

**Nursing Home Quality:
Problems, Causes, And Cures**

Written Testimony

**Testimony Before
The U.S. Senate Committee on Finance**

**Catherine Hawes, Ph.D.
Professor**

**Department of Health Policy and Management
Director, Southwest Rural Health Research Center
School of Rural Public Health
Texas A&M University System Health Science Center
College Station, Texas**

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The testimony presented here represents my views, opinions, and interpretation of data. These views do not necessarily represent the views of any of the agencies that funded the research mentioned or of the Texas A&M University System Health Science Center.

For more information on any of the studies cited here, please contact the researchers mentioned, using the information provided in the reference section, or contact me at the School of Rural Public Health at (979) 458-0081 or through the Center's main number at (979) 458-0654.

Good morning Senator Grassley and members of the Committee. Thank you for the opportunity to be here and address this important topic.

My name is Catherine Hawes. I am a Professor of Health Policy and Management and Director of the Southwest Rural Health Research Center at the School of Rural Public Health at Texas A&M.

In my testimony today, I intend to make three basic arguments:

- **First, quality improved post-OBRA but serious problems remain, and indeed, substantial evidence suggests that quality has declined over the last decade.**
- **Second, many factors have contributed to these quality problems, including inadequate regulatory processes, perverse reimbursement incentives, and so on. However, all the key stakeholders agree that inadequate staffing is the major cause of poor nursing home quality.**
- **Third, solving the staffing problem has been impeded by disagreements among key stakeholders. However, the time has come – indeed is long past – for resolving these differences and improving staffing levels and staff training.**

* * * * *

Quality improved immediately after the implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). The most notable improvement was in the huge reductions in the use of physical restraints, where use nationwide dropped from nearly 40% of residents restrained pre-OBRA to fewer than 10% by 2000 (Phillips, Hawes & Leyk-Williams, 2003; Hawes et al. 1997; Kane et al 1994). Moreover, research identified several other areas of process quality and resident outcomes that improved during the early years of OBRA implementation (Garrard et al., 1995; Hawes et al., 1997; Marek et al., 1996; Mor et al., 1997; Phillips et al., 1997; Teno et al., 1997; U.S. Senate - Aging, 1995; Vladeck, 1995).

However, even with the early improvements, some quality problems remained. Moreover, the initial pace of improvement post-OBRA was not maintained and, indeed, there is substantial evidence suggesting that quality has deteriorated over the last decade. Evidence of this can be seen in recent academic studies, reports by ombudsmen, testimony before the U.S. Senate Special Committee on Aging, and Congressional audits and include such problems as increased complaints about abuse and neglect, malnutrition and dehydration, inadequate treatment of pain, improper care for pressure ulcers, inadequate care to maximize physical functioning in activities of daily living (ADLs), and lack of adequate supervision to prevent accidents. (AOA, 2000; Bernabei et al., 1998; Blaum et al., 1995; Fries et al., 1997; Hawes, 1997; Johnson & Kramer, 1998; Kayser-Jones, 1997; Kayser-Jones and Schelle, 1997; US-DHHS OIG 1999; US GAO 1998; 1999).

There are many explanations for the seeming intractability of quality problems in nursing homes. These include such factors as inadequate staffing in facilities, perverse quality incentives in Medicare and Medicaid payment systems, and flaws in the regulatory process -- including the survey, nursing home complaint investigation, and enforcement processes (Edelman, 1997; 1998; Hawes Blevins and Shanley 2001; Hawes 2002; Harrington & Carrillo 1999; US OIG, 1999; US DHHS, 1998; US GAO, 1998; US GAO1999a, b, c, d). They also include the difficulty of implementing and sustaining quality interventions in nursing homes, the challenge of culture change even among willing facilities, and the politics of long-term care. However, the most significant problem -- and one that must be addressed before we can expect to even approach adequate quality of care for the nation's elderly -- is inadequate staffing.

The evidence is overwhelming that the most significant causes of poor quality, including abuse and neglect, are low staffing levels and inadequate staff training in nursing homes.

A discussion of "staffing" and "ratios" sounds technical. However, CNAs are eloquent about what it means to work short-staffed. What gets ignored first, out of necessity, according to CNAs, is range of motion exercises -- which leads to contractures. Next, staff report, they are unable to provide sufficient help with eating and drinking. Undernutrition, malnutrition, and dehydration inevitably follow such neglect, with the concomitant sequelae of skin breakdown, pressure ulcers, poor healing of wounds, and premature mortality -- not to mention the daily misery of being hungry and thirsty. CNAs also report they can't change residents more than once a shift if they are short-staffed, so residents sit or lie in wet clothing and bedding, an assault on dignity as well as skin integrity. What staffing adequacy really means is whether there are sufficient people on duty so that nation's grandparents receive enough help eating so that they don't slowly starve, so that day after day they don't suffer from unquenched thirst. It means that there are enough trained and caring people that our mothers are helped to use the bathroom before they wet themselves in desperation and despair.

Support for the argument that low staffing is the most significant impediment to adequate quality comes from the informed opinion of key stakeholders. As part of several studies, my colleagues and I surveyed staff in all the state survey agencies and all the state nursing home ombudsmen. We also conducted focus group interviews with Certified Nursing Assistants (CNAs) from more than 20 states. In addition, we interviewed administrators and directors of nursing (DONs) in facilities that focused on dementia care and conducted focus group interviews with state survey agency directors. Finally, we interviewed families of residents. All of these stakeholders identified staffing as critical to nursing home quality (Hawes, Blevins & Shanley 2001; Hawes & Greene 199; Hawes and Bowers, 2002).

- For a CMS-funded study of the Nurse Aide Registries, my staff and I interviewed state survey agency staff. As shown in Exhibit 1, 85% of the state survey agency staff cited low staffing levels as a main cause of abuse and neglect in nursing homes.

- In focus group interviews, CNAs asserted that short staffing was the main cause of neglect and a substantial cause of abuse (Hawes, Blevins & Shanley, 2001).

In facilities that had been identified as providing exemplary care to people with Alzheimer’s disease , DONs, nursing home administrators, and CNAs argued that staff-to-resident ratios of one CNA to six or eight residents were optimal (Hawes & Greene, 1998).

- For the Nurse Aide Registry study we interviewed the state long-term care ombudsmen in 2000. More than 90% of the respondents argued that inadequate staffing levels were the most significant cause of abuse and neglect. This was consistent with a 1999 survey in which 81% of the state and local ombudsmen responded that inadequate staffing had limited the effect of the OBRA '87 nursing home reforms (Hawes & Durand, 2000).

Exhibit 1: State Agency Views on Main Causes of Abuse and Neglect	
Cited Cause	Percent*
Staffing shortages, too few staff, bad staff to resident ratios	85%
Staffing shortages & difficulty hiring qualified staff	71%
Poor training	61%
Poor supervision, management	51%
Staff turnover	63%
Low wages	78%
Combative residents	56%
Vulnerable consumers/residents	29%
<i>*Multiple responses were allowed</i>	

Other studies have found similar results. For example:

- In 10 States surveyed by the DHHS OIG, the survey and certification staff, State and local ombudsmen, and directors of State Units on Aging identified inadequate staffing levels as one of the major problems in nursing homes. The OIG report also concluded that the type of deficiencies commonly cited “suggest that nursing home staffing levels are inadequate” (OIG, 1999a).

The findings are essentially the same in terms of the inadequacy of staff training. CNAs argued that after short staffing, inadequate training was the most significant contributor to resident abuse (Hawes, Blevins & Shanley, 2001). Other informed stakeholders who were interviewed in the Nurse Aide Registry study agreed.

- 61 percent of the aide registry directors argued that poor training was a significant factor causing abuse;
- 58 percent of the ombudsmen identified inadequate training of CNAs as a major obstacle to quality of care in nursing homes.

- CNAs noted that inadequate training of staff is particularly problematic in terms of their ability to meet the needs of residents with Alzheimer's disease. A failure by staff to understand the impact of this disease on the behavior and needs of residents is a major factor in abuse and rough treatment of residents (Hawes, Blevins & Shanley, 2001).

It does not take much to see the sense behind this argument that staff training is inadequate. In Texas, for example, a manicurist cannot be licensed unless he or she has completed 600 hours of approved training and passed a state test (<http://www.state.tx.us/professionals>). Of course, such manicurists are prohibited from treating or removing calluses, soft calluses, or ingrown nails. By contrast, CNAs provide daily hands-on care in settings where the typical resident suffers from between three and four chronic diseases, is incontinent, has some form of significant cognitive impairment, and needs help with more than four basic activities of daily living, including bathing, dressing, locomotion and using the toilet. Many exhibit challenging behaviors. Yet to be certified, a nursing assistant is required to complete only 75 hours of training. The majority of states follow this federal requirement, with only seven states requiring 120 to 150 hours of training for certification (personal communication from Charlene Harrington).

Additional evidence about the importance of staffing comes from a host of prior studies and reports on the association between staffing type, staff training, and quality (e.g., Nyman 1988; Spector & Takada, 1991). Such prior studies have been cited in several studies by the Institute of Medicine (e.g., IOM, 1986; Wunderlich & Kohler, 2000). More recent research also emphasize the importance of staffing levels -- including a study led by Charlene Harrington (Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J. and Beutel, P., 2000), another by Jack Schnelle (Schnelle et al. 2003), and, most significantly, the Phase I staffing report to Congress from the Centers for Medicare & Medicaid Services (CMS) (see US-DHHS/CMS 2001).

Unfortunately, the evidence suggests that staffing has gotten worse, not better over the last several years, particularly if one considers staffing in relation to apparent increases in the complexity and intensity of residents' care needs (Harrington et al. 1999; Phillips et al. 1997). There was some improvement in the average licensed nurse staffing (RNs and LPNs) but essentially none in CNA staffing during the mid-1990s (Harrington et al., 1999; US-DHHS/CMS, 2001). However, there has been no change from 1996 to 2002. Indeed, just completed analyses of staffing data by Dr. Charlene Harrington and her colleagues shows that licensed nurse staffing declined after the implementation of the nursing home prospective payment system in the Medicare program (Harrington, Carillo, Wellin & Shemirani, 2003). In 37 of the states and the District of Columbia, the average reported licensed nurse staffing was lower in 2002 than it was during one or more of the preceding six years. In most states, the highest licensed nurse staffing occurred in 1998 or 1999 and declined from the high point. A slight increase in CNA staffing in some states helped overcome the decrease in licensed nurse staffing so that total nurse staffing remained essentially static between 1997 and 2002. And all the evidence indicates that these levels for CNAs and licensed nurses are woefully inadequate.

The fundamental question that remains about staffing is why there has been no action at the federal level. As a member of the original IOM Committee on Nursing Home Regulation – whose recommendations were largely embodied in the OBRA '87 reforms – I can only plead temporary insanity. We largely focused in changes in process and outcome quality and, sadly, ignored the key role played by structural elements such as CNA staffing levels. And while our recommendation for a federal CNA training requirement represented progress, it is too little, particularly as the tasks expected of staff have become more demanding with the increase in resident case mix intensity.

Since then, several factors have contributed to our failure to address staffing issues. First, and probably most significantly, there is disagreement about whether or not it will take more Medicare and Medicaid funding to increase staffing levels. One side argues essentially what the head of Medicaid rate setting program asserted to us in an on-going CMS-funded study. In a state with very low payment rates, he noted that most homes were making a “healthy profit.” Thus, while he recognized that there were some significant quality problems in the state’s nursing homes, he saw no reason to give those facilities higher Medicaid rates. The other side argues that without increases in government payment, there can be no government requirement for additional staffing, for increased staff training, or for a living wage for staff.

I probably fall into the second camp for practical reasons. Some states have rates that probably don’t support adequate quality of care. But more significantly, I’ve seen little evidence that policymakers are willing to explicitly limit the profit made by some nursing homes and redirect what might be viewed as the “excess” profit into paying for better quality. Certainly, it is technically feasible to do this. There have been reimbursement systems in place that more effectively directed funds to increased spending on food and staffing and limited “profit” to efficiency incentives available only on spending not associated with direct resident care (e.g., administrative and general services spending). There have also been policies that provided additional Medicaid funding to increase staffing that have been successful – and ones that have been abused. The experience we have had with these various ways of addressing reimbursement policy and staffing suggests that some policies that are technically feasible are not necessarily politically feasible. In reality, it will prove easier to direct new funds to increased staffing than to redirect existing expenditures, much less profits. The failure to face this reality contributes to no action on improving staffing.

Second, some argue that imposing minimum staffing requirements will lead many facilities to aim for and achieve only that minimum. These critics are probably correct, but my response is that this will still represent an improvement for most facilities. Moreover, future adjustments for case mix intensity and to reflect improvements in clinical practice can be built into any system of new staffing requirements.

Third, some people argue that the survey process can address the problem of inadequate staffing. However, the reality is that the survey process fails to detect and cite many deficiencies, including cases of actual harm. Moreover, even when a deficiency is cited that is related to inadequate staffing, survey agencies often fail to

require increased staffing levels as part of the facilities' plan of correction. Indeed, this was a striking failure in the abuse and neglect complaint investigation process. Although the survey agency was charged with investigating the facilities' role in any substantiated case of abuse or neglect, most survey agency staff either could not estimate how often they looked at such issues as whether inadequate staffing levels played a role in cases of abuse or neglect or reported they investigated the facilities role in fewer than 10% of the cases (Hawes, Blevins & Shanley, 2001). Moreover, there is some evidence that suggests that if surveyors believe a nursing home is receiving an inadequate Medicaid payment rate, some will not cite deficiencies for problems whose solution would apparently require additional funds. Finally, the enforcement process and use of federal remedies is flawed, as several recent studies and Congressional audits by the General Accounting Office (GAO) have found (e.g., Edelman, 1997a and b; 1997-98; 1008; Harrington and Carrillo, 1999; Harrington, Mullan & Carrillo, 2001; Hawes, 2002). Thus, the survey and enforcement processes – at least at present – are weak reeds upon which to rely for improvements in facility staffing.

I would also note that we do not, in general, provide sufficient funds for survey and certification activities. In the last two Administrations, we have seen proposed budgets for survey and certification activities at CMS that represented decreases in resources for their activities and oversight, as well as for research activities that would support its ability to improve the survey and enforcement process. Only pressure generated by the Grassley hearings before the U.S. Senate Special Committee on Aging and the GAO reports and monitoring of the CMS quality initiatives required by the Committee have staved off total disaster. It is unrealistic to expect more of CMS or the state survey agencies without adequate funding for these essential activities. This is especially true given the budget cuts many states are experiencing.

Fourth, some argue that harnessing market forces can improve staffing and advocate public reporting facility staffing data as a way to inform consumers and pressure facilities to improve their performance. This position ignores a host of facts about how the elderly and their families choose facilities, about the time pressure they face when making such choices, about the lack of alternative options and competition, particularly in rural areas, about the ability of consumers to process information and use it to make decisions, and about the ability of facilities to recognize and correctly interpret any action by consumers (see Castle, 2003; Phillips, Hawes & Leyk, 2002). It is important to improve the quality of information available and to educate consumers, but it is no substitute for adequate staffing standards.

Finally, some argue that the total cost of increasing staffing levels, much less paying CNAs a living wage, is too high. And the truth is, there is never a particularly good time to expand funding, particularly not with the budget process Congress faces. But it is also true that 1.6 million nursing home residents don't have that much time to wait.

"As a society, we need to respect our disabled elderly enough to want to care for them and, in addition, to... foster caring in the staff, for example, with career ladders, proper pay, decent work loads."

Aide Registry Director

(Quoted in Hawes, Blevins & Shanley, 2001)

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Dr. Harrington can be reached at chas@itsa.uscf.edu or (415) 476-4030.

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Dr. Phillips can be reached at phillipscd@srph.tamushsc.edu or at (979) 458-0080.

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