Special Article

Nursing Home Care in 2001

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As we move toward the 21st century, nursing home care will become an increasingly important part of family practice. The number of nursing home residents will grow, their illnesses will become more acute, and the types of medical services provided by nursing homes will broaden. The fiscal difficulty of providing nursing home care will intensify, and a variety of innovative payment programs will be introduced in an attempt to control costs. The only way these will succeed is by a partial reallocation of health care dollars from expensive high-technology hospital care to less expensive low-technology care in nursing homes. As a result of these changes, hospitals will become more involved in the provision of what were traditionally nursing home services. Nursing homes will be used to a larger extent for medical education, and, under congressional pressure, a shrinking pool of federal research dollars will be more fairly allocated to clinical investigation in this setting.

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Why is it that two words, *nursing* and *home*, when used singly, evoke very positive emotions, but when put together have such negative connotations? Senior citizens are frightened by the prospect of ever having to enter one, politicians and policymakers are staggered by the costs involved in operating them, and physicians are either ignorant about or uninterested in what goes on in them. How much will these attitudes have changed by the year 2001?

Increased Demand

The population of North America is aging. Even in the best-case scenario, with more of the elderly remaining active longer and more services being provided in patients' homes, the demand for nursing home beds will increase.[1] It has been estimated that, for persons who turned 65 years old in 1990, 43% will enter a nursing home at some time before they die, and 21% will have a total lifetime use of nursing home care of 5 years or more.[2] The introduction of Medicare's prospective payment system through diagnosis-related groups (DRGs) has resulted in earlier discharge of sicker patients from hospitals to nursing homes.[3,4] This trend will continue. Not only will there be an increase in elderly nursing home patients by the year 2001, but with the continuation of the AIDS epidemic, an increasing number of younger patients will also spend time in nursing homes. Furthermore, although there will be a growing demand for nursing home beds between now and 2001, the more significant impact caused by the aging of the post–World War II "baby boom generation" will not be felt until about 20 years after 2001.

Sources of Funding

Most nursing home residents are severely impaired in their ability to care for themselves. Because of this, their care needs must be met by others. The nursing home industry is labor intensive and therefore expensive. It is estimated that nursing home care in the United States will cost $125 billion by the year 2000, which is more than double the current expenditure. Fifty percent of the current costs across the nation are paid by Medicaid. Only a small percentage of nursing home care is reimbursed by Medicare, a fact unknown to many elderly

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persons and their families.[5] The future funding of nursing home care is far from clear. Various options are under discussion and investigation.

One option is *private long-term care insurance*, but as recently as 1988, such insurance policies paid for no more than 1% of nursing home expenditures.[6] The number of insurance companies offering these policies and the number of persons subscribing to them is increasing, but the overall percentage of persons with coverage remains small. Consumer doubts about need and industry concerns about eventual costs have limited the expansion of long-term care insurance. It is unlikely that private long-term care insurance will contribute more than a small percentage to the funding of nursing home care by 2001.

In collaboration with the federal government and with the help of a grant from the Robert Wood Johnson Foundation, the State of Connecticut introduced a program to encourage the purchase of long-term care insurance.[7] Under this plan, if the insurees purchase $50,000 of long-term care insurance, the state will allow them to protect $50,000 of their own assets in the event that their long-term care costs exceed $50,000 and they have to apply for Medicaid to cover the remaining costs. It is anticipated that a state resident with this kind of long-term care insurance policy will be less likely to draw upon Medicaid to pay for his or her long-term care expenditures. The success of the program remains to be seen. Eight other states are introducing similar plans.[8] To promote the more widespread purchase of long-term care insurance policies, tax laws will need to be changed to allow both individuals and employers to be partially compensated for the costs.

Another option includes extending *Medicare coverage* to include more nursing home care. Under current regulations Medicare will not pay for nursing home care unless there has been at least a 3-day hospitalization during the 30 days before admission. This regulation was dropped with the passage of the Catastrophic Health Care bill, but introduced again when that legislation was repealed. This arbitrary regulation should be revoked. Lack of reimbursement for acute illness in nursing home residents is discussed in the next section.

A third option is to allow persons to accumulate *tax-free reserves* similar to individual retirement accounts (IRAs) to pay for eventual long-term care needs.[9] Such options are bound to increase the tax burden on a decreasing percentage of younger income earners to help take care of an increasing percentage of the elderly. The political implications of this will intensify between now and the end of the century. It is very likely that by 2001 Medicare benefits will be means tested and all social security payments will be taxable to help offset the impending generational imbalance. Many elderly persons will have financially secure retirements, but the majority will still be unable to cope with the huge cost of a prolonged nursing home stay. An increasing number of wealthy retirees will choose a life-care community option with long-term care coverage built into the fees. But most people will be unable to afford such guaranteed care.

Payers of nursing home care are currently using two popular methods to reduce nursing home costs. The first is to have reimbursement levels based on the care burden of the patient. Because of the fixed payment per patient in many states, it is in the interest of nursing homes to have as few sick residents as possible. Such persons require more care and therefore a larger staff. The Resource Utilization Groups (RUGS) method of reimbursement, which is currently used in New York State, has varying rates of payment depending on the patient's functional status.[10] RUGS uses a case-mix–based reimbursement system. This system in effect relates reimbursement rates to the amount of care required. There are controls within the system to ensure that nursing homes do not attempt to increase reimbursement rates by falsely rating patients. An attempt is also made to ensure maximum quality of care, which the case-mix–based system by itself will not accomplish. With the introduction of the Minimum Data Set (MDS) now used in all nursing homes, the level of care a patient requires can be more easily assessed, and a graded reimbursement system will become uniform across the country.[11]

The second is an attempt to "channel" costs away from nursing home care and toward community and home care. The rationale is that overall expenses in long-term care can be reduced if patients who would otherwise go to nursing homes can stay in their own homes with the help of additional resources. Hard evidence of a decrease in costs is difficult to obtain, but improvement in quality of life has been reported.[12] Many states already screen all prospective nursing home admissions to make sure that nursing home care is necessary. An emphasis on home care as a means of avoiding nursing home care will continue to grow.

Providers

Family physicians are involved with nursing homes and nursing home residents on a number of different levels. Family physicians have assumed medical directorship roles in nursing homes and usually receive salary support for performing this duty. A few larger nursing homes have a full-time medical director and other full-time physician staff members. Many family physicians take care of large numbers of nursing home patients, whereas

the only contact others may have with nursing homes is in the course of trying to get a patient admitted to one.

There are many disincentives for physicians to practice medicine in the nursing home environment: poor reimbursement for care provided to nursing home patients; a myriad of regulations that result in frequent calls from the nursing home staff; and inadequate training in how to manage nursing home patients. These factors have led some family physicians to choose not to take care of nursing home patients. Accordingly, some nursing homes find it difficult to find well-qualified physicians to manage their residents' medical care. In others, physician visits are made reluctantly and infrequently.[13,14]

Physicians will remain ultimately responsible for the medical care of patients in nursing homes. Persons in the community can choose whether they want to see a physician, but under current regulations all nursing home residents must have an assigned physician. This rule is not likely to change. Because of the difficulty in finding competent physicians to take care of patients, the larger nursing homes will move toward hiring full-time medical directors and medical staff. In the Netherlands this is the primary method of physician involvement with nursing home patients. Geriatric training in the Netherlands has developed as a subspecialty in nursing home medicine. This model will not become predominant in the United States, however, and individual private practitioners will still provide the majority of medical care in nursing homes.

To help make the provision of clinical services more cost-effective, private practice groups will look to physician extenders such as nurse practitioners and physician assistants to help take care of nursing home patients. Some academic nursing homes have already done this successfully.[15] These facilities have found that physician extenders have resulted in more cost-effective care and improved patient outcomes.[16,17] Because of the potential to promote a better quality of care, some nursing homes will be willing to help promote such arrangements with salary support. Physician assistants are reimbursed under Medicare Part B for nursing home care that was provided without a physician having to be physically present in the nursing home at the time the care was delivered.

Under current Medicare reimbursement arrangements, it is in the interest of physicians and nursing homes to have sick nursing home patients transferred to acute-care hospitals for treatment of illness that requires increasing numbers of physician visits and increasing care by the nursing home staff. Many nursing home residents with pneumonia, pyelonephritis, osteomyelitis, and other common conditions could be managed in the nursing home without transfer to a hospital. If the nursing home and physicians were more realistically reimbursed for the care of sick nursing home patients, considerable savings would be realized from the resulting decrease in hospitalization. Because of the lack of additional reimbursement for taking care of acutely ill patients, most nursing homes are reluctant to administer intravenous (IV) fluids or antibiotics, for these require additional staffing. By 2001, however, Medicare will reimburse the cost of caring for acutely ill nursing homes patients to a larger extent.

Regulations

The nursing home industry is highly regulated, and to date most quality assurance efforts are conducted to ensure compliance with these regulations. The licensure and certification of institutions is aimed at making sure that they have the capacity to provide a certain minimum standard of care rather than guaranteeing its actual provision. The medical director's responsibilities include ensuring that a reasonable standard of medical care is provided by the physicians or physician extenders who take care of patients in nursing homes. Areas that lend themselves well to quality of care assessment in nursing homes are falls, appropriate use of medications (particularly antipsychotic medications), use of restraints, and the proper implementation of the Patient Self-Determination Act.

Patient and family satisfaction are increasingly important measures of quality assurance. Reimbursement of care will become increasingly dependent on the quality of care provided. As one example, Illinois uses a system called QUIP (Quality Incentive Program).[18] This system is an attempt by the State of Illinois to increase the quality of care offered by nursing homes by relating bonus payment to quality of care measures. Most regulations for nursing homes concentrate on structural criteria such as compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations and evidence of correct documentation. Noncompliance leads to negative sanctions, usually fines. QUIP uses a positive-incentive approach for the provision of care in excess of the minimum requirements. Ninety percent of nursing homes in Illinois participate in the program.

Although QUIP is a step in the right direction, it has several major flaws. There is only one true outcome measure (patient satisfaction). In QUIP, the validity and reliability of the measurements used have never been established. The program was not tested in a pre- and postintervention fashion; therefore, comparisons of measurements and outcomes could not be made and assessed. However, an expansion of reimbursement based on quality and outcome measures should be anticipated.

Changes in Organization and Function

Hospitals will play a greater role in the supply of nursing home care in the next century. Many hospitals have already purchased or built their own nursing homes, and many more are planning to do so. In some states hospitals have developed hospital-based nursing home beds or "swing-beds."[19] They provide the same role as "step-down units" in both Sweden and the United Kingdom. They will become more prevalent. If administrated properly, the majority of care provided by these units is reimbursed by Medicare. From the hospital's perspective, swing-beds provide the useful function of transferring patients from acute care beds when that level of care is no longer necessary, thereby maximizing returns under the DRG system of payment. Transitional care units with a similar function can be developed in nursing homes that are either owned by or affiliated with a hospital.

Nursing homes, particularly those owned by or closely affiliated with hospitals, will seek to diversify the types of services they provide. Nursing homes hire and train staff to take care of the needs of frail dependent patients. These same staff members can assist in the provision of other services coordinated by the nursing home. Adult day care is an obvious example. Day hospitals, usually located on hospital grounds, have worked successfully in the United Kingdom. They provide most of the services offered by skilled nursing homes, and because patients return to their own homes at night and weekends, costs are substantially less. In North America these programs may be better placed within nursing homes. Hospital outpatient services including geriatric outpatient services, blood-drawing stations, radiology services, and clinical laboratory services could be located in the nursing home. In most nursing homes these services have to be brought in or the patient must leave the nursing home for them. Exercise programs, physical therapy, and screening services for older patients could also be provided in nursing homes.

Another direction of care provision in which nursing homes are rapidly moving is that of special care units (SCUs). Special dementia and Alzheimer's care units are the most common of these.[20,21] The goal of these units is to provide an environment for demented patients that caters to their special needs. In most units, there is an emphasis on having specially trained staff. Activities are tailored to the individual needs of the residents, with the avoidance of restraints (both physical and pharmacologic), close involvement of family, and an appropriate physical environment. The efficacy of these SCUs, however, has never been proven. Medicaid does not increase reimbursement for SCUs. Some nursing homes may use SCUs solely as a marketing tool. The fiscal viability of many SCUs is tenuous. In spite of this, there is a major increase in the number of SCUs across the country, and the trend will continue. Others that are likely to follow are special units for the long-term care of AIDS patients, dialysis patients, ventilator-dependent patients, and traumatic brain-injuried patients. Nursing home and hospital-based rehabilitation units will compete more aggressively for rehabilitation patients.

Nursing homes have clearly been neglected as sites for medical education. The American Board of Family Practice is in the forefront by ensuring that at least one segment of future primary care providers will have had some exposure to, and instruction in, taking care of nursing home patients. Other disciplines, and in particular internal medicine training programs, need to address this deficit in their training programs. Nursing homes are suitable environments to teach medical students clinical skills. History-taking and physical diagnosis instruction, for instance, are areas that can be taught with the help of nursing home residents.

Even though on any one day there are more residents of nursing homes than acute care hospitals, research in this setting has been severely neglected. This situation will be difficult to reverse but there are some encouraging signs in the funding of long-term care research and an increase in the numbers of publications pertaining to nursing home care. The National Institute on Aging and the Agency for Health Care Policy and Research will increase funding for research in this field.

Health promotion and disease prevention will become increasingly common aspects of nursing home care. As is the case with medical care in other settings, it is more cost-effective to prevent a problem (eg, a fall, pneumonia, pressure sores) than to treat it after it has occurred. Once again this is an area of nursing home practice that has been neglected.[22] In our own study of screening mammography to detect breast cancer,[23] we found that it was almost never provided to nursing home residents. Because of differences in life expectancy, quality of life, and functional impairment, standard health promotion and disease prevention guidelines may need to be adjusted for nursing home residents. Tuberculosis screening and influenza vaccination are of increased importance in this population. In one study,[24] a falls assessment program, which included an intervention for those found to be at risk, resulted in decreased rates of hospitalization in a nursing home population. Payers of nursing home care should value such health promotion activity, and reimbursement rates should be adjusted accordingly.

Ethics

The ethical implications of medical practice are receiving increasing scrutiny. Some of the most difficult ethical dilemmas pertain to frail older patients, many of whom reside in nursing homes. Many nursing home residents are cognitively impaired and socially isolated, making their own and their family's participation in medical decision-making difficult.

The question of futility of medical care is a concept receiving increasing attention.[25] Futility is difficult to define, however, and its definition should certainly not be left to fiscally overburdened legislative bodies alone. Withdrawal of care for ill-defined reasons of chronic disability, cognitive impairment, and functional limitations alone should never be tolerated, although it is sure to be contemplated. On the other hand, burdensome and uncomfortable treatment that is not of marked benefit to the patient should not be provided. The provision of cardiopulmonary resuscitation for many nursing home residents can be cited as an example. There is strong evidence that this particular intervention in this particular setting is of very limited benefit.[26] Many nursing homes will develop ethics committees that will, it is hoped, include residents and community members to help educate caregivers and provide guidance and advice on how to approach ethical concerns.

Conclusions

By the year 2001, nursing home care will be a larger component of family practice. Although the standard of care overall may rise, nursing home patients will continue to be neglected by large segments of the medical community. There will be a slow but inexorable movement away from a fascination with high-tech responses for acute medical problems toward a greater emphasis on maximizing function, providing comfort, and ensuring patient satisfaction. With the ever-increasing elderly population in this country, nursing homes will be at the center of this movement.

References

1. Weissert WG. Estimating the long term care population: prevalence rates and selected characteristics. Health Care Financing Review 1985; 6:83–91.
2. Kemper P, Murtaugh CM. Lifetime use of nursing home care. N Engl J Med 1991; 324:595–600.
3. Shaughnessy PW, Kramer AM. The increased needs of patients in nursing homes and patients receiving home health care. N Engl J Med 1990; 322:21–7.
4. Tresch DD, Duthie EH, Newton M, Bodin B. Coping with diagnosis related groups. The changing role of the nursing home. Arch Intern Med 1988; 148:1393–6.
5. Rivlin AM, Wiener JM. Caring for the disabled elderly, who will pay? Washington, DC: The Brookings Institution, 1988.
6. US Department of Health and Human Services, Health Care Financing Administration, Offices of National Cost Estimates. National health expenditures 1988. Health Care Financing Review 1990; 11:1–42.
7. State of Connecticut, Department of Income Maintenance. Long Term Care Insurance Disregard, 1992. Uniform Policy Manual UP-92-22.
8. Federa RD, Oettinger NL. Beyond catastrophic insurance: the future of public funding for long term care. Top Health Care Finance 1991; 17:22–31.
9. Paulson LG. Financing long-term care. The growing dilemma. J Am Geriatr Soc 1989; 37:631–8.
10. Mitty EL. Resource utilization groups. DRGS move to long term care. Nurs Clin North Am 1988; 23:539–57.
11. Morris JN, Hawes C, Fries BE, Phillips CD, Mor V, Katz S, et al. Designing the National Resident Assessment Instrument for nursing homes. Gerontologist 1990; 30:293–307.
12. General Accounting Office. The elderly should benefit from expanded home health care but increasing these service will not insure cost reductions. IPE-83-1 1982. Washington, DC: Government Printing Office, 1982.
13. Rabin DL. Physician care in nursing homes. Ann Intern Med 1981; 94:126–8.
14. Willemain TR, Mark RB. The distribution of intervals between visits as a basis for assessing and regulating physician services in nursing homes. Med Care 1980; 18:427–41.
15. Wieland D, Rubenstein LZ, Ouslander JG, Martin SE. Organizing an academic nursing home. Impacts on institutionalized elderly. JAMA 1986; 255:2622–7.
16. Kane RL, Jorgensen LA, Teterberg B, Kawahara J. Is good nursing home care feasible? JAMA 1976; 235:516–9.
17. Kane RL, Garrard J, Buchaman JL, Rosenfield A, Skay C, McDermott S. Improving primary care in nursing homes. J Am Geriatr Soc 1990; 39:359–67.
18. Miyake Geron S. Regulating the behavior of nursing homes through positive incentives: an analysis of Illinois' Quality Incentive Program (QUIP). Gerontologist 1991; 31:292–301.
19. Kovner AR, Richardson H. Implementing swing-bed services in small rural hospitals. In: Valdeck BC, Alfano GS, eds. Medicare and extended care: issues, problems, and prospects. Owings Mills, Md: Rynd Communications, 1987:91–107.
20. Berg L, Buckwalter KC, Chafetz PK, Gwyther LS, Holmes D, Mann Koepke K. Special care units for people with dementia. J Am Geriatr Soc 1991; 39:1229–36.
21. Gold DT, Sloan PD, Mathew LJ, Martha Bledsoe M, Konanc DA. Special care units: a typology of care settings for memory-impaired older adults. Gerontologist 1991; 31:467–75.
22. Richardson JP. Health promotion for the nursing home patient. J Am Board Fam Pract 1992; 5:127–36.
23. Coll PP, O'Connor PJ, Crabtree BF, Besdine RW. Prevalence of mammography use in a nursing home population. J Fam Pract 1990; 30:682–5.
24. Rubenstein LZ, Robbins AS, Josephson KR, Schulman BL, Osterwell D. The value of assessing falls in an elderly population. Ann Intern Med 1990; 113:308–16.
25. Truog RD, Brett A, Frader J. The problem with futility. N Engl J Med 1992; 326:1560–3.
26. Applebaum GE, King JE, Finucane T. The outcome of CPR initiated in nursing homes. J Am Geriatr Soc 1990; 38:197–200.