The Basis for Improving and Reforming Long-Term Care. Part 4: Identifying Meaningful Improvement Approaches (Segment 2)

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While many aspects of nursing home care have improved over time, numerous issues persist. Presently, a potpourri of approaches and a push to “fix” the problem have overshadowed efforts to correctly define the problems and identify their diverse causes.

This fourth and final article in the series (divided between last month’s issue and this one) recommends strategies to make sense of improvement and reform efforts. This month’s concluding segment covers additional proposed approaches. Despite the challenges of the current environment, all of the proposed strategies could potentially be applied with little or no delay.

Despite having brought vast increases in knowledge, the research effort may be losing its traction as a formidable force for meaningful change. It is necessary to rethink the questions being asked and the scope of answers being sought. A shift to overcoming implementation challenges is needed.

In addition, it is essential to address issues of jurisdiction (the apparent “ownership” of assessment and decision making over patient problems or body parts) and reductionism (the excessive management of these issues and problems without proper context) that result in fragmented and problematic care. Issues of knowledge and skill also need to be addressed, with greater emphasis on key generic and technical competencies of staff and practitioners, in addition to factual knowledge.

There is a need to rethink the approach to measuring performance and trying to improve quality of care and services. There are significant limits to trying to use quality measures to improve outcomes and performance. Ultimately, vast improvement is needed in applying care principles and practices, independent of regulatory sources. Reimbursement needs to be revamped so that it helps promote care that is consistent with human biology and other key concepts.

Finally, improving long-term care will require a coordinated societal effort. All social institutions and health care settings need to address their own shortcomings and contribute constructively in order to improve and reform nursing homes and health care generally. It is not helpful to scapegoat nursing homes for what are far more universal problems of care, practice, and performance. (J Am Med Dir Assoc 2010; 11: 161–170)

Keywords: Nursing home reform; quality of care; public policy; oversight and regulation of care

“[Humans] at some time are masters of their fates. The fault . . . is not in our stars, but in ourselves . . .” William Shakespeare / Julius Caesar, Act I

The 3 previous articles in this series have identified key conceptual foundations both for providing high quality care and for overseeing and trying to improve care quality.1–3

Along with the first segment,4 this second segment of Part 4 applies those discussions to assess current and prospective efforts to improve and reform nursing home care and quality (Table 1).

RETHINK THE RESEARCH AGENDA

Knowledge and Its Effective Implementation

Decades of research in geriatrics and chronic care have contributed much useful information. As discussed in this series2 and elsewhere, there is a huge gap between knowing
Table 1. Recommended Approaches to Long-Term Care Improvement and Reform

<table>
<thead>
<tr>
<th>Recommended Approaches</th>
<th>Key Elements</th>
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<tr>
<td>- Reconsider current improvement and reform efforts *</td>
<td>- Evaluate whether and to what extent various reform efforts are compatible with key philosophical and scientific principles, including evidence-based care and the full care delivery process(^2)(^3)</td>
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<td>- Focus reform efforts more on defining the issues correctly and identifying root causes and cohesive strategies, as a foundation for tailoring reform strategies(^9)</td>
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<td>- Seek and use available evidence to assess the conventional wisdom, regardless of its source(^2)(^3)</td>
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<td>- Identify and contest common practices that have become habitual and widespread, or that have become undesirable de facto “standards” of care despite being inconsistent with evidence(^2)(^3)</td>
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<td>- Challenge the conventional wisdom *</td>
<td>- Broaden the dialogue about the strengths and weaknesses of long-term care and the scope of proposals to improve and reform it(^1)(^4)</td>
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<td>- Reinforce accountability of all disciplines for proper performance and practice, at all levels</td>
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<td>- Contest incorrect and misleading advice and instructions about care practices and performance improvement, regardless of the source</td>
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<td></td>
<td>- Focus on identifying and incorporating valid existing evidence into practices of all disciplines(^2)</td>
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<td></td>
<td>- Contest efforts to rationalize inappropriate practice and performance(^3)(^4)</td>
</tr>
<tr>
<td>- Rethink the research agenda</td>
<td>- Shift balance towards implementing existing knowledge, including careful analysis of failures in implementation</td>
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<td>- Focus attention on basic care principles and processes</td>
<td>- Return to the roots of primary care medicine and nursing</td>
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<td>- Vigorously promote (and do not inhibit) the care delivery process and effective clinical problem solving and decision making(^2)(^3)</td>
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<td>- Move away from prescriptions and procedures as an inadequate substitute for dialogue and the care delivery process</td>
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<td>- Evaluate the impact of nursing home improvement and reform initiatives and activities on proper care processes and practices</td>
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<td>- Shift health care professional education to include concepts such as managing syndromes and handling patients with multiple coexisting causes(^1)(^2)</td>
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<tr>
<td>- Suppress reductionism and jurisdiction over care</td>
<td>- In all settings, focus on applying evidence and managing discrete issues in the proper context of the entire patient (phronesis)(^7)</td>
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<td>- Reconsider notions of competency and expertise</td>
<td>- Reconsider the notion of expertise and the criteria for determining who is an expert(^2)</td>
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<td>- Distinguish genuine clinical and management expertise from less desirable variants such as “topic” experts and “regulatory compliance” experts(^2)</td>
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<td>- Rethink current proposed strategies and core competencies for training current and future work force</td>
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<td>- Focus public education on improving key generic competencies that are critical to health care; eg, ability to report observations and seek causes of problems</td>
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<tr>
<td></td>
<td>- Shift health care professional education to include concepts such as managing syndromes and handling patients with multiple coexisting causes(^1)(^2)</td>
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<tr>
<td></td>
<td>- Shift the approaches to training and educating current nursing home staff to include much more real-time, case-based training and oversight</td>
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\(^{Continued}\)
something and being able to apply that knowledge in specific situations.

Clearly, just establishing an evidence basis for care does not necessarily improve that care.\(^5\) It is noteworthy that the United States has spent billions of dollars on medical research (including that related to care of the chronically ill and elderly) and then pays billions of additional dollars for care that fails to apply the evidence from research.\(^6\)

Research is a means to an end, not an end in itself. The newest or latest research is often redundant and esoteric.\(^7\) Many published studies end by commenting on the need for more research on a topic, without necessarily considering whether there might simply be a need to improve the application of existing knowledge.

We already know how to provide, oversee, and maintain high quality postacute and long-term nursing home care. Many nursing homes already give such care and there are many competent staff and practitioners. It is possible to identify why some facilities, staff, and practitioners succeed while others do not.

Thus, desirable nursing home improvement and reform activities identify and respect existing knowledge. They do not simply promote doing more research without considering whether existing knowledge has been applied effectively. They emphasize enduring and universal clinical and management\(^8\) principles such as problem solving and linking causes to one another as well as to consequences.

For example, issues related to medications, including serious adverse consequences, have been identified for decades.\(^9,10\) And yet, while researchers keep studying the topic,\(^11–13\) the problem of adverse medication consequences remains widespread and perhaps worse than ever.

Instead of continuing to study what is overtreated and undertreated in nursing home patients, the real issue is whether there is optimal medication intervention for individual patients based on effective clinical problem solving and decision making, via the care delivery process.\(^14–17\) Regrettably, facilities, practitioners, researchers, and surveyors may ignore existing information (eg, surveyor guidance within federal OBRA regulations\(^18\)) that already bridges research and clinical practice.

Thus, it may be time to think differently about the utility of research and its attempted translation into effective practice and high quality performance. As with the care of patients, the real issues relate to the ability to identify and apply existing knowledge to specific circumstances, by combining knowledge with detailed understanding of the clinical situation to be addressed.

There may be value in more pragmatic approaches outside of the research arena to assessing and improving quality, including multifactorial designs, tracking effects over time, and utilizing detailed process knowledge.\(^19\) However, the successful implementation of these approaches varies.\(^20,21\)

### Questions and Answers

In all aspects of life, the answers we get depend on the questions we ask. For example, if a lamp keeps flickering despite replacing several light bulbs, it would be appropriate to consider whether the lamp wiring is defective before replacing more light bulbs.

Similarly, if researchers overlook certain hypotheses, then the results will likely reflect only limited predetermined alternatives. For example, many researchers continue to identify depression as underdiagnosed or undertreated, even though there are many legitimate concerns about the diagnosis of depression and the use of antidepressants.\(^22\) Thus, predispositions may inhibit broader consideration of whether depression has become incorrectly or excessively diagnosed\(^23\) (eg, confused with apathy,\(^24,25\) lethargy, or medication side effects), medication interventions have become overused,\(^26,27\) or adverse consequences related to antidepressants have been downplayed or ignored.\(^28\) Similarly, problems related to end-of-life care are often related to failed processes (eg, determining decision making capacity and correctly defining...

### Table 1. Continued

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<thead>
<tr>
<th>Recommended Approaches</th>
<th>Key Elements</th>
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| - Change approaches to assessing, and trying to improve, quality | - Find a better balance between assessing outcomes and underlying processes and practices
- Emphasize training individuals and facilities to identify and address quality issues without excessive reliance on outside sources and quality measures
- Recognize the limits of measurement in improving performance, including limits in identifying and correcting root causes of issues
- Find a proper balance between measuring things and improving underlying processes and practices
- Recognize the limits of using aggregate outcomes to judge care quality for individuals
- Recognize the limits of using fixed data sets (such as the MDS) as a basis for measuring quality and assessing performance
- Recognize the key role that reimbursement plays in influencing care processes, practices, and quality
- Modify reimbursement so that it respects biology and promotes, rather than inhibits, the care delivery process and proper clinical problem solving and decision making
- Limit expectations for pay-for-performance to help correct quality, performance, or cost issues |
| - Develop biologically sound reimbursement | - Limit expectations for pay-for-performance to help correct quality, performance, or cost issues |

*Discussed in February 2009 issue.\(^*\)
and communicating medical issues) and inadequate oversight and accountability related to those processes, not just to inadequate knowledge of palliative care or the need for more research about end-of-life issues.

The Need for Context

Research-related interventions may be developed and tested under optimal conditions, which often differ from real-world conditions, and they are often highly standardized, intensive, implemented by trained research staff, and in a single setting. Although disease-specific guidelines based on research findings can be used effectively, they can be problematic unless they are applied in the proper context of a patient’s situation, instead of to isolated medical symptoms or conditions. Furthermore, too much information and advice can confuse facilities and practitioners, contributing to failures to apply information or use it properly.

Thus, genuine improvement and reform of nursing homes requires rethinking current research attitudes and approaches. Funding sources need to expand the scope of issues they are willing to fund, and should reconsider continuing to fund endless reiteration of the same topics and hypotheses, including those that embrace the conventional wisdom.

The research community should expand its hypotheses to include meaningful but largely overlooked issues identified in this series and elsewhere (Table 2), improve its search for root causes, ask far more than the usual and customary questions, focus on basic challenges of implementation, and seek more basic real-world solutions. It also has a duty to fully reveal the predispositions and conflicts of interest that may taint those who try to discredit critics and to inhibit fair dialogue and inquiry.

FOCUS ATTENTION ON BASIC CARE PRINCIPLES AND PROCESSES

Good care results from painstaking detective work by people who know where and how to look and how to process and interpret their findings correctly. No health care setting has a greater need than does the nursing home for basic competencies such as the ability to observe, describe, and document a patient’s symptoms.

As discussed in this series, genuine reform and improvement requires a return to the roots of primary care medicine and nursing, based on faithful adherence to the care delivery process by clinicians and nonclinicians alike. It has been observed that doctors and patients need to move away from prescriptions and procedures as surrogates for real health care and real dialogue.

Regrettably, care process is often weak in the very settings where it is so critical. Diagnostic inadequacies are being recognized as a basic patient safety issue. In postacute and long-term care patients, a few dozen common medical conditions occur repeatedly in various combinations. Thus, while nursing homes may not need to do highly complex diagnostic evaluations, they must improve on often speculative and rudimentary approaches to basic cause identification of diverse symptoms.

Nursing home management should recognize the many important implications of an effective care delivery process and the dangers of weak and haphazard approaches. Nursing home staff and practitioners need to minimize diagnostic failings and inhibit premature responses to the chief complaint (eg, immediate lab testing or dietary interventions for weight loss, immediate medication for insomnia, immediate urine culture and psychiatric consultation for problematic behavior).

Nursing homes face various challenges (eg, difficulty in getting a symptom history directly from patients, limited scope of available diagnostic services) in trying to provide safe and effective care. Thus, they need strong care systems to compensate for these challenges. Ironically, as discussed in this series, there are many barriers to the effective deployment of these critical skills and there is still a lot of bad and misleading advice about how to identify and manage common symptoms and conditions.

Increasingly, even federal guidance to surveyors as part of the OBRA ’87 regulations has incorporated the idea that the basis for interventions (the “why”) matters as much as the actual interventions (the “what”). However, nursing home surveyors and others who try to oversee and evaluate care, may still pay too little attention to the “why” and too much to the “what” and to the results.

Therefore, every reform and improvement initiative needs careful scrutiny for its impact on correct clinical thinking and the care delivery process. At the very least, reform and improvement activities must not inhibit or contradict these key principles; eg by giving advice that shortchanges the care delivery process. More accountability and consequences are needed for consultants and reformers, including alleged experts, who give inadequate and incorrect instruction and advice that results in problematic care.

SUPPRESS REDUCTIONISM AND JURISDICTION OVER CARE

Genuine reform requires reversing the trend to excessive reductionism and jurisdiction over aspects of long-term care. Reductionism refers to the misconception that aggregating the separate management of symptoms, risks, and medical conditions is somehow the same as managing the whole patient in the proper context.

Jurisdiction refers to the notion that various disciplines, consultants, specialties, or settings have rights of supremacy to diagnose and treat certain symptoms, risk factors, conditions, or parts of the body (eg, pain, swallowing difficulties, weight loss, impaired function, end-of-life situations), regardless of the context or their qualifications. As discussed in this series, every conclusion and patient intervention needs a proper context, with a qualified practitioner to oversee the context of care. Excessive jurisdiction (eg, to the degree that is common in many nursing homes) is biologically unsound and undermines proper clinical problem solving and decision making.

None of the many people who help get a commercial airplane flight off the ground (eg, mechanics, flight attendants) are more qualified than the pilot to fly the plane, even though each one probably knows more than the pilot does about their
part of the process. Similarly, neither the ability to deliver treatments nor in-depth knowledge about one aspect of care or one part of the body necessarily qualify someone to manage conditions or problems in the context of the whole patient.

Genuine improvement and reform require the proper interdisciplinary application of the care delivery process. Key elements for effective interdisciplinary teams have been identified, including a shared purpose and goal, clear roles and responsibilities, appropriate contributions from team members, cooperative and coordinated activities, and trust among members.42

Capable staff and practitioners willingly explain the clinical evidence basis for their conclusions and decisions, take responsibility for results (including potentially avoidable negative outcomes), and can analyze and recover from unexpected or avoidable complications. In stark contrast, others cannot or do not provide a clinically valid basis for their conclusions or recommendations, or acknowledge responsibility for contributing to avoidable negative outcomes (eg, Table 2.

**Examples of Meaningful Research Questions and Potential Hypotheses**

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<tr>
<th>Potential Research Questions</th>
<th>Hypotheses Worth Considering Further</th>
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<tr>
<td>- What is the impact of proper and improper care process and clinical problem solving and decision making on outcomes (including quality of life and quality of care)?</td>
<td>- Proper task performance related to the care delivery process is essential to improving and sustaining high-quality care</td>
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<td>- What are the levels of competency and expertise among nursing home staff and practitioners, relative to understanding and correctly applying the care delivery process?</td>
<td>- Lapses in task performance related to the care delivery process, including faulty clinical problem solving and decision making, underlie many substantial care and quality issues in long-term care</td>
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<td>- How much can nursing homes compensate for, or improve upon, knowledge and skill deficits in their staff and licensed professionals and practitioners?</td>
<td>- Failures of cause identification (including diagnostic fallacies) are common and are a major source of improper care and avoidable negative outcomes</td>
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<td>- Are certain vital issues with major impact on outcomes being overlooked or downplayed?</td>
<td>- Only some staff and practitioners in nursing homes know how to correctly perform the basic functions and tasks (eg, observe, document, report) required of them related to the full care delivery process</td>
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<td>- Is existing, reliable clinical evidence and current knowledge about care process being used correctly and consistently?</td>
<td>- There are limits to the ability of any nursing home to provide high quality care unless they start with more individuals who already have a certain level of basic knowledge and skills</td>
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<td>- Do nursing homes have criteria for adequate and appropriate performance, and do they hold their staff and licensed professionals and practitioners accountable for their performance and practice?</td>
<td>- Nursing home staff and practitioners, as well as regulatory agencies, commonly overlook critical medication-related issues that have major impact on function and quality of life</td>
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<td>- Do treatment and care decisions have a valid clinical rationale, based on matching clinical evidence to patient-specific evidence?</td>
<td>- Nursing homes are often advised or told to do things that contradict the evidence about providing complex care correctly</td>
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<td>- To what extent do inappropriate practices and inadequate care in other settings affect the outcomes of patients who are sent to nursing homes for ongoing postacute or long-term care?</td>
<td>- Current evidence is often not applied because staff and practitioners shortchange critical parts of the care delivery process</td>
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<td>- To what extent do organizational and operational issues impact care quality and outcomes</td>
<td>- Poor nursing home performance is often due to significant failures to hold staff, practitioners, and management accountable for their performance and practices, including appropriate care decision making by qualified individuals of diverse disciplines</td>
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<td>- The rationale for care decisions is often missing or invalid, or is incompatible with patient-specific evidence (eg, incorrect conclusions about causes or improper treatment selection)</td>
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<td>- Much of the care in nursing homes is based on guesswork and rote interventions that may be irrelevant or problematic</td>
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<td>- Nursing homes inherit patients with a broad spectrum of clinical problems and major risks who often have received inadequate or inappropriate care prior to transfer</td>
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<td>- Inadequate or inappropriate care prior to transfer has a major impact on the ability of nursing homes to achieve specific results and avoid preventable complications</td>
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<td>- For better or worse, facility management and care systems profoundly influence the care delivery process and the provision of appropriate, safe, and effective care</td>
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regarding inappropriate treatments that result in complications, based on incorrect conclusions about causation).

Current and future shortages of qualified staff and practitioners do not justify inappropriate practices that have damaging consequences. "Political correctness" must not prevent holding everyone accountable for their performance and practices, including setting appropriate limits on clinical decision making prerogatives.

**RECONSIDER NOTIONS OF COMPETENCY AND EXPERTISE**

Nursing homes need direct care staff and practitioners who can do the basic things discussed in this series; eg, follow directions, link causes and consequences correctly and consistently, and apply pertinent knowledge to real-life situations (Table 3).\(^{43-45}\) Skilled individuals are needed to guide, train, and oversee them.

Unfortunately, there is a shortage of both the direct care work force and professionals and practitioners (including geriatrics and others trained in geriatrics approaches). To try to remedy this, various organizations and task forces have proposed expanding and improving funding for training programs.

There are also efforts to identify and address core competencies for the professional and direct care work force.\(^{46,47}\) For example, it has been suggested that more physicians be certified specifically to provide care in nursing homes.\(^{48}\)

It could take many years, or even decades, to educate and train enough additional staff and practitioners adequately. However, while awaiting these longer-term solutions, much more could be done to improve the capabilities and performance of existing staff and practitioners, and the clinical environment in which they function.

There are diverse reasons for desirable and inadequate performance of nursing home staff and practitioners. For example, some problematic physicians are deficient in their knowledge, while others are deficient in basic clinical problem solving and decision making skills, and still others fail, for whatever reasons, to apply their knowledge effectively. Effective reform efforts must address these diverse underlying issues and their root causes.

### Functions and Competencies

Genuine improvement and reform require rethinking key strategies about what constitutes competency and "expertise" for the future work force. Topical knowledge (eg, nursing home regulations, concepts of aging, principles of pain management) is important. However, each topic must be taught in the proper context; eg, how common processes apply across topics and how diverse symptoms may have multiple causes.

For example, knowing a lot about the topic of pain does not make someone an expert on managing pain in a patient with vague symptoms and various coexisting conditions.\(^{2,3}\) Knowledge of regulations and related requirements may facilitate survey compliance, but can only help to a limited extent to provide competent care or to teach key care-related competencies.

Instead, the key to enduring and widespread improvement is to clarify individual staff and practitioner functions and to emphasize competent performance of tasks related to the care delivery process (Figure 1). For example, observers and information gatherers should be able to do an equally capable job of gathering information whether the issue is falling, pain, weight loss, or problematic behavior. Higher skill levels (such as those expected of health care practitioners) involve more extensive capabilities in performing more complex tasks (eg, performing a detailed physical exam, doing medical procedures, identifying multiple causes of symptoms).\(^{49}\)

Additionally, health professional education for all disciplines should emphasize training in the approaches and philosophies that geriatrics represents—not just geriatrics as the care of frail older individuals. For example, greater emphasis is needed in medical education and training on managing syndromes (eg, falling, incontinence, anorexia) in those of any age and on providing care in context, instead of just diagnosing and treating diseases by organ systems.\(^{50}\)

Despite assertions to the contrary,\(^{46}\) little additional research is needed to figure all this out. Instead, most competencies can be derived from understanding the roles, functions, and tasks for various individuals and disciplines in the care delivery process and related clinical problem solving and decision making; eg, making observations, seeking and linking causes, and preventing and resolving complications. For example, both individuals\(^{51-53}\) and organizations (eg, the American Medical Directors Association) have identified key roles, functions, and tasks for medical directors and physicians in enough detail to enable identification of required skills and competencies.

No matter how good their training and education activities, and no matter how enlightened their management, nursing homes can only do so much to compensate for the

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**Table 3. Critical Generic Competencies Needed in the Long-Term Care Workforce**

- Observe and report and document observations
- Collect and organize information and examine evidence
- Provide a chronological story of events in an orderly fashion
- Reason inductively and deductively
- Formulate hypotheses
- Draw conclusions (including providing the rationale for those conclusions)
- Solve problems
- Seek and identify causation
- Respond effectively to questions requiring detailed answers
- Deal with multiple simultaneous causes and consequences of a clinical problem or situation
- Follow instructions and procedures
- Recognize the limits of personal knowledge and skills

**Fig. 1. The Cascade of Competent Care**
weaknesses of their direct care and professional workforces. Thus, genuine improvement and reform requires a combined approach; eg, hire more individuals who already have the necessary skills, improve current facility approaches to education and training, and improve general public education and training in basic human competencies.

To this end, much more could be done in public education and in health professional education and training to prepare the workforce in these basic generic skills; eg, teach people how to organize and present complex information and to make and document observations effectively. None of these skills are specific to health care, although their application in health care settings often requires greater depth and scope of knowledge and performance.

Thinking about on-the-job education and training must shift, as well. There is limited proven effectiveness in the typical nursing home practice of using inservices to convey information and improve performance. Case-based training and learning, including direct oversight of actual performance on the job, is essential both before and while working in a nursing home.

**CHANGE APPROACHES TO ASSESSING, AND TRYING TO IMPROVE, QUALITY**

As discussed in this series, improving and reforming long-term care requires rethinking current approaches to assessing and improving quality. Some of the current approaches are pertinent, while others have significant limits. Some current approaches may actually impede definitive improvement in critical areas.

High quality care has certain attributes (eg, safe, effective, and so forth) and is achieved primarily by consistently doing the right thing in the right way for individual patients. This series has considered the meaning of, and criteria for, the right thing and the right way.

Quality improvement principles and practices are universal and enduring. Quality improvement activities try to influence human performance by giving feedback (eg, calculating batting averages for baseball players or critiquing a musician’s recital) over time relative to the individual as well as to others.

Nursing homes vary widely in adopting standard quality improvement approaches. All facilities receive at least some external data; eg, quality indicator reports based on MDS data. Some nursing homes also routinely collect and analyze their own data and try to improve diverse aspects of care and services, while others have few, if any, such processes.

For genuine improvement and reform to occur, facilities must be able to successfully perform their own quality improvement activities (eg, gather and interpret data, identify root causes, and act on the information) without having to depend primarily or solely on external feedback, including quality measures related to the Resident Assessment Instrument (RAI), just as they should be able to manage patients without depending excessively on the RAI.

**Limits of Measurement**

Numerous efforts are being made to try to improve quality by collecting data, based on quality indicators and measures, and giving feedback to nursing homes and practitioners about their performance relative to themselves and to others. However, not everything being measured is meaningful, and only some meaningful things are being measured.

Quality measurement and quality indicators are means to an end, not ends in themselves. For example, efforts to use data collection tools (eg, the MDS) and quality measures to address specific conditions that are of concern, such as pain and depression, may lead to other undesirable consequences (eg, harm related to diagnostic fallacies) and overlooking other important issues that are not covered by meaningful quality measures (eg, evaluation and management of anemia, specific medication-related complications).

**Balancing Outcomes and Process Emphases**

In the 1980s, reform efforts were driven in part by the concern that surveys had previously relied too much on paper compliance and on assessing the capacity of facilities to provide care, instead of the actual provision of care and its impact on the residents. A goal of the 1986 Institute of Medicine (IOM) recommendation on uniform assessment was to develop quality indicators based on data about residents that could be used to generate resident-centered measures of process and outcome quality.

Unfortunately, misunderstandings about “process” may have led to overemphasizing outcomes at the expense of critical care processes. Care process compliance cannot be considered to be “paper” compliance. Effective care delivery processes and clinical problem solving and decision making are a vital basis for outcomes.

Genuine reform requires a better balance between outcomes and processes as the basis for assessing care quality. OBRA regulations and surveyor guidance have divided review of care and services by topic (ie, so-called F-Tags). Currently, MDS-based quality measures are aggregated and reported by facility, and then each facility is compared to aggregates for their state and national composites.

However, as discussed in this series, human physiological processes are closely linked to one another and to overall function. Often, there are common causes of multiple outcomes and multiple causes of a single outcome. Thus, it is problematic to measure and report outcomes data without seeking common causes of diverse clinical and operational outcomes and diverse causes of individual outcomes.

A facility’s success at achieving optimal outcomes cannot be judged just by comparing its results to those of other facilities. Patient characteristics and other factors often influence results, even when processes and practices are sound. Or, unsound practices may sometimes produce desirable results but increase risks for potentially avoidable complications. For example, it is relevant to know whether the attempt to achieve one outcome (eg, address pain, control blood pressure, improve appetite) causes adverse consequences (eg, falling, delirium, or bowel ileus).

Thus, diverse outcomes must be aggregated per patient, not just per facility. An individualized quality evaluation (including a review of links between causes, consequences, and interventions) is needed to ascertain whether a patient’s outcomes...
are optimal or unavoidable. For example, evaluating a facility’s rates of unplanned weight loss, depression, and pain as separate entities will not provide useful clues as to whether a facility correctly managed individuals who had all of these issues simultaneously.

Reform requires a better balance between identifying aggregate outcomes and evaluating underlying processes and practices in individual cases. Some pertinent process-based quality measures for elderly individuals and for nursing home care have been developed.65–67

It is important to identify the limitations as well as the attributes of alleged quality measures and indicators. Significant limitations of MDS-based quality measures have been identified but may be downplayed too much. For example, a facility’s scores on diverse measures do not necessarily correlate and may fluctuate significantly over time, even if their underlying processes and practices remain consistent. The clinical validity of some quality measures (ie, whether they faithfully reflect performance in the aspect they are allegedly measuring) is open to question.58–63 Results on specific measures may vary over time, and may not indicate a facility’s overall quality. Improving on a specific measure does not necessarily result in improvement in care overall.64

Therefore, genuine reform requires acknowledgment that information derived from fixed data sets (eg, the MDS) may be somewhat useful but still provides only a rough and partial basis for evaluating quality. A broader and more balanced approach is required.

Efforts to Improve Performance

This article previously identified several categories of efforts to improve results by influencing performance and practice. For example, the OBRA survey process and related surveyor guidance have been modified. A national campaign was started to try to improve outcomes by using quality measures, Quality Improvement Organizations (QIOs), and local coalitions.65

Ultimately, quality measurement can only improve performance somewhat. For example, while there are many baseball statistics (eg, on-base percentage, slugging percentage, fielding percentage) related to player performance, more statistics do not necessarily produce additional improvement. Ball players must be willing and able to improve. They often need skilled guidance from capable individuals about specific aspects of performance. Furthermore, addressing root causes (eg, improper batting technique) may improve multiple performance aspects.

Nursing home reform requires recognizing and addressing root causes of diverse outcomes and performance issues, not just finding more things to measure. For example, a root cause of diverse facility performance issues may be that staff and management do not know how to use empirical problem solving approaches or that supervisors and managers are unwilling or unable to hold the staff and practitioners accountable for their performance.

DEVELOP BIOLOGICALLY SOUND REIMBURSEMENT

Whatever else might influence improvement and reform, incentives ultimately are a major influence on human behavior.66 Money is a major incentive for performance in many societies. Therefore, improvement and reform requires reimbursement that is compatible with, and does not inhibit, desirable care.

The topic of financing health care, including nursing home care, is too vast and complex to be considered fully herein. However, as discussed in this series, physiology does not obey payment rules. Instead, payment for care must be biologically sound. At present, it is only occasionally and partially sound.67

Payment for care is often based on providers and treatments instead of on patient characteristics and needs. There is ample evidence that patient characteristics, especially medical stability, complications, and comorbidities, influence multiple outcomes and could provide the basis for a more rational payment approach that reduces waste of resources and duplication of services while supporting person-centered care.68–71

Combinations of patient characteristics may help identify those needing more comprehensive and coordinated care.72

Currently, care is often reimbursed despite its incompatibility with the concepts, practices, and processes discussed in this series. Payment sources (eg, Medicare, managed care) are still unduly influenced by primary diagnoses (eg, pressure ulcer, or stroke), facility licensure or category (eg, long-term acute care hospital, assisted living, inpatient rehabilitation), or treatments and services (eg, joint replacement, rehabilitation, wound care, or intravenous therapy). Public and private insurers not uncommonly pay for treatment without adequate problem definition and cause identification in one setting (eg, hospital, nursing home, or assisted living facility), and then pay more for additional treatment in another setting that is required because of earlier process failures.

Whatever its virtues, the MDS-based Prospective Payment System (PPS) for Skilled care has become a major source of erroneous thinking about how to care for patients with complex illnesses. Its payment categories are inconsistent with some of the key concepts discussed in this series. True improvement and reform require the opposite; ie, that reimbursement for care must simultaneously consider the impact of both causes and consequences.

And yet, for all the talk about waste and inefficiency in health care, health care “reform” to date has done little to identify and tackle key root causes such as basic failures of the care delivery process in diverse settings. Genuine reform and improvement must inhibit, not promote, reimbursement that distorts care approaches and care that reflects reimbursement distortions; eg, based on labeling patients as being transferred for “rehabilitation,” “wound care,” or “IV therapy.”

“Pay for performance” has become a politically popular approach to what is often called “value based purchasing.” Despite some merits,73 there are still significant reservations about its viability and limitations in improving care overall.74,75 After all, its underlying premise is to pay a certain amount for care regardless of its efficacy, safety, or value, and then to pay more for allegedly doing it right. It is hard
to imagine how this approach can influence many of the root causes of undesirable outcomes, such as inadequate care delivery process and clinical decision making, that cut across diverse conditions and settings.

CONCLUSION

This series has covered the topic of improving and reforming nursing home care in the United States. However, unlike many other discussions, it has focused on essential biological, medical, and philosophical principles and considered whether current reform efforts reflect and promote, or inhibit, desirable approaches.

Genuine improvement and reform require that those who oversee, manage, and influence nursing homes, review, if not rethink, their current roles and recommendations. Every segment of the health care system must promote and apply key principles such as the care delivery process and the proper linking of causes and consequences. Those who oversee and manage health care organizations and facilities (including nursing homes) must ensure that the concepts covered in this series are applied properly. Politicians, regulatory agencies, and others need to understand better what they are trying to oversee and improve. Ignorance is hazardous, not blissful.

Social institutions reflect and influence a society’s culture, beliefs, and customary approaches to identifying and solving problems. The history of long-term care faithfully reflects the strengths, shortcomings, and paradoxes of American society and culture. It involves high moral principles, clashes of philosophies and values, large sums of money, inconsistent implementation of good ideas, divergent and conflicting incentives, uneven and problematic accountability, political excesses and opportunism, extremes of righteous indignation, haste to find superficial fixes to complex problems, and enduring conflict between the good and rational and the delusional and dangerous.

Respecting essential, enduring, and universal concepts and approaches typically brings more desirable results, while defying them brings perilous consequences for a society’s health and well-being. Genuine improvement and reform requires paying much more attention to the basics, and not wasting time and resources by fabricating inadequate workaround solutions.

Reform also requires universal accountability. It is time to stop scapegoating nursing homes for unsatisfactory performance that is present throughout diverse settings (“scapegoat: someone who is punished for the errors of others” 76). The politics of scapegoating are never constructive and are primarily intended to divert attention from failed responsibility and to evade accountability. For example, hospitals and their practitioners must be made aware of the consequences of misdiagnosis, pressure ulcers; failure to prevent, identify, and address medication-related adverse consequences; and various other issues that impact patients before and after discharge to other settings, including long-term care facilities.

In conclusion, the lessons of reforming long-term care apply equally to all facets of the health care system. Reform and improvement are entirely possible, but only by respecting and applying the key concepts and approaches discussed in this series. Yes, the law of gravity applies everywhere (including the United States), and we either respect it to our advantage or defy it at our own risk.

REFERENCES