RESIDENT ABUSE IN NURSING HOMES

UNDERSTANDING AND PREVENTING ABUSE

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INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE AND BACKGROUND

The OIG conducted this study to promote a better understanding of abuse in nursing homes. This is the first of two reports. It examines the nature of abuse and ways to prevent it. The second report, *Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints*, examines existing processes for resolving physical abuse complaints. Both reports reflect the experiences and perceptions of knowledgeable individuals who 1) play some part, directly or indirectly, in the resolution of abuse complaints, or 2) have an interest in nursing home or elder issues.

Abuse of the elderly is not a new phenomenon. Research findings and Congressional hearings of the 1970s and 1980s helped to increase public awareness of elder abuse. However, little research has focused on the issue of abuse of nursing home residents; certainly, no national survey has been initiated. Existing studies of abuse focus primarily on family members and caregivers in their homes. Research indicates from 1 to 10 percent of the non-institutionalized elderly population may be subject to abuse.

While there are no exact statistics on institutional abuse, any abuse is unacceptable. Each incident, 'major' or 'minor,' may be a terrifying experience and a significant breakdown in the responsibility of government to assure a safe and caring environment for elderly and disabled individuals. The price for abuse is measured in the physical and psychological harm to the resident as well as by the economic costs of treating the abused resident.

METHODOLOGY

The term abuse covers many problem areas for nursing home residents ranging from environmental conditions needing correction to actual mistreatment of residents. For purposes of this study, abuse is defined as mistreatment or neglect of nursing home residents encompassing the following seven categories:

- Physical abuse
- Misuse of restraints
- Verbal/emotional abuse
- Physical neglect
- Medical neglect
- Verbal/emotional neglect
- Personal property abuse

Since national abuse statistics are not available and states vary in how they define and collect statistics, we decided to survey knowledgeable individuals involved directly or indirectly with nursing home care. Specifically, the inspection relied on 232 interviews with respondents representing State, Federal and national organizations which are either 1) involved with receiving, investigating and/or resolving nursing home abuse complaints, or 2) knowledgeable and concerned about nursing home or elder issues.

A minimum of three principal entities were interviewed in each of the 35 sample States: (1) State Ombudsman, (2) investigator or director of State Medicaid Fraud Control Unit (MFCU), or legal counterpart where no MFCU exists, and (3) State nursing home complaint coordinator (the nursing home administrators' primary contact for abuse complaints). These entities were selected because our preinspection indicated they were the most often involved in nursing home abuse complaint receipt and resolution in most States.

Respondents, based on their functional expertise and knowledge, answered a wide range of questions about different aspects of abuse in nursing homes including their perceptions of the prevalence and severity of the seven abuse categories listed above. The experiences and perceptions of the participants coupled with a review of State and Federal policies provide the basis for the findings and recommendations of this report.

MAJOR FINDINGS

- Nearly all respondents indicate abuse is a problem in nursing homes.

- Respondents differ, however, regarding the severity of the problem. A majority of the State oversight agencies and resident advocates for nursing homes perceive abuse as a serious problem, while many nursing home administrators and industry representatives perceive the problem as minor.

- Physical neglect, verbal and emotional neglect, and verbal or emotional abuse are perceived as the most prevalent forms of abuse.

- Nursing home staff, medical personnel, other patients and family or visitors all contribute to abuse. However, aides and orderlies are the primary abusers for all categories of abuse except medical neglect.

- Respondents believe nursing home staff lack training to handle some stressful situations.

- Most respondents believe staff certification and training will help to deter resident abuse.

- Administrative or management factors also contribute to nursing home resident abuse (e.g., inadequate supervision of staff, high staff turnover, low staff to resident ratios).

RECOMMENDATIONS

Because this inspection indicates abuse may be a problem for nursing home residents, we recommend the following:

1. The Health Care Financing Administration (HCFA) should:

   a) Require, as part of its nurse aide training regulations, ongoing training concerning the aging process and mechanisms to cope with and avoid confrontational situations. Further, nursing homes should be required to document staff training and understanding of abuse and reporting responsibilities and procedures for abuse incidents.

   b) Require, as part of the admission requirements for a new resident, nursing homes to inform residents about differences between living in a nursing home environment vs. living at home, possible problems they may encounter, and ways to deal with such problems.

   c) Require, as part of its conditions of participation for nursing homes, supervisory and training staff to acquire skills necessary to effectively train and supervise paraprofessional and nonprofessional staff.

2. The HCFA should further support research concerning long term care policies which promote staff stability and provide for adequate staff-to-patient ratios necessary to control stress and abuse.

3. The Administration on Aging (AoA) should collect and disseminate information about nursing home practices which avoid stress and abuse, and promote staff stability and adequate supervision.

DEPARTMENTAL COMMENTS

This report has been modified to reflect many of the comments received from within and outside the Department of Health and Human Services. Comments from the Assistant Secretary for Planning and Evaluation, the Office of Human Development Services, the AoA, and HCFA are included in the appendix to the report. They generally agreed with our findings and recommendations. The HCFA indicates it has already done much to accomplish the recommended changes.

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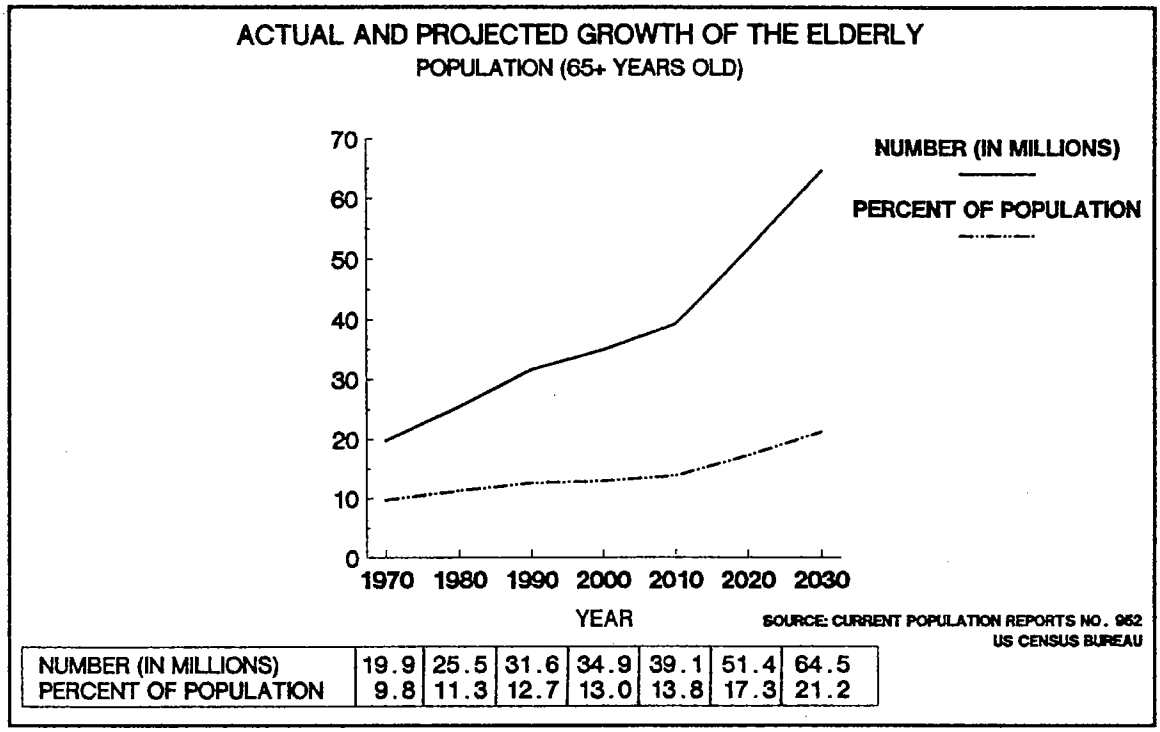


FIGURE 1

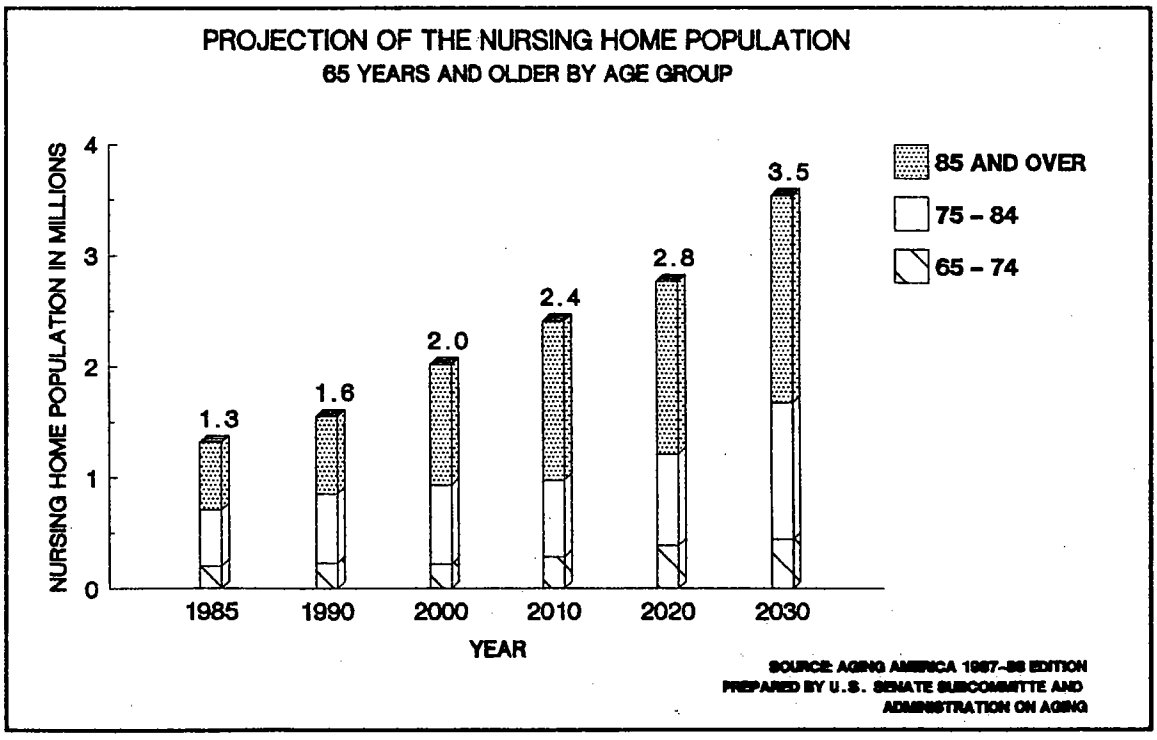


FIGURE 2

INTRODUCTION

PURPOSE

The OIG conducted this study to promote a better understanding of abuse in nursing homes. This is the first of two reports. It examines the nature of abuse and ways to prevent it. The second report, *Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints*, examines existing processes for resolving physical abuse complaints. Both reports reflect the experiences and perceptions of knowledgeable individuals who 1) play some part, directly or indirectly, in the resolution of abuse complaints, or 2) have an interest in nursing home or elder issues.

BACKGROUND

Americans are living longer, and the nation's elderly population is growing at an unprecedented rate, partially as a result of new technologies and medical advances. There are now 28 million people aged 65 or older; by 2030, they will number more than 60 million, or 21.2 percent of the total population (figure 1). As individuals live longer, their need for nursing home care may increase.

While only about five percent of the elderly population are in nursing homes at any given time, it is likely the nursing home population will continue to grow rapidly as the very old segment of the population continues to expand. Projections indicate 3.5 million elderly individuals will be living in nursing homes by 2030 (figure 2). The growth in the number of older people experiencing both disabilities and dependencies may place additional physical and emotional stress on both institutional and non-institutional caretakers. Persons advanced in age, limited by mental and/or physical impairments and dependent on others for their daily care, constitute the population most vulnerable to abuse.

Abuse of the elderly is not a new phenomenon. Research findings and Congressional hearings of the 1970s and 1980s have helped to increase public awareness of elder abuse. Existing studies of abuse have focused primarily on family members and caregivers in their own homes. Research indicates from 1 to 10 percent of the non-institutionalized elderly may be subjected to abuse. The incidence of and facts concerning institutional resident abuse are less known.

Doty and Sullivan (1983) note that both Federal and State sources report receipt of incidents of resident abuse each year. Monk, Kaye, and Litwin (1984) found that State Long-Term Care Ombudsmen receive many complaints about nursing home

staff treatment of residents. Further, they note a substantial amount of maltreatment is never reported.

Pillemer and Moore (1988) provide one random survey designed to assess the scope and nature of physical and psychological abuse in nursing homes. They found that 36 percent of the sampled nurses and nurse aides had seen at least 1 incident of physical abuse in the preceding year; 10 percent reported they had committed 1 or more physically abusive acts.

While there are no exact statistics on institutional abuse, any abuse is unacceptable. Each incident, 'major' or 'minor,' may be a terrifying experience and a significant breakdown in the responsibility of government to assure a safe and caring environment for elderly and disabled individuals. The price for abuse is measured in the physical and psychological harm to the resident as well as by the economic costs of treating the abused resident.

Federal Roles

Three Department of Health and Human Services (HHS) agencies have either direct or indirect involvement with nursing homes and services to residents of nursing homes: the Office of Human Development Services/Administration on Aging (OHDS/AoA), the Health Care Financing Administration (HCFA), and the Office of Inspector General (OIG).

Administration on Aging

The Administration on Aging (AoA) of OHDS is the primary Federal agency responsible for the State Long-Term Care Ombudsman (hereafter referred to as State Ombudsman) program. It further serves as the visible advocate for the elderly within HHS. The AoA meets the needs of the elderly mainly through a program of grants to State Agencies on Aging under Title III of the Older Americans Act (OAA) [as amended (42 U.S.C. 3001 et seq.)]. Title III also authorizes activities for the prevention of elder abuse. The Act requires each State Agency on Aging to establish and operate a State Ombudsman program to receive and review complaints concerning nursing home residents.

Health Care Financing Administration

The HCFA administers Medicare and Medicaid program operations. Within HCFA, the Health Standards and Quality Bureau (HSQ) has oversight responsibility for Medicare and Medicaid nursing home standards of care designed in part to ensure an environment free from abuse. To meet this obligation, HCFA develops and administers the regulatory requirements for nursing homes participating in either Medicare or Medicaid, develops training requirements for surveyors who conduct

nursing home inspections, conducts yearly compliance surveys of five percent of those facilities previously surveyed by the State, and monitors State compliance surveys for quality assurance.

The HCFA may directly receive complaints of abuse involving nursing home residents. However, these will usually be referred to the applicable State agency for nursing home certification unless the allegation involves an "immediate and serious threat" to patient health and safety.

Office of Inspector General

Through Public Law (P.L.) 94-505, enacted in 1976, the OIG was established as an independent unit in HHS with the authority to prevent and detect fraud and abuse in Department programs. The OIG is required to 1) recommend policies for the detection and prevention of fraud and abuse within programs and operations administered or financed by the Department and 2) conduct, supervise, or coordinate investigations related to such fraud and abuse.

Under Section 1128 of the Social Security Act, the OIG was provided authority to impose sanctions against health care providers convicted of Medicare or Medicaid offenses or suspended or excluded or otherwise legally or administratively sanctioned by appropriate State entities. In meeting this statutory authority, the OIG works with other Federal, State, and local governmental agencies and nongovernmental entities. As a further part of this authority, the OIG/Office of Investigations (OI) has oversight of and grant certification responsibility for State Medicaid Fraud Control Units (MFCUs).

The Medicare and Medicaid Patient and Program Protection Act of 1987 amends titles XI, XVIII, and XIX of the Social Security Act to protect beneficiaries from unfit health care practitioners. The Act states that if an individual is convicted of patient abuse in connection with the delivery of a health care item or service, exclusion from the Medicare and Medicaid programs is mandatory.

In September of 1986, the OIG/OI published an "Investigative Guide for the Detection of Patient Abuse." The guide was made available to State MFCUs for training and reference purposes.

Existing Nursing Home Requirements

The Medicare and Medicaid programs traditionally have used a condition of participation (COP) format to define requirements which must be met by facilities in order to participate in the programs. This format is based on the principle that each condition level statement would be a statutory requirement while standard level statements would be lesser requirements within a condition.

Under current law, a skilled nursing facility (SNF) must meet COPs to participate in the Medicare or Medicaid programs; intermediate care facilities (ICFs) must meet standards. Current COPs and standards were originally published in 1974. The SNFs have a single uniform definition which extends the same level of care requirements to both Medicaid and Medicare programs. The ICF benefit was intended to allow facilities which did not meet SNF COPs to participate as ICFs and provide health-related care, not at the skilled level, to Medicaid patients.

Provisions for resident rights are ambiguous and enforcement is difficult because a resident's rights and a facility's obligations are sometimes unclear. Recognizing that a resident's rights, living conditions, and medical care are essential components of the quality of life in a facility, HCFA developed outcome oriented survey instruments in June 1988. The emphasis of current regulations is on process, not outcomes of that process as is relates to residents. The regulations do not contain any SNF COP or ICF standard for a resident assessment. Also, there is no quality of care COP utilizing resident care outcomes, especially negative ones, to assess whether residents are receiving satisfactory care.

Existing Medicare COPs are located at 42 CFR, Part 405, Subpart K and implement Section 1861(j) of the Social Security Act. Current Medicaid standards are in 42 CFR, Part 442, Subparts D, E, and F.

Omnibus Budget Reconciliation Act of 1987 (OBRA '87), P.L. 100-203

On December 22, 1987, OBRA '87 was enacted. The law includes extensive revisions to the Medicare/Medicaid statutory requirements for nursing facilities. Nursing home reform provisions, to be implemented October 1, 1990, establish uniform requirements for Medicaid SNFs and ICFs. The law revises the conditions under which nursing homes may participate in the Medicaid/Medicare programs, the process for monitoring compliance with law, and the remedies available to Federal and State agencies in the event of noncompliance. It further expands nursing facility resident rights to include freedom from 1) inappropriate use of physical or chemical restraints and 2) physical or mental abuse or punishment.

The NF (any Medicare SNF or Medicaid facility which is not an ICF for the mentally retarded) must inform residents orally and in writing of their legal rights. The HCFA draft regulations provide all incidents of abuse be reported to the nursing home administrator or to any other agency designated by State law. Residents may file a complaint concerning abuse or neglect with the State survey/certification agency. The NF must permit the State Ombudsmen access to the resident and the resident's clinical records with the permission of the resident or the resident's legal representative.

The NFs will be required to verify the competency of applicants prior to their employment as nurse aides. No nurse aide may be employed for more than four months unless the individual has completed State-approved training or successfully passed a competency test. Verification of a nurse aide's competency will be strengthened through the required use of a State maintained nurse aide registry. This registry will certify that the individual has met the required training requirements and indicate the documented findings, not limited to convictions, of resident abuse, neglect, or misappropriation of resident property involving an individual listed in the registry. If the State determines a nurse aide has been involved in these activities, the State will, after notice and reasonable opportunity to rebut allegations in a hearing, notify the nurse aide and the nurse aide registry.

State and Local Roles

The primary responsibility for designing, operating, and coordinating services for the elderly lies with the States. Several State agencies may be responsible for resolving nursing home problems including:

- nursing home complaint coordinators,
- State Ombudsmen (under the direction of the State Agency on Aging),
- MFCU or other legal authorities where no MFCU is established,
- agencies for nursing home certification and licensure,
- licensure agencies for medical personnel,
- adult protective services, and
- local law enforcement.

The nursing home complaint coordinator is the individual designated to nursing home administrators as the central State authority to receive complaints of mistreatment or neglect of nursing home residents. This individual may be in any number of State agencies or part of a designated complaint unit, but is usually a staff member of the State nursing home survey and certification agency.

The State Agency on Aging, through the State Ombudsman, is required by the OAA:

1) to establish procedures for maintaining a State-wide reporting system to collect and analyze data related to complaints and incidents;

2) to monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long term care in the State;

3) to provide public education on their activities and long term care issues; and

4) to promote training and certification of ombudsman staff and volunteers.

The MFCUs are also required to review "complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan. If the initial review indicates substantial potential for criminal prosecution, the unit shall investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority" (Social Security Act, section 1903(q)). At the time of this inspection, there were MFCUs in 38 States. Those States without a MFCU have agencies with parallel responsibilities for investigation of fraud and abuse (e.g., State Attorney General).

SCOPE AND METHODOLOGY

At this time, there is no uniform definition of abuse among the States or researchers. The term abuse may cover many problem areas for nursing home residents ranging from environmental conditions needing correction to actual mistreatment of residents. For purposes of this inspection, abuse is defined as mistreatment or neglect of nursing home residents and encompasses seven categories of abuse, excluding environmental and financial issues. These seven categories were defined using simple definitions (figure 3) based on a review of the literature related to abuse (appendix F).

Since national abuse statistics are not available and States vary in how they define abuse and collect statistics, we decided to survey knowledgeable individuals involved directly or indirectly with nursing home care. Specifically, the inspection relied on 232 interviews with respondents representing State, national, and Federal organizations which are either 1) involved with receiving, investigating, and/or resolving abuse complaints involving nursing home residents, or 2) knowledgeable and concerned about nursing home or elder issues (e.g., State oversight agencies for nursing homes or advocates of the elderly or nursing homes). (See appendix A and figure 4 for summary information on respondents sampled.) These individuals were identified through contacts with the regional HCFA offices as well as several State agencies (e.g., State Ombudsman and single State agency for Medicaid).

A minimum of three principal entities were interviewed in each of 35 States: 1) State Ombudsman, 2) investigator or director of the State MFCU, or legal counterpart where no MFCU exists, and 3) State nursing home complaint coordinator (the nursing home administrators' primary contact for abuse complaints). These entities were selected because our preinspection indicated they were the most often involved in nursing home abuse complaint receipt and resolution in most States. In 8 of the 35 States, we interviewed additional individuals including nursing home administrators, nursing home and resident advocates, and medical professional licensure personnel. Figure 4 shows the 35 States from which respondents were selected.

Participants, based on their practical expertise and knowledge, answered a wide range of questions, by telephone or in-person interviews, concerning different aspects of abuse in nursing homes including the prevalence and severity of the seven abuse categories. While the experiences and perceptions of the participants provide the basis for the findings and recommendations of this report, these findings appear consistent with the information and statistics available from the States and independent researchers.

INSPECTION ABUSE DEFINITIONS

ABUSE: Mistreatment or neglect of nursing home residents.

1. Physical Abuse
   Infliction of physical pain or injury.
   Examples include individuals either 1) reacting inappropriately to a situation, such as pushing or slapping a resident, or 2) intentionally doing bodily harm.

2. Misuse of Restraints
   Chemical or physical control of a resident beyond physician's orders or not in accordance with accepted medical practice.
   Examples include staff failing to loosen the restraints within adequate time frames or attempting to cope with a resident's behavior by inappropriate use of drugs.

3. Verbal/Emotional Abuse
   Infliction of mental/emotional suffering.
   Examples include demeaning statements, harassment, threats, humiliation or intimidation of the resident.

4. Physical Neglect
   Disregard for necessities of daily living.
   Examples include failure to provide necessary food, clothing, clean linens or daily care of the resident's necessities (e.g., brushing a resident's hair, helping with a resident's bath).

5. Medical Neglect
   Lack of care for existing medical problems.
   Examples include ignoring a necessary special diet, not calling a physician when necessary, not being aware of the possible negative effects of medications, or not taking action on medical problems.

6. Verbal/Emotional Neglect
   Creating situations in which esteem is not fostered.
   Examples include not considering a resident's wishes, restricting contact with family, friends or other residents, or more simply, ignoring the residents' need for verbal and emotional contact.

7. Personal Property Abuse (Material Goods)
   Illegal or improper use of a resident's property by another for personal gain.
   Examples include the theft of a resident's private television, false teeth, clothing or jewelry.

FIGURE 3

RESPONDENT SAMPLE

35 States Contacted

Alabama	Louisiana	New Mexico
Alaska *	Maryland	New York
Arkansas	Massachusetts	North Dakota *
California	Michigan	Ohio
Colorado	Minnesota	Oklahoma *
Connecticut	Mississippi	Pennsylvania
Florida	Missouri *	South Carolina *
Georgia *	Montana *	Texas
Idaho *	Nebraska *	Washington
Indiana	Nevada *	Wisconsin
Illinois	New Hampshire	Wyoming *
Kansas *	New Jersey	

* States with no Medicaid Fraud Control Unit

SURVEY RESPONDENTS BY ROLE

Type of Respondent	Number	% of All Respondents
State		
Complaint Coordinator	37	16%
Survey and Certification Surveyors	16	7%
MFCUs Or Counterpart	41	18%
Professional Medical Licensure Boards	18	8%
Ombudsman	38	16%
Resident Advocacy Organizations	14	6%
Nursing Home Industry	29	13%
National Organizations		
Consumer, Industry and Local Law Enforcement	14	6%
Federal		
HCFA	14	6%
OIG	11	5%

FIGURE 4

FINDINGS

Nearly all respondents indicate abuse is a problem in nursing homes.

In each of the seven abuse categories defined for this study, 95 percent or more of the respondents indicate abuse is a problem for nursing home residents. Additionally, for every abuse category, more respondents believe it is worsening rather than improving. Respondent perceptions of increasing abuse appear to be supported by statistics from several States. Eleven States responded to our request for abuse reports and/or complaints which occurred during 1987 and 1988 or 1988 and 1989. Eight States reported increased abuse statistics, while two reported no increase, and only one reported a decrease.

Percent Change in Reported Abuse

Connecticut	+68%
Montana	+51%
Kansas	+43%
Massachusetts	+25%
Washington	+22%
South Carolina	+17%
Oklahoma	+11%
Michigan	+2%
Alaska	0%
Nevada	no reported cases
New York	-9%

These States reported receipt of 11,331 complaints or reports of abuse during 1988.

Respondents differ, however, regarding the severity of the problem. A majority of the State oversight agencies and resident advocates for nursing homes perceive abuse as a serious problem, while many nursing home administrators and industry representatives perceive the problem as minor.

Although all of the seven categories of abuse are seen as problems for residents, respondents perceive varying degrees of severity (major, moderate, minor) for each category. Figure 5 shows these varying respondent perceptions as to problem severity. There is relative consistency among four main respondent types (State Oversight agencies and resident advocates - MFCU, Survey and Certification,

Complaint Coordinator and Ombudsman) while the nursing home industry respondents consistently report lower problem severity. Differences between the respondent views on problem severity may be the result of 1) job function, 2) more direct versus indirect contact with the residents or the provider community, or 3) more knowledge or understanding of the problems. See appendix B for further respondent perceptions concerning the seven abuse categories.

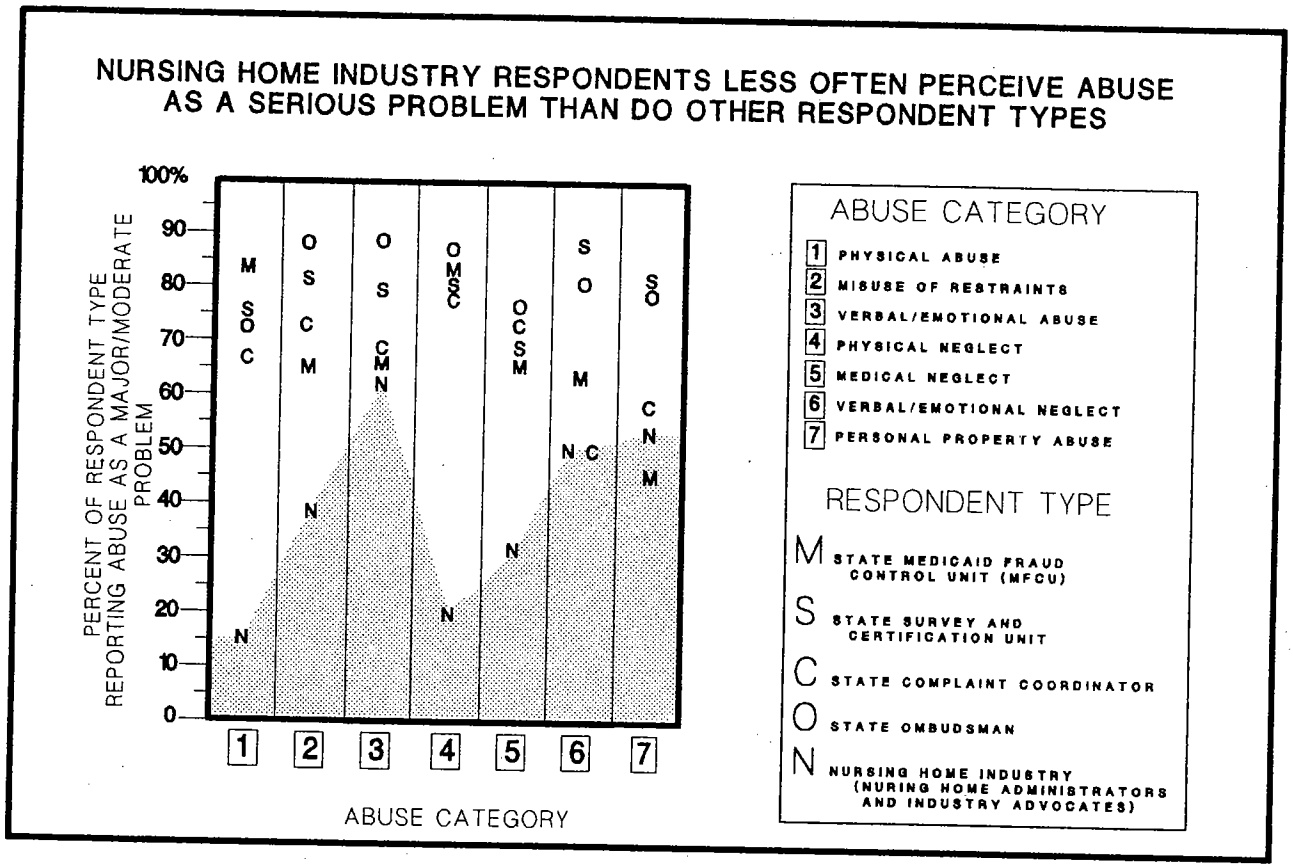


FIGURE 5

As is the case with perceptions of the severity of abuse categories, nursing home industry respondents often have a different view of the trend of abuse categories than do other types of respondents. As figure 6 shows, nursing home industry respondents typically perceive physical abuse, physical neglect, misuse of restraints, and medical neglect as improving or staying the same.

On the other hand, State Ombudsmen and complaint coordinators typically see these problems as worsening or staying the same for nursing home residents. An average of 49 percent of complaint coordinators and 41 percent of State Ombudsmen believe resident abuse problems are worsening. In contrast, 20 percent of the nursing home industry respondents see abuse problems as worsening.

RESPONDENT PERCEPTIONS OF ABUSE TRENDS: IS ABUSE IMPROVING, STAYING THE SAME OR GETTING WORSE FOR NURSING HOME RESIDENTS?

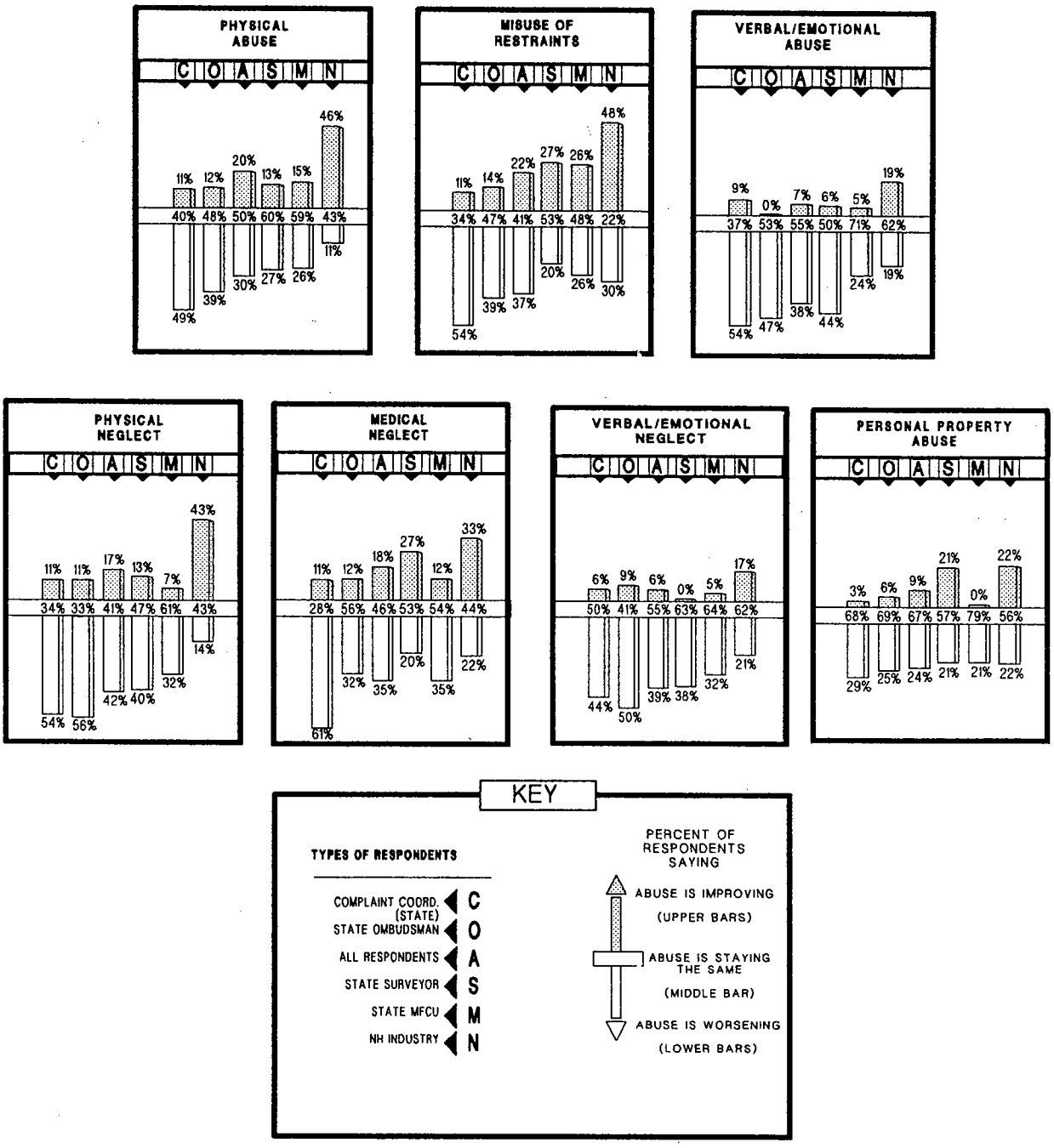


FIGURE 6

Physical neglect, verbal and emotional neglect, and verbal or emotional abuse are perceived as the most prevalent forms of abuse.

To gain an indication of the order of occurrence of the seven abuse problems, respondents were asked to rank the abuse categories in order of prevalence. Figure 7 arrays the median ranks according to prevalence. The problems at each level were ranked about equal (no discernible difference based on the median) in frequency by respondents. Because prevalence is a factor in assessing the severity of a problem (major, moderate, minor, or no problem), the most prevalent problems are often believed to be the most serious for residents.

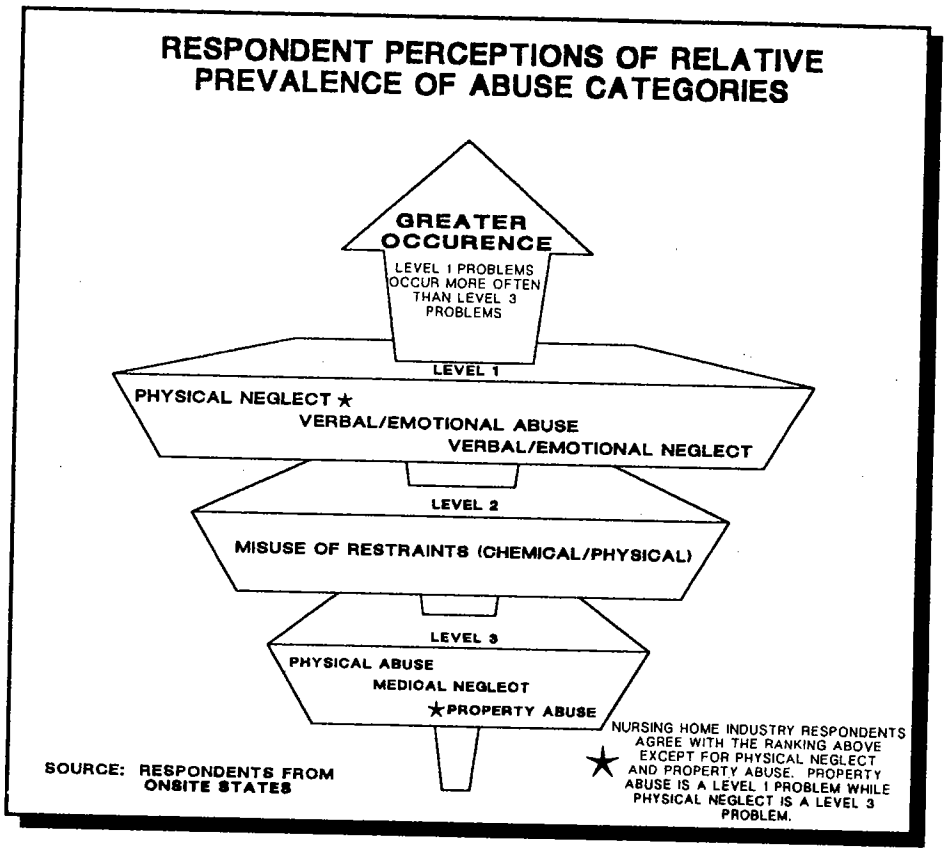


FIGURE 7

Since State nursing home abuse reporting laws typically separate resident abuse into the broad categories of physical abuse and neglect of care, many State agencies designated to receive and investigate complaints were not able to provide statistics according to the specific abuse definitions used for this study. Five States provided statistics of reports/complaints based upon the broad categories of physical abuse and neglect. Three of the five States report neglect was the most common abuse reported in 1988 while two States report physical abuse as the most often reported. The percentage by State and type of abuse is as follows:

State	Percent Neglect	Percent Physical Abuse
Minnesota	83%	17%
Massachusetts	62%	38%
New York	61%	39%
Montana	38%	62%
Kansas	35%	65%

Nursing home staff, medical personnel, other patients and family or visitors all contribute to abuse. However, aides and orderlies are the primary abusers for all categories of abuse except medical neglect.

Nurse aides and orderlies have the principal responsibility for the daily care of nursing home residents. As the primary caregiver to nursing home residents, it is not surprising most respondents, regardless of the type of respondent, say nursing home staff (specifically, direct care staff - aides and orderlies) are responsible for most incidents of abuse except medical neglect. As seen in figure 8, a significant number of respondents believe medical personnel, other patients and family or visitors also may be primary abusers of nursing home residents in one or more categories of abuse.

PRIMARY ABUSER OF NURSING HOME RESIDENTS ACCORDING TO RESPONDENTS

ABUSER ⇨ / ⇩ PROBLEM	NURSING HOME STAFF	MEDICAL PERSONNEL	OTHER PATIENTS	FAMILY OR VISITORS
PHYSICAL ABUSE	(89 %)	3 %	17 %	3 %
MISUSE OF RESTRAINTS	(56 %)	48 %	1 %	2 %
VERBAL/EMOTIONAL ABUSE	(89 %)	7 %	13 %	10 %
PHYSICAL NEGLECT	(88 %)	15 %	0 %	3 %
MEDICAL NEGLECT	25 %	(80 %)	1 %	3 %
VERBAL/EMOTIONAL NEGLECT	(84 %)	6 %	2 %	21 %
PERSONAL PROPERTY ABUSE	(79 %)	1 %	18 %	15 %

NURSING HOME STAFF

ALL STAFF EXCLUDING RNS. LVNS AND DOCTORS

MEDICAL PERSONNEL

LICENSED NURSES AND PHYSICIANS

RESPONDENTS = 206

( ) PRIMARY ABUSER OF NURSING HOME RESIDENTS

TOTAL PERCENT MAY EXCEED 100 PERCENT AS SOME RESPONDENTS GAVE MORE THAN ONE PRIMARY ABUSER IN A CATEGORY.

Graph Interpretation: **For example, in the case of physical abuse, 89 percent of respondents reported that nursing home staff are the primary abusers of nursing home residents.**

FIGURE 8

As indicated in figure 9, statistics from New York clearly support the finding that most nursing home abuse complaints can be attributed to nursing home aides and orderlies.

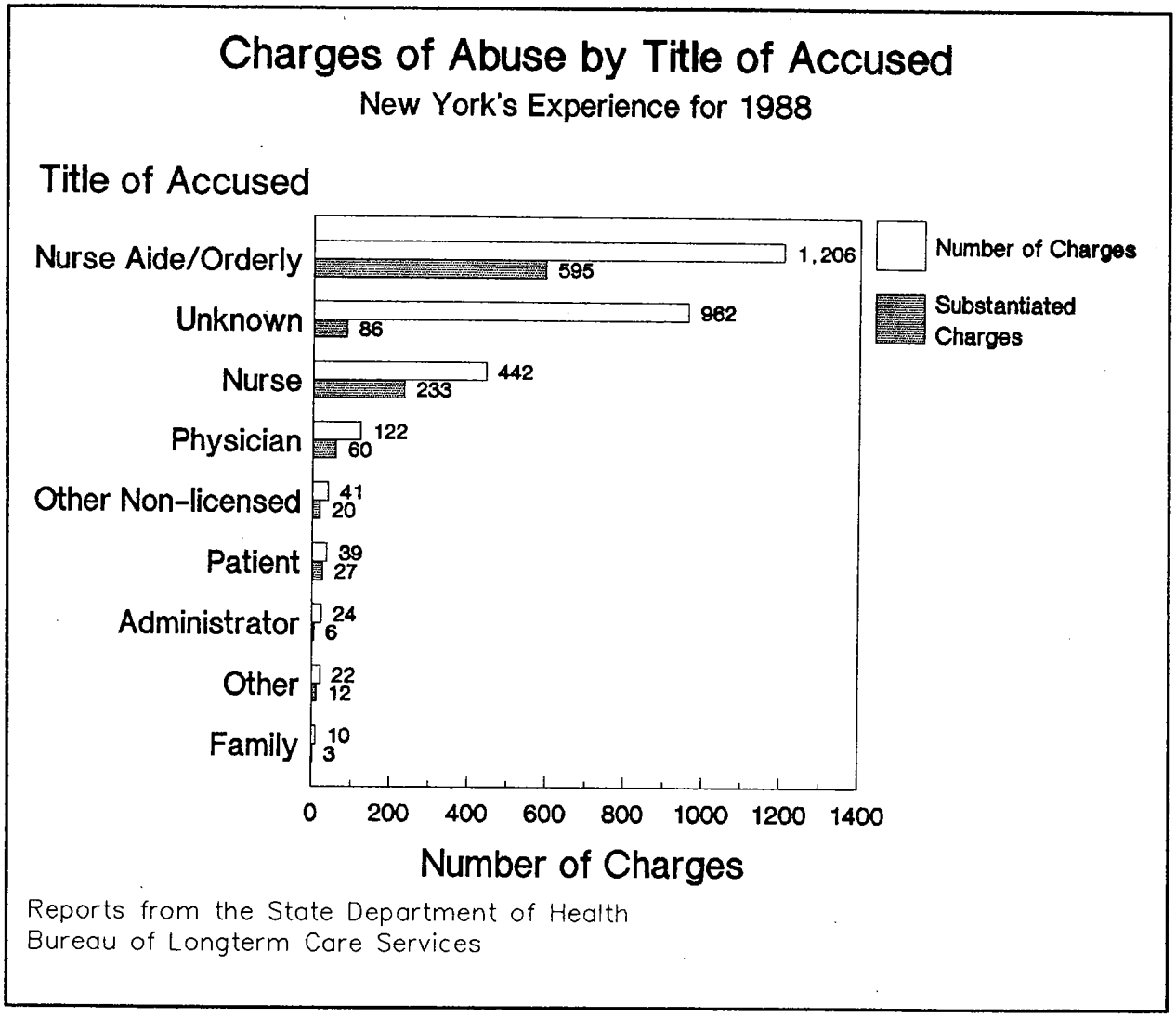


FIGURE 9

Respondents believe nursing home staff lack training to handle some stressful situations.

Many factors contribute to the potential abuse of nursing home residents by staff. Figure 10 summarizes some of the factors which respondents believe contribute to abuse.

Direct care nursing home staff frequently must cope with stressful situations. Many respondents indicate staff are inadequately trained to deal with the physical, emotional, and psychological aspects of caring for the elderly and disabled. This may result in abuse as an immediate response to a stressful or confrontational situation.

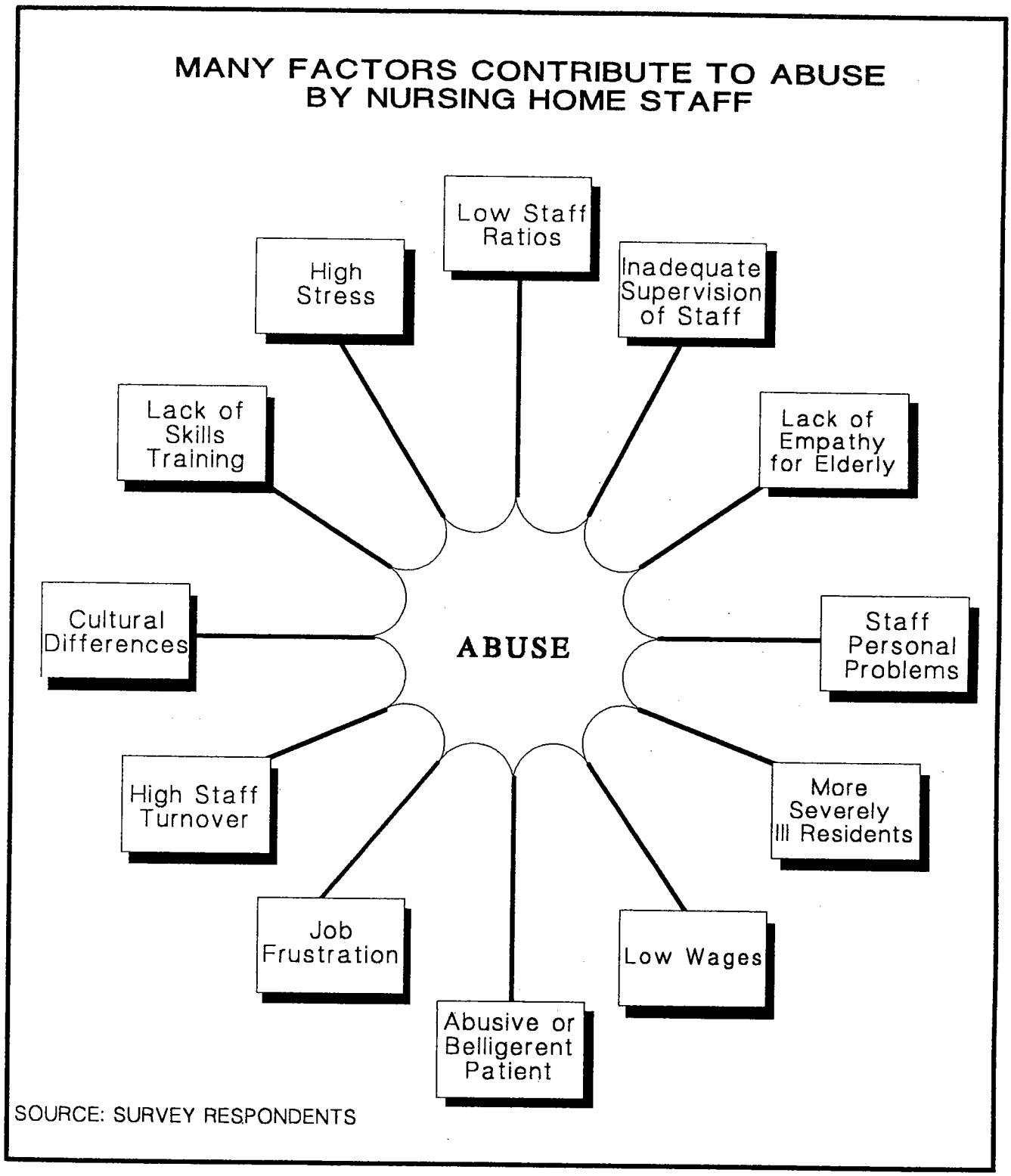

MANY FACTORS CONTRIBUTE TO ABUSE BY NURSING HOME STAFF
Low Staff Ratios
High Stress
Inadequate Supervision of Staff
Lack of Skills Training
Lack of Empathy for Elderly
Cultural Differences
ABUSE
Staff Personal Problems
High Staff Turnover
More Severely Ill Residents
Job Frustration
Low Wages
Abusive or Belligerent Patient
SOURCE: SURVEY RESPONDENTS

FIGURE 10

As one respondent states, "Faced with heavier levels of care, such as residents with more debilitating diseases, frustrated staff take out their stress on the residents."

Respondents believe staff training deficiencies include a lack of sufficient training in 1) behavioral skills to cope with or defuse confrontational situations, and 2) stress management skills. Further, some respondents believe some staff lack empathy for the elderly because they lack the knowledge needed to understand problems of the elderly (e.g., Alzheimer's disease).

Respondents cited many reasons for nursing home staff stress. Many respondents believe stress is caused by the reported increase in nursing home admissions of severely ill residents. This stress is related to the difficulties of caring for impaired and dependent residents who require help in many of the activities of daily living. According to the Senate Special Committee on Aging (figure 11), as many as 63 percent of nursing home residents suffer disorientation or memory impairment, with 47 percent suffering senility or chronic organic brain syndrome.

SELECTED CHARACTERISTICS OF NURSING HOME RESIDENTS 65 YEARS AND OLDER (1985)

Characteristic	Percent Affected
Sex:	
Male	25.4
Female	74.6
Patient Requires Help:	
Bathing	91.2
Dressing	77.7
Using Toilet Room	63.3
Getting In and Out of Bed	62.7
Eating	40.4
Difficulty With Bowel and/or Bladder Control	54.5
Disorientation or Memory Impairment	62.6
Senile or Chronic Organic Brain Syndrome	47.0

SOURCE: Aging America (1987-88 edition)
Prepared by Senate Special Committee and Administration on Aging

FIGURE 11

Other factors which may add to the stress encountered by nursing home staff and residents include cultural differences between staff and residents, personal problems of staff or residents, and abusive or belligerent residents.

Most respondents believe staff certification and training will help to deter resident abuse.

The required content, format and duration of training vary widely among States, with most training concentrating on health and safety precautions (e.g., lifting a resident, fire prevention, evacuation procedures, sanitation). Most respondents cite the value of staff certification and training.

Of all respondent types, the nursing home industry respondents (47 percent) were the least likely to report that training and certification would deter abuse. Reasons cited include: 1) present training and certification have not effectively deterred abuse; 2) training does not usually include stress management; 3) overwork resulting from understaffing is not affected; 4) inadequate salaries for hiring qualified personnel will not change; and 5) lack of professional supervision is not corrected by existing certification.

Administrative or management factors also contribute to nursing home resident abuse (e.g., inadequate supervision of staff, high staff turnover, low staff to resident ratios).

Inadequate supervision of staff, low staff to resident ratios, high staff turnover, and low wages are cited by some respondents as factors contributing to abuse of nursing home residents. As discussed previously, nurse aides spend more time providing residents necessary direct care than any other group of nursing home personnel. However, this group of employees has the highest rate of turnover, averaging 75 percent annually, according to one study by Almquist and Bates (1980). Low wages and the absence of employee benefits, recognition, and opportunities for advancement may all contribute to job dissatisfaction and rapid turnover among nurse aides.

Nurses experience many of the same problems confronting nurse aides. Additionally, nurses have an increasingly important role of supervising and training paraprofessional staff. Respondents, recognizing the nurses' problems in meeting these responsibilities, say inadequate supervision of direct care staff contributes to abuse. Although responsible for much of the training and supervision of direct care staff, nurses often lack training to adequately perform these functions. The 1985 Invitational Conference on Issues and Strategies in Geriatric Education noted deficiencies in nurse supervising and teaching skills, and indicated nurse education programs do not routinely offer training in these areas. Compounding these problems are the numerous responsibilities nurses have in other areas (e.g., administrative paperwork).

In some homes, the ratio of nurses to nurse aides may be inadequate, just as the ratio of nurse aides to residents may be inadequate. In order to meet State or

Federal facility staffing requirements and to quickly fill vacancy positions which may result from high turnover rates, many nursing home administrators have chosen to use temporary services. Some respondents believe use of such services (nurse and nurse aide pools) may be on the rise. Although temporary employees can fill critical staff shortages, several respondents expressed concern that temporary employees may not have been adequately screened or trained to care for nursing home residents.

RECOMMENDATIONS

Because this inspection indicates abuse may be a problem for nursing home residents, we recommend the following:

1. The Health Care Financing Administration (HCFA) should:

   a) Require, as part of its nurse aide training regulations, ongoing training concerning the aging process and mechanisms to cope with and avoid confrontational situations. Further, nursing homes should be required to document staff training and understanding of abuse and reporting responsibilities and procedures for abuse incidents.

   b) Require, as part of the admission requirements for a new resident, nursing homes to inform residents about differences between living in a nursing home environment vs. living at home, possible problems they may encounter, and ways to deal with such problems.

   c) Require, as part of its conditions of participation for nursing homes, supervisory and training staff to acquire skills necessary to effectively train and supervise paraprofessional and nonprofessional staff.

2. The HCFA should further support research concerning long term care policies which promote staff stability and provide for adequate staff-to-resident ratios necessary to control stress and abuse.

3. The Administration on Aging (AoA) should collect and disseminate information about nursing home practices which avoid stress and abuse, and promote staff stability and adequate supervision.

DEPARTMENTAL COMMENTS

Comments were received from the Assistant Secretary for Planning and Evaluation, the Office of Human Development Services, the Administration on Aging, and the Health Care Financing Administration. (See appendix D for the full texts.)

Assistant Secretary for Planning and Evaluation (ASPE)

The ASPE agreed with the findings and recommendations of the report. More specifically, it "supports the OIG's recommendations for improved training of nurses aides and orderlies about how to cope with stressful situations and resident behaviors without resorting to abuse."

Office of Human Development Services (OHDS)

The OHDS concurred with the report.

Administration on Aging (AoA)

The AoA agreed with the findings and recommendations of the report.

Health Care Financing Administration (HCFA)

While the HCFA generally agreed with the report, it did have concerns with the primary data gathering technique utilized, that is, an opinion survey rather than a scientifically controlled review, which resulted in opinion data "presented as fact." The HCFA also felt it would be advisable to include more information about the interviews and information gathering processes used in the study.

Additional information has been provided in the Scope and Methodology section of the report. Although evaluation studies do not produce absolutely certain information, they can provide relatively objective data. As the report indicated, there was little relevant statistical or applicable published research data concerning abuse in a nursing home.

We started with an assumption that individuals who routinely receive complaints of abuse, survey for indicators of abuse, investigate abuse, or resolve abuse incidents are knowledgeable sources. The survey method was designed to provide descriptive information of existing processes using statements of opinion from a representative population. Findings and recommendations related to the survey (to identify whether abuse was a problem, to what extent, etc.) were a result of both content and qualitative

analyses of the survey responses, available State statistics and legislation/regulation, and available research. We recognize the information provided by the respondents is significant only in the way it is regarded by the researcher or the readers. There is no absolute interpretation of the information provided.

Generally, the HCFA agreed with the recommendations of the report. The HCFA believes their implementation of the applicable statutory requirements of the Omnibus Reconciliation Act (OBRA) of 1989 and the Social Security Act will fulfill the recommendations of this report. In meeting a portion of the legislative requirements, the HCFA has revised the conditions of participation for nursing homes (effective October 1, 1990). The HCFA believes the revised requirements will contain many of the safeguards recommended by the OIG.

The HCFA indicates many of the recommendations will be met by the new regulations. We agree that draft regulations issued thus far represent a substantial improvement over regulations now in effect. However, some of these regulations are still in the public review and comment stage and may change. Even more importantly, the regulations defer to State law on the critical issues of complaint reporting, investigating, and follow-up. Hence, their impact will depend greatly on how aggressively the States move on these problems. Similarly, nursing homes will have to comply with the State law. We will, therefore, defer any assessment of whether our recommendations have been implemented until the new regulatory requirements are in place and States and nursing homes have made at least initial efforts to implement them.

APPENDICES

APPENDIX A

NATIONAL ORGANIZATION RESPONDENTS

American Association of Homes for the Aging
1129 20th Street, NW
Washington, D. C. 20036

American Association of Retired Persons - Central Office
Criminal Justice Services
1909 K Street, NW
Washington, D. C. 20049

American Health Care Association
1201 L Street, NW
Washington, D. C. 20005

American Medical Directors Association
12100 Blue Paper Way
Columbia, Maryland 21044

National Aging Resource Center on Elder Abuse
Research and Demonstration Department
810 First Street, NE
Washington, D. C. 20002-4205

National Association of Attorneys General
444 N. Capitol Street, Suite 403
Washington, D. C. 20001

National Association of Chiefs of Police
1100 NE 125 Street
Miami, Florida 33161

National Association of State Units on Aging
2033 K Street, NW, Suite 304
Washington, DC 20006

National Citizen's Coalition for Nursing Home Reform
1424 16th Street, NW
Washington, D. C. 20036

National Sheriff's Association
1450 Duke Street
Alexandria, Virginia 22150

Police Executive Research Forum
2300 M Street, NW, Suite 910
Washington, D. C. 20037

Police Foundation
1001 22nd Street, NW Suite 200
Washington, D. C. 20037

Rehabilitation Care Consultants, Inc.
6401 Odara Road
Madison, Wisconsin 53719

APPENDIX B

Tables I-VII Present Respondent Perceptions on Abuse Categories as Problems, Extent of the Problem, and Whether the Problem is Perceived as Worsening.

Table I	-	Physical Abuse
Table II	-	Misuse of Restraints
Table III	-	Verbal/Emotional Abuse
Table IV	-	Physical Neglect
Table V	-	Medical Neglect
Table VI	-	Verbal/Emotional Neglect
Table VII	-	Personal Property Abuse

TABLE I

PHYSICAL ABUSE

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

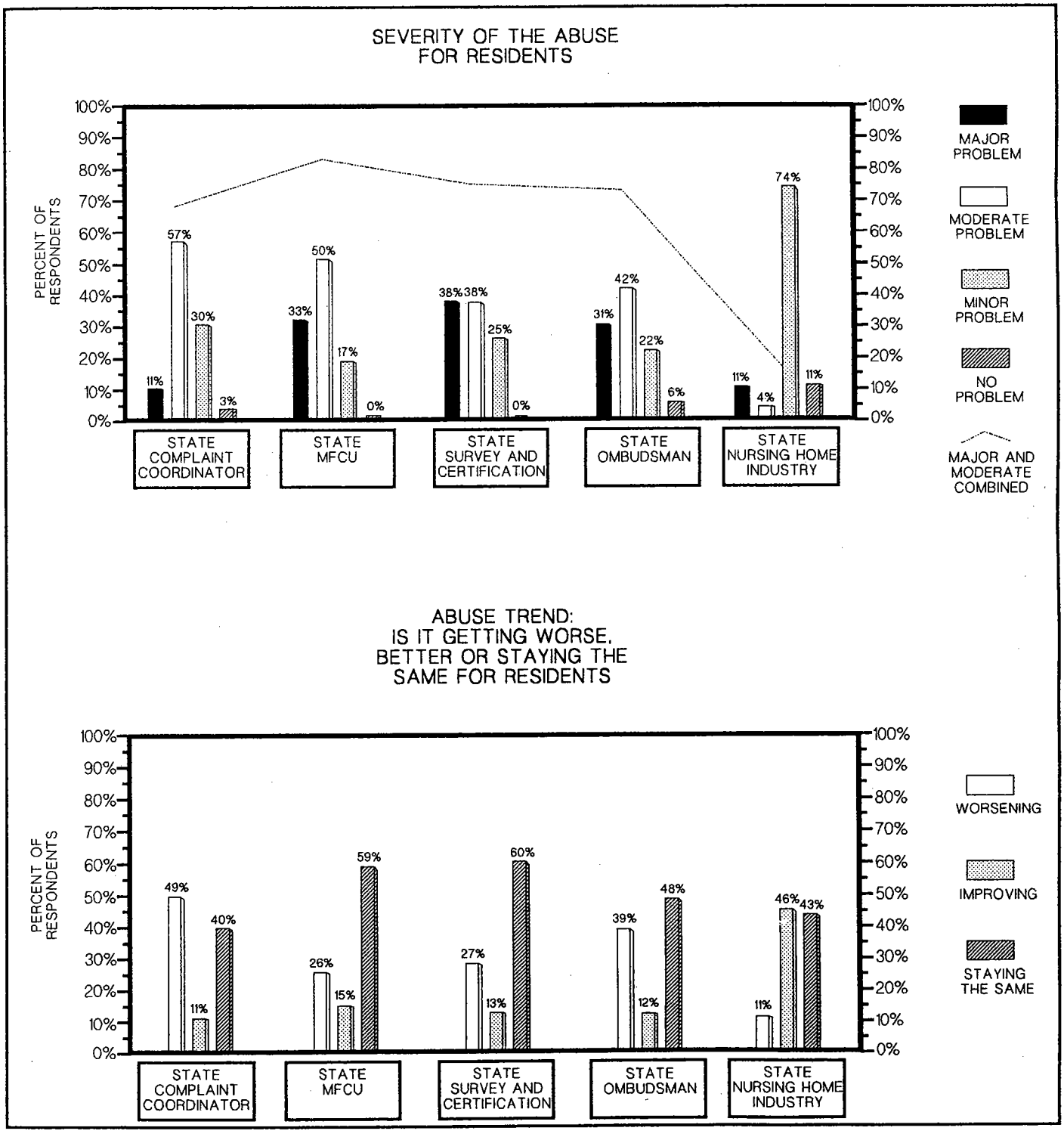


TABLE II

MISUSE OF RESTRAINTS

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

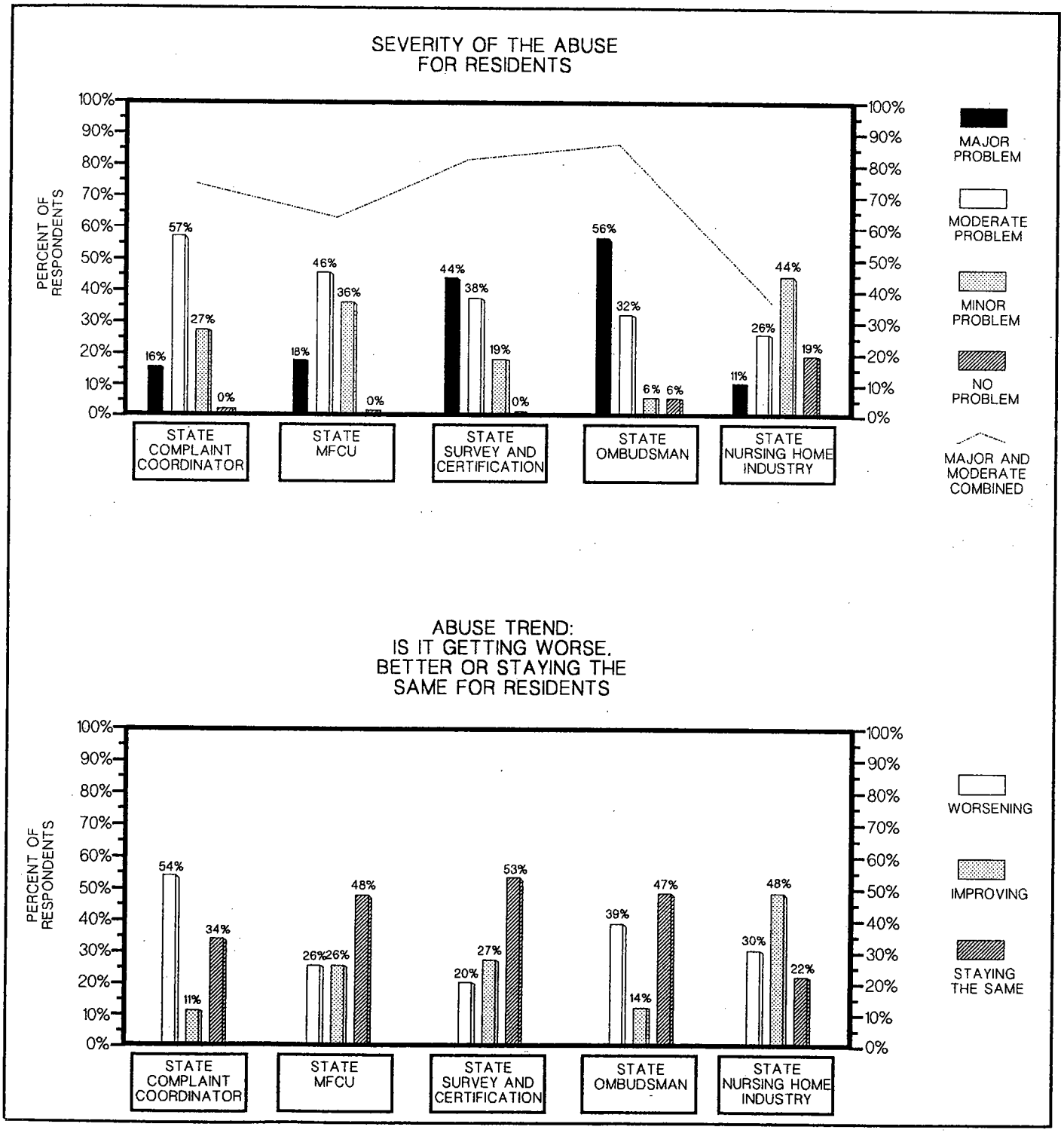


TABLE III

VERBAL/EMOTIONAL ABUSE

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

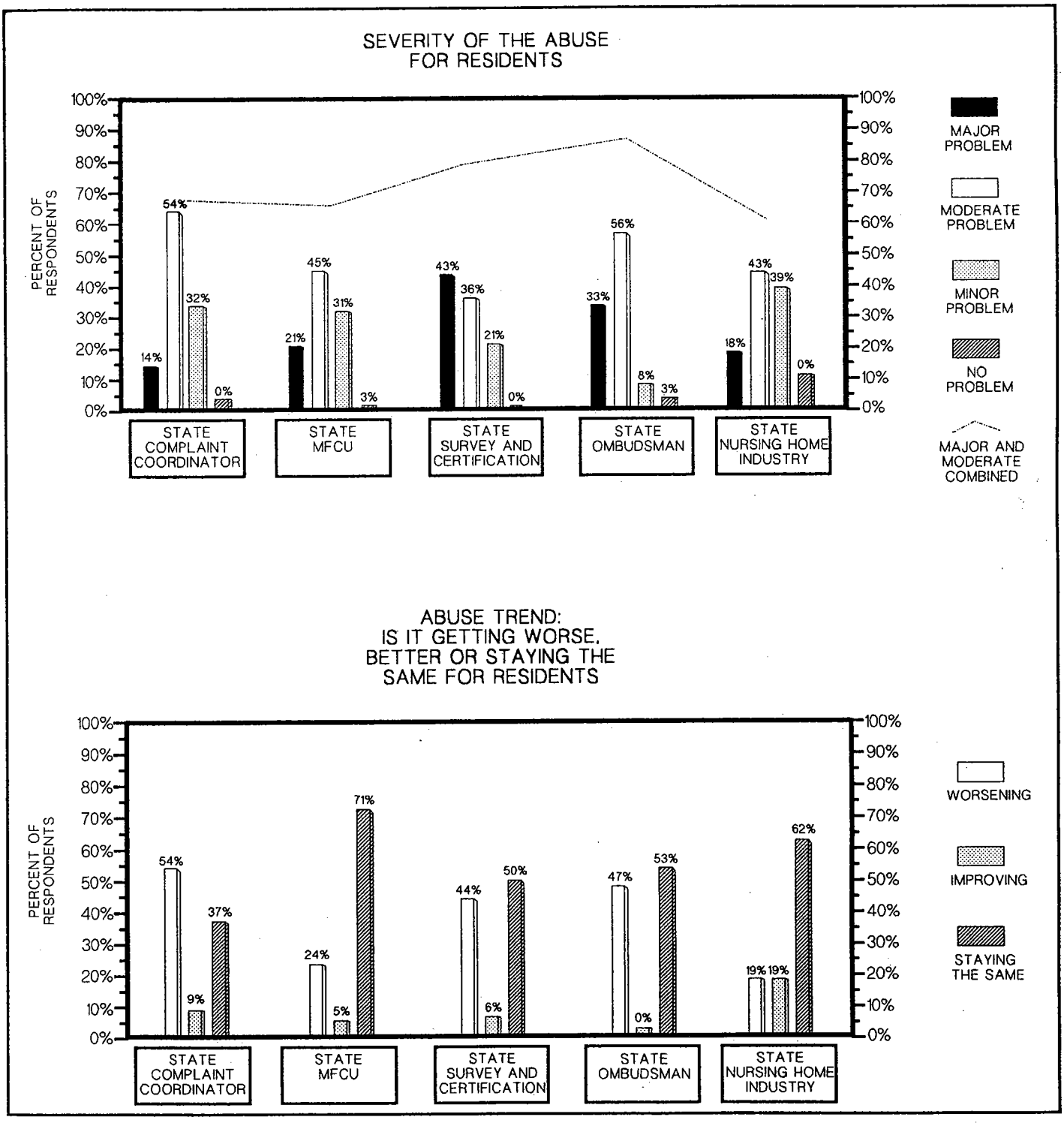


TABLE IV

PHYSICAL NEGLECT

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

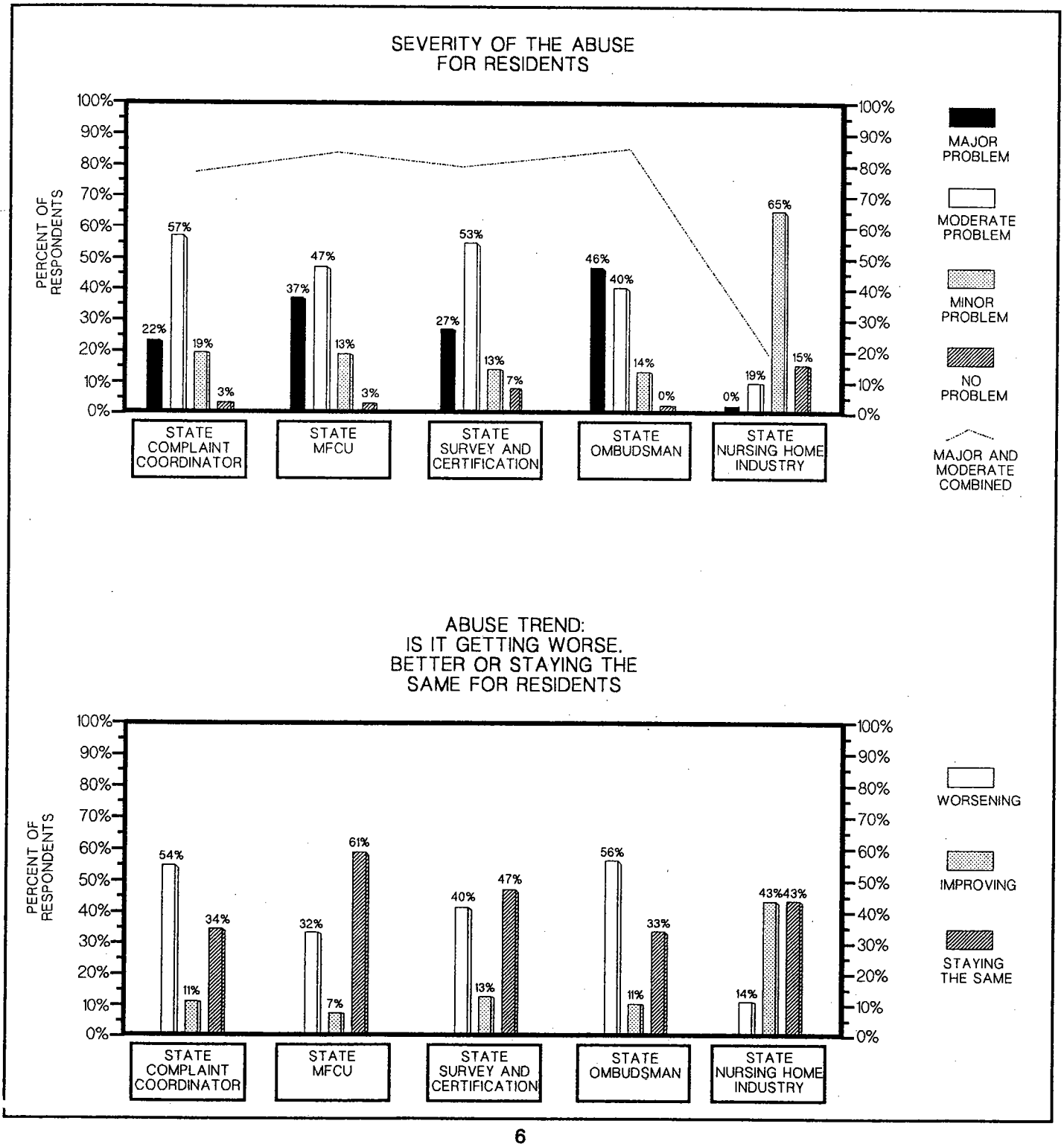


TABLE V

MEDICAL NEGLECT

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

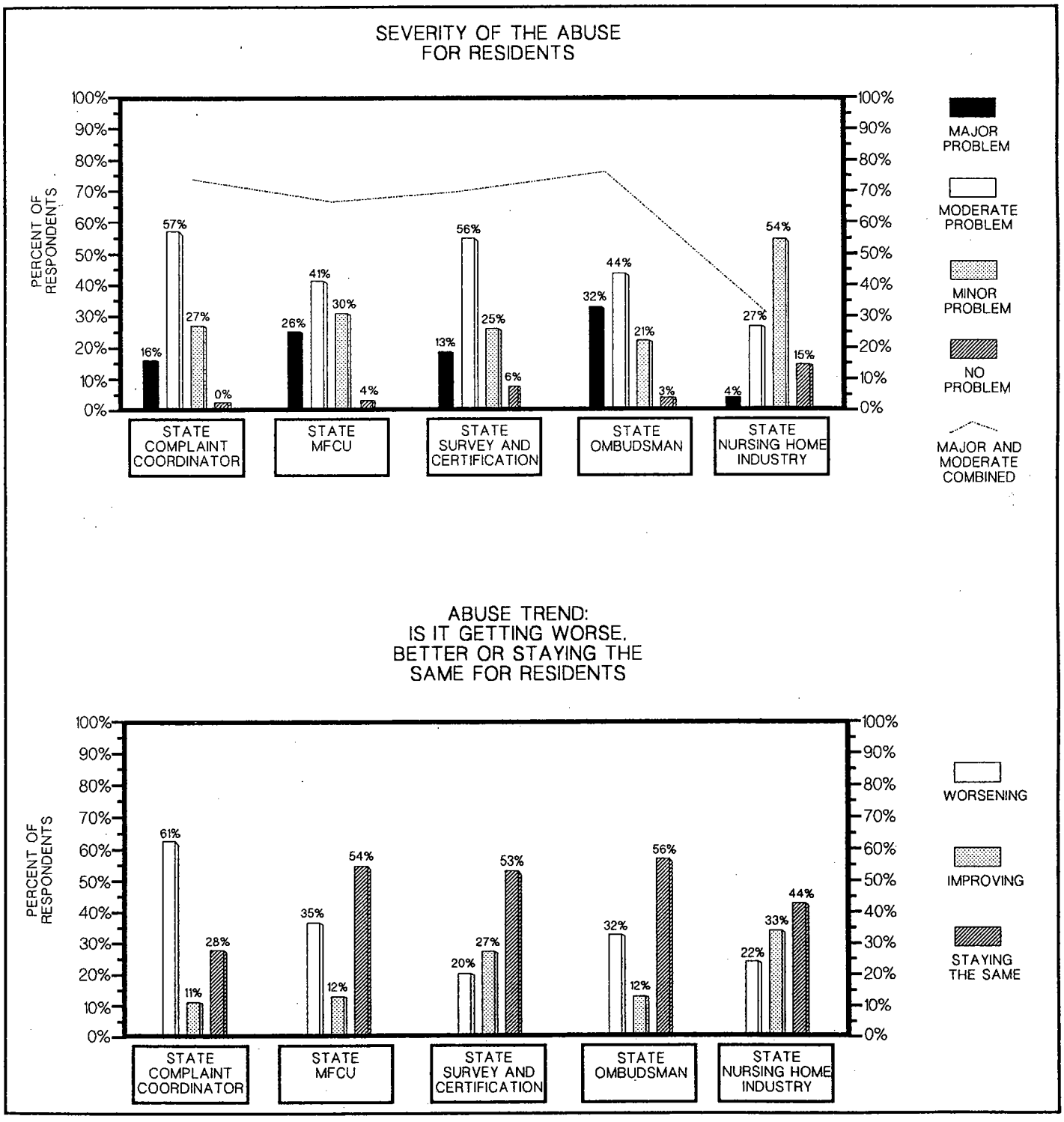


TABLE VI

VERBAL/EMOTIONAL NEGLECT

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND

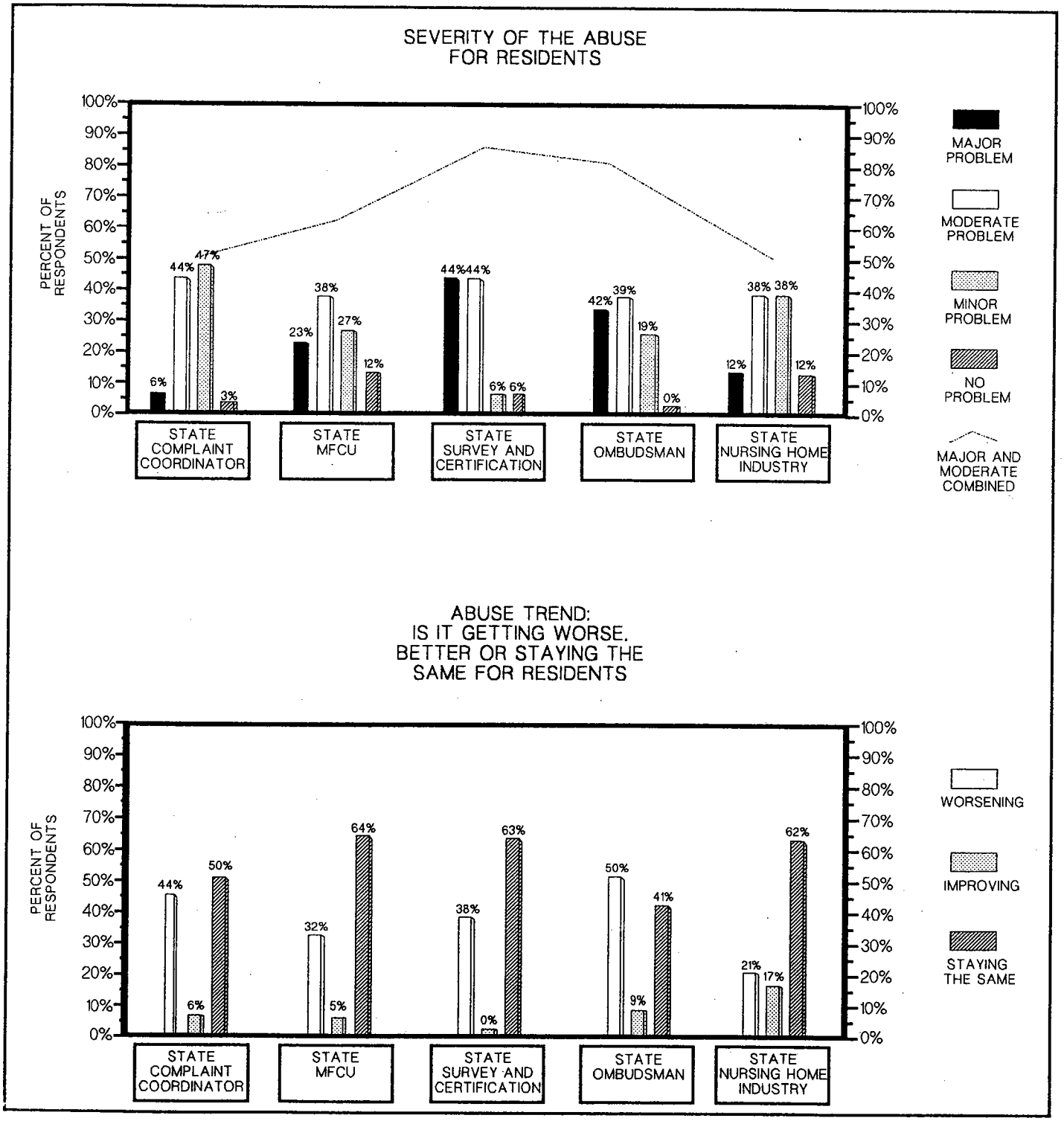
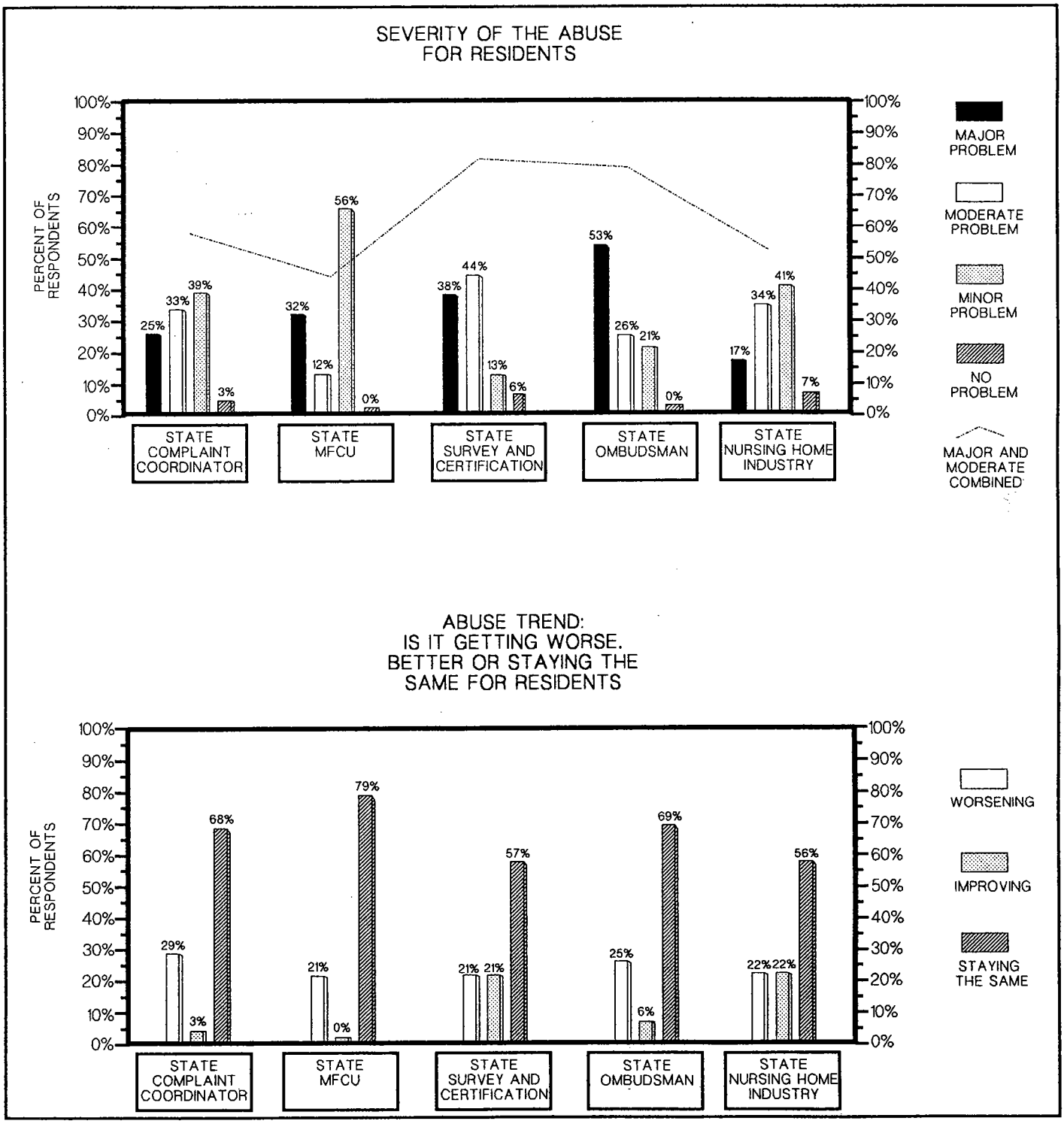


TABLE VII

PERSONAL PROPERTY ABUSE

RESPONDENT PERCEPTIONS OF SEVERITY AND TREND



DEPARTMENTAL COMMENTS

Comments on the draft reports were received from four Department of Health and Human Services entities - the Assistant Secretary for Planning and Evaluation, the Health Care Financing Administration, the Office of Human Development Services, and the Administration on Aging. The full texts of their comments are attached.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MEMORANDUM

DEC 29 1989

TO: Richard Kusserow
Inspector General

FROM: Arnold R. Tompkins
Acting Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports: (1) "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues" and (2) "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints"

I commend the OIG staff for producing two excellent reports documenting the problem of resident abuse in nursing homes and recommending strategies for dealing with it. OASPE supports the OIG's recommendations for improved training of nurses aides and orderlies about how to cope with stressful situations and resident behaviors without resorting to abuse, improved abuse complaint investigation and resolution as part of State enforcement of Federal nursing home regulations, and improved systems for abuse reporting.

In my view, these two reports merit the widest possible dissemination among Federal and State agencies concerned with nursing home regulation as well as among the nursing home industry and consumer groups.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date

From Louis B. Hays
Acting Administrator

Subject OIG Draft Reports: Resident Abuse in Nursing Homes:
(1) Respondent Perception of Issues--OAI-06-88-00360, and
(2) Resolving Physical Abuse Complaints--OAI-06-88-000361

To The Inspector General
Office of the Secretary

We are responding to your request for comments on the two subject reports. First, we disagree with your study methodology, particularly with respect to the Respondent Perception of Issues study. However, we generally agree with the recommendations, and much has already been done to accomplish the requested changes. These studies were done under the current conditions of participation, which will be in effect until October 1, 1990. On that date, revised requirements, which contain many of the safeguards recommended by OIG in these reports will go into effect. We do not believe it would be appropriate to make additional changes at this time.

We believe it would be advisable to include more information about the interviews and information gathering processes used in the study. It appears the data gathering process was an opinion survey, rather than a scientifically controlled review. Yet the data were presented as fact. This tends to produce the results found; i.e., ombudsmen and other officials who investigate abuse think it is a problem, while those representing nursing homes question the seriousness of the findings.

Our comments on the specific recommendations are attached. Please advise us whether you agree with our position at your earliest convenience.

Attachment

HCFA Comments

We agree with this recommendation and have been actively pursuing this end. As part of the nurse aide training and competency evaluation program regulations mentioned in 1a, the Secretary is required to establish regulations for the qualifications of instructors of nurse aide training and competency evaluation programs. While we cannot predict the precise content of the final rules, there will be minimum qualifications for these instructors. Also, 42 CFR 483.30 indicates that facilities "must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessment plans and individual care plans." This would include the supervisory nursing staff having the necessary skills to supervise direct care staff in a manner consistent with resident rights, including the right to be free from abuse.

Recommendation No. 2

HCFA should conduct further research concerning long term care policies which promote staff stability and provide for adequate staff-patient ratios necessary to control stress and abuse.

HCFA Comments

We believe that we have already developed an appropriate mechanism for ensuring that facilities have adequate and appropriate staff. As mentioned in our response to Recommendation 1c, HCFA will require that facilities have sufficient staff to provide for the needs of the residents, however, it is clear that increasing staff-resident ratios alone will not control abuse. This outcome-oriented requirement gives facilities maximum flexibility in determining the ways they will provide for staff stability and ensure that the needs and rights of residents are met. We also note that any further research in this area would require additional funding.

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report - Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints--(OAI-06-88-00361)

OIG recommends that HCFA, as part of its conditions of participation for hospitals and nursing homes, should:

Recommendation No. 1

Require all nursing home staff and hospital medical personnel to report all suspected incidents of abuse to the nursing home administrator or local law enforcement and to the central agency assigned responsibility for resolution of abuse complaints.

HCFA Comments

We do not agree entirely with this recommendation. We will require, effective October 1, 1990, at 42 CFR 483.13 (for nursing homes), that all alleged abuse be reported to the nursing home administrator or other official in accordance with State law. HCFA hospital conditions of participation and the Joint Commission on Accreditation of Healthcare Organizations standards do not require reporting of abuse. However, the hospital conditions of participation do require that hospitals follow State law. We are not aware of a significant abuse problem in hospitals and do not believe we need to revise our conditions of participation. We do not believe that the OIG has demonstrated a significant problem with respect to hospitals.

Recommendation No. 2

Require nursing homes to report all abuse incidents to local law enforcement, the central agency assigned responsibility for resolution of abuse complaints and to the State Survey and Certification Agency.

HCFA Comments

We do not agree fully with this recommendation. Again, effective October 1, 1990, we will require that all alleged instances of abuse be reported to the nursing home administrator or outside official in accordance with State law. We believe this is sufficient and that minor abuse incidents can be effectively handled by the administrator without the need for involvement of law enforcement personnel.

Recommendation No. 3

Require nursing homes to maintain reports of suspected incidents of abuse and the actions taken by the nursing home.

HCFA Comments

We agree and believe that the new regulations, which require that nursing homes conduct investigations of alleged abuse, maintain evidence of the investigations, and take corrective action when abuse is verified, will satisfy this recommendation.

Recommendation No. 4

Require administrators to conduct analysis of all incident reports to determine implications and appropriate actions.

HCFA Comments

We agree and believe that the new regulations cover this issue.

Recommendation No. 5

Require nursing homes to specify, as part of the nursing home residents plan of care, a plan to prevent abuse of a resident who is either mentally or physically unable to protect him/herself.

HCFA Comments

We agree and believe that the new regulations cover this issue. The regulations at 42 CFR 483.20 provide for a comprehensive assessment and development of a plan of care for every resident. The plan assessment and plan of care should include any special resident needs, including specific steps for prevention of abuse, if necessary.

Recommendation No. 6

Require nursing homes to provide ongoing monitoring and counseling of employees suspected of abusing residents.

HCFA Comments

We disagree with this recommendation. Counseling could be inadequate, and we do not believe that persons suspected of abuse should be allowed to continue to work with residents while being counseled. Their behavior must be appropriate or they must be removed from the job if expectations are not met.

Other Recommendations

HCFA agrees with the recommendation for State and local responsibilities, resolution and followup that requires each State to maintain retrievable data for HCFA.

In addition, HCFA also agrees with the joint recommendation that HCFA and the Administration on Aging develop common definitions and categories of abuse for all State and Federal reporting purposes. We will work toward this end.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

DEC 22 1989

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary
for Human Development Services

SUBJECT: Draft Reports on (1) "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues," OAI-06-88-00360 and (2) "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints," OAI-06-88-00361

Thank you for the opportunity to review the draft reports on Resident Abuse in Nursing Homes. We concur with the draft reports.

If you have any questions, please contact Deborah Bass at 245-3176.

Mary Sheila Gall

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Administration on Aging

Washington, D.C. 20201

JAN - 9 1990

TO: Richard P.Kusserow
Inspector General

FROM: Acting Commissioner on Aging

SUBJECT: Comments on the OIG Draft Reports on Resident Abuse in Nursing Homes

The Administration on Aging (AoA) appreciates the opportunity to comment on the OIG draft reports "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues" and "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints." We are pleased that the current draft reports incorporate changes which respond to most of the concerns that AoA expressed about the earlier draft materials. We want to thank George Grob for his time and diligence in making the necessary changes.

While most of our comments have been addressed, we continue to have serious concerns about one major item in the report on Resolving Physical Abuse Complaints. The Executive Summary (p.iii) under Recommendations relating to Federal Responsibilities proposes, among other things, that the Administration on Aging should expand and strengthen its efforts to issue periodic public reports concerning abuse trends. This topic is discussed further on page 17 of the report which notes that, while the AoA Ombudsman Report is a major indicator of nursing home abuse, it cannot be used to obtain reliable national counts of abuse (particularly for specific problem areas.) The report goes on to state that, for several reasons which are cited (p. 18), there are no adequate national nursing home abuse statistics to provide an incidence rate or trend for nursing home abuse.

We concur with the observation that there are no data which can be used to provide an incidence rate or trend regarding nursing home abuse. The impediments to the collection of such data which the report cites are beyond the capacity of AoA to overcome. Therefore, it is not possible for AoA to respond to the report's recommendation to expand and strengthen its efforts to issue periodic public reports concerning abuse trends. In light of the report's own conclusions regarding the significant nature of impediments to the collection of trend data, we once again request that

the recommendation concerning AoA which appears on p.iii of the Executive Summary delete any reference to issuance of reports on abuse trends and be revised to read:

- The Administration on Aging (AoA) should expand and strengthen its efforts to 1) issue best practices for preventing and dealing with resident abuse, 2) promote public awareness and education concerning abuse occuring in nursing homes and 3) promote use of volunteer Ombudsman in nursing homes.

Again, we appreciate the opportunity to review and comment on the draft reports prepared by OIG.

Joyce T. Berry

Joyce T. Berry, Ph.D.

APPENDIX D

PUBLIC COMMENTS

Comments were received from several organizations with interests pertaining to the elderly, nursing homes, or law enforcement:

American Association of Homes for the Aging
American Health Care Association
National Aging Resource Center on Elder Abuse
National Association of Chiefs of Police
National Association of Medicaid Fraud Control Units
National Citizen's Coalition for Nursing Home Reform
Police Executive Research Forum

Additional comments were received from a select representation of State and local entities involved directly or indirectly with issues relating to the elderly, nursing homes, or law enforcement. All comments were reviewed and analyzed. Findings and recommendations in both final reports reflect many of the pertinent concerns and issues raised by the commentors on the draft reports.

The following are short excerpts expressing concerns and observations of report reviewers:

"I am disturbed by the absence of national and state statistics in [the] two-part report and [the] reliance on the impressions of a small sample of individuals with a skewed view of the issue. I am further disturbed by your failure to adequately define the term, "abuse," which has resulted in confused and unreliable findings." [Nursing Home Advocate]

"We must assist families who have loved ones in a facility to become more aware of the aging process and the circumstances surrounding the institution living. Consideration should also be given whereby training modules are made available to and participation in them encouraged for relatives and friends of the institutionalized aged and infirm." [State Complaint Coordinator]

"We feel strongly that your report should acknowledge the costs to the Medicaid and Medicare programs of such [supervisory training for direct care supervisors] training, as well as the time diverted from patient care activities to fulfill such requirements -- particularly at a time when there is a national shortage of skilled nursing personnel." [Nursing Home Advocate]

"..feels strongly, and the final report of the National Commission on Nursing recognized, that the Medicaid program -- through inadequate reimbursement -- actually limits nursing home providers' ability to recruit and retain adequate members of highly skilled nursing staff. We believe that HCFA, in approving State Medicaid reimbursement plans, must ensure that reimbursement rates allow nursing homes to compete with hospitals and other health care providers for scarce nursing staff." [Nursing Home Advocate]

"I would like to see a study on the emotional makeup of the abusing aides to include mental health exams and especially depression scales since people with mild mental illnesses get much worse under stress and may be impulsive or neglectful. To prevent medical neglect I would like to see physician training in geriatrics and medical directorship be much more widely required, and a strong medical director system in nursing homes..." [Physician]

"The resistance to recommendations of this nature [involving attitudes and understanding behaviors] revolve around funding. At the risk of oversimplification, some of the problems might better be addressed and resolved if there were not the present and near impossible crazy quilt of 50 different State reimbursements for Medicaid. And there might be far less medical neglect if Medicare did not discriminate against payments for physician visits for patients in nursing homes." [Nursing Home Administrator]

"Require Medical Schools to offer courses in geriatrics, and require rotation of interns in nursing homes; move toward nationalization of Medicaid payments." [Nursing Home Administrator]

APPENDIX E

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