

QUALITY OF CARE AND REGULATION IN CALIFORNIA NURSING HOMES

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My concern about poor nursing home quality of care developed when I was the Director of the Licensing and Certification regulatory program for the State of California in 1975-76. I served on the Institute of Medicine's Committee on Nursing Home Regulation in 1986 that made recommendations for passage of the Nursing Home Reform Legislation in OBRA 1987. Today, I present data and recommendations from five years of research on nursing homes in California and nationally to suggest five key areas where HCFA can improve the survey and enforcement process.

First, facilities with high percentages of resident problems that are the result in poor quality of care should be targeted for extended surveys and enforcement action. Second, current standards for nursing staff must be increased and facilities with low nursing staff levels must be identified and targeted by surveyors for enforcement actions. Third, the survey process should be improved by focusing on special problems such as poor nutrition and preventable deaths. Fourth, stronger enforcement actions need to be taken to encourage compliance with the existing regulations. Finally, consumer advocacy and consumer information systems are needed to inform the public about quality problems. Data are presented from the HCFA On-Line Survey, Certification, and Reporting (OSCAR) system from 1991-1997-98 for California on 1,345 certified nursing facilities with 123,922 beds.

1. TARGETING FACILITIES WITH HIGH LEVELS OF RESIDENT PROBLEMS

Prevalence of Resident Problems

Nursing facilities report resident characteristics and problems at the time of each regular survey. See Figure 1. The most common problems of nursing home residents are: bladder incontinence (49 percent of residents), bowel incontinence (43.5 percent), physical restraints (23.4 percent), depression (23.1 percent), and contractures (22.2 percent). Some of the conditions and problems of residents may be under-reported by facilities and some may be erroneous because they are not audited by state surveyors.

Incontinence. Incontinence is a common problem and requires that residents be assisted in toileting and given care to prevent accidents. Incontinence can be reversed in almost half of the individuals who develop it and can be improved in other individuals. In the 1997-98 period, 49 percent of California nursing home residents had bladder incontinence and 43.5 percent had bowel incontinence. See Figures 2 and 3. Most residents with incontinence (96-97 percent) were not receiving bowel and bladder training programs appropriate for addressing their problems. The rates of bladder and bowel incontinence in California nursing facilities were similar to the U.S. averages. The rates of urinary and bowel incontinence have been consistently high during the 1991 through 1997-98 period. Those individuals with bladder and bowel problems frequently develop skin breakdown and pressure sores which can be painful and even life threatening. More important, residents with these problems suffer indignities and discomfort, which can be prevented by good nursing care.

Physical Restraints. Restraints are defined by HCFA as mechanical devices, materials, or equipment that restrict freedom of movement or normal access to one's body. Restraints may cause decreased muscle tone and increased likelihood of falls, incontinence, pressure ulcers, depression, contractures, and other problems. A number of studies have shown the value of reducing the use of restraints. In California, restraints have declined by 12 percent (from 26.7 percent in 1991 to 23.4 in 1997-98). Although restraint use has declined somewhat in California, it is 51 percent above the national average (See Figure 4).

Depression. Of the total U.S. nursing home residents, 17.5 percent were reported to have depression in 1996. In California, 23.1 percent of residents were reported to be depressed in 1997-98, which is 32 percent higher than the national average. Depression is one problem that nursing homes seek to prevent or reduce, and the high numbers in California nursing homes may either be a factor of better identification of the problem and/or the failure to address the psychosocial needs of residents.

Contractures. One goal of nursing home care is to prevent contractures (joints which are immobilized) and to maintain joint function. Contractures can be a sign that residents are not receiving appropriate joint exercises and adequate care. In California, 21.4 percent of nursing home residents had contractures in 1996 and 22.2 percent in 1997-98 (about the same rate as the national average). See Figure 5. In California, residents with contractures have increased by 40 percent, from 15.9 percent in 1991 to 22.2 percent in 1997-98. Only 16 percent of California residents were reported by nursing homes to have been admitted with contractures compared with 22.2 percent reported with contractures in 1997-98. The differences in admission rates and prevalence rates may represent differences between short-term and long term residents. It also suggests that some facilities are not providing adequate care to prevent the development of contractures.

Catheters. Urinary catheters are devices sometimes used for the convenience of facility staff rather than for medical necessity. Catheters should only be used when medically necessary because they are associated with infections and discomfort. In 1997-98, 9.6 percent of California nursing home residents had an indwelling urinary catheter, a rate 23 percent higher than the national average (in 1996). Moreover, the rate of catheter use in California has been persistently high since 1991. The use of urinary catheters can be prevented with proper nursing care of residents, including taking residents to the toilet frequently and with bladder training programs.

Physical Status and Immobility. One of the most important measures of resident characteristics is the extent to which individuals need assistance with the activities of daily living (ADLs). Three resident characteristics are considered to be particularly important in resource utilization studies: eating, transferring, and toileting. In the US, the overall average score for all three ADLs decreased from 6.1 in 1994 to 5.8 out of a possible 9 points for the most dependent residents in 1996. California ADL scores are slightly higher than the national average (6.3 in 1994, 6.1 in 1996, and 6.1 in 1997-98) (no table shown). Limitations in ADLs may be related to poor health status upon admission and/or to the failure to maintain or prevent the decline in activities of daily living through appropriate exercise and nutrition.

Mobility is another important characteristic which indicates the level of physical functioning of residents. In California, the percentage of residents who were bedfast was 9.3 in 1996 and 9.6 percent in 1997-98, or 16 percent higher than the national average. These higher rates may indicate inadequate care in some nursing homes where individuals are not kept active and out of bed. The average number of bedfast residents increased by 88 percent (from 5.1 in 1991 to 9.6 percent of residents) in the U.S.. Except when death is imminent, no resident should be bedfast.

Pressure Sores. Pressure sores are bruises or open sores on the skin (usually on the hips, buttock, heels or bony areas), from pressure or friction on the skin. Pressure sores may result in pain, infection, and can even be fatal. Good nursing care is generally able to prevent pressure sores from occurring and to ensure that the skin heals properly. Pressure sores were problems for 8.8 percent of California nursing home residents compared with 6.9 percent of residents in the U.S. in 1996 (27.5 percent higher for California). See Figure 6. Pressure sores increased to 9.1 percent of residents in 1997-98. The 1997-98 data for California showed that only 5.9 percent of residents were admitted with pressure sores but 9.1 percent of residents had pressure sores at the time of the survey, or 54 percent higher than the number reported on admission.

Psychoactive Medications. The percent of residents receiving psychoactive medications is also a concern because high percentages, particularly of hypnotic medications may represent poor care. Hypnotic and psychoactive medications may be used as chemical restraints in some facilities to control resident behavior rather than because of medical or clinical indications. California nursing home residents with psychoactive medications increased from 29.1 percent in 1991 to 39.5 percent in 1997-98 (a 36 percent increase). Although this rate is slightly below the national average, it remains high. Of California nursing home residents, 7.9 percent were given hypnotic medications. Regulations require nursing homes to review medications and to use such medications only when clinically indicated but this area needs regulatory attention.

Weight Gain or Loss. Weight gain or loss may be caused by several different factors but common reason for weight loss is poor nutrition. Many residents need assistance with eating, while others have difficulty swallowing food, dental problems, appetite loss, or other problems that put them at risk for malnutrition. Other residents become dehydrated from not receiving sufficient fluids. Of the total residents in California nursing homes, 7.7 percent had unplanned significant weight loss or gain in 1997-98, compared with 8.6 percent nationally in 1995-96. Although California reports of weight loss are not high, weight loss is probably seriously underreported based on nursing home research studies.

These resident problems have all been consistently high in California and nationally for the last seven years and California residents are more likely to report physical restraints and pressure sores than residents in other states. Some residents are admitted with problems but the data show more residents with problems than were admitted with problems, suggesting that some residents develop problems after admission to the nursing facilities because of poor care.

Targeting Facilities With Problems

One approach to improving the nursing home survey process is to identify facilities that report high percentages of patients with problems. These facilities should be targeted for more frequent surveys and extended surveys. For example, Figure 7 shows that 464 facilities in California have 11-15 percent of their residents in restraints 349 have 26-50 percent in restraints, 127 have 51-90 in restraints, and 14 facilities have over 90 percent of residents in restraints. These facilities with high percentages need to be investigated and given sanctions if these restraints are unnecessary.

Figure 8 shows that 11 percent of facilities have 75 percent or more of residents with bladder incontinence, and about 30 percent of facilities have 11 percent or more with pressure sores, catheters, and weight gain or loss. Others have high percentages of residents with contractures. At the present time, nursing homes with these unusually high resident problems are not targeted for more frequent or more extended nursing home surveys.

Nursing homes are now required to submit comprehensive resident assessments completed on the minimum data set (MDS) forms to the states in a computerized format. The University of Wisconsin under a HCFA contract developed a set of 30 quality indicators (QIs) using the MDS data that are more accurate and comprehensive than the OSCAR resident data. The QIs include 12 domains: accidents, behavioral and emotional problems, clinical problems, cognitive impairment, elimination and continence problems, infection control, nutrition and eating, physical functioning (bedfast and declines in ADLs), psychotropic drugs, quality of life indicators (restraints and inactivity), sensory/communication problems, and skin problems. Within the coming year, the MDS data will allow HCFA and states to monitor the QI changes in individual resident conditions over time and to identify residents and facilities that have unusually high rates of problems. Some states that participated in the HCFA casemix and

quality demonstration project may be using these QI data for targeting their survey efforts. Other states like California will be able to use all data in the future.

Recommendations. HCFA should require states to use data on resident problems to identify facilities with potential problems. Facilities with high percentages of resident problems should be targeted for more frequent and extended surveys to determine whether the quality of care is inadequate. Surveyors need more guidance in determining when an identified resident problem is the result of inadequate care and when the problem may be due to other factors. HCFA should develop detailed guidelines for determining when care is inadequate and/or harmful and the scope and severity of the inadequate/harmful care.

H. SETTING STANDARDS AND TARGETING FACILITIES WITH LOW STAFFING

In recognition of the low nurse staffing levels in nursing homes, the Nursing Home Reform Act (OBRA 1987) increased nurse staffing. Nursing care is critical to the provision of high quality services and nursing personnel provide the majority of care in nursing homes. Where nursing care fails to address the resident problems described above, poor and life threatening outcomes occur.

Current staffing levels in most facilities are inadequate to provide high quality of care. Figure 9 shows the nurse staffing levels for all facilities in California and in the U.S. The total nursing [registered nurses (RNs), licensed vocational/practical nurses (LVN/LPNs), and nursing assistants (NAs)] hours per resident day in California were 3.4 hours (68 minutes of care per 8 hour shift) in 1997-98. These hours include all administrative time, indirect care time (e.g. charting) and direct care time. The overall hours increased about 10 percent in California over the seven year period. The staffing levels in California are approximately the same as the national average for the period, but there are wide variations in patterns across states.

The average ratio of RNs was 0.7 hours (42 minutes) per resident day (See Figure 10), or 14 minutes per eight hour shift. This is an average of one RN for every 40 residents per day. This is completely inadequate to provide care and supervision but this meets the minimum federal standard which is for one RN Director of Nursing, one RN on duty for 8 hours a day seven days a week, and one licensed nurse (either an RN and/or LPN/LVN) on duty around the clock for nursing facilities. Unfortunately, a facility with 35 beds has the same requirement for one RN as a 1,000 bed facility. Larger facilities have lower staffing levels and these lower staffing levels are associated with higher deficiencies of all types.

The Nursing Home Reform law requires sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable level of physical, mental and psychosocial well being of each resident. HCFA regulations also require nursing homes to base staffing patterns on the actual care needs of residents, but this is not clearly defined.

The low percentage of RNs suggests that the supervision of staff in many nursing homes is inadequate. In California, RNs only provided 20 percent of total average nursing hours, LVN/LPNs provided 17 percent of total hours, and nursing assistants provided 63 percent of total hours in 1996-97. LPN/LVN hours was 0.6 hours (36 minutes) and nursing assistant hours was 2.2 hours (132 minutes) in California in 1997-98. For nursing assistants, see Figure 11. The average ratio is one LVN for every 34 residents and one NA for every 12 residents per day. There is a wide range of staffing levels across different types of facilities with a number of facilities reporting low staffing levels. For example, 7.1 percent of the nursing facilities in California reported 1.0 to 2.4 hours per resident day and another 28.1 percent of facilities had 2.5-2.9 hours per resident day.

Setting Minimum Standards for Nurse Staffing

The average hours of care in California and the nation's nursing homes are well below what is needed for good nursing care. A recent meeting of experts on nursing home care discussed the recommendations for minimum nurse staffing standards developed by the National Citizens' Coalition for Nursing Home Reform (NCCNHR). " Based upon this discussion, I recommend that HCFA establish a minimum direct care ratio of nursing staff to residents in nursing homes as follows: one nursing staff person (RN, LVN/LPN or NA) for every five residents on the day shift, one nurse staff for every 10 residents on the evening shift and one nurse staff for every 15 residents at night. See Table 1. In addition, one nurse is needed at meal times to assist every 2-3 residents that need complete help with eating and one nurse is needed for every 3-5 residents that need partial assistance with eating.

Additional nurses are needed for rehabilitation and to care for residents with higher acuity levels. At the same time, one Director of Nursing with a minimum of a bachelor's degree in nursing and gerontological education is needed, one RN is needed 24 hours a day, and one RN is needed for in- service education for every 100 residents. In the long run, we should have a goal of having Directors of Nursing and registered nurses with master's degrees in gerontological nursing.

Several research studies have shown that nurse staffing levels are associated with high quality of care in nursing facilities. One of the first studies found that homes with more RN hours per resident were associated with lower mortality rates, improved physical health, and a higher rate of discharge home. A number of other studies have identified the positive relationship between nurse staffing and quality of care. Spector and Takada (1991) found that low nurse staffing levels in homes with very dependent residents was associated with reduced likelihood of improvement, high urinary catheter use, low rates of skin care, and low rates of resident participation in organized activities." Cohen and Spector (1996) found that higher ratios of registered nurses (RNs) to residents, adjusted for resident casemix, reduced the likelihood of death and that higher ratios of licensed practical nurses (LPNs) significantly improved resident functional outcomes. Recently, a study of all nursing homes in the U.S. confirmed that that higher nurse staffing levels and other staffing levels are associated with fewer deficiencies. This study also found that higher staffing levels for therapists, activities staff, and dietary personnel also had a positive effect resulting in fewer deficiencies in nursing homes. A recent Institute of Medicine (IOM) Committee (1996) recommended adding more registered nurse staff in nursing facilities especially an RN on duty 24 hours per day.

Recommendation: The current federal nursing requirements are inadequate to ensure minimum levels of nursing care. The minimum ratios of nursing staff to residents in nursing facilities should be increased to the level recommended by consumers and experts in Table 1.

Auditing and Targeting Facilities With Low Staffing

Facilities that report extremely high or low staffing should be reviewed and targeted for more frequent and for extended surveys. HCFA does not require state surveyors to review or to audit the actual staffing levels in nursing homes with quality problems as a part of the survey process nor to conduct more frequent surveys on such facilities.

Only 5.7 percent of facilities in California received deficiencies for insufficient staff in 1997-98 and yet we know from all reports that inadequate staffing is an widespread problem. This is probably because the actual staffing levels in the months before the survey are generally not reviewed and audited by surveyors. Less than one percent of facilities received citations for inadequate RN staffing, probably because the federal standard for RNs is so low that most facilities meet the requirement for one RN on

duty eight hours per day for seven days per week. In addition, many facilities are reported to add more staff when a survey is occurring.

For example, one facility in California reported 1,432 staff hours per resident day compared with the average of 3.4 hours per resident. Eighteen facilities reported no staff and 30 facilities had 0.8 or less hours per resident (48 minutes) (these facilities were removed from the sample because they were assumed to be erroneous data).

Figure 12 shows that 7.1 percent (74 facilities) had only 1.0 to 2.4 hours per resident day and 28 percent (294 facilities) had 2.5-2.9 hours per resident data. These data suggest that surveyors are not reviewing the nurse staffing data to determine either its accuracy or its adequacy for providing minimum levels of nursing care. All those facilities reporting staffing at less than the average levels should be targeted for surveys and audited. Penalties are needed for failure to meet minimum staffing standards.

Recommendation: Using OSCAR data, HCFA should target those facilities with staffing levels below the average level for more frequent unannounced surveys. In those facilities where poor care is identified, staffing audits should be conducted by state surveyors using samples of actual facility payroll records. Staffing should especially be examined for weekends, evenings, nights, and holidays. Stricter penalties, including civil money penalties, should be enforced against those facilities that do not meet the minimum staffing levels and provide poor and dangerous care.

III. TARGETING QUALITY OF CARE AND LIFE VIOLATIONS

California surveyors identify many areas where nursing homes fail to meet the standards, but the most commonly cited deficiencies are not necessarily the most important quality of care areas. Figure 13 shows the top 10 most frequently cited deficiencies for poor care in California out of a total of about 185 federal standards. These include: clinical records, food sanitation, care plans, dignity, accident environment, accommodate needs, comprehensive assessments, unnecessary drugs, housekeeping, and social services.

In 1997-98, the most frequent deficiency was given for the failure to maintain appropriate clinical records on residents (42 percent). The second most frequent deficiency was for inadequate food sanitation in storing, preparing, distributing, or serving food to prevent food borne illness (40.3 percent of facilities). Of the total California facilities, 38 percent were given deficiencies for failure to prepare comprehensive resident care plans as required. In addition, 26.5 percent of facilities were given deficiencies for the failure to conduct comprehensive assessments of each resident.

Dignity was given a strong emphasis in the 1987 nursing home legislation and regulations. Thirty-seven percent of California nursing homes received deficiencies for failure to maintain the dignity of residents in 1997-98, which includes providing care for residents in a manner and in an environment that maintains or enhances dignity and respect. Another important area is accommodating individual needs. 26.5 percent of California residents were given citations for failure to accommodate the individual needs of residents in 1997-98.

The failure to maintain the environment free of accident hazards was cited in 28.4 percent of facilities. This requirement was established to prevent unexpected and unintended injury. The prohibition against the use of unnecessary drugs was another important area emphasized in the new 1991 federal regulatory requirements. Twenty-six percent of facilities received citations for this area in California. The failure to provide adequate housekeeping (25.7 percent) was the fifth most frequently cited deficiency in 1996. This is a quality of life requirement that includes ensuring that housekeeping and maintenance services

are provided to maintain a sanitary, orderly, and comfortable interior and that an adequate environment is provided for residents. Finally, 25.1 percent of facilities were cited for the failure to provide sufficient social services.

Other common deficiencies (not shown in the figure) were for poor quality of care (23.6 percent of facilities in California). Residents have the right to be free of physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. In 1997-98, 23.6 percent of California facilities received deficiencies for this requirement. Facilities must ensure that residents do not develop pressure sores; 22.1 percent of California facilities received deficiencies for failing to meet this standard. In summary, the California Department of Health Services is identifying many serious violations in nursing facilities.

Although these areas of the federal standards are important, other quality of care problems in nursing homes should be given more attention by surveyors. One area is incontinence care because 49 percent of residents were reported to have incontinence but only 5.9 percent of the residents were reported to be in bladder training programs. Although these problems are common, only 16.6 percent of facilities received deficiencies for the failure to provide adequate incontinence care in California (table not shown). Facilities with high percentages of bedfast residents should be targeted by surveyors, because generally residents should not be left in bed if adequate care is provided.

Poor nutritional care due to improper feeding of residents and dehydration have been reported to be common in some nursing homes. Only 11.4 percent of facilities in California were cited for problems with poor nutrition and 4.6 percent of facilities for the failure to prevent dehydration. One reason is that federal standard for weight loss of five percent in a month is not adequate to detect serious problems. The appropriate standard for identifying malnutrition should be based on low body mass and cumulative weight loss." Preventable deaths and hospitalizations are critical areas to examine because they represent jeopardy to the residents. Infection control is also important to prevent illness and death. Contractures, as noted above, are a common problem reported for 22 percent of residents.

Recommendation: HCFA should focus greater enforcement efforts on special problems areas in nursing homes such as incontinence, immobility and inactivity, poor nutrition and weight loss from time of admission, dehydration, infections, preventable deaths, preventable hospitalizations, contractures, and behavioral and emotional problems.

IV. DECLINES IN ENFORCEMENT ACTIVITIES

Nationally there has been a 42 percent decline in enforcement activities since 1991. Figure 14 shows the U.S. average number of deficiencies decreased from 8.8 deficiencies in 1991 to 5.1 per facility in 1996. California showed an increase in the average number of deficiencies per nursing facility in the 1991-1993 period. In 1993, the state averaged 17.8 deficiencies per facility but this began to decline each year until the 1997-98 period when the average number was 10.4 deficiencies.

The average number of deficiencies varied substantially across states from 1.5 per facility in Connecticut to 12.7 per facility in Nevada in 1996. California was the second highest state in the average number of deficiencies issued per facility. Even though California has a stronger record of identifying deficiencies than most other states, serious quality problems persist. This suggests that the nation's enforcement system is not working effectively.

California found 5.2 percent of its nursing facilities with no deficiencies in 1997-98. In contrast, Kentucky was the state with the highest percent of its facilities reported to have no deficiencies (56

percent in 1996). California was among the 3 states with the lowest percentage of facilities have no deficiencies, and this percentage was steady from 1991-1998. For the nation as a whole, the percent of facilities reporting no deficiencies increased from 10.8 percent in 1991 to 20.8 percent in 1996 (by 93 percent). This is another indication of reduced regulatory activities nationally.

As noted above, there are wide variations across states in the level of survey activities and deficiencies issued. The variations within states are also important. For example, data from the California State Department of Health Services showed variations across the 18 district and subdistrict offices. Although some variations are expected given differences in the quality of the care delivered in homes in different areas, it is clear that some of the variation is due to differences in surveyor training, activities, and/or philosophies. Variations in survey activities can be reduced by providing greater training and supervision of state survey agency staff.

Although the reasons for the decline in enforcement activities are complex, it is unlikely that the declines are because of substantial improvements in quality. The nursing home industry arguments that quality has improved are contradicted by frightening newspaper accounts of neglect and abuse from California to Detroit." Although some nursing homes provide excellent care, there is no research literature that suggests the overall quality of nursing home care is improving. The reasons for the decline in enforcement include: (1) weak and confusing federal enforcement regulations and procedures, (2) ineffective HCFA oversight of states, (3) some states are failing to enforce the standards vigorously, (4) strong political pressures from the nursing home industry to reduce enforcement, and (5) either inadequate resources or ineffective use of resources for the regulatory process.

Toby Edelman at the National Senior Citizens Law Center argues that HCFA fundamentally reduced its enforcement effort through a series of deliberate policy actions. These include: allowing most facilities 30-70 days to correct deficiencies (except for those that cause immediate and serious jeopardy) before imposing any penalties; imposing a moratorium on the collection of civil money penalties when the new enforcement procedures went into effect on July 1, 1995; redefining the term "widespread" to apply only to those deficiencies that affect all residents in an entire facilities (thus being overly restrictive in use of the term); creating new terms of "correction required" and "significant correction required" to avoid labeling facilities as being out of compliance with federal regulations; allowing states to avoid revisits for the lower scope and severity requirements; and encouraging states not to issue civil penalties unless they were for immediate jeopardy or poor performing facilities that had not made corrections at the time of the revisit. The procedures HCFA established for informal dispute resolution are also problematic in causing delays and pressures for reductions in enforcement actions. These many formal and informal procedures and the many changes in the system made by HCFA created both complexity and confusion in the enforcement process. The goal of the OBRA legislation for swift action against those facilities that fail to meet the minimum federal standards is not being met. The HCFA enforcement procedures need extensive revision in order for them to be more effective.

Another explanation for the decline in enforcement activities may be that the HCFA oversight procedures that monitor states are ineffective or have had negative effects. When HCFA implemented its new enforcement standards in July 1995, it established panels of staff at the central office in Baltimore to review state enforcement procedures and asked some states to reassess their deficiencies where the staff felt the citations were not justified or not properly documented. These enforcement efforts may have directly or indirectly placed pressure on states to reduce enforcement efforts. HCFA instituted extensive training on the new resident assessment system and some training was conducted for the enforcement system. Additional training of surveyors should be undertaken to ensure greater consistency within and across states. One important issue is that states that are more active in regulatory activities, such as California, should not have their activities reduced, but rather states should be encouraged by HCFA to take stronger enforcement actions.

Another possible explanation is that some states are not carrying out enforcement activities vigorously. Some states may have administrators who are less than supportive of regulation and enforcement, so perhaps state politics and philosophy are factors. The new enforcement process may increase the workload burdens on state survey agencies that have detracted from the actual process of the detection of poor care.

Political pressures from the nursing home industry to reduce enforcement at both the federal and state levels are considered by many to be strong, effective, and persistent. Legal actions by the industry against the imposition of enforcement remedies have brought delays and reductions in many civil money penalties, as illustrated in California's Department of Health Services effort to impose and collect fines for deficiencies.

Moreover, funds for nursing home enforcement efforts may not be sufficient at the federal and/or the state levels to conduct frequent in-depth surveys of states. Or it may be that resources need to be utilized in a more effective fashion. A comparative analysis of the resources available and the actual time and resources required to implement fully the survey and enforcement activities could address this problem as to what resources are necessary to have an effective system.

Recommendation: HCFA enforcement procedures should be streamlined to make it easier for states to identify substandard care and to enforce the federal standards in a timely fashion. Barriers to consistent and effective state and federal enforcement activities need to be removed. HCFA should impose penalties for non-compliance with standards, not just for failure to correct deficiencies.

V. CONSUMER ADVOCACY AND INFORMATION SYSTEMS

Consumer Advocacy

One important way to protect the public, in addition to the efforts of the regulatory agencies is to have active consumer organizations that advocate for nursing home residents. The California Advocates for Nursing Home Reform (CANHR) is a nonprofit consumer organization that provides consumer information services on individual nursing homes, legal information and referral services, legislative and administrative advocacy, family and social support, and counseling. Each year CANHR publishes a status report on California's nursing home industry. CANHR tracks all the deficiencies and enforcement against nursing homes in the state using state data and OSCAR data. They track the enforcement activities and the collection of fines and imposition of penalties. CANHR in California and the National Citizen's Coalition for Nursing Home Reform (NCCNHR) at the national level are vital organizations to informing, protecting, and advocating for nursing home residents. It is essential to the nursing home market place that there is an active advocacy system for consumers to counter the heavy political and legal power of the nursing home industry.

Recommendation. Consider providing public financial support for nursing home consumer advocacy organizations to ensure greater access to consumer information and consumer protection.

Information Systems

Another important way to improve quality is for HCFA to establish an information system about nursing homes. In collaboration with NCCNHR, the University of Wisconsin, and AARP, I have developed a

design for summarizing the OSCAR data and making it available to consumers. This effort, funded by the Agency for Health Care Policy and Research, has demonstrated that this information can be tailored to meet the needs of consumers and that it would encourage improvements in nursing home quality. Unfortunately, funding is not available for the information system to be implemented.

Two essential pieces of information are needed for the information system that are not currently available on OSCAR. One is information on corporate ownership that can be used to track nursing home owners with poor compliance records. Current OSCAR data only show the names of the facilities but not the owners. Enforcement actions against facilities are also not included on OSCAR unless the facility's certification is terminated. Such data would need to be added to OSCAR to make the system more comprehensive.

Recommendation: A consumer information system using OSCAR data should be funded so that HCFA could place the data on the Internet. This information system should include OSCAR data on all facilities in the country in a readily accessible format, including: (1) facility characteristics; (2) resident characteristics; (3) staffing; (4) deficiencies including the scope and severity of deficiencies; and (5) complaints. In addition, HCFA needs to collect and make data on corporate ownership and enforcement actions against individual nursing facilities available to consumers. The information system should include data for the past three years to identify patterns of noncompliance with regulations over time.

SUMMARY AND DISCUSSION

Much progress has been made in identifying the critical elements of quality of care and quality of life for people in nursing facilities. The quality problems in some nursing homes continue to be poor and to fall well below the federal standards. Although OBRA 1987 legislation creates a strong basis for an effective regulatory system, the trends in reduced levels of enforcement observed in California and the nation are very troubling. We need a commitment to strong enforcement. More work is needed to improve the survey and enforcement system to improve quality of care. Targeted review of facilities with high frequencies of resident problems and low staffing should be implemented. Clearer guidelines for surveyors to assist them in identifying inadequate quality of care and taking effective and consistent enforcement actions are needed. Public support for nursing home consumer advocacy organizations and for a HCFA nursing home information system for consumers is also critical.