

Recommendations to Promote High-Quality Care for Residents of Texas Nursing Facilities

As Required by House Bill 2292, 78th Legislature

Report to the 79th Texas Legislature

October 1, 2004

EXECUTIVE SUMMARY

The Nursing Facility Quality Assurance Team (NFQAT) was established by HB 2292, 78th Legislature and charged with 1) developing and recommending clearly defined minimum standards to be considered for inclusion in contracts between the Texas Department of Human Services (DHS) and nursing facilities (NFs), and 2) developing and recommending improvements to consumers' access to information regarding quality of care in NFs. The latter charge was to include types and amounts of information available, DHS data systems of NF inspection/survey data, and other NF quality-of-care data.

The NFQAT was also charged with considering Texas Department of Insurance (TDI) risk factors contributing to NF lawsuits. This charge included considering the practices TDI recommends NFs adopt to reduce lawsuits, as well as other standards to improve quality of care. The NFQAT was to develop a minimum number of critical standards needed to identify NFs with poor quality services that should not be awarded contracts. Together with DHS, the NFQAT was to assess potential financial impact of these standards to providers as well as the fiscal impact to the State.

Recommendations contained in this report are designed to ensure that the care provided by NFs to residents meets or exceeds minimum acceptable standards of care and encourages the highest quality of care.

Below is an overview of the NFQAT's recommendations. The body of the report provides the background and detail for each recommendation.

RECOMMENDATIONS—Additional Contract Standards

1. Require facility to document participation in a formal quality assessment, assurance and improvement program with measurable and sustainable outcomes as a condition for Medicaid contract renewal.
2. Terminate the provider agreement for any facility demonstrating a history of poor quality of care for two-out-of-three years. Prohibit these licensees from obtaining a Medicaid contract for this facility for a set time.
3. Require that each facility in the bottom 10% for case-mix adjusted nurse staffing, and that is not spending 100% of the direct-care component of the nursing home rate, develop a quality improvement initiative aimed at improving its staffing levels in terms of licensed nursing staff and certified nursing assistants.

RECOMMENDATIONS—Consumer Access

1. Improve public awareness of Quality Reporting System (QRS).
2. Improve access to QRS from other Texas Department of Aging and Disability Services (DADS) web pages.
3. Increase consumer confidence in understanding and navigation of QRS.
4. Evaluate usability of QRS web site and validity of Quality Indicators.

ADDITIONAL LEGISLATIVE and ADMINISTRATIVE RECOMMENDATIONS

1. Require all licensed facilities to transmit Minimum Data Set (MDS) resident assessments on all residents, not just those in Medicare/Medicaid beds.
2. Require RN staffing to be 16 hours a day.
3. Appropriate sufficient funding for DADS to examine owner history and comply with legislative mandates regarding assessment of licensure applications related to financial viability and history of care.
4. Examine history of care for owners, and encourage DADS to apply best practices gleaned from other states.
5. Request that the legislature identify factors that may help attract and retain good nursing home providers/owners.
6. Track feeding assistant hours and wages as separate line item on cost reports.
7. Establish a requirement that providers spend no less than 85% of the nursing home rate component for direct care on allowable direct care expenses – independent of participation in the staffing enhancement program.
8. Retire each expiring Medicaid contract on its anniversary and replace it with a new contract that incorporates the newly defined minimum standards.

ADDITIONAL ISSUES to STUDY

The NFQAT also identified the following issues as important to a discussion of the charge, but there was not sufficient time or resources to develop them:

1. Overall Funding Issues
2. Direct-Care Salaries
3. Career Ladders
4. Facility Financial Viability.

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INTRODUCTION and BACKGROUND

Legislative Mandate

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The NFQAT was also to consider Texas Department of Insurance (TDI) risk factors contributing to NF lawsuits. This charge included considering the practices TDI recommends NFs adopt to reduce lawsuits, as well as other standards to improve quality of care. The NFQAT was to develop a minimum number of critical standards needed to identify NFs with poor quality services that should not be awarded contracts. Together with DHS, the NFQAT was to assess potential financial impact of these standards to providers as well as the fiscal impact to the State.

Recommendations contained in this report are designed to ensure care provided by NFs to residents meets or exceeds minimum acceptable standards of care and encourages the highest quality of care.

Charge deliverables included:

- 1) Developing and making recommendations required by Section 32.060k, Human Resources Code, **not later than May 1, 2004***; and
- 2) Reporting on its work and recommendations to the Governor and the Legislative Budget Board no later than October 1, 2004, for consideration by the 79th Legislature.

* Governor's Office appointments were not completed until the last week of April 2004. (All appointments were to be made in January; a final, ninth member was appointed in late May but was not able to participate.)

CONTRACT RECOMMENDATIONS: Additional Contract Standards

Recommendation #1

Require facility to document participation in a formal quality assessment, assurance and improvement program with measurable and sustainable outcomes as a condition for Medicaid contract renewal.

Discussion:

- Facility staff, residents and family members are encouraged to participate in identifying quality improvement goals.
- Each facility will have access to a provider letter that provides guidance on what constitutes a *meaningful* quality improvement process. To have a *meaningful* quality improvement process, a facility must demonstrate the presence of the following components or processes:
 1. **Use rational process for choosing goals.**
 - Identify quality concerns related to facility operations and practices, not only those that can cause negative outcomes, but also those that enhance quality of care and quality of life for residents.
 - Identify at least one area for action in the coming 24 months.
 - Seek input/involvement from the local ombudsman program.
 2. **Develop action plans.**

When a quality deficiency or opportunity for improvement is identified, the facility should use a systematic process to develop and implement an action plan similar to the following:

 - Identify the problem and root cause(s), (e.g., What is the problem? How extensive is it? What caused it?);
 - Determine the sources of information, (e.g., medical records, facility departments);
 - If necessary, designate a task force or ad hoc committee;
 - Determine disciplines to be involved based on the nature and cause of the problem and on professional expertise and responsibilities;
 - Identify a proven care process/approach;
 - Develop a written plan specifying the tools, approaches, and evaluation of outcomes;
 - Determine goals and timelines;
 - Set timelines for completion of tasks;
 - Review existing policies and procedures; compare to evidence-based and reliable consensus-based approaches such as those in references and web sites;
 - Review literature and consult the medical director and other experts, (e.g., nurse consultant, consultant pharmacist); and

- When an opportunity for improvement is identified, identify the extent of the problem, which may include the number of residents, units, and departments/professionals involved.

3. Implement action plans.

- Create a team to provide leadership.
- Develop a statement about the team's understanding of the scope, the root cause of the problem, and the plan.
- Provide education and in-services on the defined topic.
- If leadership fails to implement the Quality Assessment and Assurance (QA&A) initiatives for which they were responsible, or if the initiatives are not effective (do not meet measurable goals), the administrator or designated supervisor reevaluates the approach and implementation and recommends changes.

4. Monitor and evaluate.

- **Data Collection/Measurability:** Collect and analyze data to be reviewed at the quarterly QA&A meeting. Revise interventions as needed if goals are not being met.
- The facility's QA&A program includes methods for monitoring and evaluating the successful implementation of quality processes and practices. There must be evidence that the facility's QA&A plans, strategies, and goals are reflected in the provision of aspects of care, as identified through facility policies and procedures, staff interviews, resident interviews, and other sources of information. The facility should demonstrate that it reviews its plans or strategies and revises them as necessary when desired outcomes are not achieved.
- Can the direct care staff, particularly Certified Nurse Aides (CNAs), identify the goals of the QA&A initiatives and key elements of the implementation strategy?
- Is there evidence that the facility is sustaining the progress on the indicator/measure?

- There must be quantifiable evidence that the facility has made measurable improvement in achieving the specified goal for a quality initiative over a 24-month period (or a span of two standard annual surveys). Progress reports shall be posted prominently in the facility. Evidence must be collected and analyzed at least quarterly at the Facility Quality Assurance Meeting.
- Examples of programs which would meet these requirements include the following:
 1. Quality First, or
 2. Texas Medical Foundation Quality Initiatives, or
 3. Implementation of at least two American Medical Directors Association (AMDA) Clinical Practice guidelines appropriate to the identified need of the facility, per the QA&A process, or
 4. Implementation of a quality risk management plan as developed by the Texas Department of Insurance, or
 5. Participation in the Quality Monitoring initiative.

Current Quality Monitoring Program Initiatives:

1. Restraint elimination
 2. Effective use of toileting for continence promotion
 3. Appropriate indications for indwelling bladder catheters
 4. Improving Influenza vaccination rates among residents and staff
 5. Improving Pneumococcal vaccination rate among residents
 6. Managing fall risk
 7. Improving pain assessment (validity and frequency)
 8. Improving pain treatment (appropriate use of World Health Organization pain ladder recommendations)
 9. Appropriate indications for and clinical monitoring of antipsychotic therapy
 10. Appropriate indications for and clinical monitoring of anxiolytic therapy
 11. Appropriate use of sleep hygiene measures and duration of hypnotic use
 12. Medication regimen simplification
 13. Improving hydration risk assessment and hydration practices
 14. Improving detection of and intervention for unintended weight loss
 15. Improving indications for artificial nutrition and hydration
 16. Improving the Advance Care Planning process (Advance Directives)
- If at the time of the next survey, the facility has not shown compliance with its QA&A plan, it has a period of 180 days to cure the compliance failure prior to initiation of contract termination.

Recommendation #2

- Terminate the provider agreement for any facility demonstrating a history of poor quality of care for two-out-of-three years. Prohibit these licensees from obtaining a Medicaid contract for this facility for a set time.
- DADS should ensure that any sale of the facility under this recommendation should not be to the parties controlling the facility at the time of Medicaid contract termination.

Discussion:

- A history of poor quality of care is defined as deficiencies related to CFR 483.13, 483.15, and 483.25 at Level H or above in two-out-of-three years.

Illustration of Patterns of Repeat Offender That Would Be Barred			
Year 1	Year 2	Year 3	Decision
Poor Quality of Care	Poor Quality of Care	No contract	
Poor Quality of Care		Poor Quality of Care	No contract
	Poor Quality of Care	Poor Quality of Care	No contract

- A long-term care facility classified as a “*historically poor quality-of-care facility*” or “*repeat offender*” for two-out-of-three consecutive years shall not be granted a new provider agreement.
- The determination of history of quality of care for this contract provision shall begin with a new provider’s first year of control at a facility.

Projected Impact:

Had the above criterion been applied to the most recent three years of regulatory compliance history, 17 facilities would have had their Medicaid contracts terminated for *poor quality of care*. This standard would have required a change of ownership for these facilities to continue operating as certified facilities and/or relocating their residents, an estimated 1200 persons.

Rationale for Performance Criterion for Facilities with a History of Poor Quality of Care:

In a 1999 report, the General Accounting Office (GAO) [now known as the U.S. Government Accountability Office, also GAO], noted that “one in four of the nation’s nursing homes had deficiencies so serious that they harmed residents or placed them at serious risk of death or injury.” Of those facilities cited for serious deficiencies, 40 % were cited for repeat deficiencies. Thus, a total of 10 % of all certified facilities had deficiencies that actually harmed residents or placed them at serious risk of death or injury *and* had repeat deficiencies. GAO also reviewed the deficiency citations of these facilities and found that “[m]ost of the repeat violators were cited for the same deficiency, and about one-third were cited for closely related problems.”

Moreover, using the Centers for Medicare & Medicaid Services (CMS) definition of “poor performing homes,” GAO found that “[t]wo-thirds of the poor-performing nursing homes GAO surveyed had repeated violations.” Despite this fact, these poor performing facilities remained licensed and certified to participate in Medicare or Medicaid.¹⁰ Indeed, in several earlier reports for the U.S. Senate Special Committee on Aging, GAO criticized state and federal regulatory approaches because they had allowed facilities to continue participating in Medicare and Medicaid despite “yo-yo” patterns of compliance. This pattern is described as one in which a facility comes into compliance long enough to get a new provider agreement but then returns to a pattern of substandard care and significant deficiencies, year after year.^{10, 11}

Thus, the issue of poor performing facilities, particularly those with a pattern of repeated deficiencies and poor performance, has been and remains an issue of great concern to the GAO and to Congress, as well as to others interested in improving nursing home quality.⁹ This group includes the National Academy of Sciences; Institute of Medicine (IOM), in its recommendations on improving nursing home quality (IOM, 1986); consumer advocacy groups, such as the National Citizens Coalition for Nursing Home Reform (NCCNHR), and the Consumers Union, which publishes a Nursing Home Watch List that identifies “repeat offenders; and researchers concerned with the quality of nursing home care.^{1, 3, 4, 5, 6, 7, 8} State survey directors and CMS have also expressed growing concern about how to enhance enforcement and address problems identified with the pattern of “yo-yo” compliance.²

Several state survey agency directors noted the difficulty of dealing with facilities with a “yo-yo” pattern of enforcement, even when those facilities have a long history of providing very poor care (Carman, Hawes and Phillips, personal communication, 2004). Data from CMS and the states bears that out. Between 1992 and 2000, a total of only 2.4% of all facilities participating in Medicare and Medicaid were involuntarily terminated from provider participation (Angelelli, Mor, Intrator, Fen & Zinn, 2003).

Recommendation #3

Require that each facility in the bottom 10% for case-mix adjusted nurse staffing, and that is not spending 100% of the direct-care component of the nursing home rate, develop a quality improvement initiative aimed at improving its staffing levels in terms of licensed nursing staff and certified nursing assistants.

- Each such facility shall report quarterly on its progress regarding staffing improvement initiatives until its case-mix-adjusted staffing rate rises above the bottom 10th percentile.
- Unless a facility exceeds the lowest 10th percentile within 12 months of being determined below this threshold, or can demonstrate it is making progress and no residents have been harmed or are at risk because of inadequate quality of care, *its provider contract shall be terminated*.
- There will be a review of progress at nine months with a final warning letter if there is no quantifiable evidence that the facility has made measurable improvement in achieving the specified goal of rising above the 10% threshold.

Discussion:

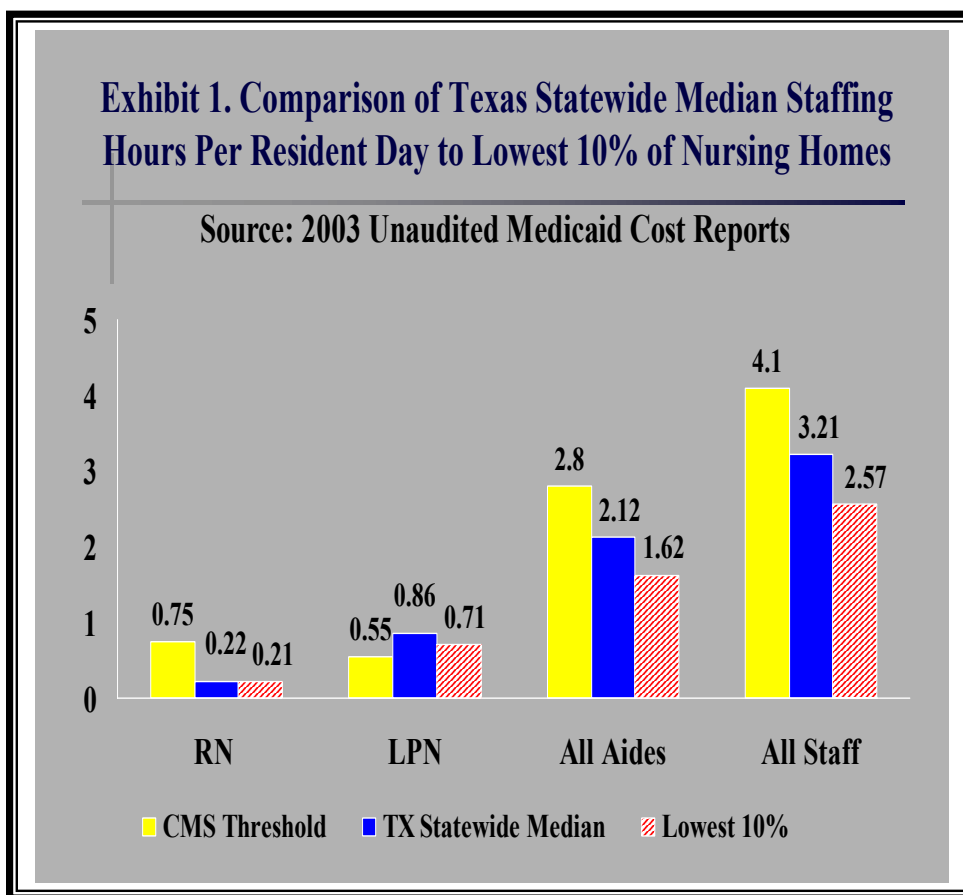
There is widespread agreement that nurse staffing levels are related to nursing home quality. This agreement is based on expert opinion and qualitative and quantitative research findings. As a result, several groups and organizations have made recommendations recently about increasing nurse staffing levels in nursing homes, including the National Academy of Sciences, the National Citizens Coalition for Nursing Home Reform (NCCNHR), and a symposium of experts convened by the Hartford Institute for Geriatric Nursing.^{5, 8, 20, 21}

RN Staffing. The most persuasive support for the relationship between staffing and quality comes from a plethora of studies over the last 25 years that have categorically demonstrated the positive relationship between Registered Nurse (RN) staffing and improved quality.^{1, 2, 3, 4, 6, 7, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21} These studies have found a wide range of benefits from higher levels of RN staffing in nursing homes, including lower mortality rates and reduced morbidity. Indeed, higher levels of RN staffing were associated with better process quality *and* better resident outcomes, such as improved physical functioning, lower prevalence of pressure ulcers, lower rates of indwelling catheter use, fewer urinary tract infections, lower rates of dehydration and unintended weight loss, and lower rates of hospital use.

CNA Staffing. Research also indicated that higher levels of CNA staffing are associated with better quality.^{6, 17} In one study, lower levels of staffing were associated with higher rates of urinary catheter use, lower rates of skin care, and lower resident participation in activities. In

other studies, lower staffing levels were associated with poor care practices, including inadequate assistance with eating during meals, poor skin care, lower activity participation, less toileting assistance, higher rates of quality-of-life deficiencies, and higher rates of total deficiencies.^{6, 10, 11, 16, 17} Research also suggests that low CNA staffing (and poor staff training) are major factors in abuse and neglect of residents.⁸

Staffing Threshold. What has been unknown is the threshold at which additional staffing does not necessarily produce improvements in quality. However, CMS recently completed a two-phase study that addressed this issue. What the study and its many component parts found was that quality improved as the staffing levels in facilities increased up to the threshold levels shown below, with no measurable increase in quality as staffing rose above those levels.¹⁸



The thresholds established by the CMS study are 0.75 RN hours per resident day, 0.55 LPN/LVN hours per resident day, and 2.8 CNA hours, as shown in Exhibit 1. Median staffing levels for Texas facilities and staffing levels for the Texas facilities in the lowest 10 % of total nursing staff are also displayed in Exhibit 1. Exhibit 2 provides greater detail, comparing the Texas statewide average staffing levels with those in facilities in the lowest decile (bottom 10%) for RN staffing, CNA staffing, and total nursing staff.¹

¹ The NFQAT gratefully acknowledges the assistance of Dr. Leslie Cortes of the Texas Department of Aging and Disability Services for his work in producing these data and for other staff in the Texas Health and Human Services Commission for verifying the accuracy of our estimates.

These exhibits show significant differences in staffing levels of the average nursing home and of those in the lowest tenth of all Texas facilities.

- In 2003, the total nurse and aide (all staff) staffing level in the median Texas nursing home was 0.64 hours per-resident, per-day, (or 25%) *higher* than comparable staff hours in the average facility in the bottom 10% of all Texas nursing homes.
- In 2003, the total *aide* staffing level in the median Texas nursing home was 0.5 hours per-resident, per-day, or 31% *higher* than aide staffing in the average facility in the bottom 10% of all Texas nursing homes.

Exhibit 2. Revised Staffing Level of Hours per- Resident/Day (HPRD) – Based on Facility Reports in 2002 Audited and 2003 Unaudited Medicaid Cost Reports							
	RN	LVN	MA	RA	CNA	All Aides	All Staff
Statewide							
Average – 2002	0.25	0.86	.017	0.04	1.91	2.12	3.23
Median – 2002	0.23	0.85	.015	0.00	1.89	2.07	3.18
Average – 2003	0.24	0.86	0.20	0.05	1.92	2.17	3.28
Median – 2003	0.22	0.86	0.19	0.01	1.89	2.12	3.21
10% with lowest combined staffing							
Median – 2002	0.20	0.72	0.14	0.00	1.41	1.56	2.53
Median – 2003	0.21	0.71	0.14	0.0	1.46	1.62	2.57
10% with lowest RN staffing							
Median – 2002	0.11	0.89	0.17	0.01	1.90	2.11	3.10
Median – 2003	0.11	0.92	0.22	0.06	1.85	2.10	3.14
10% w/ lowest staffing for all aides							
Median – 2002	0.26	0.84	0.05	0.00	1.37	1.52	2.60
Median – 2003	0.24	0.84	0.06	0.00	1.42	1.57	2.66
<i>All staff (Medicaid contracted and non-contracted beds; permanent and contract staff; RN hours include DON hours)</i>							
<i>MA = Medication Aide; RA = Restorative Aide; All Aides = MA + RA + CNA hours per resident day</i>							

The relationship between staffing levels and quality of care has been illustrated in research, literature, and practice. Increasing staff levels for both licensed nurses and nurse aides in facilities currently ranked in the bottom 10% of Exhibit 2 will help assure a higher level of care.

RECOMMENDATIONS—Consumer Access

1. Improve public awareness of Quality Reporting System.

- Reach out to surrogate decision-makers or those who assist them, such as primary care physicians (and/or their offices), ombudsmen and hospital discharge planners.
- Conduct a widespread consumer education campaign, e.g., “Planning for Your Future.”
- Require the caseworker who determines eligibility for Medicaid and nursing home level of care to give the consumer and/or family a brochure on how to select a nursing home and how to access QRS.
- Explore other mechanisms, (e.g., senior citizen groups), or methods (e.g., distribution of brochures in hospitals, physician offices or senior centers), for publicizing information about how to select a nursing home.
- Develop an annual public awareness campaign using radio, television, and billboards to publicize resources for consumers.

2. Improve access to QRS from other DADS web pages.

- Create a direct link from the DADS home page, marked by a prominent icon, to QRS.
- Increase consumer awareness of how to choose a nursing home and access other available resources; include a method of evaluating the campaign for effectiveness.
- Provide a section on how to navigate the long-term care process in all DADS publications, and list the two web sites—CMS (Nursing Home Compare) and QRS.

3. Increase consumer confidence in understanding and navigation of QRS.

- In the QRS NF Profile pages, change “dual certification” to “Medicare/Medicaid beds,” and the glossary (g) icon to “Read More.”
- Indicate Deficiency Severity using text and a color code for harm levels: levels one and two, *green*; level three, *yellow*; level four (IJ), *red*.
- Bold the entire last sentence in the QRS yellow Caution Box to stress the importance of visiting the nursing facility.
- In the QRS NF Profile pages, provide a link to Nursing Home Compare.
- Add a bar graph comparison showing facility percentile for staffing and case mix.
- Provide a list of questions concerning staffing that consumers should ask.

- Add the AAA Ombudsmen 1-800-252-2412 to the Caution Box on the QRS web site.
- Create a link at the QRS homepage that points to the DADS web page and gives alternatives to nursing homes.
- In the QRS NF Profile pages, include the number of complaints, number of allegations, and number of substantiated allegations by calendar year for three years.

4. Evaluate usability of QRS web site and validity of Quality Indicators.

- Have a Usability Expert conduct a formal evaluation of the QRS web site after all the DHS web sites have been converted successfully to DADS.
- Contract with a third party to evaluate the validity of the Quality Indicators (QIs).

Current Consumer Access initiatives:

The Texas QRS system as it currently exists has many positive qualities. It is superior, in many professionals' view, to the CMS website. Issues of note are echoed in the Castle and Lowe manuscript: Castle, N.G. and Lowe, T. 2004. "Report cards and nursing homes." *The Gerontologist*, (in press). QRS is effective because it:

- Allows consumers to compare multiple facilities and provides useful benchmarks in a geographic area (e.g., comparative performance for all NFs in a given zip code – which is how consumers typically shop – that is, in a given location);
- Is accessible to consumers through the Texas Department of Aging and Disability Services (DADS) web site (and fairly easily through the State of Texas homepage); it also provides access to guides on how to select a nursing home;
- Includes a wide diversity of QIs. This is important since quality is a multidimensional concept, and different consumers have different values and preferences;
- Uses QI data collected each quarter, which dramatically improves timeliness; and
- Cautions users on the limitations of the QIs.

As Castle and Lowe note, only three states (MD, OH, and TX) “attempted to help consumers understand how and why to use quality information.”

ADDITIONAL LEGISLATIVE and ADMINISTRATIVE RECOMMENDATIONS

1. Require all licensed facilities to transmit Minimum Data Set (MDS) resident assessments on all residents, not just those in Medicare/Medicaid beds. This requirement would provide a better representation of the status of Texas facilities and a larger denominator in the Quality Indicators/Quality Measures reports for facilities with only a few certified beds. States can opt to make this requirement.

2. Require RN staffing to be 16 hours a day.
3. Appropriate sufficient funding for DADS to examine owner history and comply with legislative mandates regarding assessment of licensure applications related to financial viability and history of care.
4. Examine history of care for owners, and encourage DADS to apply best practices gleaned from other states.
5. Request that the legislature identify factors that may help attract and retain good nursing home providers/owners.
6. Track feeding assistant hours and wages as a separate line item on cost reports.
7. Establish a requirement that providers spend no less than 85% of the nursing home rate component for direct care on allowable direct care expenses – independent of participation in the staffing enhancement program.
8. Retire each expiring Medicaid contract on its anniversary and replace it with a new contract that incorporates the newly defined minimum standards.

ADDITIONAL ISSUES to STUDY

The NFQAT also identified the following issues as important to a discussion of the charge, but there was not sufficient time or resources to develop them:

1. Overall Funding Issues
2. Direct-Care Salaries
3. Career Ladders
4. Facility Financial Viability.

NFQAT recommendations address the charge of developing additional contract standards for the purpose of improving quality. It is clear that inadequate staffing is associated with poor quality. While the recommended contract standards will ensure that direct care funds are spent on direct care, these standards do not ensure that direct care funding will be sufficient to ensure the level of staffing that will lead to improved resident care.

That providers are committed to improving staffing is demonstrated by the fact that 85% of providers participate in the state's staffing enhancement program. However, that program does not have the funding required to meet provider's existing requests for additional staffing. The NFQAT recommends the State address the existing gap in direct care funding so recommended contract standards can have the desired effect.

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