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Highlights from *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing, 2013.

- Population ageing in the United States has been slower than in most the other OECD countries: 3.7% of the population was over the age of 80 in 2010 (OECD average is 4%); projections suggest this share to increase to 7.4% (OECD average is 10%) by 2050. However, as the number of old people having to live with more than one chronic conditions continues to grow, population ageing will have a significant impact on families, health and LTC systems.
- The United States still lags behind other OECD countries on provision of home care services, often a preferred (and lower cost) option for care recipients. While in 2011, 3.9% of the population over the age of 65 received long term care in institutions (4% OECD average), only 2.6% of this population receiving care at home (OECD average 7.9%) (OECD Health Data 2012).
- Ensuring LTC quality in nursing homes has been an important policy priority in the United States. However, standards and measurement of home-care arrangements have much weaker. This could raise quality concerns as the number of LTC recipients receiving care in their homes is set to rise in the future. There are useful examples from Australia and the Netherlands where standards for quality of care have been set up for both home care and nursing home settings.
- Regarding institutional care, the United States has one of the most advanced and systematic approach to collect LTC quality data. Certified LTC providers are required to submit a Minimum Data Set (MDS) based on information from the Resident Assessment Instrument (RAI), a standardised assessment system. The instrument is used in several other OECD countries notably Canada, Iceland, Portugal and Finland, to measure needs of LTC users and generate indicators of care quality.
- While LTC workers often attend to recipients with increasingly complex care needs, skills standards for LTC workers are low in the United States. The United States requires only two weeks training for workers with a high-school diploma, while to become certified nursing aides in a federally certified nursing home, applicants need to complete 75 hours of classroom and practical training and 12 hours of continuing annual education. These require are below those set in other OECD countries. For example, Japan requiring 130 hours of training for entry level to become a certified care workers, and Sweden requires three years of training for an auxiliary nurse.
- A major challenge for the United States is to ensure coordination between health care and long-term care. Data on avoidable hospitalisation of old people for chronic conditions – an indicator of how well coordinated are primary care and LTC with hospital care – suggest high rates in the United States for Chronic Obstructive Pulmonary Disease (CODP).
- The United States is one of a few OECD countries – including Germany and Korea – that publish reports on LTC providers along with grading of their performance. This system offers LTC recipients the possibility of making choices, but it is unclear whether the quality indicators cover the issues that are most important to LTC recipients. England has discontinued a similar rating because of a new registration system of providers.

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Key Facts

- In 2010, 13% of the US population was over the age of 65 (OECD average 15%) and 3.7% of the population was over the age of 80 (OECD average 4%). By 2050, 20% of the US population will be over the age of 65 (OECD average 25%) and 7.4% of the population will be over the age of 80 (OECD average 10%) (OECD Historical Population Data and Projections Database, 2013).
- In 2011, 3.9% of the population over the age of 65 received long term care in institutions (4% OECD average) with 2.6% of this population receiving care at home (OECD average 7.9%) (OECD Health Data 2012).
- In 2010, there were 119 LTC workers (including nurses and personal carers) per 1 000 population aged 65 years and over, which is one of the highest in the OECD countries. The ratio of nurses working in LTC accounts for 54% of all LTC workers (OECD Health Data 2012).

Background

Medicaid is the main public funder of long-term care in the United States, while private contributions and out-of-pocket payments account for the largest total payment for LTC.

Medicaid is a social health insurance program jointly funded by federal and state governments, designed as a means-tested programme to assist people with limited income to pay for medical expenses. Whereas states have mandatory benefits for recipients, including institutional nursing facility services and home health care services for individuals who are entitled to nursing facility services, provision and enforcement are controlled by states. Eligibility requirements for Medicaid are based on income and personal assets and vary across US states.

Medicare is a federally funded programme created to provide health care coverage for people aged 65 and older. Medicare does not cover costs associated with Long-Term Care services, but pays only medically necessary skilled nursing care, mainly for post-acute care in LTC institutions. Medicare is designed to cover medical expenses, such as doctors appointments and hospital visits as well as cover the cost of health care. Additionally, Medicare covers hospice care and short-term home doctor visits associated with hospitalisation.

Legislation and quality framework

US quality control mechanisms in LTC focus primarily on regulation of nursing home care and less for home care agencies. The development of the current quality framework dates back to the 1986 Institute of Medicine report, “Improving the Quality of Care in Nursing Homes”, which described quality problems and recommended a drastic overhaul of LTC regulation. This led to the establishment of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) which redefined LTC quality control in the United States. Although OBRA '87 realigned many priorities, the most significant high-level change was the shift toward resident-focused, outcome-oriented standards. OBRA '87 granted residents' rights and quality-of-life standards, a regulatory status equal to that of the quality of medical care, and it incorporated direct observation and interviews with residents and families into facility inspections. The law established the conditions of participation for nursing home providers to receive Medicare and Medicaid reimbursement.

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Licensure and inspections

Nursing homes in the United States are currently subject to licensure requirements set by states, but in order to receive funding from Medicare and Medicaid, facilities need to abide to quality conditions set in certification requirements, which cover a range of items from nurse staffing and residents' rights to the minimum scope of dental services required.

The 2010 US Health Law – the Patient Protection and Affordable Care Act (PPACA) – adds includes new provisions around transparency and disclosure of nursing home ownership structures. In particular, facilities will be required to disclose information about entities with an ownership interest or managing control of their operations, in addition to reporting other entities involved in governance, administration, or operations.

Participation conditions derive from federal statutory requirements and regulations, but the task of policing compliance with these standards falls on the states. Under OBRA '87, each state must create an agency to provide regulatory oversight. While states have primary responsibility for the initial licensure of providers, they are required to use federal forms and follow federal inspection protocols during the certification process.

Voluntary quality control

Nursing homes may elect to undergo additional voluntary scrutiny. Chief among these programmes is accreditation from the Joint Commission, a non-profit standard-setting and accrediting entity financed through user fees from participating organisations.

Almost half of all nursing homes in the United States participate in the federally supported *advancing excellence campaign*, a programme that has engaged provider, advocacy, and policy stakeholders and is designed to assist nursing homes to work towards targeted, self-identified goals for quality improvement. The federal Quality Improvement Organization (QIO) programme works with providers in a more consultative way than is allowed in the regulatory process.

Non-nursing home settings

Regulations for home health agencies bear some similarities to nursing home regulations, with CMS establishing requirements and states administering them. However, the rules for these agencies are less stringent than for nursing homes, and the regulations have focused more on cost and access to care than on quality (IOM, 2001). Unlike nursing homes, home health agencies are deemed compliant with CMS if they are accredited by the Joint Commission.

Survey/certification and complaint processes

In accordance with the federal regulations, state survey agencies conduct surveys (e.g. inspections) of all nursing homes seeking reimbursement for Medicare or Medicaid services. These inspections take place every 9 to 15 months and are unannounced to the facilities. State agencies then determine whether facilities merit a “certificate of compliance” or whether receive a note on deficiencies. Following inspection, recommendations are submitted to state and federal governing agencies for final certification.

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LTC recipients may submit complaints to state or federal regulatory agencies when they experience adverse events or are generally dissatisfied with the quality of care rendered by a facility. The 2010 PPACA health reform law includes provisions to make filing complaints easier for residents.

Sanctions and compliance

For nursing homes, each deficiency is categorised and rated by its scope and severity. The remedies to address deficiencies range in seriousness from requiring a directed plan of correction, state monitoring of the facility, or directed in-service training (Category 1); denial of payment for new admissions and civil monetary penalties (Category 2); further civil penalties, temporary management (receivership), and termination from the Medicare and Medicaid programmes (Category 3).

For other LTC providers, sanctions may be imposed by the state or by CMS, when appropriate. Both the state and federal governments traditionally have been lenient in their enforcement, however.

Educational requirements

Requirements for LTC workers are more stringent in nursing homes than home care. While all nurse aides who work in nursing homes receiving federal funding are required to complete a state-approved training programme and be certified as nursing aides (75 hours of classroom and practical training and 12 hours of continuing education annually) people with a high-school diploma are required to complete only two weeks training to become a home care worker.

Protective mechanisms for elderly against abuses

Services and tools to protect older people from abuse and maltreatment can include adult protective services and complaint mechanisms. Ombudsmen's programmes act as advocates of old people and seeking more generally to improve care.

Assessment, Monitoring and public reporting

The mandatory implementation and submission of the Minimum Data Set (MDS) is one of the most crucial quality requirements set by the OBRA '87. The MDS is a database of information compiled from the Resident Assessment Instrument (RAI), which monitors the care plans and quality outcomes for all residents in a given home. The OASIS-C dataset specifically developed to capture information of home care service also set out a list of quality measures including timely initiation of care, depression assessment that have been conducted, pain intervention in care plan, improvement in bathing, improvement in hygiene, improvement in dyspnea, emergent care for injury caused by fall, and development of urinary tract infection (CMS, 2011a; CMS 2011b; CMS 2011c).

Nursing Home Compare is a national, online nursing home report card providing information on every Medicare and Medicaid certified nursing home in each state. It provides the following information by provider and facility: i) results of inspection by state government from a database containing survey information (OSCAR); ii) Results of fire and safety inspections; iii) Penalty history or any complaints or cases over the last three years. Nineteen quality measures, generated out of the Minimum Data Set (MDS), are used for public reporting, highlighting things such as ADL change, mobility change, high-risk pressure ulcers, long-term catheters, physical restraints, urinary tract infections, and pain. For short-stay nursing

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home users, it includes delirium, pain and pressure ulcers. A five-star quality rating system has been added since December 2008. Each nursing home is rated on a scale of one to five stars based on three components: health inspection results, quality measures for short-and long-term residents, and staffing levels. Each home also receives an overall quality rating. The United States is one of handful of OECD countries as in Germany, Korea and Sweden that publish reports on LTC providers along with grading of their performance. There is encouraging evidence that public reporting through Nursing Home Compare has led to more informed decision making among LTC users, although there are questions as to whether the choice of indicators is the most important to LTC recipients.

The Centers for Medicare and Medicaid Services launched a website, *Home Health Compare*, in fall 2003 that publishes 11 quality measures (ADL management, pain and pressure ulcer treatment; preventing harms and preventing unplanned hospital care) out of the OASIS data on outcomes in home health care (These publicly reported measures include outcome measures indicating how well home health agencies assist their patients in regaining or maintaining their ability to function and process measures).

Pay-for-Performance

Several state Medicaid agencies have already begun to implement performance-based compensation in their reimbursement of Medicaid-certified facilities. Moreover, to determine the prudence of applying P4P to Medicare-certified facilities, CMS directed the Nursing Home Value Based Purchasing (nursing home VBP) pilot project (which may or may not be adopted more widely) to test and measure the effect of the programme's implementation in three states, starting in 2009; the results are not yet available as yet.

References

OECD Questionnaire on Long-term Care Quality, 2012.

OECD Health Data 2012.

OECD Historical Population Data and Projections Database, 2013.

Colombo, et al. (2011) *Help Wanted: Proving and paying for long-term care*, Paris, OECD.

Country Note: the United States – Help Wanted: Providing and paying for long-term care, Paris, OECD, July 2011

Stevenson D and J Bramson, (2013) “Chapter 8: Long-term care quality assurance in the United States” in OECD/European Commission (2013), *A Good Life in Old Age: Monitoring and Improving Quality in Long-term Care*, Paris, OECD.

IOM (2001), *Improving the Quality of Long-Term Care*, National Academy Press, Washington

CMS – Centers for Medicare & Medicaid Services (2011a), *Home Health Potentially Avoidable Event Measures*, revised August, pp. 1-3.

CMS (2011b), *Home health Outcome Measures*, June, pp. 1-7.

CMS (2011c), *Home Health Process Measures*, June, pp. 1-11.

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<http://www.oecd.org/health/health-systems/good-life-in-old-age.htm>