

**The Future of the Nursing Home in a Rebalanced Long-Term
Supportive Services (LTSS) System**

**Topics in Rebalancing State Long-Term Care Systems,
Topic Paper No. 5**

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 states to explore the various management techniques and programmatic features that states have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. In October 2004, CMS accordingly commissioned this study to examine that topic. The states of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year study of rebalancing. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its state plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include state-specific case studies that look qualitatively and quantitatively at each state’s management approaches to rebalance their long-term care systems; the first set of those reports that review each state’s experiences up to July 2005, and a Highlight Report summarizing all 8 States have already been released.¹ Updates of the state-specific case studies summarizing changes up to July 2006 will appear in the fall of 2006 and more extensive follow-up is planned for release in the fall of 2007.

The other products for the study are comprised of a series of papers, called *Topics in Rebalancing*. Each topic paper highlights an issue of importance in state rebalancing efforts, and each draws on experiences in some or all of the 8 States in the rebalancing study to illustrate the issue.

For this particular Topic Paper, *The Nursing Home in a Rebalanced Long-Term Supportive Services (LTSS) System*, we drew on our original state case studies and a wide range of interviews with state officials and representatives of long-term care providers. We also reviewed documents and web materials. We thank everyone who took the time to share their experiences and impressions. We also thank our CMS, Kate King, for her continual assistance. The findings and conclusions in the paper are those of the authors and do not necessarily reflect those of CMS, its staff, or any State officials. We hope that this topic paper will stimulate discussion, and we welcome any comments or reactions.

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¹ The Executive Summary and the 8 abbreviated case studies are available on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage, as well as on <http://www.hcba.org> and the Study director’s website at <http://www.hsr.umn.edu/LTCResourceCenter/>. Longer State reports can be found at the last two sites.

Executive Summary

As states move to create more choices for long-term supportive services (LTSS), the question arises about whether nursing homes are needed in the future and, if so, how many and how might they be changed. With fewer people under 65 residing in nursing homes, this is becoming an issue that particularly affects seniors, largely people well over age 65. This Topic Paper looked at how the 8 states collaborating in the Rebalancing Research project envisage the future of nursing homes, and the policies they have put in place, if any, to forward that vision.

The 8 states—Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington—vary in their supply of nursing homes, the ownership structure of the nursing home industry, and their quality of care records. All show a gradual reduction in acuity of the population in nursing homes (a phenomenon observed nationally), which does raise the possibility that alternative settings are feasible.

All the states continue to see a need for the licensed and certified nursing home in the foreseeable future, although Vermont qualifies that judgment with the statement that there is a future for nursing homes “but only if they become more consumer oriented and accessible to their clients, including residents, families, and visitors.” Accordingly, the Legislature requested that the state agencies “develop a 10-year plan, which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the resident’s preferences, customs, and individual histories.” This is the closest we found to any comprehensive vision for how the nursing home should change, and the aspirations are still phrased at a general level. Although general statements aspiring to high quality, safety, protection, and a good quality of life for nursing home residents abound and although many states express interest in the principals of culture change, we did not identify any more particular vision for the nursing home of the future.

More specificity was found on the desired future supply of nursing homes; 4 of the 8 states (Minnesota, Pennsylvania, Vermont, and Washington) created specific projections and/or goals for how LTSS should be allocated between institutional and community care in the next decade or so. The general expectation is that reliance on nursing homes will decrease not only for people under age 65 but for older people as well.

Minnesota, Pennsylvania and Vermont have all developed policies and incentives to encourage nursing homes to downsize, Minnesota downsizing policies also work towards changing the qualitative nature of the nursing home by containing incentives for increasing single-occupancy rooms. Pennsylvania’s approach encourages facilities to diversify into housing and other community services in lieu of providing nursing home care.

The successes achieved in creating community-based services should prompt states to attempt more creative planning by envisioning, perhaps in partnership with the long-term industry, how the three basic elements of long-term care (personal care and other supportive services, housing, and medical care) can be combined to achieve high quality in all three domains simultaneously. This Topic Paper has shown that states are moving in various ways to encourage a higher quality of life in nursing homes, including: supporting culture change endeavors; providing reimbursement or certificate-of-need exceptions for facilities that renovate

to develop physical plants that support a better quality of life; developing training towards more individualized care; and creating a demand for better quality of life among potential residents and payers by report card systems and web-based public information.

A trend was also noticed towards greater enforcement of nursing home regulations and creation of monitoring systems (apart from the survey and certification process) that help nursing homes come into or remain in compliance with existing federal regulations. Such programs may well create facilities with fewer care problems, but they do not necessarily alter the fundamental model of institutional service, which critics find over-medical and insufficiently conducive to resident autonomy, choice in daily life, community integration, and quality of life.

Transforming nursing homes will undoubtedly have financial implications. Funding will be needed to encourage the transition from the current large institutions to new living designs that allow consumers a more normal life. Some models are already under development, but much more can be done to build on the experience of the MR/DD community which has virtually eschewed institutional care. In the case of nursing homes, the transition is complicated by the dual nature of contemporary nursing home care. Continuing short-term post-acute care in the same institutions that deliver long-term services confuses the picture, especially because most of the former is covered by Medicare. Financial implications are also inherent in the judgment made that nursing homes will continue to exist in the foreseeable future. The costs of serving all seniors in community settings, including those needing extensive oversight and who have no family members to provide services on an uncompensated basis would far exceed the average per participant costs of HCBS services for seniors at present.

Particular management strategies described in this Topic Paper include:

- Supply controls through moratoriums and certificate-of-need programs in all states.
- Nursing home down-sizing initiatives in Minnesota, Pennsylvania, and Vermont.
- Incentives for and encouragement of nursing home culture change in all States.
- Development of specialized regulatory standards for Green House style nursing homes
- Reimbursement incentives for nursing homes undertaking major innovation for culture change in Minnesota.
- A report card system in Minnesota that includes quality of life.
- New approaches to quality monitoring (apart from survey and certification reviews) in Florida, Texas, and Washington.

The Future of the Nursing Home in a Rebalanced Long-Term Supportive Services (LTSS) System

This topic paper examines efforts in the eight states that participated in the Rebalancing Research between 2004 and 2008 to plan for the nursing home in the future. This planning has both a quantitative focus (i.e., considering how many nursing homes, if any, will be needed in the future) and a qualitative focus (i.e., considering the desired nature of the future nursing home, or what kinds of services and service settings will be appropriate for those whose needs mirror those of nursing home residents with the highest level of care needs or the poorest health prognoses). This paper explores the extent to which the states collaborating in the rebalancing Research have engaged in thinking about and planning for nursing homes in the future, the conclusions (if any) that they have reached, and the state policies put into place to have an impact on either the size or nature of the nursing home industry going forward.

Background

Relevance to Rebalancing

“Rebalancing” is about shifting state financial resources from institutional services to community services, and shifting the locus of service for long-term support participants into community settings where consumers are assumed to be able to exercise more control and lead lives more consistent with their choices despite their disabilities. Increasingly, the term rebalancing has also been short-hand for infusing person-centered planning and consumer direction into long-term support services, and enabling people of all ages with disabilities (or their agents) to make choices about their services and their daily lives as they live disability and use services.

In the arena of services for people with developmental disabilities, many government officials and stakeholders see no place whatsoever for large state-institutions such as state-run regional centers and schools or for ICF-MRs that house more than 6 residents. Regarding services to older people, analysts less frequently state that nursing homes, which largely serve clientele well over age sixty-five, should be phased out.² Many government officials and stakeholders agree that such facilities will be different from what they are today, but little consensus is found on their desired role and function or how many are needed. Part of the confusion can be attributed to the dual role played by nursing homes. In contrast to MR/DD institutions, nursing serve two distinct but sometimes overlapping functions, providing short-term post-acute and long-term care.

CMS has called for state governments to create a rebalanced LTSS system that “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.” The principal state strategy to advance this goal has been to expand and improve the home- and community-based services (HCBS) sector. An assumption underlying diversion and transition programs (the former to prevent a likely nursing home admission and the latter to help nursing home residents move out) is that when offered adequate HCBS alternatives, most participants will choose community services over nursing homes. Yet

² Note that the major phase-out of state institutions for persons with mental retardation or developmental disabilities occurred several decades ago. During that period, contemporaneous critics asserted that state institutions would always be necessary and that energies should be devoted to improving them rather than eliminating them. For decades, providers and family members of residents of state institutions expressed concerns about eliminating an important choice crucial to a population, and remnants of this sentiment remain. By analogy, one would expect that current efforts to rethink nursing homes will be opposed by well-intended government officials and stakeholders who have difficulty envisaging an entirely new paradigm for care, but that eventually new models will be accepted. A difference worth noting, however, is that regional institutions for persons with MR/DD were state-operated. State governments had more control over them than they have over non-profit and for profit nursing homes, even though the latter are widely supported by state Medicaid funds. In forwarding a strategy of reducing nursing-home supply, some states have begun with downsizing or closing their few state-operated nursing homes and (if applicable) county-operated nursing homes. Many states also wrestle with whether four decades of state support of nursing homes creates an obligation for the state to assist nursing homes financially by “buying out beds” or helping them diversify their missions, or whether nursing homes can be allowed to fail as market demand changes.

nursing homes are an important part of the current system, affecting many participants and consuming enormous public and private resources. Quality of care has been a perennial problem, and the expected quality of life in a cramped, routine-driven institution has led to dread of nursing homes among the people most likely to use them and their family members.³ Improvement of nursing homes—both their physical plants and their staffing qualifications and ratios—would seem to be necessary, but such improvement requires that resources be taken away from expansion and improvement of HCBS.

Furthermore, some state officials express concern that on the eve of the age wave the supply of nursing homes will be inadequate for future needs. This problem of estimating the need for nursing homes cannot be solved by extrapolations of present nursing-home beds-to-elderly population ratios, because the availability of other options is increasing. What is unsettled is whether a state must endeavor to nurture a supply of entities that are licensed and certified as nursing homes, or, conversely, whether LTSS participants can be as well or better served by programs, including residentially based programs, that do not have nursing-home licenses. If there are to be nursing homes that meet the regulatory criteria for this sector, they might be restructured to offer participants a good quality of life, including choices in daily living, integration with the community, privacy, dignity, and respect for individuality.⁴ Clearly the discussion of how to plan for the quantity and quality of nursing homes in the future is highly relevant to federal and state goals of creating a rebalanced LTSS system for older people.

³ An Institute of Medicine report released more than a decade after the 1987 reforms in nursing home regulation drew the conclusion that, despite improvements, quality of care remained a problem in nursing homes, and no meaningful improvements have been made in quality of life. See Wunderlich GS, & Kohler PO (eds) (2001). Improving the Quality of Long-Term Care, Washington, DC, National Academy Press.

⁴Under a CMS contract, measures of resident self-report on 11 quality of life outcomes such as these were developed and tested. See Kane, R. A., Kling, K. C., Bershadsky, B., Kane, R. L., Giles, K., Degenholtz, H. B., et al. (2003). Quality of life measures for nursing home residents. Journal of Gerontology: Medical Sciences, 58A (3), 240-248.

Conceptual Considerations Regarding Reductions in Nursing Home Supply

Several reasons could be suggested to dramatically reduce (if not eliminate) nursing home supply in a differently balanced LTSS system:

- CMS is emphasizing policies that promote the development and implementation of alternatives (especially non-institutional services) and support individuals' choice among long-term care alternatives. There is evidence that when alternatives are available, the majority of participants would choose home- and community-based services over institutional-based services,⁵ and that when current nursing home residents and families become informed about community options, some long-stay nursing homes express a preference to move back to the community and choose to leave nursing homes.⁶
- Some experts believe that an ample supply of nursing homes increases the likelihood that nursing homes will be used—a notion that, in health care, supply influences demand rather than the reverse. Moreover, nursing homes have historically had first call on new funds, thus deterring investments in community care. Such arguments have bolstered the case for state moratoria on nursing home construction or state certificate of need programs that control supply. This conventional wisdom is somewhat contradicted by the fact that in many states with an ample array of community alternatives occupancy rates of nursing homes have fallen below 80%, suggesting that the market might eventually shrink nursing home use. However, some states find that they are paying substantially in the property component of the reimbursement for the facilities to maintain their empty beds, and are considering ways of creating incentives for nursing homes to downsize and for some to close.
- CMS envisages a system of person-centered and consumer directed services and ample opportunity for community integration. These goals are more easily implemented for those living in HCBS settings than in highly regulated institutions.
- LTSS in the community is widely believed to be more cost effective than LTSS in nursing homes. Proponents' conviction of the cost-effectiveness of HCBS relative to institutional care has fueled the rapid expansion of non-institutional long-term services and supports at the same time as concerns over HCBS costs have shaped public policies, including the requirements of cost neutrality for waivers and various strategies to minimize the anticipated woodwork effect (e.g., structuring HCBS coverage or using screening mechanisms so that

⁵ For example, in the State of Oregon, the development of a range alternative support programs beginning with its receipt of the first HCBS waiver in 1982 led to a sharp decline in nursing home use by the 1990s. Furthermore, the development of capacity for alternative services affected privately paying consumers as well as Medicaid waiver participants. For instance, when adult foster care was encouraged during the mid 1980s as a service sector and the services there were funded under the HCBS waiver, a study found that 2/3 of the users of adult foster care were privately-paying customers. See Kane, RA, Kane RL, Illston LI, Nyman J, & Finch MD (1991). Adult foster care for the elderly in Oregon: A mainstream alternative to nursing homes? American Journal of Public Health, 81(9):1113-1120.

⁶ Nishita PhD, CM, Wilber, KH, Matsumoto, S & Schnelle, JF (2008) Transitioning Residents from Nursing Facilities to Community Living: Who Wants to Leave? Journal of the American Geriatrics Society 56 (1) , 1–7

only individuals who otherwise would have accessed nursing home care use non-institutional services).⁷

Those who oppose reducing nursing home beds too dramatically or oppose reducing nursing home expenditures raise a different set of considerations:

- Nursing homes serve the most frail and vulnerable of elderly people. Some advocates and state officials doubt that HCBS services can meet the same needs and worry about reducing the supply of nursing homes as the proportion of seniors in the state is increasing until the HCBS services have proven themselves.
- As mentioned above, not everyone believes that HCBS services are cost-effective compared to nursing home services for comparable participants, especially if no uncompensated family caregiving help is available in the community. Many seniors needing long-term support have no family members to help, including many with Alzheimer's disease who need labor intensive care. Arguably it would still be possible to create community settings and very small community group settings that are geared up for such care as was done in the MR/DD field. But if seniors with very high levels of disability and a heavy burden of illness were served under HCBS waivers and other community programs, it is likely that the effects of serving everyone in the community would be higher not lower costs. The high unit costs of serving participants in MR/DD waivers is seen as a cautionary tale, given the very large numbers of seniors needing long-term supports. On average the costs under HCBS waivers for elderly people are much lower than those in the MR/DD waiver, which is partly attributed to the use of nursing homes for those with the highest needs and the least family support.
- Finally, the last decade has witnessed a movement to improve nursing homes, reflected in the activities of the Pioneer Network in Long-Term Care (which began in 1995 as a grass roots organization),⁸ higher state quality standards (including 34 states that, as of August 2007, developed staff-to-resident ratios that exceed the federal requirements), coalitions for nursing home change in many states,⁹ and provider-led initiatives to improve nursing homes. CMS has supported these efforts, incorporating nursing-home culture change into the activities of Quality Review Organizations and emphasizing quality of life in the Survey and Certification Group.¹⁰ The culture change movement has several foci, but a major goal is to increase the opportunity for autonomy and choice for nursing home residents and to individualize their

⁷ According to some observers, the evidence of the cost-effectiveness, or even the cost-savings, of HCBS waiver programs remains "weak." See, David Grabowski, "The cost-effectiveness of noninstitutional long-term care services: Review and synthesis of most recent evidence." *Medical Care Research and Review*, 2006, 63 (1):3-28.

⁸ The origins of the Pioneer Network is described in Fagan RM, Williams CC, Burger SG (1997). *Meeting of Pioneers in Nursing Home Culture Change*. Rochester, NY, Lifespan of Greater Rochester. Also see Weiner AS & Ronch JL (eds) (2003), *Culture Change in Long-Term Care*, New York, NY, Haworth Press.

⁹ For a state by state summary of culture change coalitions see Pioneer Network website, last visited May 24, 2008, at <http://www.pioneernetwork.net/champions-of-change/NewChampions.php>.

¹⁰ Quality Partners of Rhode Island, the Rhode Island QIO, plays a national lead role on Culture Change in nursing homes, and has posted many relevant materials on its website, last visited on May 20, 2008 at http://www.rqualitypartners.org/cfmodules/objmgr.cfm?Obj=NHQ_OrganizationalCulture&pmid=124&mid=143&cid=143&clear=yes&bc=Culture%20Change%20&%20Individualized%20Care&bcl=2

services. Many of these initiatives will cost money. Therefore, some leaders who are supportive of reducing the supply of nursing homes would like to redeploy the money into making nursing homes better rather than reducing expenditures in that sector.

Definition of a Nursing Home

A lay definition of nursing home is “a place that gives care to people who have physical or mental disabilities and need help with activities of daily living but do not need to be in the hospital.”¹¹ Another definition is tautological: a nursing home is an entity licensed as a nursing home by the State. Further elaborations of legal definitions are not consistent across states. Minnesota, for example, defines a nursing home as “a facility or that part of a facility which provides nursing care to five or more persons,” where “nursing care” is defined as “health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis.”¹²

Licensed nursing homes must be specifically certified to be eligible to receive Medicare and/or Medicaid payments, which in turn requires compliance with a wide variety of explicit standards. Nursing homes have been shaped by the regulations that govern licensure and certification, and typically the minimum standards on matters such as room size or staffing requirements become the maximum. States are delegated and contracted by the federal government to inspect certified nursing homes and must ensure the certified facilities meet all the federal standards. However, states are free to develop more stringent standards, and much of the detail in nursing home regulations actually is due to state rather than federal rules.¹³

¹¹ National Cancer Institute. See: http://www.cancer.gov/templates/db_alpha.aspx?CdrID=441254

¹² Minnesota Statutes 144A.01.

¹³ Nursing Home Regulations Plus, a website comparing state nursing home regulations to each other and to the federal regulations, provides the first comparison of nursing home regulations and exposes inter-state variation and intrastate contradictions; it also analyzes the extent to which regulations enhance or impede participant self-direction and resident autonomy and quality of life. See <http://www.hpm.umn.edu/NHRegsPlus/>, last visited May 19, 2008.

Nursing homes provide services to at least two distinct populations: persons who need assistance for a short period of time for recovery or rehabilitation after a serious illness or operation or for heavy care at the time of death; and persons who are anticipating stays for the indefinite future to receive long-term support. Short-term services are typically funded by Medicare, including by the Medicare hospice benefit. The Medicare benefit allows 100 days of a nursing home stay for rehabilitation per episode of illness; the first 20 days carry no consumer co-pay. The average stay for a Medicare rehabilitation patient, for example, is about 23 days).¹⁴ Rehabilitation services under Medicare are also funded in certified in-patient rehabilitation centers and at home with services provided by certified home health agencies.

This topic paper deals with the future of the nursing home as a long-stay location rather than with rehabilitation in nursing homes. But the rehabilitation function of many nursing homes adds complexity, to discussions about diversion from nursing homes and about the future of the nursing home. For participants who receive rehabilitation in a nursing home, the diversion activity (i.e., the offering of choices and the effort to divert long-term admission to a nursing home stay) may take place while the consumer is already in a nursing home for rehabilitation. Also state planning for the desired number of licensed nursing homes must take into account that the nursing home capacity needed for rehabilitation will depend a great deal on federal policy.

Nursing Homes in Eight States

Nursing Home Supply, Utilization, and Industry Characteristics

The future of the nursing home in each state will be planned in context of the particularities of the past for nursing homes in that state. Table 1 traces the supply of nursing homes in the 8 States from 1995 to 2006, and Table 2, the supply of licensed nursing home beds. Florida is the

¹⁴ Day, T About Nursing Homes. http://www.longtermcarelink.net/eldercare/nursing_home.htm.

only state in the Rebalancing Research Project that has increased its supply of both nursing homes and nursing home beds since 1995, but it is noteworthy that at the end of that period Florida still has a lower supply of nursing home beds per 1000 persons over 65 than any of the other states. In the other seven states, from 1995 to 2006 the supply of nursing homes declined from between 1.4 percent in Pennsylvania to 13.7 percent in Washington, whereas the number of nursing home beds declined from between 0.1 percent in New Mexico to 21 percent in Washington. New Mexico and Texas showed negligible changes in bed supply. Increases in Florida for the number of nursing homes and nursing home beds for this same time period were 8.8 percent and 13.3 percent, respectively.

Table 1: Change in Number of Nursing Homes in 8 States, 1995-2006

	1995	2000	2005	2006	% Change, 1995-2006
Arkansas	256	255	236	237	- 7.4
Florida	627	732	686	682	+8.8
Minnesota	432	433	404	399	-7.6
New Mexico	83	80	75	72	-13.3
Pennsylvania	726	770	720	716	-1.4
Texas	1,266	1,215	1,132	1,145	-9.5
Vermont	23	44	41	41	-6.8
Washington	285	277	247	246	-13.7

Table 2: Change in Supply of Nursing Home Beds in 8 States, 1995-2006

	1995	2000	2005	2006	% Change, 1995-2006
Arkansas	29,952	25,715	24,419	24,684	-17.6
Florida	72,656	83,365	82,519	82,319	+13.3
Minnesota	43,865	42,149	36,660	35,837	-18.3
New Mexico	6,969	7,289	7,030	6,939	-0.1
Pennsylvania	92,625	95,063	88,966	88,561	-4.4
Texas	123,056	125,052	122,486	124,364	+1.1
Vermont	1862	3,743	3,449	3,434	-8.2
Washington	28,464	25,905	22,579	22,486	-21.0

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. National Center for Health Statistics. *Health, United States, 2007*. (Hyattsville, MD: 2007). Table #117.
<http://www.cdc.gov/nchs/data/hus/hus07.pdf#page=387>

Table 3 displays other key measures for the nursing home industry, including the supply of beds in proportion to the population, the occupancy rates, the Medicaid daily rate, and Medicaid expenditures for 2005 as collected in the last available AARP state by state comparison. This table shows that the eight states fall on both sides of the national average on these metrics.

Table 3: Nursing Home Supply Relative to Population, Occupancy, and Medicaid Expenditures in 8 States in 2005

State	NH beds per 1000 persons >age 65	NH residents per 100 people >age 65	NH occupancy rate	Medicaid per day payment rate (2002)	Medicaid NH expenditures per person served (2003)	Private pay rate per day (urban average), 2005
Arkansas	67	4.8	71%	\$94	\$18,355	\$120
Florida	27	2.4	89%	\$134	\$21,674	\$166
Minnesota	59	5.4	92%	\$130	\$23,514	\$177*
New Mexico	30	2.6	87%	\$103	\$22,064	\$175
Pennsylvania	47	4.3	91%	\$138	\$25,121	\$198
Texas	54	4.1	75%	\$96	\$14,430	\$114
Vermont	42	3.8	90%	\$128	\$22,841	\$201
Washington	32	2.7	86%	\$129	\$21,091	\$196
US Average	47	4.0	85%	\$118	\$23,882	\$176

Source: Ari Houser, Wendy Fox-Gage, & Mary Jo Gibson (2006). *Across the States: Profiles of Long-Term Care and Independent Living*. Washington, DC, AARP, Public Policy Institute, on web last visited May 20, 2008 at http://www.aarp.org/research/longtermcare/trends/d18763_2006_atr.html

* Minnesota is one of 2 states (the other is North Dakota) that require privately paying residents be charged no more than residents funded under Medicaid in facilities that accept Medicaid, though Medicaid pays for private rooms only when deemed medically necessary. The private-pay daily rate would exceed Medicaid payments only for those few nursing homes that opt entirely out of the Medicaid program or those residents who chose to purchase a private room, and, therefore the rate average rate of \$177 is difficult to interpret; it is likely considerably higher than \$177 in nursing homes opting out of Medicaid.

Considerable variation is reflected in the table:

- the number of nursing home beds per 1000 persons over age 65 ranged from 27 in Florida to 67 in Arkansas (national average: 47)
- the number of nursing home residents per 100 persons over age 65 ranged from 2.4 in Florida and 2.7 in Washington to 5.4 in Minnesota (national average 4.0)

- occupancy rates ranged from 92% in Minnesota, 91% in Pennsylvania, and 90% in Florida on the high end to 75% in Texas and 71% in Arkansas on the low end.
- Medicaid per day payment rates in 2002 ranged from \$94 in Arkansas to \$138 in Pennsylvania (national average \$129).
- Medicaid nursing home expenditures per person served in 2003 ranged from to \$25,121 in Pennsylvania to \$14,430 in Texas (national average \$23,882)
- Average private pay daily rates in the urban areas ranged from \$114 in Texas to \$201 in Vermont.

The utilization rates for nursing homes need to be interpreted in context. The rate of 2.4 nursing home residents per 100 persons over 65 reflects Florida's historically low supply of nursing home beds even though, as Table 1 showed, that supply had grown from 1995 to 2005. Florida also has more assisted living beds than it has nursing homes. Florida's statistics are skewed by its high proportion of young elderly retiring to Florida and, possibly by a propensity of some Florida residents to return to their original states or the states where their children reside when they need long-term care. In contrast, the rate of 2.7 residents per 100 persons over 65 in Washington reflects that state's effective reduction in nursing home supply as a result of deliberate policy to develop and pay for community care; in 1996 that proportion was 3.6, in 1992 it was 4.9 and in 1989 when the concerted effort began to reduce nursing home use, the proportion was 5.4. Finally, Minnesota's rate of 5.4 residents per 100 persons over 65, although higher than the national average, reflects a decline in supply in a state that in 1996 had 7.2 residents in nursing home per 100 people over age 65.

The proportion of residents per population over 85 is less often calculated but is more reflective of meaningful use rates, given that most nursing home residents are over age 65. When those figures were calculated with 1996 data, Arkansas had the highest use of all states at 76.1 out of 100 persons over 85; Minnesota and Texas fell in a high use group with 58.7 and 59.5

residents per 100 people over 85 respectively, and Pennsylvania was in the middle quintile of average use rates, New Mexico, Washington, and Vermont had a low use rates, and Florida was in the very low quintile with the lowest rate in the nation for nursing home use in the population of age 85 (see Table 4). By 2005, all 8 states showed reductions in the number of residents per population over age 85, with Washington showing a reduction of more than 50%. Although Arkansas still ranked high among states (47th) in nursing home use per population over 85, its reduction was substantial, almost reaching 50%.

Table 4: Change in Nursing Home Use in Proportion to State Population 85+, 1996 to 2005

	1996		2005	
	NH residents per 1000 persons over age 85	Rank in 50 states and DC (from lowest to highest use)	NH residents per 1000 persons over age 85	Rank in 50 states and DC (from lowest to highest use)
Arkansas	761	51	387	47
Florida	270	1	186	7
Minnesota	587	41	328	33
New Mexico	384	9	228	11
Pennsylvania	465	24	260	15
Texas	595	43	378	40
Vermont	418	19	262	17
Washington	386	10	173	6
US Average	482		290	

Source: 1996 data are from Ladd, RC, Kane, RL, & Kane, RA (1999). State LTC Profiles Report, 1996. Minneapolis, MN: Division of Health Services Research & Policy, School of Public Health, University of Minnesota (Report to US Office of Assistant Secretary for Planning & Evaluation, April 1996); 2005 data are calculated from Ari Houser, Wendy Fox-Gage, & Mary Jo Gibson (2006). Across the States: Profiles of Long-Term Care and Independent Living. Washington, DC, AARP, Public Policy Institute, on web last visited May 20, 2008 at http://www.aarp.org/research/longtermcare/trends/d18763_2006_at.html

Table 5 shows ownership patterns in the 8 states. Minnesota has the highest proportion of private non-profit nursing homes in both time periods, and it also had by far the highest proportion of publicly-owned (i.e. state, county, or city-owned) nursing homes. Minnesota also had the highest proportion of hospital-owned nursing homes, some of which would swell the publicly owned totals. Except in Minnesota, the proportion of hospital-owned facilities declined to varying degrees over the 6 years in all other states, as it did nationally. Texas and Arkansas

had the highest proportion of for-profit homes, followed by Vermont, Washington, and New Mexico. The 55.2% national proportion of facilities owned by chains was exceeded substantially in Florida, New Mexico, Texas, and Washington in 2000, though in 2006 Florida was close to the national average. (Chain ownership includes small and large chains, for-profit and non-profit chains, and investor-owned chains.)

Table 5: Ownership Patterns of Nursing Home Industry in 8 States, 2000 and 2006

	2000					2006				
	% for-profit	% non-profit	% gov't	% in chains	% hosp. owned	% for-profit	% non-profit	% gov't	% in chains	% hosp. owned
Arkansas	79.6	15.6	4.8	54.8	8.8	80.1	16.1	3.8	47	7.2
Florida	75.9	22.3	1.8	69.7	9.0	70.6	27.4	1.9	54.1	2.5
Minnesota	28.3	57.6	14.1	51.2	15.9	28.1	58.3	13.6	51.1	14.4
New Mexico	62.3	29.0	8.7	71.0	11.6	67.1	27.1	5.7	70.0	7.1
Pennsylvania	41.9	52.4	5.6	49.6	13.4	48.0	46.7	5.4	53.2	8.7
Texas	81.8	15.0	3.2	72.6	8.7	82.4	14.8	2.8	63.0	4.1
Vermont	64.3	33.3	2.4	42.9	7.1	67.5	32.5	0.0	47.5	5.0
Washington	68.0	23.9	8.1	67.2	9.7	71.3	20.7	8.0	62.4	7.2
US Average	64.9	28.5	6.5	55.2	12.1	66.4	27.5	6.1	52.5	8.6

Source: Harrington, C, Carrillo, H, & Blank, BW (2007). Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 to 2006. San Francisco, CA, University of California at San Francisco. On web, last visited, May 23, 2008 at http://www.pascenter.org/nursing_homes/nursing_trends_2006.php, p. 73.

Specialized nursing home units became more common over the last decade, particularly Dementia Special Care Units. In 2005, the proportion of beds in Dementia Special Care Units as a percentage of overall beds ranged from 1.5% in Arkansas and 7.2% in Texas to 7.4% in Minnesota and 7.2% in both Pennsylvania and Washington. New Mexico and Florida slightly exceeded and Vermont fell slightly short of the national average of 4.9%. In 2008, the national percentage of Special Rehabilitation Units bed was .8% of the total beds in the country; Minnesota had the highest proportion at 2.8% and Arkansas had 1.8%. Florida and Pennsylvania were at the national average and the other states fell far below. Special care unit spaces for

persons with AIDS, hospice, persons using ventilators, and persons on dialysis fell well below 1% nationally and in all 8 states.¹⁵

Quality and Deficiencies in Eight States

Table 6 describes deficiency data in the 8 states in 2000 and again in 2006' the data are derived from the inspection program for certified nursing homes. These data tell as much the propensity of the state survey agency to cite the facilities as the actual quality of facilities, a classic problem in interpreting deficiency data. The trend in the United States was to find greater numbers of deficiencies (an increase of 27%); excluding Washington, the remaining 6 states ranged in their increase of citations from 146% in Vermont to 44% in Florida. Similarly, nationally the proportion of facilities receiving no citations decreased by 53% nationally between 2000 and 2006; again excluding Washington, the other 7 states showed the same trend, with the decrease in facilities with no citations ranging 93% in Minnesota (which went from 12.1% to 0.8 percent) to a 72% decrease in Arkansas. In Washington, where a vigorous nursing home quality assessment and quality improvement program was initiated well before 2000, the patterns were different. In 2000, Washington had the highest average number of citations per facility and the lowest percentage with no deficiencies; both these parameters improved in 6 years with a 25% reduction in the number of deficiencies per facility and a 24% increase in facilities with no deficiencies.

¹⁵ Data to calculate the proportion of beds for Special Care units came Harrington, C, Carrillo, H, & Blank, BW (2007). Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 to 2006. San Francisco, CA, University of California at San Francisco, and were tabulated from the self-report section of OSCAR (On_line Survey and Certification Assessment Review) data. On web, last visited, May 23, 2008 at http://www.pascenter.org/nursing_homes/nursing_trends_2006.php.

Table 6: Deficiencies Cited in Nursing Homes in 8 States in 2000 and 2006

	2000			2006		
	Av. # deficiencies Per NH	Percent NHs with 0 deficiencies	Percent NHs with deficiency for actual harm or immediate jeopardy	Av. # deficiencies Per NH	Percent NHs with 0 deficiencies	Percent NHs with deficiency for actual harm or immediate jeopardy
Arkansas	7.6	6	32.4	13.3	1.7	13.1
Florida	6.4	8.0	17.0	9.2	2.7	6.7
Minnesota	4.9	12.1	21.9	11.6	0.8	19.3
New Mexico	3.2	40.6	14.5	7.8	7.1	24.3
Pennsylvania	3.7	28.0	21.6	5.8	6.4	14.0
Texas	4.1	39.1	19.9	7.4	8.3	16.3
Vermont	3.0	19.1	16.7	7.4	2.5	12.5
Washington	9.3	5.8	39.0	6.9	7.2	25.7
US Average	5.9	16.6	23.5	7.5	7.7	18.1

Source: Harrington, C, Carrillo, H, & Blank, BW (2007). Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 to 2006. San Francisco, CA, University of California at San Francisco. On web, last visited, May 23, 2008 at http://www.pascenter.org/nursing_homes/nursing_trends_2006.php, pp. 79 & 81.

Facilities with the most serious citations (for actual harm or immediate jeopardy) declined 22% nationally over the time period, and declined in all states but New Mexico, with a range of 60% decline in Florida to 7% decline in Vermont. In contrast, New Mexico showed an increase of 67% in the facilities with the most serious deficiencies from 14.5% to almost a quarter of all nursing homes in the State. At present, New Mexico is pursuing a vigorous program to identify and prevent abuse in nursing homes and to improve quality.¹⁶

Characteristics of Residents in Eight States

Another issue of interest is the level of need of persons in nursing homes, which might in turn dictate the feasibility of or cost of community care. Although popular opinion suggests that

¹⁶ A highly publicized report of the General Accountability Office released in May 2008 compared the federal look-behind surveys to the State surveys and suggested that states were missing a great many serious (G to L) deficiencies that they should have cited based on available evidence at the time of the survey. New Mexico was identified as one of 2 states where serious deficiencies were found in 1/3 of the look-behind surveys. See GAO (2008). Nursing Homes; Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses (GAO-08-517). Washington, DC: GAO. On web, last visited, May 23, 2008, at <http://www.gao.gov/new.items/d08517.pdf>.

acuity and frailty of nursing home residents is increasing over time, available measures are more ambiguous. Analyses done for this project suggest that functional and cognitive impairment levels of those in nursing homes remained about the same from 2000 to 2005 despite increases in community care in most states.

Another measure of acuity of nursing home residents is the ProPac Resident Acuity Index, which examines the proportion of residents with the following characteristics: being bedfast, needing assistance with ambulation, needing full eating assistance, needing some eating assistance, having an indwelling catheter, being incontinent, having a pressure ulcer, receiving bowel or bladder retraining, and receiving special skin care. Each of these characteristics is weighted by the average amount of management minutes presumed necessary to provide care. Table 7 shows that, by this measure, overall acuity of nursing home residents has decreased between 2000 and 2006 in the United States in general and in 6 of the 8 states in the Rebalancing Project. In Washington State, where rebalancing has been particularly successful for older people, the average acuity for nursing home residents went down more than 14 points. The exceptions were New Mexico, where the average acuity score for nursing home residents rose more than 15% in the 6 years and Florida, where it rose by about 5%. One needs to be careful interpreting this index because its elements are also influenced by poor care, particularly proportions of people who are bedbound, have indwelling catheters, are incontinent, or have pressure ulcers; nonetheless, the general trend towards lesser acuity in nursing homes in the face of more opportunities for community care is striking.

Table 7: Acuity Levels of Nursing Home Residents in 8 States, 1995, 2000, and 2006

	ProPac Nursing Home Acuity Index		
	1995	2000	2006
Arkansas	101.5	105.0	102.2
Florida	97.5	102.8	107.7
Minnesota	96.0	97.0	91.8
New Mexico	83.8	90.6	105.3
Pennsylvania	108.9	105.3	104.5
Texas	102.2	103.4	99.9
Vermont	104.7	105.0	105.3
Washington	101.9	109.2	95.4
Range in US	73.7 to 130	73.3 to 119.9	42* to 127
US Average	100.4	102.5	101.6

Source: Source: Harrington, C, Carrillo, H, & Blank, BW (2007). Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 to 2006. San Francisco, CA, University of California at San Francisco; and . On web, last visited, May 23, 2008 at http://www.pascenter.org/nursing_homes/nursing_trends_2006.php

*The low average score of 42 in Alaska is an outlier, but in 2006 there were 3 states with scores below 80 (also Iowa and Nebraska), whereas in 2000, there was only one state (Iowa) with an average score below 80.

The proportion of the nursing home population accounted for by persons with MR/DD in nursing homes ranged from 1.5% of the nursing home population in Vermont to 3.5% in Arkansas. In 4 states, that proportion had decreased since 2000 (Arkansas, Minnesota, Vermont and Washington) and in the other states it slightly increased. (These figures could include elderly people or people with physical as well as intellectual disabilities.)

Other trends, not well documented in terms of state statistics, concern changing physical environments. As nursing home stock has been gradually rebuilt, a tendency has been noted to create neighborhoods or clusters, and to develop multiple dining rooms rather than a single large dining room. Some nursing homes are increasing their proportion of private rooms, or even moving exclusively to private occupancy; again this important parameter is unfortunately not documented in comparative state-statistics, although Minnesota has begun publicizing the proportion of single-occupancy rooms in each nursing home as part of its quality report card discussed below. The culture change movement for nursing homes emphasizes the interaction among caring, well-trained, and empowered direct caregiving staff; improved and normalized

physical environments; and a philosophy of individualized care, services, and routines to match individual resident interests and preferences.¹⁷

State Initiatives Influencing the Future of Nursing Homes

The major levers states can use to influence nursing homes include strategies to control the supply, payment strategies (which can also be used to downsize nursing homes), and quality regulation and enforcement. States have also developed educational efforts and have supported the nursing home culture change movement. It is also possible but unusual for states to identify a vision for nursing homes, which could range from envisaging the size and distribution of nursing homes in the state to developing a vision about whether nursing homes are necessary and what they should be like.

Envisaging the Future of the Nursing Home

Typically states shy away from comprehensive visions for nursing homes other than to enunciate the rights of nursing home residents and to aspire for high quality. None of the eight states have asserted that nursing homes are an anachronistic form of LTSS; all envisage that the licensed, certified nursing home does have a future. As part of its legislation to create Community Choices, Vermont was required to develop a plan for the future of the nursing home and the resulting document has numeric goals for reducing nursing home supply in the state. Vermont's stated commitment is to design system that assures all Vermonters who need long-term care to be "able to receive that care and support in settings that are as home-like as possible

¹⁷ A 2007 survey by the Commonwealth Foundation found that although familiarity with the concept is now commonplace, only about 31% nationwide indicate that they have "completely" or "for the most part" embraced culture change. Among the nursing homes that have adopted culture change, giving residents greater control over their daily lives is reported to be the most frequent strategy, while staff empowerment initiatives and other organizational changes are less common. Very few have facilities have changed their physical structure to make them more home-like. Doty, MM, Koren, MJ & Sturla, EL (2008). Culture Change In Nursing Homes: How Far Have We Come? Findings From The Commonwealth Fund 2007 National Survey of Nursing Homes (New York: Commonwealth Fund, May 2008), on web, last visited, April 15, 2008, at http://www.commonwealthfund.org/usr_doc/Doty_culturechangenursinghomes_1131.pdf?section=4039.

and that change to respond to consumers' needs and preferences.”¹⁸ According to its Task Force, nursing homes will be able to continue to play a key role in this new system, but only if they become more “consumer oriented and accessible” to their clients, including residents, families, and visitors. Accordingly, it recommended that the Legislature “develop a 10-year plan, which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the resident’s preferences, customs, and individual histories.”¹⁹ Key informants in Vermont are intrigued by the possibility of evolving small, community nursing homes on the scale of the very small residential settings for people with MR/DD in the state, and the Green House ® model has been considered for its potential to be adapted to the state, but no official policies have emerged.

Quantitative goals are more frequently considered. The State of Washington has built goals for nursing home use into its biannual forecasting system, and Vermont’s 10 year plan includes right-sizing the nursing home industry. In 2007, Pennsylvania’s Governor enunciated a goal to reduce the overall Medicaid expenditures on institutions to 50% by 2013. As part of that goal, he expects the Medicaid expenditures on nursing homes to be reduced from 78% of long-term care expenditures for older people in 2007 to 59% by 2013. Minnesota has put great energy into projecting the need for nursing homes under various assumptions about population growth. Such projections are rendered more difficult because of the current dual function of nursing homes as providers of Medicare-funded rehabilitation as well as Medicaid-funded and privately funded LTSS. Some of these approaches are described further in the examples at the end of the Topic Paper.

¹⁸ Department of Disabilities, Aging and Independent Living. *Nursing Facilities for the 21st Century: Report to the Legislature*. January 2007. <http://www.dail.vermont.gov/dail-publications/publications-legis-studies/nursing-facilities-for-21st-century-report-jan-2007>

¹⁹ *Nursing Facilities for the 21st Century: Report to the Legislature*.

Moratoriums and Certificates of-Need

A few states enacted certificate of need (CON) laws as early as 1964. The remainder implemented CON programs in response to Federal legislation in 1974 (P.L. 93-641) that required states to establish a framework for governmental review and approval for capital projects for hospitals and nursing homes, including new construction and expansion of existing facilities. The Federal legislation and its mandate were repealed in 1987. However, many states continued their CON programs under state legislative authority, especially for outpatient facilities and LTC services. To further strengthen their regulatory control over LTC services, some states also introduced moratoria programs (e.g., restrictions on the licensure or certification of new nursing home beds or construction projects that exceed \$1 million²⁰) to further restrict provider supply.²¹ The LTC services variously covered by state moratoria and CON programs include nursing homes, conversions of hospital to nursing home beds, ICF-MRs, residential care and assisted living, home health care agencies, and/or hospice. The debate about the appropriate use and future of moratoria and CON programs remains intense. As of February 25, 2008, there were 195 CON bills filed, pending, or resolved in the 2008 Legislative sessions in the 50 states.²²

Except for New Mexico and Texas, each state in the Rebalancing project have in place either a CON program or moratorium, or both for nursing homes (see Table 8). Florida, Minnesota, and Pennsylvania apply the more stringent moratoriums, which the last two states also apply to conversion of hospital beds to nursing home beds. Minnesota's moratorium dates back to 1981 and places strict limitations in the creation or any new nursing home beds or relocation of nursing home beds. The process for exceptions is detailed and specific and is typically granted

²⁰ Minnesota Statute Chapter 144A.071

²¹ Charlene Harrington, Sheree Anzaldo, et al., Trends in State Certificate of Need and Moratoria Programs for Long-Term Care Providers. *Journal of Health & Social Policy*, Vol. 19(2) 2004:31-58

²² National Conference of State Legislatures. Certificate of Need: State Health Laws and Programs, February 2008. <http://www.ncsl.org/programs/health/cert-need.htm>;

in the context of overall shrinkage of supply, increasing private and semi-private accommodations, and a layaway process to take beds temporarily out of services without providers losing the right to reinstate the beds within 5 years.²³ Regulating the supply of other settings is less common, and only Arkansas regulates the supply of residential care settings, Arkansas' CON process for all settings is implemented by a single entity, the Arkansas Health Permit Agency, a legislatively established agency directed by a 9-member commission that represents all the interested provider groups. Firms applying for permits will be rejected if they have a history of quality problems.

Down-Sizing Incentives

Various state policies and regulations (e.g., rate setting and other financial incentives) can impact the supply of nursing home beds and facilities. Minnesota stands out among the states in the Rebalancing Research with its comprehensive program deliberately designed to “downsize” or “right-size” the nursing home industry. Minnesota's Voluntary Planned Closure Program is a proactive program to downsize nursing homes, implemented in 2001, which gives nursing facilities financial incentives to voluntarily close beds under an approved application process. Vermont plans to follow a similar path: in 2007 a legislatively mandated task force proposed “Contracting for Resident Days” as a policy approach for “right-sizing” the nursing home industry.²⁴ Pennsylvania has also stepped up efforts to help nursing homes downsize and diversify into other types of community services, including senior housing. These initiatives are discussed below as examples.

²³ For an example, see 2007Minnesota Statutes, 144A.071 governing new construction under the moratorium on web, last visited May 24, 2008, at <https://www.revisor.leg.state.mn.us/statutes/?id=144A.071>.

²⁴ Department of Disabilities, Aging and Independent Living. *Nursing Facilities for the 21st Century: Report to the Legislature*. January 2007. <http://www.dail.vermont.gov/dail-publications/publications-legis-studies/nursing-facilities-for-21st-century-report-jan-2007>. After further exploration, too many logistic and regulatory barriers were identified and as of August 2008, contracting for beds is no longer planned.

Table 8: Moratoriums and Certificate of Need Programs in Eight States in 2008

State	Nursing Homes	Bed conversions	ICF-MRs	Residential Care and Assisted Living	Home Health Agencies	Hospice
Arkansas	CON	-	CON, MOR	CON	CON	CON
Florida	CON, MOR	CON	CON	-	-	CON
Minnesota	MOR	MOR	-	-	-	-
New Mexico	-	-	-	-	-	-
Pennsylvania	MOR	MOR	-	-	-	-
Texas	-	-	-	-	-	-
Vermont	CON	CON	CON	-	CON	CON
Washington	CON	CON	-	-	CON	CON

Sources: National Conference of State Legislatures. Certificate of Need: State Health Laws and Programs, February 2008. <http://www.ncsl.org/programs/health/cert-need.htm>; Charlene Harrington, Sharee Anzaldo, et al., Trends in State Certificate of Need and Moratoria Programs for Long-Term Care Providers, *Journal of Health & Social Policy*, Vol. 19(2) 2004:31-58

Nursing Home Culture Change

Culture change in large part emanates from the industry rather than state policy, but states can and do participate in efforts to change nursing homes qualitatively in several ways: they may actively encourage or participate in a state-wide culture change activities, they may sponsor educational activities (sometimes funded through civil monetary penalties levied on nursing homes), and they may reshape state regulations and oversight activities to promote culture change. Table 9 summarizes culture change activity in the 8 states.

Table 9: Nursing Home Culture Change Efforts in Eight States

State	Culture Change Coalition	State Role in Coalition	Regulatory & other Activity for Culture Change
Arkansas	None		Rewriting state NH regulations to support change, and writing specific regulations for Green Houses; state grants for Green House construction
Florida	Florida Pioneer Network, founded 2003	Ombudsman on Steering Committee	After advocacy by Florida Pioneer Network, Florida legislature created permissive regulation for bed placement in rooms; Florida Agency for Health Care Administration is considering an initiative requiring single occupancy in new construction.
Minnesota	Minnesota Culture	State survey agency	Competitive grants for nursing home

	Change Coalition, founded 2006	& ombudsman represented. Educational summits funded by civil monetary penalties	improvements that might improve quality of life.
New Mexico	Innovation Network of New Mexico, founded in 2004	State survey agency & ombudsman represented.	
Pennsylvania	Pennsylvania Culture Change Coalition, founded 2000	State officials on board; State resources used for training in culture change	
Texas	None		
Vermont	None		
Washington	Washington Pioneer Network, founded 2006		

Florida, Minnesota, New Mexico, Pennsylvania, and Washington have established state-wide or regional culture change coalitions dedicated to creating a climate for the kinds of changes envisaged in the culture change movement. Stimulated by provider organizations, Pennsylvania's state-wide organization goes back to 2000 and even before that a Pioneer Network organization was operating in the Pittsburgh area. Florida's activities were assisted by grants from a Florida foundation and entailed leadership from an Area Agency on Aging in Central Florida at the outset. The nursing home trade associations in the Florida, particularly the Florida Health Care Association, have been supportive of culture change and invested resources for staff to organize Family Forums statewide, and for staffing the Florida Pioneer Network. The other 3 states organized their coalitions later; generally speaking state officials, including survey agency staff and ombudsman, play active roles in the more recently formed coalitions, and the Quality Improvement Organizations (QIOs) are often involved. In Minnesota, Stratis Health, the QIO, served as convener for the coalition and the state used civil monetary penalty funds to support a state-wide educational effort.

State officials are generally interested in exploring new models for nursing homes, and most of the 8 states have arranged to become informed about culture change developments, including the Green House ®, a trade-marked model for small-house nursing homes, which are comprised of one or more self-contained houses for 10 or fewer residents and where staffing models and philosophy are dramatically altered.²⁵ Arkansas has particularly decided to facilitate such models through specialized regulation and to provide incentives for their development. This is discussed further below under exemplary initiatives.

Quality Regulation, Monitoring, and Report Cards

Nursing home regulation and quality inspection is a federal-state partnership; CMS contracts with state regulatory agencies to inspect nursing homes against federal standards. As mentioned above, however, states are responsible for licensing facilities, are free to develop their own regulatory standards beyond the federal requirements, and develop their own approaches to quality improvement. The latter can include a mixture of consultative approaches and punitive sanctions, as well as making information about quality available to consumers and other purchasers. In the state case studies developed in the Rebalancing Research, we note that some of the eight states--particularly, Texas, Vermont, and Washington--have developed unified approaches to quality assurance and regulation with a single agency in state government responsible for the whole spectrum of LTSS programs. Some states (in this group, Florida, Texas, and Washington) have developed categories of personnel that monitor and/or provide consultation and technical assistance to facilities; such teams are separate from those who do

²⁵ For a description of the Green House model, see Rabig J, Thomas W, Kane RA, Cutler LJ, McAlilly S (2006). Radical re-design of nursing homes: Applying the Green House Concept in Tupelo, MS. *The Gerontologist*, 46(4), 543-39. Also see website for project for rapid replication of the Green House Project at <http://www.ncbcapitalimpact.org/default.aspx?id=146>.

enforcement inspections and impose penalties. Arkansas is currently revising its entire group of nursing home standards to render them more compatible with culture change and individualized care. In so doing, Arkansas will develop a second set of more permissive standards for Green House and Green House-like models.

Florida established a number of initiatives to improve nursing homes, including: a Gold Seal program to recognize good nursing homes, which is eligible to nursing homes in business for at least 30 months, with excellent survey records, and who successfully undergo an audit of financial management; markedly increased staffing standards, which were to be implemented in three phases and which, when fully implemented, will be the highest nurse staffing standards in the nation; a state-mandated internal quality monitoring “risk management” program that nursing homes must develop; mandated Alzheimer’s training with curricula approved through a contractor at the University of South Florida; a state grant for a “teaching nursing home,” awarded to Jewish Home and Hospitals in Miami, which is mandated to develop training materials for the state; and the above-mentioned quality monitoring program. These diverse efforts largely grew out of a legislatively mandated Task Force report that examined the related problems of: quality in Florida nursing homes; difficulty in insurance coverage for nursing homes and assisted living; high tort liability of Florida nursing homes and assisted living settings; and the need to increase community care in Florida.²⁶ The resultant legislation gave considerable relief to facilities in terms of tort reform, but also included higher quality expectations. Also the mandated risk management program, in part, was meant to help facilities avoid legal liability, and the quality monitors were meant to provide an early detection system

²⁶ The Florida Task Force on the Availability and Affordability of Long Term Care produced a 3-volume report to the Legislature in 2000 and led to Senate Bill 1202 enacted in May 2001 and available on the Web at <http://www.leg.state.fl.us/session/index>. Much of the work and results of the Task Force is summarized in Polivka, L, Salmon, JR, Hyer, K, Johnson, C, & Hedgecock, D (2003). *The Gerontologist*, 43 (Special Issue 11), 7-18, on the web, last visited May 24, 2008 at http://gerontologist.gerontologyjournals.org/cgi/reprint/43/suppl_2/7.

for possible regulatory and legal liability. The legislature appropriated money for the higher staffing ratios and for other quality improvement provisions. Apropos of rebalancing, it is noteworthy that this infusion of money for nursing homes did reduce the expansion of HCBS services in Florida. (At this writing in the spring of 2008 the State of Florida is in budget crisis, in part because of the problems in the housing market and in part because of the governor's unwillingness to consider any new revenue generation; as a result, the implementation of the last phase of the staffing standards has been postponed.)

Another approach to quality improvement involves transparency and public reporting. To the extent that such public reporting includes resident satisfaction and quality of life, it may be move nursing homes in a new direction. Vermont has developed an optional satisfaction survey for nursing home residents; results are published on the web for participating facilities and the 13 non-participating facilities are listed by name. Minnesota has developed a much more elaborate report card system for its nursing homes, built in part on MDS data and other administrative data and in part on interviews with residents that are done by an outside firm contracting with the state. Minnesota has also instituted a Performance Improvement Project, whereby nursing homes compete to receive higher reimbursement for targeted quality improvement projects.

In the examples below we describe the Arkansas standard-setting process: the quality monitoring activities in Florida, Texas and Washington: and the Minnesota report card system.

Selected Examples from Rebalancing States

Some examples follow. We include examples from 3 states of efforts to downsize the size of the nursing home sector, and examples from 5 states of efforts to bring about qualitative change through standard-setting, regulatory processes, quality incentives, and report cards. We note, however, that influencing supply and influencing quality may be inter-related. For example,

Minnesota's down-sizing efforts provide incentives for single occupancy; many believe that single occupancy would create a huge improvement in quality of life.

Down-sizing Homes in Minnesota

Minnesota has several strategies deliberately targeting the size of its historically over-bedded nursing home industry (as measured by beds/1000 persons >age 65). The state has had a moratorium on the construction of new nursing home beds since 1983. In response to the 2001 Long-Term Care Task Force report²⁷ citing Minnesota's "over-reliance on [the] institutional model," the Legislature initiated the state's innovative, and still unique "voluntary planned closure program."²⁸ This program to downsize the nursing home industry, implemented in 2001 and modified almost annually since, now encompasses a variety of strategies including a bed layaway program, planned closure incentive payments, and a single bed incentive program. Viewed as very "upstream" approach to long-term care reform and, by 2008, "progressing full-speed" according to DHS officials, the program is now closing beds at the rate of 1000/year.

After several years administering and tweaking the planned closure program, the state is now seeking to delineate the future of the nursing home in the restructured LTSS system, and is addressing both the qualitative and quantitative dimensions of this issue. For the quantitative dimension DHS explored how big the nursing home industry in Minnesota should be in its required update to the Legislature in 2006 on the status of long-term care in Minnesota.²⁹ The department's effort to estimate the appropriate size of the nursing home industry was driven in

²⁷ State of Minnesota Long Term Care Task Force. "Reshaping Long-Term Care in Minnesota." 2001.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_005812

²⁸ S.F. 4 2001 1st Special Session

²⁹ Minnesota Department of Human Services, Aging Initiative. "Status of Long-Term Care in Minnesota in 2005: A report to the Minnesota Legislature." June 2006.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_059536

part by the success of the closure program, which had resulted in a rate reduction in nursing home bed capacity that was greater than the national average, raising the concern of a potential shortage of nursing home beds in some areas of the state.

The projection methods included estimating the current and projected rate of nursing home closures and the projected need for nursing home beds, using both demographic data and trend utilization. Separate projections for 5 and 10 years out were made for persons age 65 and older and persons age 85 and older. For persons age 65+, the utilization rate has been and is projected to decline steadily; for persons age 85+, it's been and is projected to be a more rapid decline. The report's "cautious" conclusion is that "the likely bed need will in reality be between the 65+ and 85+ projections and that a shortage of beds is unlikely to be seen, except in isolated regions of the state, before about 2015."³⁰ Such close-monitoring of the closure program's current and future impact is critical to the ongoing task of fine tuning the program in order to "right size" the state's nursing home industry.

³⁰ "Status of Long-Term Care in Minnesota in 2005: A report to the Minnesota Legislature."

“Right Sizing” the Nursing Home Industry in Vermont

In 2005, the Vermont Legislature required the Department of Disabilities, Aging and Independent Living (DAIL) to develop recommendations for the future of nursing facilities in Vermont. Included in the charge to the task force convened to conduct this study (The Nursing Facilities for the 21st Century Task Force) was the development of recommendations on “right-sizing” the nursing home industry to support the state’s numeric goal of a 50/50 split between nursing facility LTC occupancy and HCBS LTC enrollment. Finding that “relying on market forces to right-size the industry simply ends up making every one suffer as the system adjusts to the changing market and it does not give the State the ability to manage the bed supply to ensure the needs are adequately met,” the Task Force recommended instead that the DAIL explore (along with the NH industry) the best method for right sizing the industry, “including the model of Contracting for Resident Days.” Under this model, the State would project nursing home demand and then issue RFPs to select the facilities with which it would contract for the needed number of resident days.

Incentives for Down-sizing and Diversification in Pennsylvania

The Governor’s 2007-2008 budget projects that the percentage of LTSS expenditures for older people in nursing homes will decline from 72.8% in fiscal year 2007 to 59.0% in fiscal year 2013. The actual number of individuals under age 60 served in nursing facilities is projected to drop from 7,199 in fiscal year 2007 to 7,020 in 2013 while the number of individuals over age 60 will increase slightly from 73,946 in fiscal year 2007 to 75,250 in fiscal year 2013. The projections assume that home and community based services programs will divert older adults from entering a nursing facility.

The 2006 annual report from the Office of Medical Assistance Programs shows that participation in six home and community based services waiver increased 70% between fiscal year 2003 and 2006 and doubling over a six year period while the number of Medicaid beneficiaries served in nursing facilities grew only 4%. Similar trends were highlighted in the Governor's long term living budget presentation.³¹ While the number of Medicaid beneficiaries living in nursing facilities grew modestly, the number of Medicaid paid days declined almost 2% from fiscal year 2004 to fiscal year 2007, from 19,277,587 to 18,885,775 days.

Within the Office of Long-Term Living, the Bureau of Community Development is responsible for the development of the array of services. In the last several years, the Bureau expanded efforts to convert or replace nursing homes to other uses. The approach reinvests resources currently used in nursing homes to expand the community based infrastructure by offering grants or loans for nursing home owners to realign their business model. The Bureau staff reason that nursing homes remain in what may be a dying business because of cash flow problems and inability to extricate themselves from the situation. The Bureau expanded its staff and consultants to include a top-notch team of economists and accountants with nursing home experience. This group has examined the debt structure and cash flows needs of nursing homes that they target for downsizing. The bureau then offers options to owners who are willing to reduce capacity and create affordable housing or become a home and community based services provider. For example, one nursing home owner replaced its building and reduced capacity from 290 to 180 beds, and built additional supportive housing units, including an adult day care

³¹ Office of Medical Assistance Programs, annual report 2005-06. Available at: <http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/OMAP05-06AnnualReport.pdf>. Pennsylvania Cares: 2007-2008 budget presentation available at: http://www.dpw.state.pa.us/Resources/Documents/Pdf/PACares_2007-02-06.pdf, page 39.

program. The Bureau provided the owner with a \$3 million grant to support the conversion and construction. Without federal reimbursement, the state estimates that it will recoup its investment in two years by replacing nursing home beds with community based services.

The Bureau works with the Pennsylvania State Data Center to map demographic and provider information, model costs and develops rate estimates to determine market areas that require additional housing and community based service capacity. In another example, a nursing home in an area that lacked sufficient affordable housing agreed to reduce their capacity to 90 beds and build 180 apartment units, 40% of which were affordable, in a setting that would include a PACE sites and 90 Personal Care Home units, 30 that serve SSI beneficiaries. The State is discussing receiving federal Medicaid match for the grant with the Centers for Medicare & Medicaid Services.

The Bureau plans to hold seminars around state and invite nursing home operators to consider how they might realign their business in a direction that supports the state's goal to balance institutional and community based services.

Regulation and Incentives for Culture Change in Arkansas

In Arkansas, the Office of Long Term Care (OLTC) in the Department of Healthy is responsible for regulation of Arkansas nursing homes, ICF-MRs, and assisted living. Like many states, Arkansas developed nursing staffing ratios that exceeded federal regulations; indeed, advocates for nursing home residents had argued strongly for such increased staffing. For the last several years, Arkansas has been undertaking a thorough revision of all its nursing home regulations with the intent of making them as friendly to culture change efforts and trends as possible. For example, the intent is to remove references to nursing stations. At present, the

draft regulations are available for public comment and also are being looked at by leaders in the national culture change movement. They are expected to be released in 2008.

As a parallel process, Arkansas is developing regulations for a non-institutional type facility modeled after the Green House ®, which the OLTC viewed as “an attempt to enhance residents’ quality of life through the use of a non-institutional facility model resulting in a residential-style physical plant and specific principals of staff interaction.” Although the website for the National Green House Project refers to the concept as a “home for six to ten elders,”³² Arkansas has adopted a somewhat different definition in its statement of intent, stating that “the Greenhouse model utilizes small, free-standing, self-contained houses, surrounding or adjacent to a central administration unit with each home housing ten (10) to fifteen (15) private rooms, each with full bathrooms.”³³ The paragraph goes on to state that the residents’ rooms are constructed around the central familial living area (hearth, dining area, and kitchen” and that “all residents’ rooms are visible from the central common area.” This latter provision in fact is not true of all the Green House projects, nor is it a requirement of the model.

Arkansas’ intent in developing a special set of regulations specific to Green Houses “is to create a framework that both permits and encourages the construction and operation of Green House facilities; the Arkansas legislature enacted HB 1363 in February 2007 as authorizing legislation.”³⁴ During a site visit to Arkansas in November 2007, we asked key informants why special regulations were being developed rather than a more permissive set of general regulations. The response was that the OLTC did not want to make available the flexible staffing models used in the Green House whereby certified nurse’s aides (CAN) also did

³² See Green House Project website, last visited May 24, 2008, at <http://www.ncbcapitalimpact.org/default.aspx?id=148>.

³³ The Arkansas draft general regulations are available on the web and contain a brief reference to Green Houses, at <https://ardhs.sharepointsite.net/OLTC/Public%20Downloads/DRAFT%20Regulations%20for%20Nursing%20Homes.doc>

³⁴ HB 1363 is on web web, lst visited May 24, 2008, at <http://www.arkleg.state.ar.us/ftp/root/bills/2007/public/HB1363.pdf>.

cooking, meal service, light housekeeping, and personal laundry, as well as performed other roles to advance the care plan similar to those of activity aides and physical or occupational therapy aides. In promulgating the increased nursing staff hours in regular regulation, Arkansas also developed a regulatory requirement that a specific form be used to calculate and demonstrate compliance with the new nursing staff to resident ratios. Staff officials were unwilling to allow greater leeway for all nursing homes to broaden CNA roles, and were concerned about being able to develop a reporting format that would allow accurate reporting of hours spent on nursing tasks given the joint production function of these more universal workers. OLTC staff are aware, of course, that Green House is a trade-marked model. The intent is not to strictly interpret that only this trade-marked model will be allowed to use the special regulations. Rather, the OLTC reserves to itself the task of identifying those facilities who are attempting a Green-House-like project where the special standards will be applicable. Only operators with a good regulatory track record would be permitted to operate under those new regulations. Presumably when they are complete, the new Green House regulations will enable the universal worker and will modify regulations related to nursing staff, infection control, and physical environment to permit such models.

Arkansas also plans to offer incentives for construction of Green House type projects. House Bill 1363, enacted in February 2007 amends the Arkansas code as it applies to the Long-Term Care Trust Fund, established with civil monetary penalty funds.³⁵ The original legislation required that this fund be used “solely for the protection of the health or property of residents of long-term care facilities,” and illustrated such use as including but not limited to payment for the costs of relocation of residents to other facilities, operation of a facility pending correction of deficiencies, or compensating residents for personal funds lost. HB 1363 expands these uses by

³⁵ HB 1364 is on the web, last visited May 24, 2008, at <http://www.arkleg.state.ar.us/ftp/root/bills/2007/public/HB1364.pdf>.

saying that the trust fund may be put to uses that “in the determination of the Director of the Office of Long-Term care, embrace the quality of life for long-term care facility residents through adoption of principles and building designs established by the Eden Alternative or Green House programs or other means.” This is an important principle that may be applicable to other states, many of which limit use of Civil Monetary Penalty Funds to narrow purposes related to assisting residents in substandard facilities rather than using the funds to promote resident quality of life. Approximately five million dollars in that fund will be made available on a competitive basis to assist three facilities to establish Green Houses. At present, the only Green House in Arkansas is an assisted living facility. According to staff at the OLTC, the priority for these funds will be for nursing homes, but funds can be used for assisted living facilities if qualified nursing homes do not step forward.

Nursing Home Report Card System in Minnesota

Among Minnesota’s initiatives to improve the quality of nursing homes are the nursing home report card, pay-for-performance payment system, and a new program to assess nursing home quality that includes quality of life measures.

The interactive, web-based Nursing Home Report Card program provides consumers with information on all Medicaid-certified nursing homes, allowing them to comparison-shop. The Report Card provides scores, using a 5-point system, on 8 quality measures (such as quality of life and satisfaction, staffing data, and inspection findings); scores are based on the measures the consumer selects as most important.³⁶

In 2006, DHS proposed a payment system for nursing homes that uses the NH report card’s 8 quality measures to create a score that would affect each home’s payment, after adjustments for

³⁶ The Nursing Home Report Card home web page is at: www.health.state.mn.us/nhreportcard

case mix.³⁷ Although this proposal was not adopted, the Legislature passed a “quality add-on” payment of up to 3% to nursing home payment rates as an initial step to link payment to quality.³⁸ This add-on payment is based on 5 of the 8 quality measures of the NH Report Card. In addition, a Performance-Based Incentive Payments program allows nursing homes to submit proposals for quality improvement projects which, if accepted, are funded with additional payments (up to 5% of the facility’s base rate). Each project must have an evaluation plan that uses the quality measures developed for the Report Card.

Quality Monitors in Florida, Texas, and Washington

Three of the States in the rebalancing project have developed substantial experience with developing a system of quality monitoring to provide technical assistance to facilities that functions separately from the survey process. The idea is that these personnel can function in a less adversarial way to assist facilities in improving quality and meeting regulatory standards. The programs developed in the three states differ from each other in terms of their expressed purpose and operations, but they are all variations on this theme.³⁹

Quality monitors in Florida. Florida’s quality monitoring program was established in 1999 by House Bill 1971, and was meant to “create a positive partnership between the Agency [i.e., the Florida Agency for Health Care Administration or AHCA, which administers the survey and certification program] and nursing homes and ultimately yielded improved quality of care to

³⁷ Kane, R. L., Arling, G., Mueller, C., Held, R., & Cooke, V. (2007). A quality-based payment strategy for nursing home care in Minnesota. *The Gerontologist*, 47(1), 108-115.

³⁸ Minnesota Statutes, 256B.441 (2006)

³⁹ This section is based on our own site visits in 2004 and 2007, but also, in part, on a study conducted by Abt Associates under a grant from OASPE, which specifically examined quality monitoring systems and, which included site visits to all three states. See White, a, Manard, B, Deitz, D, Moore, T, Hurd, D, & Landino, C (2003). State Nursing Home Quality Improvement Programs: Site Visit and Synthesis Report. (prepared under contract #282-98-0062 between the U.S. Department of Health and Human Services , Office of Disability, Aging and Long-Term Care Policy and Abt Associates, May 15, 2003). On web, last visited May 24, 2008 at <http://aspe.hhs.gov/daltcp/reports/statenh.htm>.

residents.” The program, funded by general revenue and some matching federal funds, wcalled for yearly monitoring visits of all nursing homes, and quarterly visits to facilities with care problems. Senate Bill 1202 modified the House Bill by increasing the number of staff positions for monitors from 13 to 19 and mandating quarterly visits to all facilities with additional visits to facilities at high risk. Facilities on the Nursing Home Watch List had the highest priority, followed (in order) by those with a history of intermittent non-compliance, those where analysis of MDS quality indicators suggest potential weaknesses, nursing homes that have recently changed ownership, administrators, or directors of nursing, and new facilities. The quality monitors were required to be registered nurses, preferably with surveyor experience. All received surveyor training and passed the surveyor minimum qualifications test. Each had a caseload of about thirty facilities in a geographic area.

Quality monitors made visits (initially unannounced, toured the facility, observed residents and staff, and conducted interviews with residents and staff. At the end of the visit, the monitor meets with the administrator to discuss findings, and provide a written report. Monitors make suggestions about quality improvement and best practices, share materials, and clarify state and federal regulations; they walk a thin line in avoiding being prescriptive or telling facilities how they should do things. Since May 2002, the monitors’ roles have been expanded to assess internal operations of quality improvement, newly mandated internal risk management programs (see section below), and adverse incident reports. They were also assigned to visit facilities that are financially monitored, closing, or immediate jeopardy. These activities bring the quality monitors activities into closer collaboration with the survey personnel and reduce some of the original emphasis on early detection and prevention of quality problems.

Quality Monitors in Texas. The Texas quality monitoring program was introduced as part of the Nursing Home Quality of Care Act of 2001 (Senate Bill 1839 of the 77th Legislative Session). This bill in general reflected a pendulum swing to more a provider-friendly stance between the Department of Aging and Disability Services (DADS) and the industry. The provisions were funded by a shift of about five million in federal and state funds for the Survey and Certification Agency to these new activities, which translated into transferring 82 FTEs from the survey function to the new activities; 50 FTEs were transferred to the monitoring activity, which was somewhat modeled on the Florida experience. However, Texas designed its program with significant input from provider and consumer stakeholders and the resultant model differs from Florida's program.

The enabling legislation specified that quality monitors must include a pharmacist or nutritionist with long-term care experience, that the visits must be unannounced, that facilities with deficiencies be prioritized, that they assess "overall quality of life" in the facilities; that they observe care and services and conduct informal interviews with residents, family, staff, and guests; and that the findings be presented in writing. As the program evolved, the mission of the Quality Monitoring Program was defined as "to promote consistent use of evidence-based resident care planning and resident care practices that offer residents the highest possible quality of care and life." This emphasis is consistent with a parallel activity in the DADS Division for Regulatory Affairs to develop evidence-based Quality Improvement Protocols. During their visits, the Quality Monitors use a highly structured set of assessments and protocols to determine whether care comports with evidence-based quality criteria. Furthermore, the initial focus was directed at three clinical care issues, all of which are also highly related to quality of life: use of psychoactive medications, promotion of continence, and use of restraints. As in Florida, the

monitors provide specific suggestions yet avoid being prescriptive. Their procedures include an “entrance conference,” which gives staff an opportunity to describe their challenges as they see them, as well as an exit conference, followed by a written report.

The Texas quality monitoring program is separate from the survey program with two exceptions: 1) as in Florida and as required by the Texas enabling statute, immediate jeopardy situations are reported to the survey agency; and 2) Quality Monitor reports are available over the IntraNet to surveyors and are reviewed as part of survey preparation.

Quality Assurance Nurse Program in Washington. In the State of Washington, the Quality Assurance Nurse (QAN) program dates back to the 1980s, although at that time QAN functions were completely separate from Survey Functions. When the program was re-energized in the 1990s, QAN staff were also assigned survey roles, spending about 75% of their time on QAN and the rest on surveys. QAN is one of three planks in the state’s quality assessment and improvement program, the others being complaint monitoring and surveys. QAN and complaint monitoring are the more proactive, early detection programs. In Washington, the QAN has 5 functions: 1) they provide technical assistance to facilities; 2) they review the accuracy of the MDS, which is the basis for the state’s case-mix payment system; 3) they conduct discharge reviews, which also helps determine whether consumers are presented with choices around discharge; 4) they serve as monitors for facilities out of compliance; and 5) they conduct regular surveys and, if needed, complaint investigations. (The fifth function is not part of QAN duties.) The State is divided into 6 regions for survey purposes with a core staff of surveyors and dedicated complaint investigators in each region. Each region also has a team of QAN staff who do routine monitoring to a caseload of 8 to 12 facilities, which they are expected to visit at least quarterly. When the QAN nurses do surveys, they typically perform them in other regions so as

not to confound their roles, though they do perform the MDS accuracy reviews in their own areas. If the QAN identifies a deficiency during a QAN visit, they could issue a citation, though they do so only in cases of egregious problems. The QANs apply quality protocols derived from the MDS-generated Resident Assessment Protocols. All QANs, by definition, have to meet the criteria for a surveyor, which in Washington means that they are Masters Level nurses; additionally QANs are expected to have considerable nursing experience.

What do these monitoring programs mean in terms of the future of the nursing home? In some ways they are a tangential to the main focus of this Topic Paper. On the other hand, to some extent, they reflect a different vision of the nursing home. In Texas, in particular, they are focused on quality of life as well as quality of care. And in Washington, the monitoring is also geared towards ensuring that consumers have choices at discharge. In all three states, the monitoring program is meant to create a new, more positive, and less adversarial relationship between the state and the facilities. They are generally rated positively by providers, consumer advocates (such as ombudsmen), and state agencies. Yet the problems that are cited with the monitoring programs do suggest limitations in overlaying this model on a more traditional regulatory structure. The Abt study, cited above, identified much concern on the part of providers and consumers about the lack of separation between the monitoring and the surveying function, and in the tendency of the monitoring programs to slip away from consultation and early warning systems to monitoring facilities in jeopardy. In the last analysis, the regulations for nursing homes remain intact and the monitors are involved in helping facilities stay out of regulatory disrepute as opposed to trying to move towards a changed model of nursing homes.

Conclusions

As states move to create more choices for long-term supportive services (LTSS), the question arises about whether nursing homes are needed in the future and, if so, how many and how might they be changed. With fewer people under 65 residing in nursing homes, this is becoming an issue that particularly affects seniors, largely people well over age 65. This Topic Paper looked at how the 8 states collaborating in the Rebalancing Research project envisage the future of nursing homes, and the policies they have put in place, if any, to forward that vision.

All the states continue to see a need for the licensed and certified nursing home in the foreseeable future, although Vermont qualifies that judgment with the statement that there is a future for nursing homes “but only if they become more consumer oriented and accessible to their clients, including residents, families, and visitors.” Accordingly, the Legislature requested that the state agencies “develop a 10-year plan, which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the resident’s preferences, customs, and individual histories.” This is the closest we found to any comprehensive vision for how the nursing home should change, and the aspirations are still phrased at a general level. Although general statements aspiring to high quality, safety, protection, and a good quality of life for nursing home residents abound and although many states express interest in the principals of culture change, we did not identify any more particular vision for the nursing home of the future.

More specificity was found on the desired future supply of nursing homes; 4 of the 8 states (Minnesota, Pennsylvania, Vermont, and Washington) created specific projections and/or goals for how LTSS should be allocated between institutional and community care in the next decade

or so. The general expectation is that reliance on nursing homes will decrease not only for people under age 65 but for older people as well.

The future of the nursing home in terms of both their share of the LTSS market and their nature is unclear. Most states continue to see a need for the licensed and certified nursing home, although Vermont qualifies that statement by stating that there is a future for nursing homes “but only if they become more consumer oriented and accessible to their clients, including residents, families, and visitors.” Accordingly, the Legislature requested that the state agencies “develop a 10-year plan, which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the resident’s preferences, customs, and individual histories.” This is the closest we found to any comprehensive vision for how the nursing home should change, and the aspirations are still phrased at a general level. Although general statements aspiring to high quality, safety, protection, and a good quality of life for nursing home residents abound and although many states express interest in the principals of culture change, we did not identify any more particular vision for the nursing home of the future. More specificity was found on the desired future supply of nursing homes; 4 of the 8 states (Minnesota, Pennsylvania, Vermont, and Washington) created specific projections and/or goals for how LTSS should be allocated between institutional and community care in the next decade or so. The general expectation is that reliance on nursing homes will decrease not only for people under age 65 but for older people as well.

Minnesota, Pennsylvania and Vermont have all developed policies and incentives to encourage nursing homes to downsize, Minnesota downsizing policies also work towards changing the qualitative nature of the nursing home by containing incentives for increasing

single-occupancy rooms. Pennsylvania's approach encourages facilities to diversify into housing and other community services in lieu of providing nursing home care.

The successes achieved in creating community-based services should prompt states to attempt more creative planning by envisioning, perhaps in partnership with the long-term industry, how the three basic elements of long-term care (personal care and other supportive services, housing, and medical care) can be combined to achieve high quality in all three domains simultaneously. This Topic Paper has shown that states are moving in various ways to encourage a higher quality of life in nursing homes, including: supporting culture change endeavors; providing reimbursement or certificate-of-need exceptions for facilities that renovate to develop physical plants that support a better quality of life; developing training towards more individualized care; and creating a demand for better quality of life among potential residents and payers by report card systems and web-based public information.

A trend was also noticed towards greater enforcement of nursing home regulations and creation of monitoring systems (apart from the survey and certification process) that help nursing homes be in compliance with existing federal regulations. Such programs may well create facilities with fewer care problems, but they do not necessarily alter the fundamental model of institutional service, which critics find over-medical and insufficiently conducive to resident autonomy, choice in daily life, community integration, and quality of life.

Transforming nursing homes will undoubtedly have financial implications. Funding will be needed to encourage the transition from the current large institutions to new living designs that allow consumers a more normal life. Some models are already under development, but much more can be done to build on the experience of the MR/DD community which has virtually eschewed institutional care. In the case of nursing homes, the transition is complicated by the

dual nature of contemporary nursing home care. Continuing short-term post-acute care in the same institutions that deliver long-term services confuses the picture, especially because most of the former is covered by Medicare. Financial implications are also inherent in the judgment made that nursing homes will continue to exist in the foreseeable future. The costs of serving all seniors in community settings, including those needing extensive oversight and who have no family members to provide services on an uncompensated basis would far exceed the average per participant costs of HCBS services for seniors at present.