Topic Page: Nursing homes

Definition: **nursing home** from *The Macquarie Dictionary*

1.

a nursing residence equipped for the care of patients who have chronic or terminal diseases, or who are disabled in some way.

Plural: nursing homes

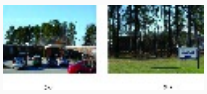

Image from: **Thomasville nursing home** in *Clinical Technologies: Concepts, Methodologies, Tools and Applications*

Summary Article: **NURSING HOMES**
From *The Encyclopedia of Elder Care*

end-of-life care, health care continuum, hospice care, Medicaid, Medicare, nursing care, nursing home, older adult, quality-of-care, reimbursement

Continuity of Patient Care, Hospice Care, Medicaid, Medicare, Nursing Care, Nursing Homes, Quality of Health Care, Terminal Care

The nursing home (NH) industry remains an important part of the health care continuum, providing housing and health care services to more than 1.4 million older adults (Centers for Disease Control and Prevention [CDC], 2014). As the population continues to age at an unprecedented rate, the typical NH resident demonstrates higher acuity, more comorbid conditions, and higher care needs than ever before (Mor, Caswell, Littlehale, Niemi, & Fogel, 2009). NHs care for an old, frail population and are devoting more resources to the care and treatment of persons needing short-term rehabilitation, persons needing continuous medical monitoring, persons with profound dementia/cognitively impaired and functional disabilities, and the terminally ill. Resident acuity, or intensity of need, has increased since the 1990s, with many NHs providing services and care previously provided only in acute care facilities.

FACILITY CHARACTERISTICS

As of 2014, there were approximately 16,000 NHs in the United States with almost 1.6 million Medicare and/or Medicaid certified beds (CDC, 2014). Overall, the number of NHs has declined over the past 10 years, but the number has stabilized within the past 5 years (Centers for Medicare & Medicaid [CMS], 2015). In 2014, the number of dually certified NHs for both Medicare and Medicaid continued to increase to almost 95%, whereas the number of Medicare-only and Medicaid-only have decreased. On average, 67% of NHs are for-profit; 25%, nonprofit; and 8%, government and other (CMS, 2015). Approximately 55% of for-profit homes are group or chain affiliated, compared with 46% of nonprofit homes.

Despite a reduced bed supply relative to those aged 65 years and older (e.g., in 2005: 45.7 beds/1,000 older adults; in 2014: 36 beds/1,000 older adults), occupancy rates continue to gradually fall from 85% occupancy in 2005 to 82.4% occupancy in 2014 (CMS, 2015). The decline is attributed to reductions in reimbursements, as well as increasing home care options and less restrictive environments such as assisted-living residences (Castle & Engberg, 2009). Of the 1.4 million current NH residents, 77% are 65 years and older, and 8% are 95 years and older (CDC, 2014). These statistics can be explained by the fact that people are living longer and NH care has become more medically

sophisticated over the last 15 years.

RISK FACTORS FOR ADMISSION AND SERVICES PROVIDED

Approximately 1.4 million people (approximately 12% of the population aged 65 years and older) are in a NH on any given day, with 36% admitted from a hospital (CDC, 2014). Risk factors for admission are primarily advanced age, medical diagnosis, living alone, loss of self-care ability, mental status, race, lack of informal supports, poverty, hospital admission, bed immobility, and female gender. Mentally ill, developmentally disabled, or mentally retarded individuals cannot be admitted to a NH unless the type or intensity of services needed, determined through a formalized screening process, can be provided.

NH goals of care are to maintain or improve physical and mental function, eliminate or reduce pain and discomfort, offer social involvement and recreational activities in a safe environment, reduce unnecessary hospitalizations and emergency room use, and ensure a dignified death. As of 2014, 19.8% of all NH residents received no assistance in activities of daily living (ADL), compared with 15% receiving assistance in five ADL domains (CMS, 2015). NHs must provide dental, podiatric, and medical-specialty consultation services; social services; and mental health and nutrition services. Some homes have fully equipped dental, podiatric, and x-ray suites; laboratory facilities; and pharmacies.

All NHs provide care at the end of life. Approximately 78% of NHs provide hospice care, although this can vary from a consultative relationship with a certified hospice agency to one in which the resident's care is planned, managed, and monitored by the hospice agency in the NH (CMS, 2015). Residents receiving hospice services have better pain management, fewer hospitalizations, and less use of feeding tubes than residents receiving standard end-of-life care.

Virtually all homes provide rehabilitative services (i.e., physical therapy, occupational therapy, speech, hearing), but the intensity of the service varies with the home's program operation and Medicare participation. Slightly more than 15% of NHs have formally designated special care units (SCUs), constituting approximately 7% of all NH beds. These units care for residents with dementias, hospice, rehabilitation, and ventilator-dependent residents.

RESIDENT CHARACTERISTICS

Most NH residents are White (78%) and female (65.5%); 15% are younger than 65 years (CMS, 2015). Black residents were twice as likely as White residents to be younger than 65 years. The most frequent admission diagnoses were related to diseases of the circulatory system, mental disorders, and diseases of the nervous system (CMS, 2014>). As of 2015, more than one third of residents were incontinent of bowel or bladder.

Approximately 50.4% of NH residents have Alzheimer's disease or another type of dementia; 48.7% have a diagnosis of depression, and 32.4% have a diabetes mellitus. The percentage of residents receiving psychoactive medication at least once in the past 7 days decreased from 63% in 2004 to 21.7% in 2014 (CMS, 2015). One third of residents exhibit inappropriate or dangerous behavior. The use of physical restraints in the past 7 days has decreased to 1% in 2014 from 7.5% in 2004 and is attributed to increased regulatory oversight and staff education (CMS, 2015).

According to Wang, Shah, Allman, and Kilgore (2011), NH residents are prominent users of the emergency department, accounting for more than 2.2 million visits annually. Also, NH residents had higher acuity than non-NH residents, were more likely to be admitted to the hospital, exhibited higher mortality, and were more likely to have been discharged from the hospital within the prior 7 days.

Influences on hospitalization decisions include physician practice pattern in the NH and local area, hospital vacancy rate, Medicare eligibility, staff and family pressure, and NH resources (e.g., diagnostic services, intravenous therapy, insufficient RNs, systemic infectious processes, cost of antibiotic therapy, pulmonary disease, payment source, advanced age). In 2011, one fourth of NH patients were transferred for inpatient admissions, accounting for $14.3 billion of Medicare spending. The most common reason for admission, was septicemia. On comparison, for-profit NHs had higher rates of hospital transfers than nonprofit (Harrington, Carillo, & Garfield, 2015).

Of all NH residents, 65% have some form of advance directive (including do not resuscitate [DNR] orders); 66% of all residents die in the NH. An anticipated increase in do-not-hospitalize (DNH) requests (currently, 4%–6% of NH residents) and refusal of life-sustaining interventions will likely result in fewer hospitalizations and more “planned deaths” in NHs.

The average length of stay (LOS) for long-term residents is 835 days. Justification of continued-stay review, intensive rehabilitation, and aggressive outplacement to cheaper, lesser levels of care, such as assisted-living or home care, are resulting in shorter NH LOS. Increasingly, more residents are being discharged back to the community, “recovered or stabilized.”

STAFFING

Of the 1.7 million full-time equivalent (FTE) employees in NHs in 2014, almost two thirds were nursing staff (i.e., RN, licensed practical nurse [LPN], certified nurse assistant [CNA]). Nursing staff turnover is pervasive and costly and impacts negatively on quality of care. In some states, CNA turnover exceeds 100% annually. Turnover is associated with staffing levels lower than in comparable NHs, poor quality of care, larger facilities, and for-profit ownership (Castle & Engberg, 2009). The “interdisciplinary team” consisting of nursing and social services, activities, dietician services, rehabilitation therapy, and physician services, are accountable for resident care and outcomes.

NHs with 60 or more residents require that an RN must be that on duty 8 consecutive hours per day, 7 days per week. An RN or LPN must be used for the remaining 16 hours. Total nursing care hours per resident day increased from 3.7 hours in 2004 to 3.8 hours in 2014 (American College Health Association [ACHA], 2016). On average, current staffing per resident day is RNs, 0.6 hour; LPNs, 0.7 hour; and CNAs, 2.3 hours. Several studies found a positive relationship between RN staffing and quality outcomes. The Patient Protection and Affordable Care Act (PPACA) implemented a requirement in 2015 to include dementia and resident abuse training as part of 12 hours per year of continuing education training for nurse aides (Harrington et al., 2015).

Every resident must have a physician who is legally responsible for the plan of care. Few NH physicians are certified geriatricians. A full-time NH physician can have 60 to 80 residents and also serve as the medical director. Every NH is required to have a medical director on-site a minimum of 20 hours per week, with responsibilities that include quality improvement, patient services, resident rights, and administration (U.S. Office of Inspector General [USOIG], 2012).

Some 12% of NHs have no physical therapists, 20% have no occupational therapist, and 26% have no speech/language therapist. The number of social workers, activity therapists, and nutritionists varies with facility size. NH administrators must be licensed and, in most states, have a bachelor's degree in long-term care administration or a related health field.

COSTS AND REIMBURSEMENT

Approximately 65 of NH residents are dually eligible (Medicare/Medicaid) beneficiaries; 29.7% have Medicare only, and less than 5% have Medicaid only. Medicaid is the primary payer for approximately 63% of NH residents. Historically, nursing facilities have preferred Medicare rates and private-pay rates. Higher Medicaid reimbursement rates have been associated with high staffing and higher care quality (Harrington et al., 2015). Private pay accounted for 44% of NH revenue in 1985, 28% in 1996, and 23% in 2014. Whereas at time of admission a dual-beneficiary resident is likely to be Medicare covered, Medicaid is likely to cover the extended-stay non-Medicare portion of NH residence. The Medicare component of the NH program remains essentially restricted to 100 days of only posthospital skilled nursing and/or skilled rehabilitation. A year of long-term care in a nursing facility costs approximately $80,000. In 2013, national spending on skilled nursing facility care cost approximately $155.8 billion (Harrington et al., 2015).

Implementation of a prospective payment system (PPS) for Medicare reimbursement in 1998 (Balanced Budget Act [BBA] Pub. L. No. 105–33) placed NHs under increasing pressure to maximize revenue and reduce costs. This system shifted payment from a cost-based system with limits for routine operating costs to a per-diem payment system based on a resident's resource utilization group (RUG) defined by the types of services required and other resident characteristics (Huckfeldt, Sood, Romley, Malchiodi, & Escarce, 2013). At least 17 states are using some kind of case-mix reimbursement system that classifies residents into homogeneous RUGs and links reimbursement to residents' characteristics and resource use. Almost two thirds of Medicare-covered NH stays in 1999 were provided to residents in three of the five Rehabilitation RUG-III groups and in the Extensive Care RUG-III Group (Centers for Medicare & Medicaid Services, 2011).

QUALITY OF CARE MONITORING

In 1987, NHs were subject to sweeping reforms contained in the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203, 101 Stat. 1330) or the Nursing Home Reform Law. NHs have an unannounced survey every 9 to 15 months by a state's health department acting as agents for the CMS. There can be a "look-behind" survey by federal Medicare surveyors. The CMS Nursing Home Compare website provides NH-specific data that include 12 long-term and 3 short-stay quality measures and that compares NHs within states and with national benchmarks (CMS, 2016). Review and accreditation by The Joint Commission is optional for all NHs but mandatory for hospital-based NHs and those seeking managed-care contracts or affiliations. The Joint Commission's Nursing Care Center (NCC) is an accreditation program launched to replace the Long-Term Care Accreditation program. In 2014, new requirements regarding memory care have been implemented to improve care for residents with cognitive impairment (The Joint Commission, 2015). In 2015, CMS added new measurements to the star rating system to make a five-star rating more difficult to obtain (Harrington et al., 2015).

Quality-of-care and quality-of-life deficiencies are characterized by their scope (i.e., number of residents potentially or actually affected) and severity. The most frequently cited deficiencies in 2014 were related to infection control (42.6%), accident environment (39.7%), food sanitation (38.9%), quality of care (33.1%), and unnecessary drugs (25.6%). More than one in five facilities received a deficiency for actual harm or jeopardy (Harrington et al., 2015). The top 10 deficiencies concerned accidents, resident dignity, pressure injuries, and comprehensive care planning (CMS, 2014). Pain management has improved significantly. Reduction in problems with quality, since 1999, might be attributable to inconsistencies in how states conduct surveys and understatement of serious deficiencies (U.S. Government Accountability Office, 2010). In 2015, the PPACA proposed regulations

to outline standards for quality-assurance and performance-improvement programs. These regulations built on the existing requirements to address quality deficiencies. The new requirements also focus on food services and residents' rights to address common deficiencies in these areas (Harrington et al., 2015).

FUTURE TRENDS

At least 46% of the older adults in the United States spend some time in a NH as they age. The potential for technology to improve quality of care and quality of life in NHs includes fall prevention (e.g., chair alarms, rehabilitation equipment to improve strength), wandering management (i.e., low- or high-tech), incontinence care (e.g., voiding reminders), and passive call systems. Barriers to implementation include lack of experience and skill in application of advanced technologies, absence of industry standards and applicable regulations regarding use of the technologies, and insufficient financing. To improve quality of care, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. No. 113-118; 128 Stat. 1952) was passed to standardize the clinical assessment data reported by all post-acute care providers, and requires hospitals to provide consumers with information on the quality of post-acute providers before discharge.

The notion of *culture change*, articulated by the Pioneer Network in the late 1990s, has captured the attention of the NH industry, as well as industry regulators; the movement seeks to improve quality of care and quality of life in NHs and creates a model for and sets policies that support resident growth and creativity through person-centered care and staff empowerment. NHs are reinventing themselves so that resident dependency, in part a product of the institutional model, is less likely to occur in the future. Emerging best practices in NHs include mentoring programs, staff involvement in decision making, flexible work schedules, data-driven plan of care, family involvement, and a home-like environment that includes resident choices and input into facility operations (USOIG, 2009). In 2015, the USDHHS announced a goal to link 90% of Medicare payments to quality- or value-based payments. These goals have the potential to create stronger initiatives for NHs to partner with organizations to improve quality, reduce readmissions, and lower costs.

See also Advance Directives; Assisted Living; Dementia: Special Care Units; Nursing Home Managed Care; Nursing Home Reform Act.

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Web Resources

- American Association of Homes and Services for Aging: http://www.aahsa.org.
- American Health Care Association: http://www.ahca.org.
- National Center for Health Statistics: http://www.cdc.gov/nchs.
- Nursing Home Compare: http://www.medicare.gov/NHCompare.
- Pioneer Network (Culture Change): http://www.pioneernetwork.org.
- Burwell S. Secretary, U.S. Department of Health and Human Services, January 26, 2015 [Press statement]: http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-inhistoric-announcement-hhs-setsclear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html.

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MLA

Renz, Susan M., and Emily C. Stout. "Nursing Homes." *The Encyclopedia of Elder Care*, Elizabeth Capezuti, Springer Publishing Company, 4th edition, 2017. *Credo Reference*, https://search.credoreference.com/content/topic/nursing_homes. Accessed 14 Oct. 2019.