided that reviews are made at least every 30 days for the first 90 days and at least every 90 days thereafter. Before the expiration of each new period, the case must be reviewed again in like manner, with such reviews being repeated as long as the stay continues beyond the scheduled review dates and notice has not been given pursuant to paragraph (e) of this section.

(e) *Standard: Admission or further stay not medically necessary.*

(1) A final determination of the committee or group that an admission or continued stay is not medically necessary is made by at least two physician members of the committee or groups, except that the final determination may be made by one physician member where the attending physician, when given an opportunity to express his views, does not do so, or does not contest the finding that the admission or continued stay is not medically necessary. (See 405.166 regarding the restriction on payment after an adverse decision by the committee or group.)

(2) If the committee or group, or its nonphysician representative where a physician member concurs, has reason to believe from the review of an admission or an extended duration case or a case reviewed as part of a medical care evaluation study that further stay

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is no longer medically necessary (or that admissions were not medically necessary), the committee or group shall notify the individual's attending physician and afford him an opportunity to present his views before it makes a final determination. If the final determination of the committee or group is that further stay is no longer medically necessary, written notification of the finding is given to the facility, the attending physician, and the individual (or where appropriate, his next of kin) no later than two days after such final determination is made and, in no event in the case of an extended duration case, later than 3 working days after the end of the extended duration period specified pursuant to paragraph (d) of this section.

(f) *Standard: Administrative responsibilities*. The administrative staff of the facility is kept directly and fully informed of committee activities to facilitate support and assistance. The administrator studies and acts upon recommendations made by the committee, coordinating such functions with appropriate staff members.

(g) *Standard: Utilization review records*. Written records of committee activities are maintained. Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any). Minutes of each committee meeting are maintained and include at least:

(1) Name of committee,
(2) Date and duration of meeting,
(3) Names of committee members present and absent,
(4) Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject and reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions, and follow-up on implementation of recommendations made from previous studies, and
(5) Summary of extended duration cases reviewed, including the number of cases, case identification

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numbers, admission and review dates, and decisions reached, including the basis for each determination and action taken for each case not approved for extended care.

(h) *Standard: Discharge planning*. The facility maintains a centralized, coordinated program to ensure that each patient has a planned program of continuing care which meets his postdischarge needs.

(1) The facility has in operation an organized discharge planning program. The utilization review committee, in its evaluation of the current status of each extended duration case, has available to it the results of such discharge planning and information on alternative available community resources to which the patient may be referred.

(2) The administrator delegates responsibility for discharge *planning* , in writing, to one or more members of the facility's staff, with consultation, if necessary, or arranges for this service to be provided by a health, social, or welfare agency (see 405.1121(i)).

(3) The facility maintains written discharge planning procedures which describe (i) how the discharge coordinator will function, and his authority and relationships with the facility's staff; (ii) the time period in which each patient's need for discharge planning is determined (preferably within 7 days after the clay of admission); (iii) the maximum time period after which a reevaluation of each patient's discharge plan is made; (iv) local resources available to the facility, the patient, and the attending physician to assist in developing and implementing individual discharge plans; and (v) provisions for periodic review and reevaluation of the facility's discharge planning program.

(4) At the time of discharge, the facility provides those responsible for the patient's postdischarge care with an appropriate summary of information about the discharged patient to ensure the optimal continuity of care. The discharge summary includes at least current information relative to diagnoses, rehabilitation potential, a

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summary of the course of prior treatment, physician orders for the immediate care of the patient, and pertinent social information.

(i) *Standard: Applicability of utilization review requirements approved under Title XIX*. Notwithstanding the preceding paragraphs of this section, if the Secretary determines that the utilization review procedures established by a State pursuant to Title XIX of the Social Security Act are superior in their effectiveness to the procedures required under this section, any provision of the State plan for which the waiver of the requirements set forth in this section for utilization review in skilled nursing facilities is granted shall, to the extent deemed appropriate by the Secretary, be utilized by skilled nursing facilities in that State, instead of the procedures specified in this section.

(j) *Correlation of PSRO review-Medicare utilization review activities*. Review activities under section 1158(a) of the Act shall be in lieu of the requirements of this section if a Professional Standards Review Organization (PSRO) has assumed review responsibility in accordance with the applicable provisions of Part 463 of this chapter for services provided by or in the facility to inpatients who are entitled to benefits under this Part 405. (See 463.25, 463.26, and 463.28 for provisions concerning the correlation of functions under Titles XI-B and XVIII of the Act.

B. STANDARDS FOR INTERMEDIATE CARE FACILITIES (ICFS) OTHER THAN FACILITIES FOR THE MENTALLY RETARDED (42 CFR 442.300 THROUGH 442.346 (1974))

Administration

1. *Methods of Administration.* An ICF must have methods of administrative management that insure that it meets the requirements of Standards (2) through (15).
2. *Staffing*. The ICF must have staff on duty 24 hours a day sufficient in number and qualifications to carry out the policies, responsibilities, and programs of the ICF.

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3. *Administrator.*

(a) The ICF must have an administrator who is:

(1) A nursing home administrator with a current State license; or
(2) A hospital administrator, if the ICF is a hospital qualifying as an intermediate care facility.
(b) The administrator's responsibilities must include:

(1) Managing the ICF; and
(2) Implementing established policies and procedures.
4. *Resident Services Director.*

(a) The ICF must designate the administrator or a professional staff member as resident services director.
(b) The duties of the resident services director must include coordinating and monitoring each resident's overall plan of care.
5. *Written Policies and Procedures: General Requirements.* The ICF must have written policies and procedures that:

(a) Govern all services provided by the ICF; and
(b) Are available to the staff, residents, members of the family and legal representatives of residents, and the public.
6. *Written Policies and Procedures: Admission.* The ICF must have written policies and procedures that insure that it admits as residents only those individuals whose needs can be met:

(a) By the ICF itself;
(b) By the ICF in cooperation with community resources; or
(c) By the ICF in cooperation with other providers of care affiliated with or under contract to the ICF.
7. *Written Policies and Procedures: Transfer and Discharge.* The ICF must have written policies and procedures that insure that:

(a) It transfers a resident promptly to a hospital, skilled nursing facility, or other appropriate facility,

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when a change occurs in the resident's physical or mental condition that requires care or service that the ICF cannot adequately provide; and

(b) Except in an emergency, it:

(1) Consults the resident, his next of kin, the attending physician, and the responsible agency, if any, at least 5 clays before a transfer or discharge; and
(2) Uses casework services or other means to insure that adequate arrangements are made to meet the resident's needs through other resources.

8. *Written Policies and Procedures: Chemical and Physical Restraints.* The ICF must have written policies and procedures that:

(a) Define the uses of chemical and physical restraints;
(b) Identify the professional personnel who may, under 442.311(h), authorize use of these restraints in emergencies; and
(c) Describe the procedures for monitoring and controlling the use of these restraints.

9. *Written Policies and Procedures: Resident Complaints and Recommendations.* The ICF must have written policies and procedures that:

(a) Describe the procedures that the ICF uses to receive complaints and recommendations from its residents; and
(b) Insure that the ICF responds to these complaints and recommendations.

10. *Written Policies and Procedures: Resident Records.* The ICF must have written policies and procedures governing access to, duplication of, and dissemination of information from the resident's record.

11. *Written Policies and Procedures: Residents' Bill of Rights.* The ICF must have written policies and procedures that insure the following rights for each resident:

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(a) Information.

(1) Each resident must be fully informed, before or at the time of admission, of his rights and responsibilities and of all rules governing resident conduct.
(2) If the ICF amends its policies on residents' rights and responsibilities and its rules governing conduct, each resident in the ICF at that time must be informed.
(3) Each resident must acknowledge in writing receipt of the information and any amendments to it.
(4) Each resident must be fully informed in writing of all services available in the ICF and of the charges for these services including any charges for services not paid for by Medicaid or not included in the ICF's basic rate per day. The ICF must provide this information either before or at the time of admission and on a continuing basis as changes occur in services or charges during the resident's stay.

(b) Medical condition and treatment.

(1) Each resident must (i) Be fully informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated; (ii) Be given the opportunity to participate in planning his total care and medical treatment; (iii) Be given the opportunity to refuse treatment; and (iv) Give informed, written consent before participating in experimental research.
(2) If the physician decides that informing the resident of his health and medical condition is medically contraindicated, the physician must document this decision in the resident's record.

(c) Transfer and discharge. Each resident must be transferred or discharged only for:

(1) Medical reasons;
(2) His welfare or that of the other residents; or
(3) Nonpayment except as prohibited by the Medicaid program.

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(d) Exercising rights. Each resident must be:

(1) Encouraged and assisted to exercise his rights as a resident of the ICF and as a citizen; and
(2) Allowed to submit complaints or recommendations concerning the policies and services of the ICF to staff or to outside representatives of the resident's choice or both, free from restraint, interference, coercion, discrimination, or reprisal.
(e) Financial affairs. Each resident must be allowed to manage his personal financial affairs. If a resident requests assistance from the ICF in managing his personal financial affairs:

(1) The request must be in writing; and
(2) The ICF must comply with the recordkeeping requirements of 442.320.
(f) Freedom from abuse and restraints.

(1) Each resident must be free from mental and physical abuse.
(2) Each resident must be free from chemical and physical restraints unless the restraints are (i) Authorized by a physician in writing for a specified period of time; or (ii) Used in an emergency under the following conditions: (A) The use is necessary to protect the resident from injuring himself or others. (B) The use is authorized by a professional staff member identified in the written policies and procedures of the facility as having the authority to do so. (C) The use is reported promptly to the resident's physician by that staff member.
(g) Privacy.

(1) Each resident must be treated with consideration, respect, and full recognition of his or her dignity and individuality.
(2) Each resident must be given privacy during treatment and care of personal needs.
(3) Each resident's records, including information in an automatic data bank, must be treated confidentially.
(4) Each resident must give written consent before the ICF may release information from his record to someone not otherwise authorized by law to receive it.

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(5) A married resident must be given privacy during visits by his spouse.
(6) If both husband and wife are residents of the ICF, they must be permitted to share a room.
(h) Work. No resident may be required to perform services for the ICF.
(i) Freedom of association and correspondence. Each resident must be allowed to:

(1) Communicate, associate, and meet privately with individuals of his choice, unless this infringes on the rights of another resident; and
(2) Send and receive personal mail unopened.
(j) Activities. Each resident must be allowed to participate in social, religious, and community group activities.
(k) Personal possessions. Each resident must be allowed to retain and use his personal possessions and clothing as space permits.
12. *Written Policies and Procedures: Delegation of Rights and Responsibilities.*

(a) The ICF must have written policies and procedures that provide that all rights and responsibilities of a resident pass to the resident's guardian, next of kin, or sponsoring agency or agencies if the resident:

(1) Is adjudicated incompetent under State law; or
(2) Is determined by his physician to be incapable of understanding his rights and responsibilities.
(b) If the resident is determined to be incapable of understanding his rights and responsibilities, the physician who made the determination must record the specific reason in the resident's record.
13. *Emergencies.* The ICF must:

(a) Have a written plan for staff and residents to follow in case of an emergency such as a fire or an explosion and rehearse the plan regularly; and
(b) Have written procedures for the staff to follow in case of an emergency involving a resident. These emergency procedures must include directions for:

(1) Caring for the resident;

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(2) Notifying the attending physician and other individuals responsible for the resident; and

(3) Arranging for transportation, hospitalization, or other appropriate services.

14. *Staff Training Programs.* The ICF must:

(a) Conduct an orientation program for all new employees that includes a review of all its policies;

(b) Plan and conduct an inservice staff development program for all personnel to assist them in developing and improving their skills; and

(c) Maintain a record of each orientation and staff development program it conducts. The record must include the content of the program and the names of the participants.

15. *Health and Safety Laws.* The ICF must meet all Federal, State, and local laws, regulations, and codes pertaining to health and safety, such as provisions regulating:

(a) Buying, dispensing, safeguarding, administering, and disposing of medications and controlled substances;

(b) Construction, maintenance, and equipment for the ICF;

(c) Sanitation;

(d) Communicable and reportable diseases; and

(e) Post mortem procedures.

16. *Transfer Agreements.*

(a) Except as provided in paragraph (b) of this section, the ICF must have in effect a transfer agreement with one or more hospitals sufficiently close by to make feasible the prompt transfer of the resident and his records to the hospital and to support a working arrangement between the ICF and the hospital for providing inpatient hospital services to residents when needed.

(b) If the survey agency finds that the ICF tried in good faith to enter into an agreement but could not, the ICF will be considered to meet the requirements of paragraph (a) of this section, as long as the survey agency finds that it is in the public interest and

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essential to assuring ICF services for eligible individuals in the community.

17. *Arrangements with outside resources.*

(a) If the ICF does not employ a qualified professional to furnish a required institutional service, it must have in effect a written agreement with a qualified professional outside the ICF to furnish the required service.

(b) The agreement must:

(1) Contain the responsibilities, functions, objectives, and other terms agreed to by the ICF and the qualified professional; and

(2) Be signed by the administrator or his representative and by the qualified professional.

(c) The ICF must maintain effective arrangements with outside resources for promptly providing medical and remedial services required by a resident but not regularly provided within the ICF.

18. *Resident Record System.*

(a) The ICF must maintain an organized resident record system that contains a record for each resident.

(b) The ICF must make resident records available to staff directly involved with the resident and to appropriate representatives of the Medicaid agency.

(c) Each resident's record must contain:

(1) Identification information;

(2) Admission information, including the medical and social history of the resident;

(3) An overall plan of care as described in 442.319;

(4) Copies of the initial and periodic examinations, evaluations, progress notes, all plans of care with subsequent changes, and discharge summaries;

(5) Description of treatments and services provided and medications administered; and

(6) All indications of illness or injury including the date, time, and action taken regarding each.

(d) The ICF must protect the resident records against destruction, loss, and unauthorized use.

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(e) The ICF must keep a resident's record for at least 3 years after the date the resident is discharged.

19. *Overall Plan of Care.* The overall plan of care required by 442.318 must:

(a) Set the goals to be accomplished by the resident;
(b) Prescribe an integrated program of activities, therapies, and treatments designed to help each resident achieve his goals; and
(c) Indicate which professional service or individual is responsible for each service prescribed in the plan.

20. *Resident Financial Records.*

(a) The ICF must maintain a current, written financial record for each resident that includes written receipts for:

(1) All personal possessions and funds received by or deposited with the ICF; and
(2) All disbursements made to or for the resident.
(b) The financial record must be available to the resident and his family.

Safety Standards

21. *Fire Protection.*

(a) Except as provided in 442.322 and 442.323 and paragraph (b) of this section, the ICF must meet the provisions of the Life Safety Code of the National Fire Protection Association, 1967 edition, that apply to institutional occupancies.
(b) If the Secretary finds that the State has a fire and safety code imposed by State law that adequately protects residents in ICF's, the State survey agency may apply the State code for the purposes of the Medicaid certification instead of the Life Safety Code.

22. *Fire Protection: Exception For Smaller Icf's.* The State survey agency may apply the lodgings or rooming houses section of the residential occupancy requirements of the Life Safety Code of the National Fire Protection Association, 1967 edition, instead of the institutional

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occupancy provisions required by 442.321 to an ICF that has 15 beds or less if the ICF is primarily engaged in the treatment of alcoholism and drug abuse and a physician certifies that each resident is:

(a) Ambulatory;
(b) Engaged in an active program for rehabilitation designed to and reasonably expected to lead to independent living; and
(c) Capable of following directions and taking appropriate action for self-preservation under emergency conditions.

23. *Fire protection: Waivers.*

(a) The State survey agency may waive specific provisions of the Life Safety Code required by 442.321, for as long as it considers appropriate, if:

(1) The waiver would not adversely affect the health and safety of the residents;
(2) Rigid application of specific provisions of the Code would result in unreasonable hardship for the ICF as determined under guidelines contained in the HCFA Long-Term Care Manual; and
(3) The waiver is granted in accordance with criteria contained in the Long-Term Care Manual.

(b) If the State survey agency waives provisions of the Code for an existing building of two or more stories that is not built of at least 2-hour fire-resistive construction, the ICF may not house a blind, nonambulatory, or physically handicapped resident above the street-level floor unless it is built of:

(1) One-hour protected, noncombustible construction as defined in National Fire Protection Association Standard No. 220;
(2) Fully sprinklered, 1-hour protected, ordinary construction; or
(3) Fully sprinklered, 1-hour protected, wood frame construction.

Environmental and Sanitation Standards

24. *Resident living areas*. The ICF must:

(a) Design and equip the resident living areas for the comfort and privacy of each resident; and

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(b) Have handrails that are firmly attached to the walls in all corridors used by residents.

25. *Residents' rooms*.

(a) Each resident room must:

(1) Be equipped with or conveniently located near toilet and bathing facilities;
(2) Be at or above grade level;
(3) Contain a suitable bed for each resident and other appropriate furniture;
(4) Have closet space that provides security and privacy for clothing and personal belongings;
(5) Contain no more than four beds
(6) Measure at least 100 square feet for a single-resident room or 80 square feet for each resident for a multi-resident room; and
(7) Be equipped with a device for calling the staff member on duty.

(b) For an existing building, the State survey agency may waive the space and occupancy requirements of paragraphs (a)(5) and (6) of this section for as long as it is considered appropriate if it finds that:

(1) The requirements would result in unreasonable hardship on the ICF if strictly enforced; and
(2) The waiver serves the particular needs of the residents and does not adversely affect their health and safety.

26. *Bathroom facilities*. The ICF must:

(a) Have toilet and bathing facilities that are located in or near residents' rooms and are appropriate in number, size, and design to meet the needs of the residents;
(b) Provide an adequate supply of hot water at all times for resident use; and
(c) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by residents.

27. *Linen supplies*. The ICF must have available at all times enough linen for the proper care and comfort of the residents and have clean linen on each bed.

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28. *Therapy and isolation areas*.

(a) The ICF's therapy area must be of sufficient size and appropriate design to:

(1) Accommodate the necessary equipment;
(2) Conduct an examination; and
(3) Provide treatment.
(b) The ICF must make provision for isolating residents with infectious diseases.
29. *Dining, recreation, and social rooms*.

(a) The ICF must provide one or more areas, not used for corridor traffic, for dining, recreation, and social activities.
(b) A multipurpose room may be used if it is large enough to accommodate all of the activities without their interfering with each other.
30. *Building accessibility and use*.

(a) The ICF must:

(1) Be accessible to and usable by all residents, personnel, and the public, including individuals with disabilities; and
(2) Meet the requirements of American National Standards Institute (ANSI) standard No. A117.1 (1961), American standard specifications for making building and facilities accessible to and usable by the physically handicapped.
(b) The State survey agency may waive, for as long as it considers appropriate, provisions of ANSI standard No. A117.1 (1961) if:

(1) The construction plans for the ICF or a part of it were approved and stamped by the responsible State agency before March 18, 1974;
(2) The provisions would result in unreasonable hardship on the ICF if strictly enforced; and
(3) The waiver does not adversely affect the health and safety of the residents.

Meal Service

31. *Meal service*. The ICF must:

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(a) Serve at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;
(b) Procure, store, prepare, distribute, and serve all food under sanitary conditions; and
(c) Provide special eating equipment and utensils for residents who need them.

32. *Menu planning and supervision.*

(a) The ICF must have a staff member trained or experienced in food management or nutrition who is responsible for:

(1) Planning menus that meet the nutritional needs of each resident, following the orders of the resident's physician and, to the extent medically possible, the recommended dietary, allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (Recommended Dietary Allowances (8th ed., 1974) is available from the Printing and Publications Office, National Academy of Sciences, Washington, D.C. 20418); and
(2) Supervising the meal preparation and service to insure that the menu plan is followed.
(b) If the ICF has residents who require medically prescribed special diets, the ICF must:

(1) Have the menus for those residents planned by a professionally qualified dietitian, or reviewed and approved by the attending physician; and
(2) Supervise the preparation and serving of meals to insure that the resident accepts the special diet.
(c) The ICF must keep for 30 days a record of each menu as served.

Medications

33. *Licensed pharmacist*. The ICF must either:

(a) employ a licensed pharmacist; or
(b) Have a formal arrangement with a licensed pharmacist to advise the ICF on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

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34. *Orders for medications.*

(a) The resident's attending or staff physician must order all medications for the resident.
(b) The order may be either oral or written.
(c) If the order is oral:

(1) The physician must give it only to a licensed nurse, pharmacist, or another physician; and
(2) The individual receiving the order must record and sign it immediately and have the attending physician sign it in a manner consistent with good medical practice.

35. *Methods to control medication dosage*. The ICF must have written policies and procedures for controlling medication dosage, by automatic stop orders or other methods, when the physician does not include in the order a specific limit on the time or number of doses. These procedures must include notice to the attending physician that the medication is being stopped as of a certain date or after a certain number of doses.
36. *Review of medications.*

(a) A registered nurse must review medications monthly for each resident and notify the physician if changes are appropriate.
(b) The attending or staff physician must review the medications quarterly.

37. *Administering medications.*

(a) Before administering any medication to a resident, a staff member must complete a State-approved training program in medication administration.
(b) The ICF may allow a resident to give himself a medication only if the attending physician gives permission.

Health Services

38. *Health services.*

(a) The ICF must provide for each resident health services that:

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(1) Meet the requirements of 442.339 through 442.342; and
(2) Include treatment, medications, diet, and any other health service prescribed or planned for the resident.

(b) The ICF must provide these services 24 hours a day.
39. *Supervision*.

(a) The ICF must have a registered nurse or a licensed practical or vocational nurse to supervise the ICF's health services full time, 7 days a week, on the day shift.
(b) The nurse must have a current license to practice in the State.
(c) If the ICF employs a licensed or practical or vocational nurse to supervise health services, the ICF must have a formal contract with a registered nurse to consult with the licensed practical or vocational nurse at regular intervals, but not less than 4 hours each week.
(d) To be qualified to serve as a health services supervisor, a licensed practical or vocational nurse must:

(1) Be a graduate of a State-approved school of practical nursing;
(2) Have education or other training that the State authority responsible for licensing practical nurses considers equal to graduation from a State-approved school of practical nursing; or
(3) Have passed the Public Health Service examination for waivered licensed practical or vocational nurses.
(e) The ICF may employ as charge nurse an individual who is licensed by the State in a category other than registered nurse or licensed practical or vocational nurse if:

(1) The individual has completed a training program to get the license that included at least the same number of classroom and practice hours in all nursing subjects as in the program of a State-approved school of practical or vocational nursing; and

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(2) The State agency responsible for licensing the individual submits a report to the Medicaid agency comparing State-licensed practical nurse or vocational nurse course requirements with those for the program completed by the individual.

40. *24-hour staffing*. The ICF must have responsible staff members on duty and awake 24 hours a day to take prompt, appropriate action in case of injury, illness, fire, or other emergency.

41. *Individual health care plan.*

(a) Appropriate staff must develop and implement a written health care plan for each resident according to the instructions of the attending or staff physician.

(b) The plan must be reviewed and revised as needed but at least quarterly.

42. *Nursing care*. The ICF must provide nursing care for each resident as needed, including restorative nursing care that enables each resident to achieve and maintain the highest possible degree of function, self-care, and independence.

Other Services

43. *Rehabilitative services.*

(a) The ICF must provide rehabilitative services for each resident as needed.

(b) The ICF must either provide these services itself or arrange for them with qualified outside resources.

(c) The rehabilitative services must be designed to:

(1) Maintain and improve the resident's ability to function independently;

(2) Prevent, as much as possible, advancement of progressive disabilities; and

(3) Restore maximum function.

(d) The rehabilitative services must be provided by:

(1) Qualified therapists or qualified assistants, as defined in 42 CFR 405.1101(m), (n), (q), (r), and (t), in accordance with accepted professional practices; and

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(2) Other supportive personnel under appropriate supervision.

(e) The rehabilitative services must be provided under a written plan of care that is:

(1) Developed in consultation with the attending physician and, if necessary, an appropriate therapist; and

(2) Based on the attending physician's orders and an assessment of the resident's needs.

(f) The resident's progress under the plan must be reviewed regularly and the plan must be changed as necessary.

44. *Social services*.

(a) The ICF must provide social services for each resident as needed.

(b) The ICF must either provide these services itself or arrange for them with qualified outside resources.

(c) The ICF must designate one staff member, qualified by training or experience, to be responsible for:

(1) Arranging for social services; and

(2) Integrating social services with other elements of the plan of care.

(d) These services must be provided under a written plan of care that is:

(1) Placed in the resident's record; and

(2) Evaluated periodically in conjunction with the resident's overall plan of care.

45. *Activities program*. The ICF must:

(a) Provide an activities program designed to encourage each resident to maintain normal activity and to return to self-care;

(b) Designate one staff member, qualified by training or experience in directing group activity, to be responsible for it;

(c) Have a plan for independent and group activities for each resident that is:

(1) Developed according to his needs and interests;

(2) Incorporated in his overall plan of care;

(3) Reviewed, with his participation, at least quarterly; and

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(4) Changed as needed.

(d) Provide adequate recreation areas with sufficient equipment and materials to support the program.

46. *Physician services.*

(a) The ICF must have policies and procedures to insure that the health care of each resident is under the continuing supervision of a physician.

(b) The physician must see the resident whenever necessary but at least once every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision.

C. STANDARDS FOR HOSPITALS AND SNFS PROVIDING ICF SERVICES (42 CFR 442.254)

(a) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF services other than ICF/MR services, it must meet the following ICF standards

(1) Section 442.304, resident services director.

(2) Section 442.317(a), (b), agreements with outside resources for institutional services.

(3) Section 442.319, plan of care.

(4) Section 442.320, resident financial records.

(5) Section 442.324(b), handrails.

(6) Sections 442.338 through 442.342, health services.

(7) Section 442.343, rehabilitative services.

(8) Section 442.344, social services.

(9) Section 442.345, activities program.

(10) Section 442.346, physician services.

(b) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF/MR services, it must meet the standards in Subpart G of this part.

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Appendix C

Report of Survey of State Health Facility Licensure and Certification Agencies

PURPOSE

The Institute of Medicine Committee on Nursing Home Regulation conducted a mail survey of 50 state and the District of Columbia health facility licensure and certification agencies to

1. obtain data about the resources committed by each jurisdiction to inspect and certify nursing homes under the Medicaid and Medicare programs, and
2. obtain data on the statutory availability and use by states of various types of intermediate sanctions for enforcing compliance with nursing home standards.

The survey was designed with the cooperation and assistance of the officers and board members of the National Association of State Health Facility Licensure and Certification Directors. The survey questionnaire was developed, and pretested in September 1984 on three health facility licensure and certification directors. On the basis of the pretest, 18 questions were modified. The final version covered eight topics:

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(1) organization of nursing home activities,
(2) survey agency personnel and budget,
(3) survey agency workload,
(4) state standards,
(5) special surveyor training,
(6) survey procedures and coordination agreements,
(7) enforcement, and
(8) survey directors' views on federal regulation.

A copy of the questionnaire is attached to this Appendix.

Clearance to conduct the survey was received from the Office of Management and Budget on November 28, 1984. The questionnaires were mailed, with an endorsement from the Association of State Health Facility Licensure and Certification Directors, on November 29, 1984. The recipients were the 51 current Health Facility Licensure and Certification directors. Forty-seven responded.

From January to March 1985, staff collected and analyzed the data, which were then used to produce descriptive and inferential statistics, to make interstate comparisons, and to observe changes in survey agency resources and enforcement activities from 1980 to 1984. The survey data were also merged with existing state demographic and nursing home data available from the Medicare/Medicaid Automated Certification System (MMACS), and with other data from the HCFA Office of Research and Development and from published literature, so that factors contributing to state variations could be determined. Because of the population size, and the nominative level of most of the data, the major analyses performed were (1) frequencies for all variables, and (2) two-by-two and two-by-three contingency table comparisons of major variables such as survey agency budgets, staff, numbers of surveys completed, surveyor training, and survey and enforcement procedures. Frequencies, medians, and ranges of various responses of variables are reported in the attached copy of the actual survey. Significant associations and correlations are discussed in the "Summary of Findings" section.

Data validity was assessed. Because the committee intentionally designed the survey to gather information

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that could not be obtained from other sources, Medicare and Medicaid budget data supplied by the HCFA were the only external data available to check the validity of the information collected by the survey. Staff compared the total federal Medicare and Medicaid 1983/1984 allocations as reported in the survey with federal Medicare and Medicaid allocations to the states as reported by the HCFA. Of the comparisons (43 Medicare and 39 Medicaid), 16 of the survey figures and those provided by the HCFA were identical; 44 were within a tolerable error. Of the remaining 22 discrepancies, only 4 could not be corrected. With these corrections, the data demonstrated external validity.

The survey data also were checked for their power to discriminate. Questions that received the same answer from all, or nearly all, of the respondents, and questions that had received little or no response, were not used for correlational analyses. In the first case, the information collected does not discriminate among respondents. In the second, insufficient information was collected. Although the consistency or the unavailability of data were themselves interesting and noted in the frequency analyses, the responses received were not useful as variables for comparative analyses and were therefore excluded from further analysis.

Questions were considered nondiscriminating if 37 or more (80 percent) of the 47 respondents answered the question in the same way. Questions were considered to provide insufficient information if 37 or more (80 percent) of the respondents failed to answer the question.

The survey data provided the committee with factual information concerning the feasibility and desirability of changing the current survey and certification system. Many of the committee's conclusions on the survey process, on state agency resources, and on state enforcement activities are based on survey findings.

SUMMARY OF FINDINGS

Major findings for each of the eight topics covered by the survey are summarized below. In each case, the number

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of respondents is given as a proportion of the total respondents.

Organization of Nursing Home Regulation Activities

All 47 responding agencies conduct Medicare certification inspections; 46 conduct licensure, Medicaid certification inspections, and complaint investigation visits to nursing homes. Two-thirds conduct life safety code inspections (32/47) and just over a third (17/47) also are responsible for inspection of care visits. Very few make certificate-of-need determinations (7/47) or set Medicaid nursing home reimbursement rates (2/47).

The majority of the agencies are also responsible for licensing and certification activities for other types of health facilities. All but three handle acute care hospitals, all but two handle home health agencies and hospices, and most also are responsible for board-and-care facilities (33/47).

Survey Agency Personnel and Budget

State agencies vary greatly in the size of their budget and staff per nursing home. The percentage of total survey agency resources allocated to nursing-home-related activities ranges from a high of 93 percent to a low of 14 percent; the median is 56 percent. The amount of money allocated for regulatory activities per nursing home ranges from a minimum of $1,296 to a maximum of $13,018, with a median of $4,700. The number of nursing homes per available full-time equivalent (FTE) licensing and certification field surveyor varies from a low of 0.78 to a high of 41.96, with a median of 13.00.

Nineteen states reported that their licensing funds increased by less than 50 percent from 1980 to 1984; 17 reported that their funds increased by more than 50 percent. About half the states reported that their total budget decreased between 1980 and 1984; the other half reported that their budget increased between 1980 and 1984. Half the states reported that the number of field surveyors had decreased between 1980 and 1984; the other half reported that the number had increased.

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Twenty-two reported that total staff decreased between 1980 and 1984; 19 reported that total staff increased.

Survey Agency Workload

Of the 17 state survey agencies performing inspection-of-care (IOC) reviews in addition to licensure and certification surveys, 9 indicated that these reviews are done by the same team at the same visit as the certification survey. In the other states, IOC is done by a different team or during a separate visit. Thirty-four states reported that complaints are investigated by the regular surveyors; 10 reported that they have a separate survey staff to investigate complaints.

The length of facility certification visits varies by state, by facility classification, and by type of visit. Combined licensing and certification surveys for the average-quality 100-bed nursing home ranged from 1.0 to 12.0 person-days for ICFs (with a median of 5.9), and from 1.5 to 18 person-days for SNFs (with a median of 6.8). Post-certification follow-up visits ranged from 0.5 to 4.0 person-days for ICFs (with a median of 1.5), and from 0.5 to 6.0 person-days for SNFs (with a median of 2.0). Post-certification visits average about one per facility. Complaint visits vary in length by state, but not by type of facility. The longest average visit is 2.0 and the shortest 0.4 person-days, with a median of 1.0 for both SNFs and ICFs.

Eleven states reported that the total number of visits to facilities decreased between 1980 and 1984; 20 reported that the total number of visits to facilities increased. The change in the number of follow-up visits made between 1980 and 1984 ranged from a decrease of 1,013 to an increase of 631 (or a 96 percent decrease to a 215 percent increase).

State Regulatory Standards

Just over half (24/47) of the respondents judged that their state's licensure requirements for ICFs are more

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stringent than those of the federal government, one-quarter (11/47) said they were the same, and one-quarter (12/47) said they were less stringent. One-third (17/47) of the directors asserted that their state's licensure requirements for SNFs are more stringent than the federal requirements, one-third (14/47) said they were about the same, and one-third (14/47) said they were less stringent.

Special Surveyor Training

Thirty-three states reported that they conduct special enforcement training for surveyors. The median number of hours of training is 7.5, but ranged in different states from 1 to 96 hours. Nine states reported that training is conducted by internal staff, 1 said training is conducted by external staff, 2 use outside consultants, and 22 said that they use a combination of the above. Twenty-six pay for training in a line item in the agency budget, seven include training funds in another line item, one uses funds external to the agency, and two use a combination of internal and external funds.

All of the states that have special enforcement training think that it has improved the surveyor's work and that training should continue.

Survey Procedures and Coordination Arrangements

Most of the agencies conduct licensure inspections once every 12 months (40/47) and certification inspections once every 12 months (42/47). All states reported that licensure and certification surveys are combined, with roughly three-quarters always doing combined surveys (33/47); the remainder combine surveys only some of the time. Seven states indicated that they use a screening or abbreviated survey to determine which facilities should receive a full-licensure or certification survey.

Most agencies reported that their surveyors review previous licensure (45/47), previous certification (47/47), inspection-of-care reports (34/47), and complaint

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reports (42/47) before conducting a survey. Thirty-three states indicated that surveyors always conduct "hands-on" assessments of residents during certification surveys. Most surveyors complete HCFA Form 2567 at the office, most within 10 days of the inspection (41/47). The number of days varies from 2 to 18.

Thirty-three states indicated that some aspect of their licensure and/or certification procedures has been changed in recent years.

Enforcement

Nearly all state survey agencies responding indicated that they have at least several intermediate licensure sanctions available to them, but very few are applying any formal sanctions, federal or state. Eighty-five percent of the total actions are taken in 13 states. Most respondents, however, did rate their state's enforcement efforts favorably.

Thirty-nine states said that any surveyor has the authority to cite a deficiency; three said that the team leader must make the decision to cite; two said that a supervisor must make the decision; and three states listed "other" authorities.

Thirty-six states reported that the number of standards out of compliance that would cause the nursing services condition to be marked out-of-compliance "depends." Usually they said it depended on "the severity" of the violation. Five states listed specific standards which 'would put the nursing services condition out of compliance: standards 124, 134, and 181 (director of nurses, 24-hour nursing, and administration of drugs, respectively). Two states said any standard out of compliance would put the condition out of compliance; one said one standard was sufficient; two said two; and one said three.

Thirty state directors thought that one onsite visit to a facility is adequate to verify a plan of correction; 13 said that several visits are necessary; 3 said that none are necessary. Most states do a routine follow-up visit for each full survey; it lasts one-third as long as the

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original visit. Most survey agency directors think this is a reasonable procedure.

Twenty-three states reported that they do not have attorneys on staff who are specially designated to deal with enforcement actions. Ten states have one attorney who specializes, five have more than one. Only 6 reported that they have hearing officers designated for nursing home enforcement; 28 do not. Four have special investigators; 30 do not. Two have special assignment surveyors.

When the states take court action, 13 have a staff attorney available to defend them; 31 have a departmental attorney available, and 3 have no attorney available. Twenty said that their attorney carried out their request to file an action all of the time, 11 said most of the time, 12 said some of the time, and 2 have never requested an action.

States have, on the average, 8 available sanctions under their state licensure laws. The survey inquired about 14. Some states had all 14, and some had only a few. Most states have the authority to revoke a facility's license (44/47), to decertify a facility (40/47), and to seek a court injunction (37/47).

Additionally, 36 states reported having authority to relocate residents from substandard facilities; 35 have the authority to issue conditional licenses; 32 have the authority to suspend all new admissions; 30 have the authority to impose criminal penalties for patient abuse; 26 have administrative fining authority; 25 have the authority to take licensure records into consideration in certificate-of-need recommendations; 21 have the authority to place a facility into receivership; 19 report having the authority to withhold Medicaid payments to noncompliant facilities; 15 have the authority to issue probationary licenses; 9 have the authority to reduce the Medicaid reimbursement rates of noncompliant nursing homes; and 7 have the authority to appoint a monitor to a facility (see attached copy of survey questionnaire).

In states that have the sanction, the survey agencies usually have the authority to recommend a sanction but not necessarily the authority to decide whether to carry out a sanction. In 9 of the 14 categories, most of the state agencies that have the sanction have the authority to

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recommend the sanction, but less than half have the authority to decide whether to use the sanction.

The availability of sanctions in a state seems to be associated with (1) whether surveyors receive special enforcement training, (2) the agency budget per nursing home, (3) the total number of state agency visits to nursing homes, and (4) the survey agency director's opinion of the survey process regulations. States that have special enforcement training are more likely to have more types of sanctions available. States with high budgets per nursing home also have high numbers of sanctions available. States that make a lot of visits are likely to have more sanctions available. And agency directors who are content with the procedural regulations are more likely to have more sanctions available to them.[*] States that have committed significant efforts to strengthening nursing home regulation, whether in special staff training, increased survey agency budgets, or frequency of inspection visits, are also those that have elected to have a variety of sanctions available. Perhaps political pressures have stirred all of these interests simultaneously, or perhaps the greater training and resource allocations have uncovered the need for more sanctions.

Regarding enforcement actions, 20 states report that they have written guidelines for when and how to take a formal enforcement action; 27 do not.

The total numbers of enforcement actions taken by states in each category in 1983 ranged from one to dozens, to several hundred in a few categories (civil fines, criminal penalties, and withholding of payments). However, at least 75 percent of the actions taken in each category were taken by one, two, or three states. (It was not necessarily the same state in each category; states seem to favor one or two sanctions.) The median number of types of enforcement actions used by an agency was two. The median total number of actions taken was 11.

The number of reported actions taken increased in all but one category (conditional licensing) from 1980 to

[*] Findings are significant at the .10 level of confidence.

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1983-1984. In 1983, 15 states revoked the license of at least 1 facility; 15 suspended admissions to one or more facilities; 14 relocated residents from a facility; 14 issued conditional licenses; 13 issued fines; 13 decertified facilities; 10 took licensure records into account on certificate-of-need recommendations; 9 obtained injunctions; 8 placed a facility into receivership; 5 issued probationary licenses; 3 withheld Medicaid payments to a facility; 3 appointed a monitor to a facility; and 1 reduced Medicaid rates to a facility.

Of those reporting having taken enforcement actions, the number of types of actions taken and the total number of actions taken seem to be correlated with (1) special enforcement training, (2) whether recent changes in the survey process have taken place, (3) minimum number of required nursing hours, (4) percentage of agency resources allocated to nursing homes, (5) survey agency budget per nursing home, (6) total numbers of visits in 1983-1984, (7) changes in state licensing funds, (8) number of sanctions available, and (9) statewide per capita income. More training was positively linked with using more types of enforcement actions, as well as implementing more actions. Changes in the survey process were also positively linked with numbers of types and numbers of actions taken. States with higher nursing requirements, and those with more monetary resources and more staff/time resources allocated to nursing homes, implement more kinds of sanctions and more sanctions. Larger increases in state licensing funds from 1980 to 1983-1984 are related to fewer enforcement actions; smaller increases are related to more types and numbers of enforcement actions. The number of available sanctions is directly related to their use. And a higher per capita income is related to a higher number of types of sanctions applied.

The correlations with enforcement activity seem to be a reflection of the amount of political interest states take in nursing homes. Those that have higher nursing requirements, special training, more available sanctions, that have made recent changes in the survey process, and that allocate more resources to nursing home surveying seem to be more active in enforcement. Or perhaps these factors make it easier for states to bring enforcement

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actions. States that take more enforcement actions have more knowledge, better rules, and more resources for monitoring the situation.

Agencies tend to rate sanctions favorably. In 11 of the categories, well over half of those using the sanction rated it as very effective or effective. Fifteen agencies said that their overall enforcement efforts were very effective, 29 said their efforts were effective, and 3 said their efforts were not effective. These opinions did not correlate with availability and use of sanctions. Agencies may be reluctant to downgrade the effectiveness of the sanctions available to them, or their own efforts. When actions were taken to court, three agency directors said that the court supported the agency's position all of the time, 20 said most of the time, 15 said some of the time, and 9 have never taken a facility to court. Again, these opinions were not related to use of sanctions.

Twenty states said that particular sanctions are effective because they affect the income of the provider. Other reasons given included the ability to implement the action quickly (7), the ability to remove an operator (4), and publicity (5). The obstacle to enforcement that was mentioned most often was time delays in implementing a sanction, both administrative and legal (11). Others mentioned the difficulty of administering some of the sanctions (3), potential harm to residents (transfer trauma, decreases in funds being taken out on patients) (4), and too little impact on the provider's income (2). More states listed reasons for the success of sanctions than listed obstacles (37 as opposed to 19). This is because several did not rate unfavorably any of the sanctions they used.

Views on Federal Regulations

The majority of respondents believe that current federal certification regulations could ensure nursing home services of adequate quality with certain modifications. A few forwarded specific suggestions for changes.

Eight state agency directors reported that they believe that current federal SNF Conditions of Participation can

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ensure adequate nursing home services as they are; 9 believe that they could ensure this quality if some unnecessary or unmeasurable provisions were deleted; 20 believe that they could ensure this quality if certain additions and modification were included; and 10 believe that they cannot ensure adequate-quality nursing home services without a major overhaul and reorientation. Six directors believe that current federal ICF Standards can ensure adequate-quality nursing home services as they are; 8 believe that certain deletions are needed and 16 believe that certain additions are needed. Thirteen believe that these standards cannot ensure adequate-quality nursing home services without a major overhaul and reorientation. Regarding the current federal survey procedures, 11 state agency directors think that the regulations work reasonably well as they are; 7 think they would work with some deletions; 20 think they would work with changes and additions; 7 think they would work if the federal government gave states more support; and 2 think they need to be completely revised.

Regarding specific changes, only two respondents identified a specific federal survey and certification standard as inhibiting the quality of patient care: the utilization control condition. The utilization control condition was also mentioned consistently as not worth the time and cost of surveying (11/47). Twenty-three other standards were stated to be not worth the time and cost by 1, 2, or 3 respondents. Consistently mentioned as ineffective were the utilization control condition (11/47) and the quarterly staffing reports standard (5/47). Twenty-seven other standards were mentioned by either 1, 2, or 3 respondents. Consistently named as needing modification were the conditions for nursing services (5/47), medical director (4/47), and physician services (4/47). Thirty-three others were mentioned by 1, 2, or 3, respondents. Few agencies listed more than one federal regulation as ineffective, or not worth the time and cost. Few agencies listed more than two choices for regulations which should be retained in a modified form.

The five SNF Conditions of Participation identified most often as being the most important for ensuring adequate-quality patient care were nursing services

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(36/47), dietetic services (30/47), pharmaceutical services (24/47), physician services (19/47), and physical environment (13/47).

Thirty-two agency directors agreed that the federal regulations should incorporate minimum nurse-to-patient staffing ratios. Thirty-six replied that the regulations, procedures, and forms for surveying skilled and intermediate-level facilities should be combined into one comprehensive survey. Thirty-four thought that states should require certification of nurse's aides. Thirty-four thought that the survey process should include a screening instrument. Twenty-eight said the time-limited agreement should be dropped. Forty-five agreed that the survey should include patient assessment. Thirty wanted survey results publicly posted. Forty-six disagreed with the proposal to allow JCAH accreditation to replace surveys.

SURVEY QUESTIONNAIRE

The attached copy of the IOM Committee on Nursing Home Regulation Survey of Health Facility Licensure and Certification Directors contains the frequencies of responses for each of the questions asked. For questions that had unique responses from each state, such as budget, staffing, and survey visits, the median, the lowest number, and the highest number are given.

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Survey of State Licensure and
Certification Agency Directors

Form Approved
OMB No.:0938-0395

Instructions. This survey is being conducted by the Committee on Nursing Home Regulation of the Institute of Medicine, National Academy of Sciences. In order to provide a complete picture of each state's nursing home regulatory system to the study Committee, this questionnaire seeks information about state laws, organizations, staffing, workload, and procedures.

Please fill out the following questionnaire as completely as possible, and return it in the enclosed envelope by December 15, 1984. There are lines whenever short answers are required. There are parentheses whenever a check mark is required. Please use an "X" for the check mark. In order to complete the questionnaire, you may need to confer with others.

In the questionnaire, "survey agency" refers to the state agency which administers licensure and/or certification surveys of nursing homes, and "Medicaid agency" refers to the single state agency which administers Title XIX funds.

Thank you very much for your cooperation.

If you have any questions regarding the questionnaire, please call Mike McGeary at the Institute of Medicine (202) 334-2312.

1. Name of State:

2. Name of respondent:

3. Title of respondent:

4. Name of organizational unit headed by respondent:

5. Name of department in which unit is located:

6. Phone number of respondent (required in case clarifying information is needed):

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OMB No. 0938-0395 STATE:____________

A. Organization of Nursing Home Regulation Activities

7. Does the survey and certification unit do any of the following activities concerning nursing homes in your state:

	Activity	Yes/no	If no, name responsible agency and its dept.
a.	State licensure surveys of nursing homes?	46/1	
b.	Medicaid certification surveys?	46/0	
c.	Medicare certification surveys?	47/0	
d.	Inspection of care reviews?	17/29	
e.	Setting of Medicare reimbursement rates for nursing homes?	2/44	
f.	Complaint investigations concerning nursing homes?	46/1	
g.	Life safety code inspections of nursing homes?	32/15	
h.	Certificate of need determinations	7/37	

8. Does your agency also survey any of the following types of health facilities?

	Facility type	Yes/no	If no, name of responsible agency
a.	Hospitals	44/3	
b.	Home health agencies	45/2	
c.	Hospices	45/2	
d.	Board and care/domiciliary/ rest homes	33/14	
e.	Supervised or congregate living facilities	13/33	

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9. Are nursing home surveys officially delegated by your state to any city or county level government agencies?

a. (43) No.

b. (4) Yes, they are delegated to (do not include your own district office, please list): ________________________

B. Survey Agency Personnel and Budget*

10. What is the total number of all full-time equivalent persons in your survey agency? (Include those who work on other than nursing home surveys.)

Median = 43.5; Range = 3 to 530

11. What were your licensing and certification expenditures for all facilities for fiscal years 1980 and 1983 or 1984 (the most recent year for which you have data)?

Budget category	FY ends**_____: 1980 Median	Range	(check appropriate year) 1983 ( ) or 1984 ( ) Median	Range
a. SNF 18	101,139	3,346- 1,689,724	117,970	2,327- 2,486,881
b. Non-SNF 18	246,699	48,827- 1,863,714	286,130	13,376- 4,500,121
c. Total Title 18	240,743	65,820- 3,533,438	307,113	36,123- 6,494,925
d. Federal Title 19	396,425	41,000- 4,294,143	411,115	51,876- 3,673,755
e. State match for Title 19	56,915	2,913- 2,129,361	209,773	11,633- 3,244,319
f. Total Title 19	541,981	66,175- 7,049,190	636,659	63,509- 6,964,348
g. State licensure only	206,880	45,386- 7,365,516	376,928	79,376- 6,964,348
h. TOTAL	1,321,052	131,995-15,592,224	1,526,960	99,632-35,450,768

*Please attach an organization chart of your agency and department.
**If your FY ends on a different date for each of the following questions, please note date; otherwise write S for same as listed in question 11.

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12. Number of full-time equivalent employees engaged in all health facility licensing and certification activities in:

FY ends: ______	1980		(check appropriate year) 1983 ( ) or 1984 ( )	
Position	Median	Range	Median	Range
a. Surveyors	23	3-200	26	3-151
b. Others (e.g., supervisory, administrative, clerical)	13	2-114	14	2-114
c. TOTAL	48	6-250	44	6-246

13. Overall, what percentage of your state agency's total state survey and federal certification effort is devoted to:

	Median	Range	
a.	56%	14-93	Nursing homes (SNF and/or ICF)?
b.	20%	2-65	Other long-term care facilities and services (e.g., ICF/MRs, hospices, home health agencies, board and care/domiciliary/rest homes, congregate or supervised living facilities)?
c.	20%	0-54	Other health facilities (e.g., hospitals, laboratories, ESRDs, etc.)?
	100%		TOTAL

14. If your agency conducts inspection of care reviews, what were your expenditures in fiscal years 1980 and 1983 or 1984 (the year for which you have the most recent data)? Please leave blank if not done in your agency.

FY ends: ______	1980		(check appropriate year) 1983 ( ) or 1984 ( )	
Budget	Median	Range	Median	Range
a. Title 19	540,721	17,419-6,575,526	570,066	77,570- 8,506,510
b. State match	349,045	5,806-2,586,882	288,904	33,496- 3,448,966
c. Total IOC expenditures	1,019,700	23,225-9,162,408	770,088	129,284-11,195,547

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15. How many full-time equivalent employees in your agency were engaged in inspection of care review?

FY ends:______	1980		(check appropriate year) 1983 ( ) or 1984 ( )	
Position	Median	Range	Median	Range
a. RNs	11	0- 84	9.5	0-84
b. Social workers and others	9	0-373	5.5	0-268
c. Total FTEs	26	0-439	18.0	0-308

16. In addition to the personnel who carry out survey and inspection of care functions who are listed above, does your agency have personnel whose specific duties are to process enforcement actions against facilities or individuals who violate nursing home regulations? (If yes, please indicate full-time equivalent positions on the appropriate line.)

	Response	0	1	2	3	4	8	11
a. Attorneys	# States	23	10	2	1	1		1
b. Hearing officers/admin. law judges		28	4	1	1			
c. Investigators		30	3			1		
d. Special assignment surveyors		30	1				1	
e. Other (specify): ______________________								

17. Does your agency have under state law a nursing home complaint and abuse reporting system?

a. (34) Yes.

b. (7) No, but such a system is operated by another agency (please specify): ____________________________________

c. (6) No, there is no statutory complaint system.

18. If your agency handles nursing home complaints, are they investigated by:

a. (35) the regular surveyors?

b. (10) a separately staffed unit of Median = 5; Range = 1-30 FTEs?

c. (0) others? (please specify): __________________________

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C. Survey Agency Workload

19. How many noncertified nursing homes with SNF and/or ICF-like services did your agency license (as of September 1984) that have no federally certified beds?

Median = 7.5; Range = 0-211

20. How many visits to certified SNFs and ICFs did your agency make in 1980 and in 1983 or 1984?

FY ends: _______	1980		(check appropriate Year) 1983 ( ) or 1984 ( )	
Type of Visit	Median	Range	Median	Range
a. Full licensure or certification surveys	250.5	15- 5,331	282	18- 5,432
b. Abbreviated or partial surveys	0	0- 405	0	0- 708
c. Post certification revisits	268	0- 1,827	187	0- 2,280
d. Complaint investigations	151.5	0- 5,371	142	0- 7,218
e. Inspection of care visits	166.5	0- 1,975	102	0- 1,900
f. Other visits	59	0- 1,157	76	0- 6,004
Total	914	24-14,370	1,091.5	26-21,839

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21. In an average visit, how many person-days would your agency spend on site conducting the following activities in a nursing home of average size - approximately 100 beds - and quality? (E.g., a three person team spending two days in a facility would spend six person-days).

	SNF		ICF		SNF/ICF	
	Median	Range	Median	Range	Median	Range
a. Certification and Licensure Survey(s)	6.8	1-18 da	5.9	1-12 da	6.5	1.5-20 da
b. Inspection of Care	8.0	3-14 da	7.5	2-17 da	8.0	3.0-20 da
c. Post Certification Revisits	2.0	0.5-6 da	1.5	0.5-6 da	2.0	0.5-25 da
d. Complaint Investigations	1.0	0.4-2 da	1.0	0.4-2 da	1.0	0.4- 4 da
e. Other:	0.5	.5-6 da	1.0	0.5-6 da	1.0	0.5- 2 da

22. Do all the surveyors in your agency work out of the central office?

a. (24) Yes, they are all based at the central office.

b. (22) No, we have Median = 4; Range = 1-17 field or district offices and/or Median = 0; Range = 0-8 staff who work out of their homes.

D. State Regulatory Standards

23. In comparison with current federal Conditions of Participation and standards, are your state's licensing requirements for skilled facilities:

a. (14) Exactly or about the same as the federal rules?

b. (14) Less stringent than the federal rules? Stringent means operationally defined and demanding. The major differences are: ____________________

____

c. (17) More stringent than the federal rules? The major differences are: ____________________

____

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24. In comparison with current federal standards, are your state's licensing requirements for intermediate facilities:

    a. (11) Exactly or about the same as the federal rules?

    b. (12) Lower/less stringent than the federal rules? The major differences are: ____

    ____

    c. (24) Higher/more stringent than the federal rules? The major differences are: ____

    ____

E. Special Surveyor Training

25. Have your surveyors received "specific" training to better justify enforcement actions when necessary, including 1) how to prepare better documentation of evidence; 2) how to be a better participant/witness in enforcement proceedings; 3) how to work with the court, with the district or state attorneys, and hearing officers?

    a. (33) Yes. (If yes, answer question 26.)

    b. (14) No. (If no, skip to question 31.)

26. How many hours of such training does each surveyor receive in a year?

    7.5 Median Range = 1-96

27. Who conducts the training?

    a. (9) Staff internal to our agency

    b. (1) State staff external to our agency, e.g. the District Attorney's office

    c. (2) Outside consultants

    d. (22) Combination of the above

28. Who pays for the training? Where do the funds come from?

    a. (26) Line item in our budget

    b. (7) Included in another line item

    c. (1) Funds external to agency

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29. Has the training assisted the surveyor to carry out his/her duties?

a. (33) Yes: comment, how ____________________

b. (0) No: comment, how ____________________

30. Should the training continue?

a. (34) Yes.

b. (0) No.

F. Survey Procedures and Coordination Arrangements

31. Are licensure and certification surveys combined?

a. (2) Our state only conducts the federal certification survey

b. (33) Yes, all the time.

c. (11) Yes, sometimes. Please explain:____________________

d. (1) No, but they are both done by this agency on different visits

e. (0) No, our agency does one; another agency does the other

32. How frequently are facilities in your state given the full licensure and certification surveys?

a. All facilities are surveyed for licensure every 12 months.

b. All facilities are surveyed for certification every 12 months.

c. The time period between full surveys varies, depending on:

9 responses

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33. If a full survey is not always given, do you use a screening or abbreviated survey to determine which facilities should receive a full licensure or certification survey?

    a. (7) Yes.

    b. (22) No.

34. During licensure/certification surveys, do surveyors conduct a "hands-on" assessment of residents?

    a. (33) Always, as as matter of agency policy.

    b. (12) Sometimes, if necessary to collect information.

    c. (2) Rarely.

35. Have you changed your licensure and/or certification survey procedures in recent years?

    a. (14) No.

    b. (33) Yes; the major changes are:________________________________

    ____

    ____

36. Does your agency have written guidelines or policies and procedures on how surveyors should interpret State regulatory standards?

    a. (16) Yes. (If yes, please return a copy of the guidelines with this questionnaire.)

    b. (31) No.

37. When is the statement of deficiency form (HCFA 2567) completed?

    a. (3) At the facility, for the exit interview.

    b. (41) At the survey agency office within Median = 10; Range = 2-18 days after the survey is completed.

    c. (3) Other, explain: ________________________________

    ____

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38. Who has the authority to decide whether or not an F-number on the HCFA 1569 form or T-number on the HCFA 3070 form is not met, resulting in a statement of deficiency on the HCFA 2567 form?

a. (39) Any surveyor.

b. (3) The survey team leader.

c. (2) A supervisor.

d. (3) Other (please specify): ____________________________________

39. In surveying a nursing home for SNF certification, how many standards have to be deficient for the nursing services condition (F123) to be marked "not met"?

Check the appropriate box and explain if required.

a. (2) any one
b. (1) 1
c. (2) 2
d. (1) 3
e. (0) 4
f. (0) 5
g. (0) 6
h. (0) 7
i. (0) 8
j. (0) 9
k. (5) only specific F's, namely Director of Nursing (3); 24-hr nursing (4); administration of drugs (3)
l. (36) it depends on ____________

40. Which of the following documents does a surveyor routinely review prior to conducting a survey? Check all that apply.

a. (45) previous licensure
b. (47) previous certification
c. (11) MMACS
d. (34) inspection of care reports
e. (42) complaints
f. (0) none of the above
g. (7) ombudsman reports
h. (16) other
i. ( ) total Median = 4; Range = 2-7

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41. A number of agencies in addition to the survey unit collect or receive information about conditions in specific nursing homes. When information is received indicating that a facility is providing questionable care, what other units or agencies do you usually notify? Do they usually notify the survey agency when they receive information? Please check the appropriate boxes.

Agency	We Inform Them			They Inform Us		
	Yes Regularly	Yes Sometimes	No	Yes Regularly	Yes Sometimes	No
a. Medicaid Agency	36	8	1	29	12	3
b. State Ombudsman	14	24	6	21	24	2
c. Your own agency's complaint unit	27	2	0	23	3	1
d. Your own agency's consultant unit	19	2	4	20	4	1
e. Certificate of Need unit	7	13	16	11	8	15
f. Resident Advocacy Groups	4	9	25	6	20	13
g. State Department of Aging	10	21	8	12	26	3
h. HCFA Regional Office	35	11	0	34	9	1
i. Inspection of Care Unit	27	6	6	29	7	3
j. Medicaid Fraud Unit	12	26	4	6	25	6
k. Other:______________	5	8	1	4	8	2
______________________	2	1	0	2	1	0

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42. If your agency conducts inspection of care reviews, they are done:

    a. (2) At the same visit as the certification survey.
    b. (3) At a different visit.
    c. (0) By the same team which conducts the certification survey.
    d. (2) By a separate team.

    Both a and c: 9
    Both a and d: 0
    Both b and c: 1
    Both b and d: 3

43. Are inspection of care review findings cited as part of the documentation of deficiencies on the HCFA 2567 form?

    a. (14) Yes (if yes, how frequently?):
        i. (8) often/all the time.
        ii. (5) sometimes/about half the time.
        iii. (1) rarely/almost never.
    b. (17) No.

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G. Enforcement

44. Different states have different legal provisions for enforcing their nursing home standards. Below is a table that lists down on the first column several provisions. There are six other column headings labeled A through F.* As instructed please complete columns A through F. For Column A, "State Has Provision," if your state has the provision, place a "y" on the appropriate line. If it does not, place an "n" on the appropriate line. Column B, "Recommending Agency," we are also interested if the survey agency and/or some other agency recommends the legal action. If your agency recommends the action, place a "y" on the appropriate line. If another agency recommends, write the name of the agency on the provided line. In many states different agencies determine whether the legal provision will be carried out depending on the sanction. For each sanction please list the appropriate agency or individual in Column C, "Deciding Agency." In Column D, "Number of Recommendations Carried Out," we would like to know the number of times the recommended actions were carried out in 1980 and 1983. Please write the numbers on the provided lines. In Column E, "Order of Importance," please rank order your perspective of the importance to the regulatory process of each of the provisions using the numbers 1,2,3 or 4 where

4 = Very important
3 = Important
2 = Unimportant
1 = Very unimportant

Finally, in Column F, "Order of Effectiveness," please rank order how effective you feel these provisions are in assuring compliance. Please rank each of the provisions using the numbers 1,2,3 or 4 where

4 = Very effective
3 = Effective
2 = Uneffective
1 = Very uneffective

If you do not use some of these sanctions, place an "X" on the line.

*The following table is a modified version of the table used in the original survey. A few columns have been changed to show more clearly the composite response from the 47 states that replied to the survey. Columns A, B, and C are the same here as in the original survey. Columns D, E, and F constitute an expansion of the original column D, which simply requested the number of actions taken by each state in 1980 and 1983. (The new columns D, E, and F deal with 1983 only; figures for 1980 were dropped because of a low response rate.) The new column G shows the number of states that ranked the sanction effective and the number that ranked it ineffective and is similar to original column F ("Order of Effectiveness"). The original column E ("Order of Importance") was dropped because the responses were basically the same as those in column G.

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STATE:_____________

	A	B		C	D	E	F	G
Legal Provision	State Has	Recommending Agency: Survey Agency	Other (identify)	Deciding Agency	# States Carrying Out 1983	1983 Range of # Actions Taken	1983 Total # Actions	Effective/ Ineffective
Civil or administrative fines	26	24	1	17	13	2-450	900	19/5
Court-appointed receiver	21	19	3	8	8	1-4	12	15/3
State-appointed monitor	7	8	7	4	3	1	3	4/2
Suspension of all admissions	32	24	6	17	15	1-29	96	26/5
Consideration of past record in evaluation of certificate of need application	25	17	12	7	10	1-36	105	26/11
Court injunctions against substandard operation	37	36	1	17	9	1-3	13	19/11
State-initiated relocation of residents from substandard homes	36	31	5	21	14	1-8	27	22/8
Reduced Medicaid rates for inferior performance	9	6	12	3	1	10	10	4/2
Conditional or provisional licensing	35	34	2	22	14	1-72	268	23/8
Probationary license	15	14	6	8	5	1-72	154	9/3
Criminal penalties for patient abuse	30	16	14	9	5	1-300	376	13/11
License revocation	44	41	0	28	15	1-13	59	33/4
Involuntary decertification	40	39	1	22	13	1-55	129	26/7
Withholding of payments	19	8	14	5	3	4-263	272	3/2

Per State: Total sanctions available: Median = 8; Range = 1-14
Number of types of sanctions applied: Median = 2; Range = 1-12
Total number of sanctions applied: Median = 11; Range = 1-457

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45. Does your agency have written guidelines on when or how formal enforcement action should be taken against a facility with deficiencies?

    a. (20) Yes. (If yes, please return a copy of the guidelines with this questionnaire.)

    b. (27) No.

46. Does your state have a law requiring mandatory reporting of patient abuse?

    a. (38) Yes. b. (9) No.

47. Does your state have a law permitting residents to sue facilities to protect their rights?

    a. (24) Yes. b. (18) No.

48. Does your state have other legal provisions which can be used to enforce quality of care standards?

    a. (30) No. b.(16) Yes. Send copy or list: ______________________

    ____

49. Does your state have a system which rates nursing homes and publicly discloses the ratings?

    a. (41) No. b. (6) Yes, it is operated by Survey Agency.

50. Do nursing homes with good compliance records (e.g., few deficiencies) receive higher Medicaid reimbursement rates or receive an incentive payment?

    a. (6) Yes. b. (41) No. skip to question 52

51. What proportion of the homes in your state are currently receiving the higher rate(s)?

    Median = 30%; Range = 28-32%

52. When you recommend court action, is there an attorney on staff to take care of this?

    a. (13) Yes, the attorney is part of my agency's staff

    b. (31) Yes, the attorney is part of the state or district attorney's staff but is assigned to my unit.

    c. (3) No.

    d. (0) Don't know; we have never requested court action.

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53. When you recommend court action, does the state attorney general carry out your request by filing suit?

    a. (20) All of the time

    b. (11) Most of the time

    c. (12) Some of the time

    d. (2) Don't know; we have never requested court action.

54. When you have taken a facility to court, do you think the courts have supported the agency's position?

    a. (3) All of the time

    b. (20) Most of the time

    c. (15) Some of the time

    d. (9) Don't know; we've never taken a facility to court.

    The next several questions address the effectiveness of various enforcement efforts. For these questions effectiveness is defined as getting the facilities to comply with nursing home regulations, terminating contracts with facilities that fail to comply, as well as the speed and thoroughness with which the sanction is carried out; e.g. new admissions to the facility were stopped immediately on court order. You need to refer to your answers to question 44.

55. In general, would you say your agency or state enforcement efforts have been

    a. (15) Very effective?

    b. (29) Effective?

    c. (3) Not effective?

56. Why are the sanctions you ranked "number 4" listed in question 44, Column F, "Order of Effectiveness," effective?

    Affect income of provider (20)
    Quick implementation (7)
    Publicity (5)
    Ability to remove operator (4)

57. What are the obstacles to effective use of the sanctions you ranked "number 1" in question 44, Column F, "Order of Effectiveness?"

    Delays (11)
    Difficulty of Administering (3)
    Potential harm to residents (4)
    Small impact on provider income (2)

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OMB No. 0938-0395 STATE:___________

H. Views on Federal Regulations

58. The current federal Conditions of Participation for skilled nursing facilities:

a. (8) Can ensure nursing home services of adequate quality as they are.

b. (9) Can ensure nursing home services of adequate quality, if they deleted some unnecessary or unmeasurable provisions.

c. (20) Could ensure adequate quality services if they included certain additions and modifications.

d. (10) Cannot ensure adequate quality services without a major overhaul and reorientation.

59. The current federal standards for intermediate nursing facilities:

a. (6) Can ensure nursing home services of adequate quality as they are.

b. (8) Can ensure nursing home services of adequate quality, they deleted some unnecessary or unmeasurable provisions.

c. (20) Could ensure adequate quality services if they included certain additions and modifications.

d. (13) Cannot ensure adequate quality services without a major overhaul and reorientation.

Which of the following statements do you feel is an accurate description of the situation in your state?

60. The current federal survey procedures:

a. (11) Work reasonably well as they are in assuring that Medicare- and Medicaid-funded residents do not receive substandard services.

b. (7) Would work as well if certain unnecessary or unmeasurable items were dropped.

c. (7) Would work reasonably well if HCFA gave the states more support when they move to terminate substandard facilities.

d. (20) Would work adequately if some changes and additions were made.

e. (2) Need to be completely revised.

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61. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) inhibit quality patient care?

Utilization Control (2)

62. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) are currently ineffective and should be dropped completely?

Utilization Control (11)
Quarterly Staff Reports (5)

63. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) should be retained in a modified or alternative form?

Nursing Services (5)
Medical Director (4)
Physician Services (4)

64. Which, if any, federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) are neither effective nor worth the time and cost?

Utilization Control (11)

65. List what you feel are the five most important federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) for ensuring adequate quality patient care?

1. Nursing Services (36)
2. Dietetic Services (30)
3. Pharmaceutical Services (24)
4. Physician Services (19)
5. Physical Environment (13)

66. What, if anything, should be in the federal survey and certification regulations (including both the Conditions of Participation and the Subpart S regulations) that is not there now?

Resident Assessment Outcomes (13)
Intermediate Sanctions (6)
Staff Ratios (5)

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67. The current requirement for annual surveys of all federally certified nursing homes should be made more flexible to permit less frequent surveys of facilities with histories of compliance and more than annual surveys of facilities with histories of noncompliance.

a.	(12)	Strongly agree	23
b.	(11)	Agree	
c.	(10)	Disagree	24
d.	(14)	Strongly disagree	

68. The time-limited agreement requirement should be dropped because its usefulness as an enforcement tool is outweighed by the consequent ability of facilities to predict the timing of survey visits.

a.	(14)	Strongly agree	28
b.	(14)	Agree	
c.	(12)	Disagree	19
d.	(7)	Strongly disagree	

69. A short screening instrument should be used in conjunction with more flexible survey cycles to identify which facilities should receive more frequent full surveys.

a.	(11)	Strongly agree	34
b.	(23)	Agree somewhat	
c.	(6)	Disagree	13
d.	(7)	Strongly disagree	

70. It is desirable and practical to include a patient-centered assessment in the certification survey process.

a.	(30)	Strongly agree	45
b.	(15)	Agree	
c.	(0)	Disagree	1
d.	(1)	Strongly disagree	

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71. A sample of alert nursing home residents should be interviewed and their opinions be included as part of the survey process.

a. (10) Strongly agree)
) 18
b. (8) Agree)

c. (3) Disagree)
) 3
d. (0) Strongly disagree)

72. How many on-site visits should be required to verify correction with all items identified as deficiencies in a Statement of Deficiencies/Plan of Correction form?

a. (30) One on-site revisit is adequate and more practical in most cases.

b. (13) Several; there should be a series of on-site visits if there are multiple deadlines for corrections.

c. (3) None, because on-site visits are expensive and some common deficiencies can be adequately verified by telephone or mail.

73. Accreditation by JCAH or some other accrediting body should be permitted to stand in place of state surveys for federal certification purposes.

a. (1) Strongly agree)
) 1
b. (0) Agree)

c. (11) Disagree)
) 46
d. (35) Strongly disagree)

74. The federal regulations should require posting of survey results. The posting should include whether or not the facility is in compliance in general and list the specified elements found not to be in compliance. This posting should be in a prominent location in each facility.

a. (17) Strongly agree)
) 30
b. (13) Agree)

c. (13) Disagree)
) 17
d. (4) Strongly disagree)

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OMB No. 0938-0395 STATE:____________

75. The regulations, procedures, and forms for surveying skilled and intermediate level facilities should be combined in to one comprehensive survey.

a. (18) Strongly agree)
) 36
b. (18) Agree)

c. (9) Disagree)
) 10
d. (1) Strongly disagree)

76. Should the inspection of care review system be integrated with the process of surveying nursing homes for certification?

a. (26) Yes, they both should be done at the same visit by different teams so that significant inspection of care problems can be cited and corrected in the survey process while the burden on providers is reduced.

b. (6) Yes, and to save costs and avoid duplication, they should be done by the same team as well as during the same visit.

c. (7) No, the two functions should be conducted by separate agencies or departments, because they have different foci (patient vs. facility) and/or two visits allow better surveillance of facilities.

d. (7) No, they are separate functions, but they should be under the same supervisor in the state health or health and human services department so that the pertinent findings of each process can be shared.

77. Federal regulations should contain a requirement for state certification of nurses aides.

a. (14) Strongly agree)
) 34
b. (20) Agree)

c. (10) Disagree)
) 12
d. (2) Strongly disagree)

HCFA-466

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OMB No. 0938-0395 STATE:____________

78. Specific minimum nursing staff to patient ratios should be adopted in the federal regulations.

a. (13) Strongly agree)
) 32
b. (19) Agree)

c. (13) Disagree)
) 15
d. (2) Strongly disagree)

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Appendix D

Selected Data on Nursing Homes and Residents

The following tables show national and state statistics on characteristics of the nursing home industry, of the nursing home population, and of state regulatory agencies. These tables show information the committee considered important for understanding the nursing home industry, its residents, and its regulators. They do not represent all of the information gathered and used by the committee for its study. The following tables are attached:

TABLE A National Totals of Certified Facilities by Certification Status, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE B Number of Facilities by Certification Status and State, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE C Number and Percentage of Facilities by Level of Care and State, 1981. (SOURCE: Health Care Financing Administration, Medicare

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Medicaid Automated Certification System. 1981.)

TABLE D Number of Certified Facilities by Ownership Status and State, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE E Number of Facilities and Percentage by Bed Size and State, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE F Total Nursing Home Beds During 1978, 1980, and 1983, and Percentage Change in Number of Beds, by State, 1978-1983. (SOURCE: Aging Health Policy Center, University of California. 1983.)

TABLE G Comparison of Nursing Home Beds per 1,000 Population Aged 65 and Over in 1978, 1980, and 1983 and Percentage Change During 1978-1983, by State. (SOURCE: Aging Health Policy Center, University of California. 1983.)

TABLE H Total Nursing Home Beds per Licensed Nurse, Total Licensed Nurses, and Ratio of RNs to LPNs, by State, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE I Number of Facilities, by State and by Level of Care, with Fewer Than Five Licensed Nurses, 1983. (SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Research in Progress. 1984.)

TABLE J Number of Licensed Nurses Needed in Facilities with Fewer Than Five Licensed Nurses, by State and Type of Facility, 1983. (SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Research in Progress. 1984.)

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TABLE K State Minimum Requirements for Nursing Hours per Resident-Day, 1985. (SOURCE: American Health Care Association. 1985.)

TABLE L State Minimum Requirements for Nurse's Aide Training, 1985. (SOURCE: American Health Care Association. 1985.)

TABLE M Average SNF and ICF Medicaid Reimbursement Rates per Resident-Day, by State, 1982. (SOURCE: Analysis of State Medicaid Program Characteristics. La Jolla, California. 1983.)

TABLE N Total SNF and ICF Resident-Days of Care (in thousands) Reimbursed by Medicaid, by State, 1982. (SOURCE: Analysis of State Medicaid Program Characteristics. La Jolla, California. 1983.)

TABLE O Elderly Population by State, 1981. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

TABLE P U.S. Life Expectancy (by sex) at Birth, Age 65, and Age 85, 1960-2040. (SOURCES: Social Security Administration, Office of the Actuary, 1983, and U.S. Bureau of the Census, 1984.)

TABLE Q Projected Number (in thousands) of U.S. Nursing Home Residents by Age and Sex, 1980-2040. (SOURCE: National Center for Health Statistics, Office of Analysis and Epidemiology. 1977.)

TABLE R Percentage Distribution of Nursing Home Residents Who Were Dependent in Activities of Daily Living, 1973-1974 and 1977. (SOURCE: National Center for Health Statistics, National Nursing Home Survey. 1977.)

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TABLE S Health Care Financing Administration Expenditures (in millions of dollars) for State Survey Activities, 1977-1984. (SOURCE: Health Care Financing Administration, Health Standards Quality Bureau. 1984.)

TABLE T Total 1980 Expenditures (in millions of dollars) for State Survey Agency Activities, and Percentage Change in 1983-1984. (SOURCE: Institute of Medicine Survey. 1985.)

TABLE U Total State Survey Agency Staffing in 1980 and Percentage Change in 1983-1984. (SOURCE: Institute of Medicine Survey. 1985.)

TABLE V Total Survey Visits Made by State Survey Agencies in 1980 and Percentage Change in 1983-1984. (SOURCE: Institute of Medicine Survey. 1985.)

TABLE W Percentage of Facilities Cited with A-Key Deficiencies, by State, 1983. (SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.)

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TABLE A National Totals of Certified Facilities by Certification Status, 1981

FACILITY	MEDICARE ONLY	MEDICARE/ MEDICAID	MEDICAID ONLY	TOTAL
SNF ONLY	Not available	1,999 (15%)	533 (4%)	2,532 (19%)
SNF/ICF DISTINCT PART	Not applicable	1,333 (10%)	666 (5%)	1,999 (15%)
SNF/ICF DUAL	Not applicable	1,866 (14%)	1,199 (9%)	3,065 (23%)
ICF ONLY	Not applicable	Not applicable	Not applicable	5,730 (43%)
TOTAL	Not available	5,197 (39%)	8,129 (61%)	13,326

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System, 1981.

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TABLE B Number of Facilities by Certification Status and State, 1981

State	Total Certified Facilities	Total SNF Only	Total SNF/ ICF Distinct Part	Total SNF/ ICF Dual	Total ICF Only
AK	13	0	0	10	3
AL	206	5	149	33	19
AR	207	81	1	1	124
AZ	25	25	0	0	0
CA	1,184	914	27	207	36
CO	173	5	22	117	29
CT	231	164	41	0	26
DC	6	0	1	2	3
DE	26	3	9	4	10
FL	306	29	25	246	6
GA	301	28	26	176	71
HI	34	13	3	10	8
IA	427	6	11	8	402
ID	62	2	0	54	6
IL	687	27	45	314	301
IN	424	16	103	14	291
KS	368	8	18	29	313
ICY	204	24	70	1	109
LA	225	10	2	1	212
MA	513	45	217	3	248
MD	174	8	5	79	82
ME	145	5	11	1	128
MI	421	41	9	242	129
MN	454	65	197	50	142
MO	237	10	21	56	150
MS	143	20	2	97	24
MT	94	2	55	26	11
NC	202	43	101	2	56
ND	83	0	6	51	26
NE	217	5	7	18	187
NH	74	6	19	0	49
NJ	233	14	8	191	20
	43	2	2	0	39
NV	26	2	1	20	3
NY	570	330	192	3	45
OH	856	23	28	317	488
OK	363	7	2	0	354
OR	178	28	22	2	126
PA	556	362	151	7	36
RI	106	3	56	1	46
SC	123	7	0	85	31
SD	114	1	21	36	56
TN	229	5	5	47	172
TX	976	80	124	2	770
UT	80	0	6	34	40
VT	44	6	17	0	21
VA	163	10	41	1	111
WA	262	11	25	188	38
WI	438	3	49	273	113
WV	74	0	2	32	40
WY	26	0	0	17	9
TOTAL	13,326	2,504	1,955	3,108	5,759

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE C Number and Percentage of Facilities by Level of Care and State, 1981

State	SNF and SNF/ICF		ICF Only		Total Facilities
	Number	Percentage	Number	Percentage	
AK	10	77	3	23	13
AL	187	91	19	9	206
AR	83	40	124	60	207
AZ	25	100	0	0	25
CA	1,148	97	36	3	1,184
CO	144	83	29	17	173
CT	205	89	26	11	231
DC	3	50	3	50	6
DE	16	62	10	38	26
FL	300	98	6	2	306
GA	230	76	71	24	301
HI	26	76	8	24	34
IA	25	6	402	94	427
ID	56	90	6	10	62
IL	386	56	301	44	687
IN	133	31	291	69	424
KS	55	15	313	85	368
KY	95	47	109	53	204
LA	13	6	212	94	225
MA	265	52	248	48	513
MD	92	53	82	47	174
ME	17	12	128	88	145
MI	292	69	129	31	421
MN	312	69	142	31	454
MS	119	83	24	17	143
MO	89	37	150	63	239
MT	83	88	11	12	94
NC	146	72	56	28	202
ND	57	69	26	31	83
NE	30	14	187	86	217
NH	25	34	49	66	74
NJ	213	91	20	9	233
NM	4	9	39	91	43
NV	23	88	3	12	26
NY	525	92	45	8	570
OH	368	43	488	57	856
OK	9	2	354	98	363
OR	52	29	126	71	178
PA	520	94	36	6	556
RI	60	57	46	43	106
SC	92	75	31	25	123
SD	58	51	56	49	114
TN	57	25	172	75	229
TX	206	21	770	79	976
UT	40	50	40	50	80
VA	52	32	111	68	163
VT	23	52	21	48	44
WA	224	85	38	15	262
WI	325	74	113	26	438
WV	34	46	40	54	74
WY	17	65	9	35	26

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE D Number of Certified Facilities by Ownership Status and State, 1981

				State/Local		Voluntary/Other Nonprofit					
		For Profit		Govt-Owned		Total		Church-Related		Voluntary	
State	Total	No.	%	No.	%	No.	%	No.	%	No.	%
AK	13	3	23	3	23	7	54	1	8	6	46
AL	206	169	82	25	12	12	6	10	5	2	1
AR	207	159	77	19	9	29	14	5	2	24	12
AZ	25	14	56	2	8	9	36	1	4	8	32
CA	1,184	949	80	32	3	203	17	83	7	120	10
CO	173	114	66	17	10	42	24	11	6	31	18
CT	231	192	83	3	1	36	16	13	6	23	10
DC	6	1	17	1	17	4	66	2	33	2	33
DE	26	11	42	3	12	12	46	4	15	8	31
FL	306	227	74	15	5	64	21	29	10	35	11
GA	301	239	79	36	12	26	9	11	4	15	5
HI	34	12	35	11	32	11	33	3	9	8	24
IA	427	278	65	18	4	131	31	49	12	82	19
ID	62	38	61	14	23	10	16	2	3	8	13
IL	687	479	70	50	7	158	23	71	10	87	13
IN	424	366	86	5	1	53	13	36	9	17	4
KS	368	216	59	44	12	108	29	53	14	55	15
KY	204	140	69	12	6	52	25	15	7	37	18
LA	225	197	88	7	3	21	9	14	6	7	3
MA	513	440	86	15	3	58	11	21	4	37	7
MD	174	117	67	11	6	46	27	15	9	31	18
ME	145	118	81	4	3	23	16	4	3	19	13
MI	421	292	69	53	13	76	18	38	9	38	9
MN	454	175	38	86	19	193	43	98	22	95	21
MO	237	140	59	19	8	78	33	18	8	60	25
MS	143	112	78	22	15	9	6	2	1	7	5
MT	94	34	36	29	31	31	33	6	6	25	27
NC	202	154	76	10	5	38	19	17	9	21	10
ND	83	18	22	1	1	64	77	28	34	36	43
NE	217	85	39	48	22	84	39	23	11	61	28
NH	74	38	52	12	16	24	32	7	9	17	23
NJ	233	157	67	24	10	52	23	27	12	25	11
NM	43	17	39	5	12	21	49	8	19	13	30
NV	26	20	77	6	23	0	0	0	0	0	0
NY	570	293	51	54	10	223	39	72	13	151	26
OH	856	704	82	32	4	120	14	74	9	46	5
OK	363	318	88	8	2	37	10	21	6	16	4
OR	178	133	75	16	9	29	16	14	8	15	8
PA	556	269	48	58	11	229	41	145	26	84	15
RI	106	87	82	0	0	19	18	7	7	12	11
SC	123	88	72	26	21	9	7	4	3	5	4
SD	114	42	37	4	3	68	60	20	18	48	42
TN	229	150	66	49	21	30	13	17	7	13	6
TX	976	875	90	15	1	86	9	50	5	36	4
UT	80	65	81	9	11	6	8	1	1	5	7
VA	163	108	66	16	10	39	24	11	7	28	17
VT	44	29	66	0	0	15	34	2	5	13	29
WA	262	206	79	10	4	46	17	22	8	24	9
WI	438	212	48	82	19	144	33	66	15	78	18
WV	74	47	64	6	8	21	28	6	8	15	20
WY	26	10	39	5	10	11	42	1	4	10	18
U.S.	13,326	9,357	70	1,052	8	2,917	22	1,258	9	1,659	13

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE E Number of Facilities and Percentage by Bed Size and State, 1981

State	Total Facilities	Percentage of Facilities by Size		
		1-60 Beds	61-120 Beds	121+ Beds
AK	13	69	23	8
AL	206	27	46	28
AR	207	22	59	19
AZ	25	16	44	40
CA	1,184	34	47	19
CO	173	36	39	25
CT	231	36	34	29
DC	6	50	0	50
DE	26	31	46	23
FL	306	25	48	26
GA	301	23	54	23
HI	34	56	24	21
IA	427	39	48	13
ID	62	45	40	15
IL	687	15	44	41
IN	424	38	35	27
KS	368	56	38	6
KY	204	26	48	26
LA	225	13	56	31
MA	513	38	38	24
MD	174	25	33	43
ME	145	58	35	7
MI	421	25	43	32
MN	454	24	48	28
MO	239	27	49	24
MS	143	47	41	12
MT	94	57	31	12
NC	202	24	55	21
ND	83	41	47	12
NE	217	38	49	13
NH	74	43	39	18
NJ	233	17	40	43
NM	43	28	65	7
NV	26	31	46	23
NY	570	15	35	50
OH	856	46	37	17
OK	363	41	50	9
OR	178	34	51	15
PA	556	29	36	35
RI	106	48	32	19
SC	123	31	46	23
SD	114	47	46	6
TN	229	27	45	28
TX	976	25	51	24
UT	80	53	43	5
VA	163	26	34	40
VT	44	59	32	9
WA	262	31	44	26
WI	438	25	40	35
WV	74	47	47	5
WY	26	46	50	4

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE F Total Nursing Home Beds During 1978, 1980, and 1983, and Percentage Change in Number of Beds, by State, 1978-1983

State	Total Beds			Percentage Change 1978-1983
	1978	1980	1983	
AK	823	823	814	-1.1
AL	19,954	20,522	21,476	7.6
AR	18,548	19,111	20,405	10.0
AZ	5,354	6,197	7,834	46.3
CA	110,826	111,556	113,612	2.5
CO	20,066	18,305	18,030	-10.1
CT	24,169	26,127	26,395	9.2
DC	1,881	1,748	2,573	36.8
DE	2,997	3,646	4,269	42.4
FL	34,003	37,420	44,745	31.6
GA	31,496	32,881	36,689	16.5
HI	2,171	2,620	2,605	20.0
IA	32,125	32,277	34,021	5.9
ID	4,454	4,637	4,645	4.3
IL	85,888	87,284	87,918	2.4
IN	41,010	42,445	50,078	22.1
KS	26,227	25,793	26,356	0.5
KY	16,167	18,154	18,884	16.8
LA	22,541	25,600	26,980	19.7
MA	45,300	46,830	46,050	1.7
MD	19,322	20,582	23,056	19.3
ME	8,693	8,872	9,191	5.7
MI	46,026	46,477	48,275	4.9
MN	44,492	45,681	44,940	1.0
MO	34,706	38,142	45,134	30.0
MS	12,399	12,245	14,051	13.3
MT	6,270	6,267	6,317	0.7
NC	17,424	19,652	21,880	25.6
ND	5,956	6,277	6,757	13.4
NE	18,284	18,108	18,536	1.4
NH	6,253	6,696	6,981	11.6
NJ	26,790	29,659	31,229	16.6
NM	2,910	3,276	4,531	55.7
NV	2,009	2,170	2,470	22.9
NY	90,178	92,162	95,727	6.2
19	65,126	70,714	74,334	14.1
OK	28,122	28,944	29,797	6.0
OR	14,653	14,922	15,254	4.1
PA	66,673	72,205	78,632	17.9
RI	8,228	8,685	9,252	12.4
SC	9,875	11,362	12,899	30.6
SD	7,386	7,589	7,731	4.7
TN	18,505	23,003	26,596	43.7
TX	99,000	101,101	100,986	2.0
UT	5,758	5,548	5,600	-2.7
VA	16,283	19,177	22,625	38.9
VT	2,852	2,826	3,111	9.1
WA	28,225	26,876	27,379	-3.0
WI	50,542	51,689	53,627	6.1
WV	4,789	5,086	7,038	47.0
WY	1,962	2,050	2,098	6.9
U.S.	1,315,691	1,372,019	1,450,413	10.2

SOURCE: Aging Health Policy Center, University of California.

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TABLE G Comparison of Nursing Home Beds to 1,000 Population Aged 65 and Over in 1978, 1980, and 1983 and Percentage Change During 1978-1983, by State

State	Total Beds per 1000 Population 65 and Over			Percentage Change 1978-1983
	1978	1980	1983	
AK	82.3	71.4	58.1	-29.4
AL	48.8	46.6	45.8	-6.1
AR	63.5	61.2	62.0	-2.4
AZ	19.8	20.2	22.0	11.4
CA	49.3	46.2	43.4	-11.9
CO	86.5	74.0	66.8	-22.8
CT	69.5	71.6	66.3	-4.5
DC	26.1	23.6	34.8	33.1
DE	54.5	61.5	65.7	20.5
FL	22.3	22.2	24.0	7.4
GA	66.6	63.6	65.2	-2.1
HI	32.4	34.4	29.3	-9.7
IA	85.2	83.3	84.2	-1.2
ID	51.2	49.5	44.2	-13.6
IL	71.3	69.2	66.1	-7.4
IN	73.1	72.5	80.3	9.8
KS	88.3	84.2	82.6	-6.4
KY	41.8	44.3	43.8	4.9
LA	60.9	63.4	63.3	4.0
MA	64.7	64.5	60.4	-6.7
MD	52.2	52.0	53.1	1.7
ME	65.4	63.0	61.7	-5.6
MI	53.0	50.9	49.1	-7.4
MN	96.3	95.2	88.5	-8.1
MO	55.4	58.8	67.0	21.0
MS	45.9	42.3	46.4	1.0
MT	77.4	74.1	67.9	-12.3
NC	31.6	32.6	32.8	3.7
ND	76.4	78.0	79.5	4.1
NE	90.5	88.1	87.0	-3.9
NH	65.1	65.0	62.9	-3.4
NJ	32.5	34.5	33.9	4.2
NM	28.0	28.3	34. g	24.6
NV	35.9	33.0	30.5	-15.0
NY	43.0	42.7	43.1	0.0
OH	57.9	60.5	59.5	2.6
OK	79.0	77.0	75.8	-4.0
OR	51.4	49.2	45.8	-10.9
PA	45.6	47.2	48.0	5.1
RI	68.0	68.4	68.5	0.8
SC	38.3	39.5	40.2	5.0
SD	83.0	83.4	81.4	-1.9
TN	38.7	44.4	48.0	24.0
TX	78.3	73.7	68.7	-12.2
UT	56.5	50.8	45.5	-19.3
VA	34.8	38.0	40.8	17.4
VT	51.9	48.6	50.2	-3.2
WA	70.4	62.3	57.6	-18.1
WI	92.7	91.6	89.4	-3.6
WV	21.6	21.4	28.0	30.0
WY	54.5	55.1	52.5	-3.8
State Avg	57.4	57.5	55.8	-2.8

SOURCE: Aging Health Policy Center, University of California.

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TABLE H Total Nursing Home Beds per Licensed Nurse, Total Licensed Nurses, and Ratio of RNs to LPNs, by State, 1981

State	SNF and ICF Beds per Licensed Nurse	Total Licensed Nurses	RN/LPN Ratio
AK	4.5	143	1.3
AL	8.4	2,469	0.3
AR	11.0	1,799	0.3
AZ	16.2	199	1.6
CA	9.3	12,308	0.7
CO	10.8	1,753	1.3
CT	6.8	3,645	1.6
DC	6.5	179	1.3
DE	7.1	393	1.5
FL	11.0	3,155	0.8
GA	9.0	3,405	0.4
HI	4.8	524	1.1
IA	11.8	2,891	0.8
ID	8.3	575	0.9
IL	12.7	7,095	1.2
IN	16.9	2,462	0.9
KS	16.9	1,520	0.8
ICY	12.6	1,611	0.5
LA	11.3	2,181	0.3
MA	7.5	6,000	1.1
MD	9.2	2,273	1.1
ME	8.5	1,075	1.1
MI	10.1	4,582	0.9
MN	10.1	4,588	0.9
MS	5.6	2,195	0.3
MO	12.2	2,151	0.6
MT	8.2	772	1.1
NC	8.2	2,649	0.8
ND	9.7	677	1.1
NE	13.8	1,263	0.8
NH	7.1	949	1.9
NJ	8.1	3,979	1.7
NM	9.0	396	0.5
NV	6.6	344	1.5
NY	5.8	16,228	0.9
OH	9.0	7,867	0.8
OK	18.8	1,507	0.4
OR	11.6	1,282	1.3
PA	7.6	9,075	1.1
RI	7.3	1,171	1.3
SC	6.9	1,577	0.7
SD	11.5	685	1.2
TN	9.6	2,556	0.3
TX	12.9	7,757	0.2
UT	8.9	586	0.6
VA	7.1	2,877	0.7
VT	7.0	426	1.1
WA	8.5	2,926	1.5
WI	10.4	5,155	1.0
WV	7.8	733	0.8
WY	9.7	196	1.2

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE I Number of Facilities, by State and by Level of Care, with Fewer Than Five Licensed Nurses, 1983

State	SNF Only	SNF/ICF	ICF Only	Total	Percentage
AK	0	0	0	0	0
AL	0	3	11	14	7
All	0	0	41	41	20
AZ	6	0	0	6	24
CA	71	9	15	95	8
CO	0	4	9	13	8
CT	5	0	9	14	6
DC	0	0	0	0	0
DE	0	0	2	2	8
FL	4	37	1	42	14
GA	0	0	3	3	1
HI	1	0	3	4	1
IA	1	0	107	108	25
ID	1	5	2	8	13
IL	4	49	46	99	14
IN	0	0	156	156	37
KS	3	6	246	255	69
KY	1	1	69	71	35
LA	0	0	6	6	3
MA	0	0	96	96	19
MD	0	0	14	14	8
ME	1	0	44	45	31
MI	2	28	36	66	16
MN	7	14	67	88	19
MS	1	0	8	9	6
MO	2	2	58	62	26
MT	0	4	6	10	11
NC	2	1	9	12	6
ND	0	4	10	14	17
NE	1	0	133	134	62
Nit	0	0	5	5	7
NJ	0	8	6	14	6
NM	0	0	1	1	2
NV	1	0	0	1	4
NY	4	1	5	10	2
OH	2	15	185	202	24
OK	1	0	244	245	67
OR	12	0	48	60	34
PA	23	1	11	35	6
RI	0	3	32	35	33
SC	0	0	6	6	5
SD	0	2	46	48	42
TN	0	1	16	17	7
TX	2	1	206	209	21
UT	0	3	22	25	31
VA	0	0	6	6	4
VT	0	1	2	3	7
WA	5	15	24	44	17
WI	0	9	75	84	19
WV	0	0	9	9	12
WY	0	2	4	6	23

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Research in Progress. 1984.

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TABLE J Number of Licensed Nurses Needed in Facilities with Fewer Than Five Licensed Nurses, by State and Type of Facility, 1983

State	SNF Only	SNF/ICF	ICF Only	Total
AK	0	0	0	0
AL	0	2	21	23
AR	0	0	63	63
AZ	12	0	0	12
CA	110	10	31	151
CO	0	6	14	20
CT	10	0	12	22
DC	0	0	0	0
DE	0	0	2	2
FL	8	61	1	70
GA	0	0	3	3
HI	1	0	7	8
IA	2	0	160	162
ID	1	7	3	11
IL	7	97	87	191
IN	0	0	255	255
KS	6	10	555	571
KY	2	1	166	169
LA	0	0	10	10
MA	0	0	144	144
MD	0	0	22	22
ME	1	0	95	96
MI	5	62	74	141
MN	12	22	134	168
MS	3	0	13	16
MO	4	4	106	114
MT	0	4	12	16
NC	2	0	13	15
hid	0	6	15	21
NE	1	0	267	268
NH	0	0	10	10
NJ	0	10	21	31
NM	0	0	1	1
NV	0	0	0	0
NY	8	1	11	20
OH	2	25	299	326
OK	1	0	498	499
OR	8	0	4	12
PA	30	1	12	43
RI	0	3	84	87
SC	0	0	10	10
SD	0	4	90	94
TN	0	1	23	24
TX	5	1	345	351
UT	0	3	46	49
VA	0	0	8	8
VT	0	0	3	3
WA	10	23	55	88
WI	0	12	182	194
WV	0	0	18	18
WY	0	2	9	11

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Research in Progress. 1984.

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TABLE K State Minimum Requirements for Nursing Hours per Resident-Day, 1985

State	SNF	ICF	Notes
AK	—	—	Follows federal requirements
AL	0.32-0.8		Varies by shift; refers to RN, LPN only
AR	0.17		Refers to RN, LPN only
AZ	2.5		
CA	2.8	0.9	
CO	2.0		
CT	1.9	0.87	
DC	2.4		
DE	2.5	2.25	
FL	0.53-1.0		Varies by shift
GA	2.0		
HI	3.2-4.0		Varies by number of residents
IA	1.68-2.24	1.7	Varies by number of residents; RN, LPN only
ID	1.5		
IL	2.5	1.0-1.7	
IN	2.5	1.5	
KS	2.0	1.75	
KY	—	—	Follows federal requirements; RN for SNF
LA	2.0	1.0	
MA	2.6	2.0	
MD	2.0		Varies by number of residents
ME	0.5-1.12		Varies by shift and number of residents
HI	2.25		Varies by shift and number of residents
MN	2.0		
MS	2.33	0.4-0.53	Varies by shift and number of residents
MO	0.8-1.6		Varies by shift and number of residents
MT	0.4-0.9		Varies by shift and number of residents
NC	1.1-1.2		Varies by shift and number of residents
ND	—	—	Follows federal requirements
NE	—	—	Follows federal requirements; requires RN
NH	0.32		Refers to RN only
NJ	2.75	1.25-2.5	
NM	—	—	Follows federal requirements
NV	2.25-3.0	0.25-2.0	
NY	1.0-4.0		Varies by functional status of residents
OH	1.4	0.16-0.53	Varies by shift
OK	2.0	0.8	Varies by number of residents
OR	2.5	1.61	
PA	2.5	2.0	
RI	0.58-1.5		Varies by shift and number of residents
SC	0.53-1.73	0.9	Varies by number of residents; RN, LPN only
SD	1.16	1.28	
TN	0.16		Refers to RN, LPN only
TX	0.53	0.26	Refers to RN, LPN only
UT	2.5	2.0	
VA	0.32		Refers to RN, LPN only
VT	1.9	1.6	
WA	—	—	No minimum
WI	2.0	1.25-2.0	
WV	—	—	Follows federal requirements; requires PN
WY	2.25	1.5	

SOURCE: American Health Care Association. 1985.

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TABLE L State Minimum Requirements for Nurse's Aide Training, 1985

State	Applicability	Hours		Timing
		Classroom	Clinical	
CA	Nursing homes only	50	100	Complete training within 9 months of date of employment
CT	Nursing homes only	25	50	Complete training within 90 days of employment
FL	Nursing homes only	Varies; aide must pass exam		Enrolls in next course
IL	Nursing homes	80	40	Begun within 45 days of employment and completed within 120 days
IA	Hospitals and nursing homes	30	30	Begun at time of employment
KS	Nursing homes only	Total 90 hours 40 hours of direct patient care skills must be completed prior to giving hands-on care		Begun by 91st day of employment, completed within 6 months
MD	Nursing homes	30	28	Completed within 180 days
ME	Hospitals and nursing homes	60	60	Preemployment and begun within first month
MN	Nursing homes only	Total 30 hours		Begun within 2 months
MO	Nursing homes	35	100	Begun within 60 days, completed within 12 months
NE	Nursing homes	Total of at least 20 hours plus reporting suspected abuse or neglect		Completed within 120 days of employment
NH	Nursing homes, hospitals, and home health agencies	30	70	Preemployment, but facilities having certified program and instructor are given 90 days to begin program
OR	Hospitals and nursing homes	32	28	Begun/completed within 12 months
RI	Nursing homes	15	30	Begun following a 30- or 60-day probationary period determined by facility policy
TX	Nursing homes	19	Open until skills inventory satisfied	3 hours' orientation within 10 days; completed within 4 months
VA	Nursing homes	30	50	Within 90-120 days of employment
WA	Nursing homes	25	50	Completed within 6 months

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations, Research in Progress. 1984.

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TABLE M Average SNF and ICF Medicaid Reimbursement Rates per Resident-Day, by State, 1982

State	SNF Rate	ICF Rate
AK	97.39*	104.26
AL	37.61	25.81
AR	26.35	25.35
CA	36.10*	28.90*
CO	30.90	30.92
CT	41.49*	26.57*
DC	65.90*	50.87*
DE	44.28*	44.28*
FL	36.26	33.21
GA	28.20	25.94
HI	71.56*	58.18*
IA	59.69	25.89
ID	32.39	31.33
IL	28.35	34.04
IN	41.98	32.68
KS	27.88*	22.16*
KY	49.92	31.95
LA	31.85*	26.62*
MA	44.40	33.24
MD	36.14*	36.14*
ME	64.47	40.30
MI	36.72	36.72
MN	44.81*	35.88*
MS	31.32	29.12
MO	42.10	32.53
MT	36.75*	36.75*
NC	46.73	33.49
ND	40.85	30.00
NE	44.64	26.07
NH	53.62	44 54
NJ	51.91	43.81
NM	51.14	32.08
NV	48.26	43.61
NY	78.70	49.21
OH	42.26	36.80
OK	30.00	26.53
OR	42.34	32.85
PA	42.26	37.62
RI	43.48	38.95
SC	42.99	32.05
SD	30.08	26.88
TN	46.50*	27.40*
TX	35.51	26.79
lit	39.32*	34.06*
VA	61.90	42.66
VT	44.07	44.07
WA	35.08	34.37*
WI	42.00*	32.00*
WV	44.39	37.46
WY	33.71*	33.71*
U.S.	42.88	35.98

SOURCE: Analysis of State Medicaid Characteristics, La Jolla, California. 1983.
* 1981 data.

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TABLE N Total SNF and ICF Resident-Days of Care (in thousands) Reimbursed by Medicaid, by State, 1982

State	SNF Days	ICF Days	Total Days
AK	4	159*	163
AL	—	5,718	5,718
AR	2,568	3,168	5,736
AZ	—	—	—
CA	23,854	2,215	26,064
CO	1,179	2,788	3,767
CT	5,125	949	6,074
DE	17	434	451
FL	2,075	5,546	7,621
GA	3,310	5,521	8,831
HI	313	420	733
IA	30	5,800	5,830
ID	338	626	964
IL	4,872	13,332	18,204
IN	1,400*	7,406*	8,806*
KS	124	4,297	4,421
KY	723	3,806	4,529
LA	124	6,601	6,725
MA	5,248	6,019	11,267
MD	4,527	4,527	4,527
ME	52	2,438	2,490
HI	2,699	8,974	11,673
MN	8,071	5,210	13,281
MS	2,012	1,821	3,833
MO	132	5,378	5,510
MT	79	1,355	1,434
NC	2,011	3,281	5,292
ND	662	583	1,245
NE	187	2,566	2,753
NH	27	1,490	1,517
NJ	452	6,670	7,122
NM	25	797	822
NV	30	595	625
NY	18,550	7,335	25,885
OH	7,579	7,561	15,140
OK	—	6,206	6,206
OR	131	2,840	2,971
PA	10,752	4,591	15,343
RI	57	2,105	2,162
SC	3,119	3,119	6,238
SD	150	1,381	1,531
TN	306	6,722	7,028
TX	1,423	21,667	23,090
UT	225	1,076	1,301
VA	276	4,440	4,716
VT	20	743	763
WA	8	8	16
WI	6,900	7,000	13,900
WV	520*	523	523
WY	426	426	852

SOURCE: Analysis of State Medicaid Characteristics, La Jolla, California; 1983.
* 1981 data.

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TABLE O Elderly Population by State, 1981

State	State Population	State Population		Percentage of State Population	
		65 Years and Over	85 Years and Over	65 Years and Over	85 Years and Over
AK	412,000	11,798	780	2.9	6.6
AL	3,917,000	436,338	37,963	11.1	8.7
AR	2,296,000	306,952	28,019	13.4	9,1
AZ	2,794,000	308,222	21,846	11.0	7.1
CA	24,196,000	2,400,017	234,995	9.9	9.8
CO	2,965,000	250,151	26,074	8.4	10.4
CT	3,134,000	370,905	38,811	16.8	10.5
DC	631,000	70,074	8,055	11.1	11.5
DE	598,000	60,739	5,680	10.2	9.4
FL	10,183,000	1,626,466	128,205	16.0	7.9
GA	5,574,000	511,582	42,865	9.1	8.4
HI	981,000	77,613	6,071	7.9	7.8
IA	2,899,000	391,503	47,288	13.5	12.1
ID	959,000	97,707	8,957	10.2	9.2
IL	11,462,000	1,256,995	124,195	11.0	9.9
IN	5,468,000	590,198	56,868	10.8	9.6
KS	2,383,000	307,320	35,377	12.9	11.5
KY	3,662,000	407,365	37,548	11.1	9.2
LA	4,308,000	385,639	37,380	9.0	9.7
MA	5,773,000	723,376	81,324	12.5	11.2
MD	4,263,000	390,757	35,826	9.2	9.2
ME	1,133,000	144,618	15,416	12.8	10.7
MI	9,204,000	935,958	88,287	10.2	9.4
MN	4,094,000	487,635	57,077	12.0	11.7
MS	2,531,000	283,613	27,459	11.2	9.7
MO	4,941,000	644,610	65,941	13.1	10.2
MT	793,000	87,670	9,301	11.1	10.6
NC	5,953,000	606,456	49,280	10.2	8.1
ND	658,000	82,844	8,807	12.6	10.6
NE	1,577,000	207,141	25,083	13.1	12.1
NH	936,000	105,766	10,490	11.3	9.9
NJ	7,404,000	866,691	79,645	11.7	9.2
NM	1,328,000	118,353	10,115	8.9	8.5
NV	845,000	69,547	4,246	8.3	6.1
NY	17,602,000	2,137,685	221,811	12.1	10.4
OH	10,781,000	1,182,861	115,930	11.0	9.8
OK	3,100,000	366,271	35,671	11.8	9.7
OR	2,651,000	308,877	30,425	11.7	9.9
PA	11,871,000	1,543,787	141,335	13.0	9.1
RI	953,000	126,589	12,908	13.3	10.2
SC	3,167,000	287,630	22,251	9.1	7.7
SD	686,000	92,788	11,168	13.6	12.0
TN	4,612,000	511,766	44,460	11.1	8.7
TX	14,766,000	1,345,669	118,969	9.1	8.8
UT	1,518,000	112,166	9,691	7.4	8.6
VA	5,430,000	502,867	45,489	9.3	9.0
VT	516,000	59,314	6,389	11.5	10.8
WA	4,217,000	438,947	44,337	10.4	10.1
WI	4,742,000	578,070	59,906	12.2	10.4
WV	1,952,000	235,914	20,799	12.1	8.8
WY	492,000	38,711	3,758	7.9	9.7
U.S.	229,311,000	25,492,531	2,440,571	11.1	9.5

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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TABLE P U.S. Life Expectancy (by sex) at Birth, Age 65, and Age 85, 1960-2040

Date and Age	Male	Female
1960		
Birth	66.66	73.24
65	12.91	15.89
85	4.61	5.11
1980		
Birth	69.94	77.52
65	14.04	18.36
85	5.09	6.32
1982*		
Birth	70.63	78.10
65	14.50	18.79
85	5.24	6.60
2000		
Birth	73.65	81.11
65	15.65	20.66
85	5.98	7.75
2040		
Birth	75.70	83.36
65	17.10	22.46
85	6.89	9.00

SOURCE: Social Security Administration, Office of the Actuary. Life Tables for the United States: 1900-2050, Actuarial Study No. 89, 1983.

* From U.S. Bureau of the Census, Estimates and Projections, Series P-25, No. 952, Projections of the Population of the United States, by Age, Sex, and Race, 1983 to 2080. pp. 147-148, Table B-4A, 1984.

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TABLE Q Projected Number (in thousands) of U.S. Nursing Home Residents by Age and Sex, 1980-2040

Sex and Age	1980	2000	2020	2040
TOTAL				
All ages	1,511.3	2,541.3	3,370.8	5,227.1
Under 65	196.4	225.8	241.5	248.1
65 & over	1,314.9	2,316.1	3,129.3	4,979.0
65-74	226.6	265.1	434.4	424.5
75-84	525.4	849.8	1,005.6	1,651.4
85 & over	562.8	1,201.2	1,639.4	2,903.1
MALE				
All ages	421.5	640.9	864.8	1,303.6
Under 65	93.3	107.4	115.0	118.3
65 & over	328.2	533.5	749.5	1,185.3
65-74	86.6	104.8	175.0	172.2
75-84	134.5	224.7	280.0	469.0
85 & over	107.1	204.0	294.8	544.0
FEMALE				
All ages	1,089.8	1,900.9	2,506.1	3,923.5
Under 65	103.1	118.3	126.5	129.8
65 & over	986.7	1,782.6	2,379.5	3,793.7
65-74	140.0	160.3	259.4	252.3
75-84	390.9	625.1	725.6	1,182.4
85 & over	455.7	997.2	1,394.6	2,339.1

SOURCE: National Center for Health Statistics, Office of Analysis and Epidemiology. 1977.

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TABLE R Percentage Distribution of Nursing Home Residents Who Were Dependent in Activities of Daily Living, 1973-1974 and 1977

Activity	1973/74	1977
I. Total Percentage Dependent in:		
Bathing	70.7	86.3
Dressing	58.9	69.4
Toileting	52.7	52.5
Transferring	51.6	66.1
Continence	33.8	45.3
Eating	17.6	32.6
II. Cumulative Percentage Dependent in Activities of Daily Living, Katz Index		
Not dependent	23.5	9.6
Dependent in one activity	12.7	12.4
Dependent in bathing and one other activity	8.4	12.2
Dependent in bathing, dressing, and one other activity	4.5	8.5
Dependent in bathing, dressing, toileting, and one other activity	14.3	9.6
Dependent in bathing, dressing, toileting, transferring, and one other activity	16.0	15.6
Dependent in all six activities	14.4	23.3
Other combinations of dependencies	6.2	8.9
	100.0	100.0

SOURCES: U.S. Department of Health and Human Services, National Center for Health Statistics, Nursing Home Costs—1972, United States, National Nursing Home Survey, August 1973 - April 1974, Vital and Health Statistics , Series 13, No. 38; November Home Survey, 1977 Summary for the United States, Vital and Health Statistics, Series 13, No. 43, June 1980.

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TABLE S Health Care Financing Administration Expenditures (in millions of dollars) for State Survey Activities, 1977-1984

Fiscal Year	Medicare	Medicaid	Total
1977	23.6	33.2	56.8
1978	24.9	36.2	61.1
1979	25.3	34.4	59.7
1980	27.4 (+ 8.3%)	38.4 (+11.6%)	65.8 (+10.2%)
1981	24.6 (-10.2%)	34.2 (-10.9%)	58.8 (-10.6%)*
1982	13.6 (-44.7%)	31.8 (- 7.0%)	45.4 (-22.8%)
1984	35.6	32.2	67.8

SOURCE: Health Care Financing Administration, Health Standards Quality Bureau. 1984.
* Federal matching for surveyor salaries, travel, and training was cut from 100 to 75 percent in 1981.

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TABLE T Total 1980 Expenditures (in millions of dollars) for State Survey Agency Activities, and Percentage Change in 1983-1984

	1980		1983/1984	
Expenditures	Statewide Median	National Total	Statewide Median (% Change)	National Total (% Change)
Title 18	0.4	18.5	0.7 (+75%)	32.0 (+73%)
Title 19	1.0	39.3	1.1 (+10%)	49.3 (+25%)
State Licensing	0.2	21.3	0.3 (+50%)	29.0 (+36%)
Total		79.1		110.3

SOURCE: Institute of Medicine, Survey.

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TABLE U Total State Survey Agency Staffing in 1980 and Percentage Change in 1983-1984

	1980		1983-1984	
	State Median	National Total	State Median (% Change)	National Total (% Change)
RNs	23	1,463	26 (+13%)	1,742 (+19%)
Other	13	902	14 (+7%)	962 (+7%)
Total		2,365	(+19%)	2,704 (+8%)

SOURCE: Institute of Medicine, Survey. 1985.

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TABLE V Total Survey Visits Made by State Survey Agencies in 1980 and Percentage Change in 1983-1984

	1980		1983/1984	
	Statewide Median	National Total	Statewide Median (% Change)	National Total (% Change)
Full Licensing/ Certification	280	21,458	285.5 (+2%)	24,619 (+15%)
Post Certification	275.5	14,619	193.5 (-30%)	15,880 (+8%)
Complaint Investigation	154	15,556	143 (-7%)	24,438 (+57)
Inspection of Care	248	5,929	110 (-56%)	8,408 (+42%)
Total Visits		36,104		48,726 (+46%)

SOURCE: Institute of Medicine, Survey. 1985.

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TABLE W Percentage of Facilities Cited with A-Key Deficiencies, by State, 1983

State	Percentage Facilities with No A-Key Deficiencies	Percentage Facilities with 1 or More A-Key Deficiencies
AK	78	22
AL	75	25
AR	30	70
AZ	65	35
CA	55	45
CO	48	52
CT	67	33
DC	00	100
DE	60	40
FL	66	34
GA	62	38
HI	82	18
IA	68	32
ID	78	22
IL	72	28
IN	52	48
KS	51	49
KY	59	41
LA	54	46
MA	51	49
MD	81	19
ME	65	35
MI	80	20
MN	83	17
MS	54	46
MO	74	26
MT	68	32
NC	72	28
ND	68	32
NE	30	70
NH	69	31
NJ	44	56
NM	33	67
NV	62	38
NY	54	46
OH	68	32
OK	67	33
OR	89	11
PA	89	11
RI	78	22
SC	70	30
SD	31	69
TN	71	29
TX	75	25
UT	44	56
VA	74	26
VT	54	46
WA	77	23
WI	95	05
WV	67	33
WY	41	59

SOURCE: Health Care Financing Administration, Medicare Medicaid Automated Certification System. 1981.

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Appendix E

Key Indicators of Quality of Care

Key indicators are resident outcomes that suggest the presence of either good or bad care. They should be chosen because they indicate the extent of a facility's compliance with regulatory criteria, that is, the elements, standards, and conditions of participation. Key indicators of inadequate care are *prima facie* evidence of a problem, but further investigation is required to determine whether the problem stems from bad care or from factors that are not within the facility's control. Key indicators can be used to distinguish between adequate and poor-quality care and between adequate and good or excellent care.

The following illustrative list contains key indicators that have been tested and used by various states or facilities. Some apply to all residents, others only to residents in one or two of the four case-mix groupings proposed in Chapter 4.

EXAMPLES OF KEY INDICATORS OF CARE QUALITY TO BE USED BY SURVEYORS

Medications. Excessive use of tranquilizers and antipsychotic drugs, medication errors, and adverse drug

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interactions are evidence of poor quality in nursing homes.[1-7] Thus, one means of measuring the quality of a nursing home's performance would be to examine the use of chemical restraints and medication errors.

Survey procedures and protocols for determining proper medication administration for nursing home residents have been developed and are being used.[8-12] Elements from these protocols for proper drug administration could be used in examining facility records, observing medication passes for a sample of residents in the facilities, and observing residents. Using the "case-mix referencing" system for selecting samples of residents, the survey could focus its observation on those particularly at risk for overmedication (for example, residents with depression or anxiety).

Decubitus Ulcers. Another potential indicator of poor quality of care is the development of bed sores.[13,14] Protocols have been developed for identifying and measuring the severity of such skin breakdowns and pressure sores.[10,13-15] The survey would particularly concentrate on a sample of very physically dependent residents (those who are bed- and chair-fast) and measure the incidence and severity of decubiti.

Urinary Tract Infections. The development of infections among nursing home residents with indwelling urinary catheters may also be a sign of poor care.[16-20] One measure of quality, for purposes of comparing facility performance, would be the incidence of urinary tract infections among the residents in the facility who are catheterized.

Management of Urinary Incontinence. Another indicator of quality might be the use of indwelling catheters as opposed to bladder training programs and prompt staff attention to individuals when they need to urinate. Many view the excessive use of indwelling catheters as a sign of poor care, and protocols have been developed for their proper use.[10,14,16,17,21,22] Thus another measure of quality would be the number of indwelling catheters among incontinent residents in nursing homes. The survey should take into account whether the facility has attempted a bladder training program for catheterized residents.

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Dehydration. Dehydration among nursing home residents is frequently cited by physicians in admitting hospitals as a major problem.[23,24] It is also a predictor of poor care and has been proposed as one of the sentinel health events that should be preventable, given adequate care. As Himmelstein and colleagues note,[24] in the absence of documentation in the resident's record of rapid free water loss, dehydration usually indicates inadequate attention to fluid intake. The survey would focus in particular on every physically dependent and severely mentally impaired resident in surveying for dehydration.

Other Examples of Medical, Nursing, and Rehabilitative Care Indicators. Other key indicators of medical and rehabilitative care include the blood pressure of hypertensive residents (because elevated diastolic pressure has been shown to correlate directly with events such as heart attack and stroke), changes in weight, contractures, existence of physical restraints, decline in functional status, and the ability to perform the activities of daily living (ADL).

Nursing and Personal Care. Issues relating to nursing and personal care are very relevant to both quality of care and quality of life experienced by nursing home residents and to their sense of well-being, satisfaction, and mental and social functioning.[26] In their outcome-oriented licensure survey, the Iowa Department of Health utilizes an index of service delivery on 17 nursing and personal care items, involving observation and resident interviews.[8,9] When the observations and interviews are completed on all 17 items, a score is constructed to indicate the level and quality for this service. A similar set of items and scoring procedures could be developed for the federal survey. Examples of items include whether residents' hair and nails are clean and neat, whether they are dressed in their own clothing, whether the clothing is clean, and whether residents receive daily oral hygiene. In addition, the surveyors might observe whether call lights and other resident requests for assistance are promptly acknowledged, whether indwelling catheter tubes are clean, and whether catheter tubes and bags touch the floor.

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Mental Status. While the elderly in nursing homes suffer from mental disorders that affect younger persons (for example, schizophrenia, neuroses), the two most frequent diagnoses among nursing home residents are depression and intellectual impairment (organic brain syndrome, confusional states, dementia).[27] In the case of depression, the elderly are just as responsive to psychiatric treatment as younger people.[28] Depression, demoralization, and social isolation have been measured and associated with social functioning,[26] physical health status, premature mortality,[29-32] and activity levels.[33] Thus, greater attention should be paid to mental health aspects of care, including appropriate assessment and management techniques for mental and behavioral problems, and specialized activities programs?

One possible indicator of quality in this domain is appropriate use of medications for this population, particularly for residents with depression. Some measures of resident satisfaction (discussed below) may also capture important elements of mental status, particularly depression, demoralization, and social isolation.

There is substantial evidence that environmental circumstances of older persons have an influence on personal well-being.[34,35] For example, environments that foster autonomy, integration, and personalized care promote higher morale, life satisfaction, and better adjustment.[36,37] Some of the measures of facility-level capacity and performance, such as availability and appropriateness of activities, and some of the residents' satisfaction items, will be relevant to this domain of quality.

Diet, Nutrition, and Food Service. Diet, nutrition, and food service are especially important to quality of care and life for residents of a nursing home. Therapeutic diets, for instance, are vital to the physical health status of some residents (for example, those with conditions such as hypertension and diabetes). Adequate nutrition is essential to the physical health status of all residents. Residents with functional impairments may require assistance in eating or special utensils. Without such needed assistance, the quality of the diet or

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menu is meaningless, since such residents may not, in effect, "receive" the food they require and the facility provides. Finally, the quality of the food—whether it is warm when served, well seasoned, and whether residents have some choice in their menus—has been found to be a major element of their rating of the "quality" of a facility.[38,39] As Rosalie Kane observes,[40] "Most people sit down to meals rather than to diets; the criteria for a satisfying meal may not be the same as those for a satisfactory diet, yet both are relevant." A key indicator of food quality, adequacy, and choice could be the proportion of residents not eating their entire meals or residents' personal observations about food quality.

Activities and Social Participation. A variety of activities and choices among activities have been shown to be significant elements of residents' concepts of quality.[38] Environmental circumstances, the availability of individualized activities, opportunities for social interaction and participation in activities inside and outside the nursing home that reduce social isolation are associated with improved mental and physical status.[34-37,40]

Quality of Life. The quality of the living environment, particularly cleanliness and the ability of residents to have personal possessions and furnishings in their rooms, is one of the prime components of residents' concepts of quality.[40] The quality of the living environment is related to the physical safety of residents (for example, in bathrooms) and their health (cleanliness is related to risk of infection). Staff attitudes and treatment of residents also affect quality of life. The dignity with which residents are treated and the friendliness and caring of staff, especially aides, are critical prerequisites to a quality life experience. Opportunities for personal choice in the details of daily life— mealtimes, time to rise and retire, activities, and clothing—can allow residents a small but important measure of control over their surroundings and personal lives and significantly enhance the quality of life in a nursing home.

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OPERATIONAL USE OF KEY INDICATORS

The proposed standard survey relies on key indicators to determine whether a facility is providing high quality, moderate but acceptable quality, or potentially poor quality of care and quality of life. Taken together, the indicators must therefore discriminate among the degrees of quality. And the "pass/fail" score for each must be developed. For facilities failing the key indicators in the standard survey, a full or partial extended survey will be conducted, more fully to investigate whether there are care or life deficiencies and the reasons for them.

Following is a brief illustrative list of possible key indicators in various domains of quality of care and life and the types of follow-up investigation that would be required in the extended survey.

Nursing Care. Key Indicator: A given percentage of residents with weight loss of 5 pounds within 30 days (source of data: medical records and observations of residents). In the extended survey, the procedures would include examining records for acceptable reasons for weight loss (diagnosis of cancer, obesity, recent physical activity level changes), examining the current dietary program (caloric intake), observing residents for treatable conditions (poor or missing teeth, depression), observing meal presentation (temperature and taste of food), observing and interviewing residents regarding eating habits, need for assistive devices or staff assistance, food preferences, and investigating nursing staff levels and policies regarding food supplementation and nursing assistance in eating.

Key Indicator: A given proportion of residents with urinary tract infections associated with indwelling catheters (source of data: medical records). The extended survey procedures would include interviewing nursing staff and examining nursing procedures regarding fluid administration; investigating nursing staff levels; and investigating physician oversight of residents' care.

Key Indicator: A given percentage of residents physically restrained (source of data: observation of residents, medical records). In the extended survey, surveyors would investigate reasons for restraints to

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determine justification from medical records and staff interviews; investigate quality of care for restrained residents by observing positioning, release, and exercising of residents (from medical record reviews and staff interviews); and investigate nursing staff levels and nursing procedures.

Mental Status. Key Indicator: A given percentage of mentally unimpaired residents with depression (source of data: resident mental status interviews and medical records). The extended survey would encompass investigating the causes (physical disability, drugs, dissatisfaction with quality of care or life); and determining whether depression has been diagnosed and noted in the record and whether a plan of treatment has been formulated and is being carried out.

Medical Care. Key Indicator: Number of medications per resident exceeding a threshold level (source of data: medical records, resident interviews, and observation of medication administration). The extended survey would entail review of medical records and care planning procedures to determine whether medications are reconsidered monthly; review of drug interactions; investigation of the adequacy of pharmacy review; investigation of the extent of Medical Director involvement in the drug prescription process; investigation of nursing procedures regarding physician contacts; investigation of nursing oversight of medication complications; and investigation of the adequacy of care planning.

Dietary Service. Key Indicator: Are a given percentage of residents eating most of the food served? (Source of data: observation of meal service.) The extended survey would investigate nursing staff levels; investigate availability of assistive devices; investigate whether residents not eating are missing teeth or have other dental or medical problems impeding eating; interview residents as to whether they are given an opportunity to make choices and express preferences for food; and investigate excessive and rigid use of therapeutic diets.

Quality of Life. Key Indicator: Do a given percentage of residents report having friends among the staff? (Source of data: resident interviews.) The

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extended survey would investigate whether resident isolation has been identified and recorded in medical record and review care plan to determine if it is being addressed, and investigate staff training by interviewing staff and examining training procedures.

Key Indicator: Do a given percentage of resident rooms have personal memorabilia, rugs, curtains, pictures, plants? (Source of data: observation.) The extended survey would involve interviews with residents to determine why rooms lack personalization, and interviews with staff and the administrator. Facility policies regarding personal possessions in rooms would also be reviewed.

NOTES

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Glossary

Accredited Facility: a hospital accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA), or a SNF, ICF, or HHA accredited by the JCAH.

Activities of Daily Living (ADL): basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation, which are widely used as a basis for assessing individual functional status.

Acute Care: medical care designed to treat or cure disease or injury, usually within a limited time period. Acute care usually refers to physician and/or hospital services whose duration is less than 3 months.

Adult Day-Care: social and health services provided for physically or mentally impaired individuals in a nonresidential, day-care setting.

Aged: persons aged 65 and over.

Age-Specific Rate: the rate of occurrence of an event (for example, death, marriage, birth, illness) for a specified age group in a population.

Aging of the Population: the increasing proportion in the total population of older (age 65 and over) relative to younger (less than age 65) persons. It is generally

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measured in percentage distribution by age group, but also measured in median age, the age at which 50 percent of the population is older and 50 percent is younger.

A-Key Deficiencies: violations of certain Conditions of Participation that were identified as being of primary importance by the HCFA in 1981. Violations of these conditions were, at that time, considered more serious than the remaining, or B-level, deficiencies.

Allowable Costs: costs of operating a facility, which are reimbursable by the state under the state Medicaid program.

Alzheimer's Disease: the most common form of dementia, an organic brain disease leading to progressive loss of brain function and eventual death. The cause is unknown and there is no effective standard medical treatment.

Annual Survey: the process of inspecting a health care facility for compliance with state licensing regulations and/or Federal Conditions and Standards of Participation.

Assessment Technology: testing instruments or procedures to measure and evaluate. In long-term care, instruments or procedures used to measure the physical, mental, and social functioning of individuals.

Assistive Device: a tool, prosthesis, or adaptive equipment that helps an individual compensate for certain functional impairments, such as a hearing aid for hearing loss, glasses for vision loss, a cane to aid walking, or a universal cuff for difficulty in eating.

Average Per Diem State Rates: the average amount spent by a state for each Medicaid long-term-care resident each day.

Bed-Fast, Bed-Bound: a condition in which one is confined to bed and not able to walk, sit, or move about independently.

Bed-to-Population Ratio: the number of beds certified for a specific health care service to every 1,000 persons in the group intended to use the service. For example, the number of SNF beds per 1,000 persons aged 65 and over.

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Board and Care Homes: nonmedical facilities that Provide room and board and some degree of protective supervision on a 24-hour basis. Examples include adult foster homes, group homes, larger residential care facilities, and retirement homes.

Case Mix: the combination of diagnoses, medical care, and social care needs present in the population of a health care facility.

Case-Mix Payments: a reimbursement system based on the principle that payment for services should take into account the illness level of the resident. Each resident is assessed at some standard time interval and receives services appropriate to those determined needs. The *case mix model* develops an average patient profile for each facility. The state then pays that average rate for all Medicaid residents in that facility. The *case mix system model* establishes a rate for each patient which is determined at each assessment.

Categorically Needy: under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet financial eligibility requirements for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or an optional state supplement.

Ceiling, Cap: highest allowable cost payable by the state under the state Medicaid program.

Certificate of Need (CON): a certification made by the state under P.L. No. 92-641 that determines that a certain health service is needed and authorizes a specific operator, at the operator's request, to provide that service.

Certification for Medicaid: the survey's determination regarding a Medicaid provider's compliance with health and safety requirements.

Certification for Medicare: a recommendation made by the state survey agency to the federal agency regarding the compliance of providers with the Conditions of Participation and Conditions of Coverage.

Charge Nurse: a person who is (1) licensed by the state in which practicing as a registered nurse or practical

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(vocational) nurse who (a) is a graduate of a state-approved school of practical (vocational) nursing, or (b) has 2 years of appropriate experience following licensure by waiver as a practical (vocational) nurse, and has achieved a satisfactory grade on a proficiency examination approved by the state's Secretary of Health, or on a state licensure examination which the Secretary finds at least equivalent to the proficiency examination (such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualifications as a practical (vocational) nurse after December 31, 1977); and (2) is experienced in nursing service administration and supervision in areas such as rehabilitative or geriatric nursing, or acquires such preparation through formal staff development programs.

Charges: the dollar rates that a provider of the services places on the services provided. The provider's cost and charges are not necessarily identical, because the charge may also contain a handling and/or profit rate.

Chronic Condition: a physical or mental illness or disorder characterized by a long duration (usually more than 3 months) or frequent recurrence.

Class-Based or Flat-Rate Reimbursement Systems: rates set statewide or for groups of facilities in a particular state, based on the cost history of the entire group. The state may determine groups by geographic regions, size, ownership status, or any other characteristics it chooses.

Cohort: a population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common cohort is the "birth cohort," a group of individuals born within a defined time period, usually a calendar year or a 5-year interval.

Complaint Visit: a brief visit made by the state survey agency to a health care facility in response to a complaint made about the facility to the agency.

Conditions of Participation: the regulatory criteria, as outlined in 42 CFR 405.1122 and the following, by which a state survey agency determines whether a skilled nursing facility is eligible to participate in the

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Medicare or Medicaid program. Conditions are composed of a number of items (standards), which may be composed of several additional items (elements). Standards and elements are intended to explicate Conditions.

Cost: actual expenses incurred for inputs. For example, the cost of nursing home care includes direct costs such as staff salary, facility, equipment, supplies, and indirect costs such as mortgage, general and administrative fees, and cost of capital.

Cost-to-Charge Ratio: a constant used by researchers and policymakers to calculate the charges or cost of a given input when only partial or incomplete charge or cost figures are readily available.

Decertification or Termination: the process of suspending or revoking a health care facility's certification to participate in the Medicare and/or Medicaid programs.

Decubitus Ulcer, Decubiti: a break in the surface of the skin that appears in areas under pressure in reclining or sitting because of a circulatory defect in the area under pressure. Also called bed sores, pressure sores.

Deficiencies: the designation a surveyor makes on finding a facility out of compliance with Conditions and Standards of Participation.

Dementia: the loss of intellectual mental function, due to many different acute and chronic diseases, including Alzheimer's disease, which may affect the white matter and blood supply of the cerebrum.

Diabetes Mellitus: a familial constitutional disorder of carbohydrate metabolism that is characterized by inadequate secretion or utilization of insulin, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.

Diagnosis-Related Groups (DRGs): a classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. In October 1983, Medicare instituted a prospective reimbursement system based on 467 DRGs. Under this system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Dietetic Service Supervisor: a person who (1) is a qualified dietician; or (2) is a graduate of a dietetic

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technician or dietetic assistant training program (corresponding or classroom), approved by the American Dietetic Association; or (3) is a graduate of a state-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietician; or (4) has training and experience in food service supervision and management in a military service.

Dietician: a person who (1) is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or (2) has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

Director of Nursing Services: a registered nurse who is licensed by the state in which practicing, and has 1 year of additional education or experience in such areas as rehabilitative or geriatric nursing, and participates annually in continuing nursing education.

Disability: the inability to perform an activity in the manner or in the range considered normal because of physical or mental impairment.

Discharge: a formal release from a hospital or a skilled nursing facility (SNF). Discharges include persons who died during their stay, or were transferred to another facility.

Distinct Part Facility: a nursing home which is certified by the state agency to provide both skilled and intermediate care in separate designated areas of the facility.

Drug Administration: an act in which a single dose of a prescribed drug is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper patient, and promptly recordingthe time and dose given.

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Drugs and Biologicals: substances included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

Dually Certified Facility: a nursing home which is certified by the state agency to provide both skilled and intermediate care in all areas of the facility.

Elements: regulatory certification requirements which explicate standards and conditions of participation. See Conditions of Participation and Standards of Participation.

Expenditure: under Medicaid, an amount paid out by a state agency for the covered medical expenses of eligible participants.

Extended Care Services: items and services furnished to an inpatient of a skilled nursing facility including (1) nursing care provided by or under the supervision of a registered professional nurse; (2) bed and board in connection with the furnishing of such nursing care; (3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients; (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement, under a teaching program of such hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and (7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities; excluding, however, any item or service if

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it would not be included if furnished to an inpatient of a hospital.

Extended Survey: a comprehensive survey requiring surveyor to review all conditions, standards, and elements, and to interview a large number of residents.

Facility-Specific Reimbursement Rates: rates set for each facility based on that facility's cost history.

Follow-up Visit: a brief return visit made by the state survey agency to a health care facility within 90 days of an annual survey in order to determine a facility's progress on correcting violations found by the survey agency during the annual survey.

Functional Dependence: the inability to attend to one's own needs, including the basic activities of daily living. Dependence may result from the changes that accompany natural aging, or from a disease or related pathological condition.

Functional Impairment: inability to perform basic self-care functions such as eating, dressing, and bathing, or instrumental activities of daily living, including home management activities such as cooking, shopping, or cleaning, because of a physical, mental, or emotional condition.

Handicap: a disadvantage resulting from a physical or mental impairment or disability that limits or prevents the fulfillment of a role that is normal (for that individual) in a given environment.

Heavy-Care Residents: residents of skilled or intermediate care facilities who require a great deal of attention for medical care, nursing care, and/or assistance with activities of daily living. Bed-fast or severely demented residents are examples of heavy-care residents.

Home Care: medical, social, and supportive services provided in the home, usually intended to maintain independent functioning and avoid institutionalization.

Home Health Agency (HHA): a public or private organization providing skilled nursing services, other therapeutic services and other assisting services in the patient's home, and which meets certain conditions to ensure the health and safety of the individuals who receive the services.

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Hospital-Based Facility: a designated area of a hospital certified by the state to provide skilled and/or intermediate care.

Impairment: a physical or mental abnormality that can be readily identified or diagnosed.

Independent Professional Review: see Inspection of Care.

Input Measurement: examination of resources, activities, or tools used to provide a service in order to determine the quality of service provided.

Inspection of Care: a regular program of medical review (including medical evaluation) by one or more medical review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) to determine (1) the care being provided in nursing facilities; (2) the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in the home (or institution); (3) the necessity and desirability of the continued placement of patients in the nursing home (or institution); and (4) the feasibility of meeting the patient's health care needs through alternative institutional or noninstitutional services.

Instrumental Activities of Daily Living (IADL): home management and independent living activities such as cooking, cleaning, using a telephone, shopping, doing laundry, providing transportation, and managing money.

Intermediate Care Facility (ICF): an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

Intermediate Sanctions: penalties short of termination of a facility's Medicaid or Medicare contract, which are imposed by states against health care facilities found out of compliance with state or federal regulations.

Key Indicators: measures of quality of care and quality of life which focus on care given to residents, the results (outcome) of such care, and the manner (process)

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in which the care is given, for example, use of certain drugs, and incidence of infections and decubiti.

Level of Care: the amount of medical care and assistance with activities of daily living needed by individuals in a group. Traditionally, level of care refers to the SNF and ICF groups.

Licensed Nursing Personnel: registered nurses or practical (vocational) nurses licensed by the state in which they practice.

Life Care/ Continuing Care Communities: communities that provide a range of services for elderly residents, including homes or apartments for independent living, home care services, infirmary, and sometimes nursing home services. Payment of an initial membership or entrance fee and a monthly fee guarantees the individual most types of health and social services for the rest of his/her life.

Life Expectancy: a measure of the average remaining years of life at specified ages for different subgroups (for example, by sex and race) of a population.

Life Safety Code (LSC), Fire Safety Code: regulatory criteria used by the state health agency or fire marshall to determine whether a physical plant is structurally safe and adequately prepared against fire.

Long Stayers: nursing home residents who are no longer able to live outside of institutions and who generally reside in nursing homes for many months or years, often until they die.

Long-Term Care: a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.

Long-Term-Care Facility: any skilled nursing facility, intermediate care facility, nursing home, adult care home, or similar institution regulated by a state.

Medicaid: a federal/state program, authorized by Title XIX of the Social Security Act, to provide medical care for low-income individuals. Federal regulations specify mandated services, but states can determine optional

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services and eligibility standards. The federal government's share of costs ranges from 50 to 78 percent and is based on per capita income in the state.

Medicaid Retrospective Reimbursement Systems: state reimbursement systems in which a facility's costs are reimbursed after the expenditure. Each state may have different allowable costs and ceilings, and may vary costs by factors such as region or size of facility.

Medically Needy: under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, and whose income resources are above the limits for eligibility as categorically needy (AFDC or SSI) but because of their medical problem are considered within limits set under the Medicaid state plan.

Medicare: a federally funded health insurance program authorized by Title XVIII of the Social Security Act to pay for medical care for elderly and disabled beneficiaries. Medicare reimburses part of the costs for acute care and some types of long-term care. Beneficiaries pay an annual deductible and co-payments for most covered services. The program is divided into two sections: Part A, which covers hospital and inpatient physicians' services, and an optional Part B, which covers outpatient physician and some other outpatient services.

Medicare Cost-Based Reimbursement: a uniform federal payment system that is based on a facility's costs for providing that service.

Medicare Medicaid Automated Certification System (MMACS): a data base system operated by the Health Care Financing Administration to collect data from state survey agencies on certification activities.

Nurse-Bed Ratio: the number of full-time equivalent nursing personnel to the number of beds. The ratio can be presented at the facility, local, state, regional, or national level.

Nurse's Aide, Nursing Aide, Nursing Assistant: people who, under the supervision of a licensed nurse, provide medical care and assistance with activities of daily living to residents, and who are not themselves licensed to independently provide care.

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Nursing Home: a residential long-term-care facility that provides 24-hour care, skilled nursing care, and personal care on an inpatient basis. The definition of a nursing home varies by state.

Nursing Services: services provided under the direction or supervision of one or more registered nurses or licensed practical or vocational nurses.

Ombudsman: a state representative or a representative of a public agency or a private nonprofit organization (which is not responsible for licensing or certifying long-term care services) who (1) investigates and resolves complaints made by or on behalf of older individuals who are residents of long-term-care facilities relating to administrative action that may adversely affect the health, safety, welfare, and rights of such residents; (2) monitors the development and implementation of federal, state, and local laws, regulations, and policies with respect to long-term-care facilities in that state; (3) provides information as appropriate to public agencies regarding the problems of older individuals residing in long-term-care facilities; (4) provides for training volunteers and promotes the development of citizen organizations to participate in the ombudsman program; and (5) carries out such other activities as the State Health Commissioner deems appropriate.

Outcome Measurement: examination of the results of a service in order to determine the quality of the service provided.

Out-of-Pocket Expenditures: amounts not covered by any third-party payor that must be paid directly by the consumers, out of their own pockets.

Patient Assessment Computerized (PAC) System: a standard resident assessment system developed and used by a private nursing home chain, the National Health Corporation, located in Murfreesboro, Tennessee.

Patient Care and Services (PaCS): a new survey protocol developed by the Health Care Financing Administration.

Patient Care Profile: a standard resident assessment system developed by Mr. William Thoms, a nursing home administrator in New Hampshire. It is now being used by

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the Hillhaven Corporation, a national nursing home chain.

Payment: the dollar amount that is transferred on behalf of the recipient from one or more agents to the provider of the service.

Physicians' Services: professional services performed by physicians, including surgery, consultation, and home, office and institutional calls.

Plan of Correction: the form by which a facility documents its procedures and time frame for correcting violations of certification regulations cited by the state survey agency.

Process Measurement: the examination of methods of providing a service in order to evaluate the quality of the service provided.

Professional Standards Review Organization (PSRO): a physician or other professional medical organization (consisting of physicians and other health professionals with independent admitting hospital privileges) that enter into an agreement with the U.S. Department of Health and Human Services to assume the responsibility for the review of the quality and appropriateness of services covered by Medicare, Medicaid, and the Maternal and Child Health program. PSROs determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the appropriate setting.

Prospective Reimbursement Systems: systems in which the day rate or line item rate is set beforehand, based on a formula that takes into account historical expenditures. Typically these systems are adjusted annually and use an inflation or similar factor as the basis for future adjustment.

Rehabilitation: social or medical care designed to restore patients to their former capacity or to a condition of health or independent activity.

Resource Utilization Groups (RUGS): a standard method of grouping nursing home residents in accordance with the services they require (and, therefore, with the staff and other resources needed to supply those services).

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Retrospective Reimbursement Systems: systems in which the amount of reimbursement is based on the cost of the services already provided. These amounts are usually controlled or limited by a cap, a ceiling, or percent of actual costs incurred.

Risk Factors: characteristics, behaviors, substances, or environmental and other factors that are statistically associated with an increased likelihood of developing a given condition.

Short Stayers: nursing home residents who generally come from hospitals and wil be discharged home or will die in a very short time.

Skilled Nursing Facility (SNF): defined by the federal government as an institution that has a transfer agreement with one or more participating hospitals, and that is primarily engaged in providing to inpatients skilled nursing care and rehabilitative services, and that meets specific regulatory certification requirements.

Social Worker: a person who is licensed, if applicable, by the state in which practicing, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

Spend-Down: under the Medicaid program, a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements. A resident spends down when she/he is no longer sufficiently covered by a third-party payor (usually Medicare) and has exhausted all personal assets. The resident then becomes eligible for Medicaid coverage.

Standard Survey: a semiannual inspection based on review of a facility's performance with regard to key indicators and interviews with a stratified sample of residents.

Standards of Participation: the regulatory criteria, as outlined in 42 CFR 442.300 and the following, by which a state survey agency determines whether an intermediate care facility is eligible to participate in the Medicaid

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program. Standards are composed of elements. See also Conditions of Participation.

State Plan: a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with federal requirements.

State Survey Agency: the state health agency or other appropriate state or local agency that performs survey and review functions for Medicare and Medicaid.

Substate Ombudsman: a representative of the state ombudsman who performs ombudsman responsibilities in a given area of the state. See also Ombudsman.

Supplemental Security Income (SSI): a program of income support for low-income aged, blind, and disabled persons, established by Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI): a voluntary insurance program (also known as Medicare Part B) that provides insurance benefits for physician and other medical services in accordance with the provisions of Title XVIII of the Social Security Act, for aged and disabled individuals who elect to enroll under such program. The program is financed by premium payments by enrollees, and contributions from funds appropriated by the federal government.

Swing-Beds: beds located in a hospital that are certified by the state for use by patients in need of acute or skilled care.

Title III of the Older Americans Act: federal legislation that provides funding to states for development and coordination of services for the elderly. The Administration on Aging allocates Title III funds to states primarily on the basis of the proportion of each state's population aged 60 and over.

24-Hour Nursing Services: services for which nursing personnel are on duty 24 hours a day. The term "nursing personnel" includes registered nurses and licensed practical or vocational nurses.

Urinary Incontinence: inability to control urinary function.

Utilization Review: a review, on a sample or other basis, of admissions to the institution, the duration of stays

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therein, and the professional services (including drugs and biologicals) furnished, to determine the medical necessity of the services and the most efficient use of available health facilities and services. It is made by either a staff committee of the institution composed of two or more physicians with or without participation of other professional personnel, or by a group outside the institution that is similarly composed and that is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (if there has not been established such a group serving such institution) that is established in such other manner as may be approved by the state's Secretary of Health.

Waivers: exemption from meeting a particular regulatory requirement. Waivers for certification requirements may be given by states to facilities. Waivers for program requirements may be given by the federal government to states.

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Acronyms and Initialisms

AAA	- Area Agency on Aging
AAHA	- American Association of Homes for the Aging
AARP	- American Association of Retired Persons
ADL	- Activities of Daily Living
AHCA	- American Health Care Association
AoA	- Administration on Aging
ASHFLCD	- Association of State Health Facility Licensing and Certification Directors
DRG	- Diagnosis-Related Group
GAO	- U.S. General Accounting Office
HCFA	- Health Care Financing Administration (U.S. Department of Health and Human Services)
HEW	- U.S. Department of Health, Education, and Welfare
HHA	- Home Health Agency
HHS	- U.S. Department of Health and Human Services
HSQB	- Health Standards Quality Bureau (U.S. Department of Health and Human Services, Health Care Financing Administration)
ICF	- Intermediate Care Facility
IOC	- Inspection of Care
IOM	- Institute of Medicine

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IPR	- Independent Professional Review
JCAH	- Joint Commission on Accreditation of Hospitals
MMACS	- Medicare Medicaid Automated Certification System
NCCNHR	- National Citizen's Coalition for Nursing Home Reform
NCHS	- National Center for Health Statistics
NIA	- National Institute on Aging
NNHS	- National Nursing Home Survey
OAA	- Older Americans Act
ONHA	- Office of Nursing Home Affairs
ORD	- Office of Research and Development (U.S. - Department of Health and Human Services, Health Care Financing Administration)
OTA	- Office of Technology Assessment (U.S. Congress)
PRO	- Professional Standards Review Organization
SNF	- Skilled Nursing Facility
SSA	- Social Security Administration
SSI	- Supplemental Security Income
UR	- Utilization Review
VA	- U.S. Veterans Administration

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