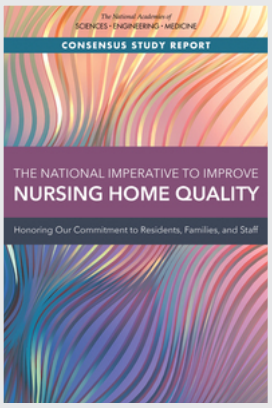

The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff (2022)

DETAILS

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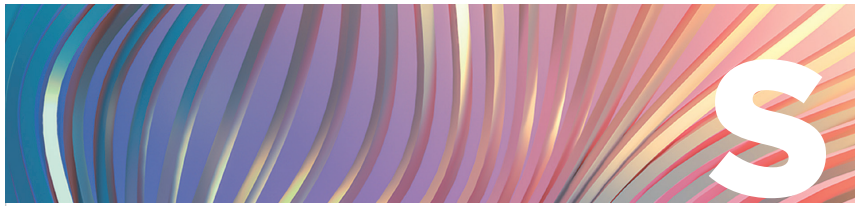

Summary

"The pandemic has lifted the veil on what has been an invisible social ill for decades."

—Daughter and caregiver of two parents with dementia who needed nursing home care.

Nursing homes play a unique dual role in the nation's long-term care continuum, serving as a place where people receive needed health care as well as a place they call home. Nearly 1.3 million Americans reside in more than 15,000 certified nursing homes in the United States. Although long-term care is increasingly provided in home and community-based settings, nursing homes will likely always be needed for individuals who have complex care needs, are without family or friends able to assist with their care, or lack the resources to be cared for at home.

The 1986 Institute of Medicine[1] report *Improving the Quality of Care in Nursing Homes* identified a variety of significant problems, including neglect and abuse of residents, poor quality of life, excessive cost, inconsistent (or lack of) oversight, and the need for high-quality outcomes data. The Omnibus Reconciliation Act of 1987 (OBRA 87) established more stringent standards for nursing homes in a wide range of areas. While many important quality improvements have been made over the past four decades, ineffective responses to these complex challenges combined with the challenges

[1] As of March 2016, the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (National Academies) continues the consensus studies and convening activities previously carried out by the Institute of Medicine (IOM). The IOM name is used to refer to reports issued prior to July 2015.

associated with caring for a heterogeneous nursing home population have resulted in a system of nursing home care that often fails to provide the supports and care necessary to ensure the well-being and safety of nursing home residents—an unacceptable situation that has long been apparent to those who study, work in, or have loved ones in nursing homes.

The COVID-19 pandemic "lifted the veil," revealing and amplifying long-existing shortcomings in nursing home care such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and deficiencies that result in actual patient harm. The pandemic also highlighted nursing home residents' vulnerability and the pervasive ageism evident in undervaluing the lives of older adults. The COVID-19 virus is particularly dangerous for individuals with serious underlying health conditions, which are common among nursing home residents. As a result, nursing home residents suffered disproportionately high rates of cases, hospitalizations, and deaths compared to the general population. For example, despite making up less than one-half of 1 percent of the U.S. population, as of October 2021, nursing home residents accounted for approximately 19 percent of all COVID-19 deaths. As of February 2022, more than 149,000 nursing home residents and more than 2,200 staff members had died of COVID-19. The ubiquity of COVID-19 cases and deaths in nursing homes of all types (across facilities with high and low quality ratings) is indicative of a more systemic problem, one that will require systemic solutions.

The pandemic's enormous toll on nursing home residents and staff drew renewed attention to the long-standing weaknesses that continue to impede the provision of high-quality nursing home care. In this context, the National Academies of Sciences, Engineering, and Medicine, with support from a coalition of sponsors, formed the Committee on the Quality of Care in Nursing Homes in 2020 to examine how the United States delivers, finances, regulates, and measures the quality of nursing home care.[2]

OVERARCHING CONCLUSIONS

After an extensive review of the evidence, the committee arrived at seven overarching conclusions.

First, **the way in which the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable**. Despite significant measures to improve the quality of nursing home care in OBRA 87, the current system often fails to provide high-quality care and underappreciates and underprepares nursing home staff for their critical responsibilities.

Second, **immediate action to initiate fundamental change is necessary**. Even prior to the pandemic, nursing home care was neither consistently

[2] The complete Statement of Task is presented in Chapter 1 of this report.

comprehensive nor of high quality; such shortcomings jeopardized the health and wellbeing of nursing home residents. Regulations in place for 35 years have not been fully enforced, further amplifying residents' risk of harm. Those same shortcomings rendered nursing homes, their residents, and staff unprepared to respond to the COVID-19 pandemic.

Third, federal and state governments, nursing homes, health care and social care providers, payers, regulators, researchers, and others need to **make clear a shared commitment to the care of nursing home residents.** Fully realizing the committee's vision will depend upon the collaboration of multiple partners to honor this commitment to nursing home residents, their chosen families, and the staff who strive to provide the high-quality care every resident deserves.

Fourth, extreme care needs to be taken to ensure that quality-improvement initiatives are implemented using strategies that **do not exacerbate disparities in resource allocation, quality of care, or resident outcomes** (including racial and ethnic disparities), which are all too common in nursing home settings.

Fifth, **high-quality research is needed to advance the quality of care in nursing homes.** Much of the available research relies on retrospective cohort designs and is constrained by limited available data. This lack of evidence presents challenges to determining the best approaches that will improve quality of care in several areas.[3]

Sixth, **the nursing home sector has suffered for many decades from both underinvestment in ensuring the quality of care and a lack of accountability for how resources are allocated.** For example:

- Low staff salaries and benefits combined with inadequate training has made the nursing home a highly undesirable place of employment.
- Inadequate support for oversight and regulatory activities has contributed to the failure of state survey agencies to meet standards in a timely manner.
- Quality measurement and improvement efforts have largely ignored the voice of residents and their chosen families.
- Lack of transparency regarding nursing home finances, operations, and ownership impedes the ability to fully understand how current resources are allocated.

Implementing the committee's recommendations will likely require a significant investment of financial resources at the federal and state levels and from nursing homes themselves. However, this investment should not be viewed as simply adding more resources to the nursing home sector as it

[3] Appendix C includes tables for priority areas of measurement and research and data collection among the committee's recommendations.

currently operates, because that alone would not likely result in significant improvements. Rather, the committee calls for targeted investments that (combined with current funding) would be inextricably linked to requirements for transparency. Such transparency will enable stronger and more effective oversight to ensure resources are properly allocated to improving the quality of care.

Finally, key partners, such as the Centers for Medicare & Medicaid Services (CMS) and other federal agencies, may not currently have the full authority or resources to carry out the actions recommended. Therefore, as a final overarching conclusion, the committee notes that **all relevant federal agencies need to be granted the authority and resources from the U.S. Congress to implement the recommendations of this report.**

COMMITTEE VISION AND GUIDING PRINCIPLES

As the committee began its extensive review of the literature, a first step was to develop an overarching framework for this study, which clearly laid out the vision and guiding principles for high-quality nursing home care. These in turn, helped identify the committee's goals and recommendations (see Box S-1).

While the committee's vision identifies what high-quality nursing home care should look like, the guiding principles serve as a strong reminder that existing regulations *require* nursing homes to provide comprehensive, person-centered care. Using these guiding principles as a foundation, the committee developed seven goals (with associated recommendations) that represent an integrated approach to improving the quality of nursing home care.

The following sections provide a high-level overview of the committee's extensive set of recommendations, which can be found in full detail in Chapter 10.[4] Though the recommendations focus on diverse areas for improvement, they all share a common underlying premise: the challenges facing nursing homes are complex and multifaceted and require immediate attention on multiple fronts by many stakeholders. Some recommendations are intentionally broad, allowing flexibility in how they are implemented, while others are more targeted, with more specific details on how to achieve the objectives. Some can be implemented immediately, while others will require a longer time line to be fully operational (but still require immediate initiation); some should be relatively straightforward to operationalize, while others are more aspirational and will require coordinated efforts to create significant long-term changes.[5] Importantly, the committee's

[4] Appendix D includes a table of the committee's recommendations organized by the key partners responsible for implementation.

[5] Appendix E includes the committee's estimated implementation timeline.

BOX S-1
Committee Vision and Guiding Principles for High-Quality Nursing Home Care

COMMITTEE VISION:

Nursing home residents receive care in a safe environment that honors their values and preferences, addresses goals of care, promotes equity, and assesses the benefits and risks of care and treatments.

GUIDING PRINCIPLES:

To achieve this vision, nursing homes should deliver comprehensive, person-centered, interdisciplinary team-based care that meets or exceeds established quality standards and supports strong connections to health care and social service systems and resources, family, friends, and the community more broadly.

High-quality nursing home care provides an environment that promotes quality of life; aligns with residents' medical, behavioral, and social care needs; reflects residents' values and preferences; promotes autonomy; and manages risks to ensure residents' safety. Such comprehensive, high-quality care includes the following, as appropriate:

- Physical health care
- Behavioral health care
- Psychosocial care
- Oral health care
- Hearing and vision care
- Rehabilitative care
- Dementia care
- Palliative care
- End-of-life care

Furthermore, it is the right of every nursing home resident to have equitable access to high-quality comprehensive, person-centered, and culturally sensitive nursing home care.

recommendations should be viewed and implemented as an interrelated package of reform measures.

GOAL 1: DELIVER COMPREHENSIVE, PERSON-CENTERED, EQUITABLE CARE THAT ENSURES THE HEALTH, QUALITY OF LIFE, AND SAFETY OF NURSING HOME RESIDENTS; PROMOTES RESIDENT AUTONOMY; AND MANAGES RISKS.

While person-centered care (as described by the principles in Box S-1) is foundational to the basic requirements specified in federal regulations for nursing home care, such care is not yet a reality to many nursing

home residents. Significant gaps and shortcomings exist in the quality of services in areas ranging from the development of a comprehensive care plan for each resident to behavioral health, psychosocial care, oral health, and end-of-life care. Moreover, significant disparities in the quality of care also exist across nursing homes.

Care Planning

The resident care planning process has a central role in the full realization of person-centered, comprehensive, high-quality, and equitable care in the nursing home setting. This process encompasses four critical components: (1) creating the care plan, (2) reviewing it, (3) implementing it and evaluating its effectiveness, and (4) regularly revisiting it. Ideally, all components of the process are implemented, but this has yet to become a reality in all nursing homes. As a foundation to operationalizing person-centered care, Recommendation 1A[6] calls for immediate and consistent compliance with existing regulations, including the following:

- **Identification of care preferences of residents and their chosen families using structured, shared decision-making approaches; and**
- **Documentation, review, and evaluation of the resident's care plan and its implementation.**

Models of Care

Nursing homes provide an array of services to both short-stay (post-acute) and long-stay residents of all ages with a wide range of health conditions. Yet research on best practices related to clinical, behavioral, and psychosocial care delivery in nursing homes is scarce. Moreover, nursing homes are often not well integrated into the communities in which they are located nor with the broader health care system. Finally, little is known about how specific factors (e.g., staffing, environment, financing, technology, leadership) affect innovative models of care or how to ensure the sustainability of these approaches. To address these gaps, Recommendation 1B proposes a series of actions including:

- **Translational research and demonstration projects for the most effective care delivery models in nursing home settings;**
- **Prioritization of models that reduce disparities and strengthen connections to the community and broader health care systems; and**
- **Evaluation of innovations in all aspects of care.**

[6] The numbers of the recommendations are provided here and can be found in their full detail in Chapter 10.

Emergency Preparedness and Response

Prior to the COVID-19 pandemic, there were numerous examples of nursing homes being unprepared to respond to emergencies and natural disasters. For example, in 2016, the top deficiency cited in nursing homes was infection control (45.4 percent of citations). The COVID-19 pandemic provided undeniable evidence of the pernicious impact of this lack of planning and preparedness. To be better positioned to respond to emergencies of all types, nursing homes need to be included as integral partners in emergency management planning, preparedness, and response on the national, state, and local levels. Moreover, as demonstrated by the prohibition against friends and family members visiting during the COVID-19 pandemic and the resultant harm of loneliness and social isolation, it is imperative to strike a careful balance between residents' safety and their behavioral and psychosocial health needs. To safeguard nursing home residents and staff against a broad range of potential public health emergencies and natural disasters, recommendations 1C and 1D call for the following:

- **Reinforcement and clarification of the emergency support functions of the National Response Framework;**
- **Formal relationships between nursing homes and local, county, and state-level public health and emergency management departments;**
- **The representation of nursing homes in emergency and disaster planning and management sessions and drills;**
- **Ready access to personal protective equipment (PPE); and**
- **Enforcement of existing regulations; and**
- **Inclusion of measures related to emergency planning in Care Compare.**

Physical Environment

Although the nursing home's physical environment is critical to residents' quality of life, the nursing home infrastructure is aging, and most nursing homes resemble institutions more than homes. Smaller, home-like environments play key roles in infection control and enhancing the quality of life for residents as well as staff. Recommendation 1E calls for the following:

- **Creating incentives for new construction and renovation of nursing homes to provide smaller, more home-like environments and smaller units within larger nursing homes;**
- **Ensuring that new designs include private bedrooms and bathrooms; and**
- **Allowing flexibility to address a range of resident care and rehabilitation needs.**

GOAL 2: ENSURE A WELL-PREPARED, EMPOWERED, AND APPROPRIATELY COMPENSATED WORKFORCE

Workers in nursing homes are often underappreciated, undercompensated, and underprepared for their roles in providing increasingly complex care. Decades of evidence support the need to enhance their training, salaries, and working conditions, yet little progress has been made to improve the quality of these jobs. The committee recommends increasing both the numbers and the qualifications of virtually all types of nursing home workers, which can exacerbate the challenges of recruitment. The committee recognizes that such a recommendation is particularly concerning given the current dire staffing situations for many nursing homes, largely due to the impact of the COVID-19 pandemic. However, robust evidence demonstrates the positive impact of enhanced staffing and training requirements on the quality of care. Enhanced requirements will further professionalize the nursing home workforce, which, when accompanied by improvements in the working environment, will contribute to the desirability of working in a nursing home. Nursing home leaders need to drive culture change, because high-quality care cannot be delivered without a complete transformation of workers' training and stature.

Compensation

Nursing home workers earn significantly less income than if they chose to work in other care settings. For example, the annual mean wage for registered nurses (RNs) in nursing homes is approximately $10,000 less (more than 10 percent less) than RNs in acute-care hospitals, and certified nursing assistants (CNAs) may earn little more than workers in other comparable entry-level jobs, such as cashier, food service worker, and warehouse worker. Successfully recruiting and retaining a high-quality nursing home workforce depends on more than "adequate" compensation—rather, competitive compensation is needed (in comparison to other job opportunities) in conjunction with a variety of incentives and supports to improve the desirability of these jobs. Recommendation 2A calls for the following:

- **Ensuring competitive wages and benefits through a variety of mechanisms.**

Providing benefits may encourage some nursing homes to reduce staffing levels or hire part-time rather than full-time staff. Thus, the committee emphasizes that nursing homes need to offer full-time, consistently assigned work whenever possible and desired by the workers in order to ensure high-quality care.

Staffing Standards and Expertise

Minimum staffing standards in nursing homes, particularly for licensed nursing staff, have been evaluated for decades. Despite substantial evidence demonstrating the relationship between nurse staffing and the quality of care in nursing homes, and 24-hour registered nurse (RN) coverage being recommended for decades, today's nurse staffing requirements remain vague. Furthermore, CMS has not established minimum staffing requirements for certain key members of the interdisciplinary team. For example, despite social workers' key role in resident care, current federal regulations require only those nursing homes with 120 or more beds to hire a "qualified social worker" on a full-time basis. Moreover, this individual does not need to have a social work degree. Nursing homes are required to designate an infection prevention and control specialist, yet regulations did not fully prepare them for the impact of the COVID-19 pandemic. Recommendation 2B calls for the immediate implementation of the following requirements in nursing homes:

- **Direct-care RN coverage (in addition to the director of nursing) at a minimum of a 24-hour, 7-days per week basis, with additional RN coverage as needed;**
- **Full-time social worker with a minimum of bachelor's degree in social work from an accredited program and 1 year of supervised experience in a health care setting; and**
- **An infection prevention and control specialist who is an RN, advanced practice RN (APRN), or a physician, at a level of dedicated time sufficient to meet the needs of the size and case mix of the nursing home.**

There have been numerous calls over the years to increase nurse staffing in an effort to improve the quality of care in nursing homes. However, the same federal staffing regulations have been in place for decades, even though the types of residents and the complexity of their needs have changed dramatically. To inform future staffing requirements, Recommendation 2C calls for the following:

- **Research on minimum and optimal staffing standards for all direct-care staff, including weekend and holiday staffing, based on resident case mix and type of staff needed for the care of specific populations; and**
- **Updated regulatory requirements based on findings from this research.**

While nursing homes may meet current minimum staffing standards, additional expertise is often needed for the development of complex clinical

care plans, staff training, and overall planning for care systems and quality improvement. Not every facility will have the ability or need to keep such expertise on staff; those who do not will need to develop ongoing relationships with a variety of professionals for consultation as needed. Recommendation 2D calls for the following:

- **Establishing consulting or employment relationships with qualified licensed clinical social workers at the master's or doctoral. level, APRNs, clinical psychologists, psychiatrists, pharmacists, and others**
- **Creating incentives for the direct hire of qualified licensed clinical social workers at the master's or doctoral level as well as APRNs for clinical care, including Medicare billing and reimbursement for these services**

Empowerment of Certified Nursing Assistants

Direct-care workers (primarily CNAs) provide the majority of hands-on care to nursing home residents. The demand for CNAs is increasing, yet nursing homes have persistent challenges in recruiting and retaining them. Furthermore, CNAs often have little opportunity for advancement. Because of the crucial role of this position in nursing homes, significantly improving the quality of care for nursing home residents requires investing in quality jobs for CNAs and enabling more workers to enter the CNA pipeline. To advance the role of and empower the CNA, Recommendation 2E calls for the following:

- **Career advancement opportunities and peer mentoring;**
- **Free entry-level training and continuing education;**
- **Coverage of time for completing education and training programs;**
- **Expansion of the role of the CNA; and**
- **New models of care that take greater advantage of the role of the CNA as a member of the interdisciplinary team.**

Education and Training

The education and training requirements for a variety of nursing home staff are inadequate or non-existent. For CNAs, existing training curricula tend to focus on basic tasks rather than on achieving competencies to meet the complex care needs of nursing home residents. Minimum education and competency requirements need to be enhanced (or established) for a variety of nursing home workers and made standard at the national level. Current workers may need assistance in achieving these standards.

Finally, a key issue underlying the preparation of all types of workers for nursing home care is the inadequate foundation for a variety of geriatrics-related topics provided in their education and training programs. Recommendation 2F calls for the following:

- **Minimum education and national competency requirements for nursing home administrators, medical directors, directors of nursing, and directors of social services;**
- **Increased minimum training hours and competency-based training for CNAs;**
- **Pathways to achieve baseline requirements for current staff; and**
- **Inclusion of content on gerontology, geriatrics assessment, long-term care, and palliative care in education programs for all health care professionals working in nursing homes.**

Competency-based training for CNAs needs to include specific instruction related to health conditions and topics relevant to nursing home populations, such as dementia, infection prevention and control, behavioral health, chronic diseases, the use of assistive and medical devices, and cultural sensitivity and humility.

Beyond these enhanced baseline requirements, the education, training, and competency of the nursing home workforce need to be augmented on an ongoing basis. For example, workforce roles differ substantially in racial and ethnic makeup, and residents are increasingly diverse in terms of racial and ethnic, LGBTQ+, and younger populations. Additionally, the committee recognizes that family caregivers are an essential and valued part of the nursing home workforce and need support and training to be effective members of the care team. To enhance the education and training of the entire nursing home workforce, Recommendation 2G calls for the following:

- **Annual continuing education for all nursing home staff;**
- **Ongoing diversity, equity, and inclusion training for all staff (including leadership), tailored to the unique community and worker needs;**
- **Resources and training for family caregivers; and**
- **Participation of chosen family as part of the caregiving team (in the manner and to the extent desired).**

Data Collection and Research

In addition to enhanced requirements for nursing home staff, a greater number of more highly trained professionals need to be involved in the delivery of care in nursing homes. However, data are limited on the prevalence

of these types of workers in nursing homes and on the extent of their training and expertise. Similarly, limited data exist for the contract and agency staff providing care in nursing homes. While evidence exists on the association between APRNs and the quality of care in nursing homes, baseline data are needed for other professionals to more fully assess their impact on the quality of care. Recommendation 2H calls for the following:

- **Routine collection and reporting of data regarding:**
  - **Baseline demographic information of medical directors, administrators, and directors of nursing;**
  - **The training, expertise, and staffing patterns of medical directors, APRNs, social workers, physicians and physician assistants; and**
  - **Numbers and staffing patterns for all contract and agency staff.**

While many of the barriers to recruitment and retention of nursing home workers are well known, more research is needed to understand persistent systemic barriers, including the influence of systemic and structural racism that has created and sustained racial and ethnic disparities among long-term care workers. Recommendation 2I calls for the following:

- **Research on systemic barriers and opportunities to improve recruitment, training, and advancement of all nursing home workers; and**
- **Collection of gender, ethnicity, and race-related outcomes of job quality indicators.**

GOAL 3: INCREASE TRANSPARENCY AND ACCOUNTABILITY OF FINANCES, OPERATIONS, AND OWNERSHIP

A key barrier to effective nursing home oversight has been lack of transparency related to nursing home finances, operations, and ownership. CMS makes some ownership information available, but these data are incomplete; often difficult to use (by researchers, consumers, and others); and do not allow for determining the corporate structure, finances, and operations of individual nursing homes or assessing quality across facilities owned or operated by the same entity. Moreover, there is little transparency regarding the practice of some nursing homes to contract with related-party organizations (those also owned by the nursing home owner) for services such as management, nursing, or therapy.

Increased transparency of and accountability regarding data on the finances, operations, and ownership of all nursing homes are needed for multiple purposes, including to more fully evaluate both how Medicare and Medicaid payments are spent and how ownership models and spending

patterns impact the quality of care. Recommendations 3A and 3B call for the following:

- **Collecting, auditing and making detailed facility-level data on the finances, operations, and ownership of all nursing homes publicly available;**
- **Making data available in a real time, making the data readily usable, and maintaining the data in a searchable database;**
- **Ensuring the ability to assess data by common owner (i.e., owners of nursing home chains or of multiple nursing homes) or management company;**
- **Evaluating and the tracking quality of care by owner or management company; and**
- **Assessing the impact of ownership models and related-party transactions.**

GOAL 4: CREATE A MORE RATIONAL AND ROBUST FINANCING SYSTEM

The current approach to financing nursing home care in the United States is highly fragmented. The federal-state Medicaid program plays a dominant role as a payer of long-stay nursing home care, but is constantly subject to state budget constraints. The federal Medicare program only covers short-stay post-acute care in nursing homes. Services such as hospice care are paid separately and not well integrated into standard nursing home care. Private insurance coverage for long-term care is limited, and relatively few people can afford to pay out of pocket for an extended nursing home stay. Eligibility rules also differ across states and sites of care. Such payment and eligibility differences can lead to unintended consequences. The separation of financing and payment systems for home- and community-based care from those for institutional care presents barriers to the rational cross-setting allocation of resources that would take into account costs as well as individuals' needs and preferences.

The committee's vision of improving the quality of nursing home care as well as expanding access, enhancing efficiency, and advancing equity will require a more stable system of financing over the long term and will likely require a federal benefit. While the committee acknowledges that enacting a new long-term care benefit will be politically challenging, a federal benefit has the most potential to achieve the following:

- increase access to long-term care services and reduce unmet need,
- reduce arbitrary barriers between sites of care,
- reduce inequities in access to high-quality care,

- reduce differences in resources across nursing homes, and
- guarantee that payment rates are adequate to cover the expected level of quality.

To expand access and advance equity for all adults who need long-term care, including nursing home care, Recommendation 4A[7] calls for the following:

- **Moving toward a federal long-term care benefit by studying how to design such a benefit and then implementing state demonstration programs to test the model prior to national implementation.**

Ensuring Adequacy of Medicaid Payments

Nursing homes rely on higher payments for Medicare services to cross-subsidize lower Medicaid payments—an inefficient and unsustainable arrangement. Many nursing homes have a high number of Medicaid recipients and therefore receive relatively little benefit from higher Medicare payments. Lower Medicaid rates encourage nursing homes to prefer short-stay patients (covered by Medicare) to long-stay residents (covered by Medicaid), resulting in selective admission practices and unnecessary hospitalization of long-stay residents in order to have their post-acute care paid for by Medicare upon their return to the nursing home.

In general, the law requires states to provide assurances (and sometimes evidence) that their Medicaid programs' payments are adequate to provide access to high-quality care. Nursing home payment rates, however, are not subject to this requirement. To ensure adequate investment in caring for long-stay nursing home residents, Recommendation 4B calls for the following:

- **Use of detailed and accurate nursing home financial information to ensure that Medicaid (or, eventually, federal) payments are at a level adequate to cover the delivery of nursing home care across all domains of care (as specified in Box S-1).**

Paying for Direct-Care Services

An extensive body of research supports a strong connection between spending on direct care for residents and the quality of that care. The Patient Protection and Affordable Care Act required CMS to develop new Medicare cost reports to capture specific information on nursing home

[7] One committee member declined to endorse this recommendation.

costs in four categories: (1) direct and indirect care, (2) housekeeping and dietary services, (3) capital expenses, and (4) administrative services. However, nursing homes are not required by law to devote a specific portion of their payment to direct care. This results in great variability among nursing homes in terms of the actual dollar amount devoted to direct care as opposed to non-care costs (e.g., monitoring fees, lease payments). Recommendation 4C calls for the following:

- **Designation of a specific percentage Medicare and Medicaid payments for direct-care services for nursing home residents, including staffing (including both the number of staff and their wages and benefits), behavioral health, and clinical care.**

Value-Based Payment for Nursing Home Care

Nursing homes are one of the most common sites of post-acute care. To control rising post-acute care costs, Medicare joined the prevailing trend toward value-based payment and more strongly linking payment to value and quality of care rather than to the quantity of services. Medicare has implemented alternative payment models (APMs), such as accountable care organizations and bundled payments that hold care providers accountable for total costs of care. Research on Medicare APMs reveals that they are associated with reductions in both costs and service use without adverse consequences on patient outcomes.

Given the importance of controlling costs for post-acute care in nursing homes while maintaining or improving the quality of care, Medicare needs to build on the experience of existing value-based payment demonstrations. In contrast to the current bundled payments made to nursing homes for a limited number of conditions, however, such arrangements will need to be extended to cover all the costs of care for all conditions, including both acute care in the hospital and post-acute care in the nursing home setting. Bundled payments will shift financial accountability, and thus risk, for nursing home post-acute care to hospitals. Importantly, hospitals and other clinicians need to work collaboratively during an episode of care and be held financially accountable by linking payment to quality metrics. As bundled payments are expanded to all conditions, close monitoring and rigorous study of the impact on patient outcomes will be required to mitigate any unintended consequences. Thus, to improve the value of and accountability for Medicare payments for short-stay post-acute care in nursing homes, Recommendation 4D calls for the following:

- **Extending the existing bundled payment initiatives to all conditions; and**

- **Holding hospitals financially accountable for Medicare post-acute care spending and outcomes.**

The impact of APMs for long-stay nursing home care is unknown, but their use warrants exploration and testing in real-world situations. Given the uncertainty surrounding their impact, the committee emphasizes the critical importance of tying such payments to value through quality metrics on staffing, resident experience, functional status, and end-of-life care to ensure that APMs maintain quality of care. Equally important is the need for a targeted focus on reducing health disparities. To eliminate the current financial misalignment for long-stay residents created by having Medicaid coverage for nursing home services and Medicare coverage for health care services, Recommendation 4E calls for the following:

- **Demonstration projects to explore the use of APMs for long-term nursing home care, separate from bundled payment initiatives for post-acute care, including:**
  - **Use of global capitated budgets;**
  - **Making care provider organizations or health plans accountable for the total costs of care;**
  - **Inclusion of post-acute and hospice care in the capitated rate;**
  - **Tying payments to broad-based quality metrics.**

GOAL 5: DESIGN A MORE EFFECTIVE AND RESPONSIVE SYSTEM OF QUALITY ASSURANCE

Despite substantial changes in nursing home care since the implementation of OBRA 87, the general standards for oversight have largely remained the same.

State Surveys and CMS Oversight

States assist with the assessment of nursing homes' compliance with CMS requirements of participation through regular inspections and, as necessary, the investigation of complaints. Although federal oversight standards and processes are uniform across states, considerable variation exists in the implementation of routine inspection responsibilities, in the imposition of sanctions, and in the investigation of complaints. The survey process often fails to properly identify serious care problems, fully correct and prevent recurrence of identified problems, and investigate complaints in a timely manner. Moreover, CMS does not provide sufficient oversight of or transparency in the state survey process or adequately enforce existing

sanctions for states' failures to perform these duties consistently. Recommendation 5A calls for the following:

- **Ensuring that state survey agencies have adequate capacity, organizational structure, and resources for their responsibilities including monitoring, investigation of complaints, and enforcement;**
- **Refining, expanding, and publicly reporting oversight performance metrics of state survey agencies; and**
- **Using existing strategies of enforcement when states consistently fall short of expected standards.**

Despite the prominent role of nursing home oversight and regulation, the evidence base for its effectiveness in ensuring a minimum standard of quality is relatively modest. The current quality assurance process is largely a standardized enterprise. Although a range of enforcement options are available, civil monetary penalties have been the most common sanction. The regulatory model needs significant improvement, particularly in relation to uneven enforcement, but there is little consensus (or evidence) to suggest which approaches would ultimately lead to improvement in the quality of care for nursing home residents. Recommendation 5B calls for the following:

- **Developing and evaluating strategies to improve quality assurance efforts, including:**
  - **Enhanced data monitoring to track performance and triage inspections;**
  - **Oversight across a broader segment of poorly performing facilities;**
  - **Modified formal oversight activities for high-performing facilities, provided adequate safeguards are in place; and**
  - **Greater use of enforcement options beyond civil monetary penalties.**

The committee notes that specific concerns have been raised pertaining to whether oversight can be reduced in some manner (e.g., less frequent or intense surveys) for high performers given that substantial safety risks or markers of decreases in quality (e.g., significant changes in staffing patterns) might occur between surveys. Therefore, the committee emphasizes the importance of using real-time quality metrics as an "early warning system" in conjunction with testing new approaches to ensure ongoing monitoring of safety and quality and enable rapid intervention if problems arise.

The Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman Program is the only entity within the nursing home system whose sole mission is to be an advocate for the residents to ensure that they receive the care to which they are entitled. In general, limited funding affects a program's ability to reliably meet federal and state requirements and fully provide residents and their families with the strongest support possible. Recommendation 5C calls for the following:

- **Increased funding for the Long-Term Care Ombudsman Program to:**
  - **Hire additional paid staff;**
  - **Train staff and volunteers;**
  - **Bolster programmatic infrastructure;**
  - **Make data on programs and activities publicly available;**
  - **Develop metrics to document the effectiveness of the programs; and**
  - **Eliminate cross-state variation in capacity.**
- **Developing plans for collaboration with other relevant state-based entities.**

Quality Assurance, Transparency, and Accountability

As noted earlier, the committee concluded that increased transparency and accountability will help to improve the quality of care. For quality assurance, the availability of more accurate and complete data on the finances, operations, and ownership of nursing homes will enable regulators to assess the quality of care across facilities with a common owner and levy sanctions as appropriate. Recommendation 5D calls for the following:

- **Implementing strengthened oversight across facilities with a common owner; and**
- **Denying licensure and imposing enforcement actions on owners with a pattern of poor-quality care across facilities.**

Certificate-of-Need Regulations and Construction Moratoria

As part of quality assurance, some states maintain certificate-of-need requirements to regulate expansions in the health care market, purportedly to constrain health care spending. Additionally, construction moratoria prohibit building any new health care facilities. However, these policies do not have much impact on overall Medicaid nursing home spending. Instead, they have been found to limit choice and reduce access, especially in rural

areas; decrease the quality of care for some measures of quality; and discourage innovation. Recommendation 5E calls for the following:

- **Elimination of certificate-of-need requirements and construction moratoria.**

Eliminating such restrictive policies is not intended as a mechanism to increase the use of nursing homes or invest in nursing homes in lieu of other settings for long-term care. Rather, the committee seeks to expand consumer choice for those who need and choose nursing home care.

GOAL 6: EXPAND AND ENHANCE QUALITY MEASUREMENT AND CONTINUOUS QUALITY IMPROVEMENT

The primary purpose of quality measurement is to improve the quality of care and outcomes. Effective quality measures can be used for continuous quality improvement activities.

Quality Measurement

The CMS website Care Compare provides public reporting of quality measures for nursing homes. However, it does not directly report on a key domain of high-quality care—resident and family satisfaction and experience. Many other key indicators of high-quality care are also omitted, and several improvements are needed to enhance the quality of the publicly reported data. Care Compare needs to be enhanced and expanded to more fully reflect the quality of care in nursing homes. Recommendations 6A and 6B call for the following:

- **Addition of measures to Care Compare related to:**
  - **Resident and family experience; and**
  - **Weekend staffing and staff turnover by role.**
- **Increased weight of staffing measures within the five-star composite rating;**
- **Facilitation of the ability to examine quality performance across facilities with common ownership or management company;**
- **Improvement in the validity of Minimum Data Set–based clinical quality; and**
- **Additional testing to improve differentiation in the five-star composite rating.**

Finally, several other key domains of high-quality care are not reflected among the measures in Care Compare, and more work is needed to

develop valid measures for these domains. Recommendation 6C calls for the following:

- **Developing and adopting new measures for Care Compare related to:**
  - **Palliative care and end-of-life care;**
  - **Implementation of the resident's care plan;**
  - **Receipt of care that aligns with resident's goals, and the attainment of those goals;**
  - **Staff well-being and satisfaction;**
  - **Psychosocial and behavioral health; and**
  - **Various structural measures (e.g., health information technology adoption and interoperability, emergency preparedness and response, financial performance, staff employment arrangements).**

Health Equity

The quality of nursing home care is particularly concerning for several high-risk populations who experience significant disparities in care, including racial and ethnic minorities and LGBTQ+ populations. However, the lack of robust data specific to race and ethnicity in nursing homes makes it difficult to document the true extent and impact of disparities in care. While developing measures of disparities in nursing home care is needed, doing so needs to be based on an overall health equity strategy for nursing homes. Recommendation 6D calls for developing the following:

- **An overall health equity strategy for nursing homes;**
- **A minimum data set to identify and describe disparities;**
- **Measures of disparities to be included in a national report card;**
- **Culturally tailored interventions and policies; and**
- **Strategies to identify the types and degree of disparities in order to prioritize when action is needed, and promising pathways to reduce or eliminate those disparities.**

Quality Improvement

Quality measures help guide quality-improvement efforts, but the extent to which individual nursing homes engage in quality improvement (and the effectiveness of such activities) is unknown. Many facilities lack adequate expertise and resources for effective quality improvement. The committee recognizes the role of CMS' Quality Improvement Organization (QIO) program in providing technical assistance to improve the quality of health care

in general. However, the focus of the QIO program varies by scope of work, and attention to nursing homes specifically has been inconsistent. State and local programs providing onsite assistance by expert clinical staff have been shown to be effective in improving care quality, and nursing homes widely accept their help. Such programs have been effective at building trusting relationships, modifying technical assistance approaches to meet local needs and skills, and keeping up to date with scientific content.

The committee concluded that nursing homes would benefit from the availability of technical assistance from individuals at the state (or even local) level who are most familiar with their specific communities and challenges and have specific expertise in nursing home quality and a consistent and ongoing focus on nursing homes. Recommendation 6E calls for the following:

- **Developing state-based, non-profit, confidential technical assistance programs with an ongoing and consistent focus on nursing homes that include:**
  - **Standards to promote comparable programs across states;**
  - **Ongoing analysis and reporting of the effectiveness of services;**
  - **Coordination with state surveyors and ombudsmen; and**
  - **Partnerships with relevant academic institutions of higher education.**

GOAL 7: ADOPT HEALTH INFORMATION TECHNOLOGY IN ALL NURSING HOMES

Health information technology (HIT) has the potential to contribute to increased efficiency in care delivery, enhanced care coordination, improved staff productivity, the promotion of patient safety, and reduced health disparities. HIT includes a range of applications, including telehealth, videoconferencing, and electronic health records (EHRs). The COVID-19 pandemic underscored the critical importance of HIT applications, which provided vitally important means of connectivity and communication when nursing home lockdowns led to limited access to in-person clinical visits and residents' isolation from friends and family members.

Nursing home residents often have complex medical conditions that require care coordination among specialists in hospitals and other care settings, further underscoring the need for nursing homes to have EHRs that communicate with other systems to ensure smooth and safe care transitions as patients move from one health care setting to another. While federal programs provided incentives to eligible health care professionals and hospitals to support EHR adoption, nursing homes were not designated as eligible for such incentives. The long-term care sector, and nursing homes in particular,

has been slower to adopt EHRs, due in part to the associated costs. Recommendation 7A calls for the following:

- **Identifying pathways to provide financial incentives to nursing homes for certified EHR adoption.**

As more nursing homes adopt HIT, it will be critical to monitor and track HIT adoption and interoperability (ability to communicate with other EHRs). The level of HIT adoption varies among nursing homes, so a baseline measure of adoption needs to be developed. Furthermore, it is vital to understand the various barriers and facilitators to HIT use in nursing homes in order to improve the efficiency, effectiveness of, and satisfaction with HIT—for staff as well as residents and their families. Recommendation 7B calls for the following:

- **Developing and reporting measures of HIT adoption and interoperability; and**
- **Measuring and reporting nursing home staff, resident, and family perceptions of HIT usability.**

If HIT is to realize its potential to improve the quality of care and increase staff productivity, it will require training nursing home leadership and staff, among other factors. However, despite evidence that training is a key contributor to staff satisfaction with HIT, most nursing homes do not provide adequate training. Recommendation 7C calls for the following:

- **Development and ongoing implementation of training in core HIT competencies for nursing home leadership and staff.**

To create an environment of continuous quality improvement, ongoing evaluation studies will be needed to assess the impact of HIT on resident outcomes, examine innovative ways to use HIT to improve resident care, and understand the key challenges of HIT adoption. Moreover, studies will need to explore the disparities in HIT adoption and use across nursing homes, paying particular attention to differences in geographic location, ownership status, the size of the nursing homes, and specific patient populations. Recommendation 7D calls for the following:

- **Rigorous evaluation studies of HIT use, disparities in HIT adoption and use, innovative HIT applications, and assessment of perceptions of HIT usability.**

CONCLUSION

The urgency to reform how care is financed, delivered, and regulated in nursing home settings is undeniable. Failure to act will guarantee the continuation of many shortcomings that prevent the delivery of high-quality care in all nursing homes. The COVID-19 pandemic provided powerful evidence of the deleterious impact of inaction and inattention to long-standing quality problems on residents, families, and staff. The pandemic, however, also serves as a stark reminder that nursing homes need to be better prepared to respond effectively to the next public health emergency, and serves as an impetus to drive critically important and urgently needed innovations to improve the quality of nursing home care. Implementing the committee's integrated set of recommendations will move the nation closer to making high-quality, person-centered, and equitable care a reality.

It has been 35 years since the passage of OBRA87 and landmark nursing home reform measures. It is of the utmost importance that all nursing home partners work together to ensure that residents, their chosen families, and staff will no longer have to wait for needed improvements to the quality of care in nursing homes. The time to act is now.