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Issue Brief

The Impact of a Regulatory Intervention on Resident-Centered Nursing Home Care: Rhode Island's Individualized Care Pilot

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Abstract: In an effort to use the annual nursing home survey process to promote resident-centered care practices, the Rhode Island Department of Health implemented the Individualized Care Pilot from November 1, 2007, to April 30, 2008. The initiative promoted resident-centered care primarily through activities integrated with the annual recertification inspection. In addition to enhancing existing survey processes, the pilot incorporated a visit from the state Quality Improvement Organization into the survey process itself. This study assessed the impact of that pilot on resident-centered care practices. Online surveys were sent to administrators at all Rhode Island nursing homes pre- and post-pilot. Based on reports from participating homes, the pilot helped nursing home administrators understand, consider, and implement resident-centered care. The findings paint a promising picture about the potential to spur provider change through a multipronged approach centered on the regulatory process.

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OVERVIEW

The Nursing Home Reform Act—passed as part of the Omnibus Budget Reconciliation Act of 1987—has defined the nursing home regulatory environment for more than two decades. Commonly referred to as OBRA '87, the law addressed major shortcomings identified at the time by advocacy groups, the federal government, and the Institute of Medicine.¹ Responding to the sense that previous standards focused too heavily on structural elements of quality, OBRA '87 reforms were meant to ensure that residents' rights and quality-of-life standards had a regulatory status equal to that of medical care quality. The law incorporates direct observation and interviews with residents and families into facility inspections and requires that facilities “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.”

Several studies have documented improvements that occurred subsequent to OBRA '87, including increased staffing levels and decreased rates of pressure

ulcers, restraint use, and catheter use for residents.² Nevertheless, nursing home quality problems have occurred with troubling regularity, with facilities often cycling in and out of regulatory compliance.³ Even more fundamentally, the broader nature of nursing home care in the United States does not yet match consumer preferences for homelike environments, resident autonomy, and individualized care.⁴

Broadly defined as practices that help and encourage nursing home residents to make choices and set priorities about their own care and daily routines, “resident-centered care” (RCC) is arguably at the heart of the OBRA ’87 standards emphasizing residents’ rights and quality of life. RCC orients staffing assignments, physical environments, and daily routines around resident preferences, and it actively involves residents in decision-making. A range of stakeholders agree that these ideals remain largely unrealized. There is less consensus, however, about the extent to which the regulatory process itself, including the enforcement of existing standards, has been a facilitating or limiting factor.⁵

This issue brief examines the impact of an initiative undertaken by the Rhode Island Department of Health in 2007–08 to use the annual recertification process to promote RCC practices. Known as the Individualized Care Pilot, it sought to raise awareness among Rhode Island nursing homes of how current regulations support RCC and to facilitate implementation of several features of such care. We evaluated the impact of the pilot on RCC practices through an online survey administered to all nursing homes in Rhode Island before and after implementation. As discussed below, the pilot was successful in helping many nursing home administrators understand, consider, and implement resident-centered care.

ABOUT THE INDIVIDUALIZED CARE PILOT

Developed with input from the Centers for Medicare and Medicaid Services (CMS), and financially supported by The Commonwealth Fund, the Individualized Care Pilot ran from November 1, 2007, to April 30, 2008. Pilot activities were coordinated by the state

survey agency and promoted three components of resident-centered care: 1) resident choice in waking, sleeping, and bathing; 2) personalized environment, specifically regarding sound levels, room decor, access to public/common areas, home-like bathrooms, and dining alternatives; and 3) staff–resident relationships to support quality of care and quality of life. These three goals were pursued through the annual recertification survey, through feedback on current practices by a nonregulatory entity (the state’s Quality Improvement Organization (QIO)), and through peer-to-peer sharing of RCC implementation efforts.

Nursing home surveyors underwent nearly 20 hours of training to learn about RCC and the protocols of the pilot. These training sessions were supplemented with follow-up discussions after each pilot survey and discussions during monthly staff meetings. The training encouraged surveyors to examine their attitudes about RCC, instructed them about how to establish facility compliance with regulatory standards, and educated them about how to approach staff and resident interviews.

Several core activities of the pilot occurred around standard recertification surveys, 51 of which took place during the pilot period. These surveys included supplemental interview questions focusing on whether resident preferences for waking, sleeping, and bathing were met, whether any systems/processes were in place to assess these or other preferences, and whether the facility was engaged in broader efforts to orient staff and care practices to resident quality of life. Surveyors used an environmental checklist to note whether specific elements of RCC were present, such as personalized resident rooms, homelike bathrooms, and comfortable sound levels.

One notable innovation was the incorporation of a visit from the state QIO into the pilot surveys, with group meetings between QIO staff and the facility’s frontline and administrative staff. Usually occurring on the second or third day of the survey, these two-hour sessions described key elements of RCC and sought to stimulate facility self-assessment and discussion. A nonregulatory report was sent to facilities within

21 days of the survey visit to provide feedback about information collected through interviews and the environmental checklist and to reference relevant educational resources.

The pilot included educational activities throughout its implementation. All providers in the state initially were notified of the pilot through a “fax blast” and subsequent teleconference. Formal education efforts began with development of a resource binder and project [Web site](#) describing the pilot and including a range of educational resources.⁶ The binder was distributed to all facilities in the state, and the Web site was updated throughout the effort. To facilitate peer-to-peer learning, the SSA and QIO jointly hosted monthly sessions at which staff from Rhode Island nursing homes were invited to share best practices and to raise questions and challenges about implementing RCC practices.

THE PILOT’S IMPACT ON RESIDENT-CENTERED CARE

To assess the impact of the Individualized Care Pilot on resident-centered care practices, we sent online surveys to all 92 nursing home administrators in Rhode Island in late 2007, prior to the pilot’s launch, and again in late 2008, after it concluded. The pre-pilot survey asked about the extent to which residents have access to various elements of RCC, resident involvement in nursing home decision-making, and facilities’ progress toward selected aspects of RCC. The post-pilot survey also included questions about the perceived impact of the pilot on facility practices. (For complete study [methodology](#), see box at the end of this brief.)

We received pre-pilot survey responses from 82 percent (75/92) of nursing homes in Rhode Island, post-pilot survey responses from 59 percent (54/92) of nursing homes, and pre- and post-pilot survey responses from 53 percent (49/92) of nursing homes. Our analyses focus on this last group of 49 facilities. Given that we did not link survey responses to any facility information, we cannot say whether respondents differ from nonrespondents in identifiable traits. Of these 49 facilities, 25 received a survey visit during

the pilot and 24 did not. Facilities that received a survey visit during the pilot generally improved more in the course of the pilot than facilities that did not have a survey visit; however, only a few of these differences were statistically significant, most likely because of small sample size.

The extent to which residents had access to elements of RCC increased significantly across six of the eight surveyed dimensions between the pre-pilot and post-pilot periods (Exhibit 1). The largest of these improvements occurred for residents being able to eat when they want (43% of facilities reported improving on this measure between the pre-pilot and post-pilot periods; the mean change score [see [methodology](#) for definition] across all facilities was 0.53), residents being able to choose when to bathe/shower (47%; 0.49), and residents being able to access appliances for meal preparation (35%; 0.45). Around one-third of facilities reported improvements in giving residents access to food from a refrigerator when they wanted (33%) and in allowing residents to request foods not on the menu (35%), but neither of these changes was significant.

Resident involvement in nursing home decision-making increased significantly between the pre-pilot and post-pilot periods in all dimensions that were surveyed (Exhibit 2). The largest of these improvements occurred for residents participating in decisions about personnel working in their part of the nursing home (64% of facilities reported improving on this measure between the pre-pilot and post-pilot periods; the mean change score across all facilities was 0.79), residents helping decide how to decorate common areas (56%; 0.60), and residents helping create meal schedules (46%; 0.42). Interestingly, fewer facilities made progress in involving residents in decisions about who provides their own care (44%; 0.33) than in decisions about personnel who work in their part of the facility.

Progress in facility planning for systems-oriented activities about which we surveyed was significant in two categories between the pre-pilot and post-pilot periods (Exhibit 3): 1) enabling residents to

Exhibit 1. Extent to Which Residents Have Access to Elements of Resident-Centered Care

Element of resident-centered care		Not at all	Sometimes	Usually	Always	Percent of facilities that improved ^a	Pre–Post change ^b
Eat when they want	Pre-ICP	4.1%	36.7%	30.6%	28.6%	42.9%	0.53*
	Post-ICP	0.0%	14.3%	34.7%	51.0%		
Choose when to bathe/shower, even with supervision	Pre-ICP	6.1%	14.3%	57.1%	22.5%	46.9%	0.49*
	Post-ICP	0.0%	8.2%	38.8%	53.1%		
Access appliances necessary to prepare their own meal (e.g., microwave, stove, sink)	Pre-ICP	36.7%	30.6%	12.2%	20.4%	34.7%	0.45*
	Post-ICP	26.5%	24.5%	10.2%	38.8%		
Get up when they want	Pre-ICP	4.1%	12.2%	44.9%	38.8%	40.8%	0.35*
	Post-ICP	0.0%	4.1%	38.8%	57.1%		
Choose how they are bathed	Pre-ICP	8.2%	10.2%	36.7%	44.9%	40.8%	0.35*
	Post-ICP	0.0%	8.2%	30.6%	61.2%		
Access food from a refrigerator whenever they want	Pre-ICP	18.4%	30.6%	12.2%	38.8%	32.7%	0.33
	Post-ICP	12.2%	18.4%	22.5%	46.9%		
Go to bed when they want	Pre-ICP	2.0%	4.1%	46.9%	46.9%	34.7%	0.29*
	Post-ICP	0.0%	2.0%	28.6%	69.4%		
Request favorite foods not on menu	Pre-ICP	4.1%	28.6%	30.6%	36.7%	34.7%	0.12
	Post-ICP	0.0%	22.5%	42.9%	34.7%		

^a Improvement defined as greater provision of care practice in post-ICP period relative to the pre-ICP period (e.g., moving from “not at all” to “sometimes,” “usually,” or “always”).

^b Pre–Post change based on movement of facilities across response categories between pre-ICP and post-ICP periods (e.g., moving from “not at all” to “sometimes” moves one level, moving from “not at all” to “usually” moves two levels, etc). A positive value reflects greater provision of the practice in the post-ICP period relative to the pre-ICP period.

* Change is statistically significant ($p < 0.05$).

Results based on facilities that responded to pre-ICP and post-ICP surveys (N=49).

determine their own daily schedules (45% of facilities moved closer to implementing this measure, with a mean change score across all facilities of 0.49); and 2) ensuring that certified nursing assistants (CNAs) are regularly assigned to the same residents (17.4%; 0.26). Consistent assignment—the practice of the same staff caring for nursing home residents on a regular basis—aims to achieve better resident care and improved staff satisfaction by fostering deeper relationships between residents and staff.⁷ Between 9 percent and 40 percent of facilities improved on other measures, but no other category showed significant improvements across all facilities between the pre-pilot and post-pilot periods.

On the post-pilot survey, administrators were asked how they would characterize the impact of the pilot on the care they provide to residents. Nineteen

percent of respondents reported that the pilot had not affected the care they provide, 26 percent reported that the pilot had helped them begin thinking about ways to make care more resident-centered, and 55 percent reported that the pilot had helped them implement, or continue to implement, the changes necessary to make care more resident-centered.

DISCUSSION

Based on results reported by the participating nursing homes, Rhode Island’s Individualized Care Pilot achieved impressive gains in helping homes understand, consider, and implement resident-centered care. Relative to the pre-pilot period, facility administrators reported greater provision of six out of eight elements of RCC about which we surveyed, as well as greater

Exhibit 2. Resident Involvement in Nursing Home Decision-Making

		By staff without resident input	By staff with some resident input	Jointly by residents and staff	By residents independently	Percent of facilities that improved ^a	Pre–Post change ^b
Decisions about personnel who work in household, neighborhood, or unit	Pre-ICP	59.2%	40.8%	0.0%	0.0%		
	Post-ICP	2.1%	78.7%	14.9%	4.3%	63.8%	0.79*
Decorating communal areas	Pre-ICP	46.9%	42.9%	10.2%	0.0%		
	Post-ICP	2.1%	70.4%	27.1%	0.0%	56.3%	0.60*
Creating the schedule for meals	Pre-ICP	22.5%	46.9%	30.6%	0.0%		
	Post-ICP	0.0%	56.3%	37.5%	6.3%	45.8%	0.42*
Decisions about who provides their own hands-on-care	Pre-ICP	10.2%	69.4%	16.3%	4.1%		
	Post-ICP	0.0%	56.3%	39.6%	4.2%	43.8%	0.33*
Developing the resident's care plan	Pre-ICP	6.3%	56.3%	37.5%	0.0%		
	Post-ICP	0.0%	41.7%	56.3%	2.1%	31.9%	0.30*
Planning social events, activities, and outings	Pre-ICP	4.1%	55.1%	40.8%	0.0%		
	Post-ICP	0.0%	35.4%	64.6%	0.0%	31.3%	0.27*
Planning menus	Pre-ICP	10.4%	64.6%	25.0%	0.0%		
	Post-ICP	0.0%	59.6%	38.3%	2.1%	30.4%	0.26*

^a Improvement defined as a greater involvement of residents in decision-making in post-ICP period relative to the pre-ICP period (e.g., moving from “without resident input” to “with some resident input,” “jointly by residents and staff,” or “by residents independently”).

^b Pre–Post change based on movement of facilities across response categories between the pre- and post-ICP periods (e.g., moving from “by staff without resident input” to “by staff with some resident input” moves one level, moving from “by staff without resident input” to “jointly by residents and staff” moves two levels, etc). A positive value reflects greater involvement of residents in decision making in the post-ICP period relative to the pre-ICP period.

* This change is statistically significant ($p < 0.05$).

Results based on facilities that responded to pre-ICP and post-ICP surveys (N=49).

resident involvement in all seven dimensions of facility decision-making. Facilities made less progress in planning for broader RCC initiatives, but significant advances occurred in two areas consistent with pilot goals: enabling residents to determine their own daily schedules, and implementing consistent CNA assignment. When asked to characterize the impact of the pilot on facility care, more than 80 percent of administrators reported that the pilot had either helped the facility begin to think about ways to make care more resident-centered or helped them to implement these changes.

The pilot included multiple components: survey visits with an RCC emphasis, provider education, feedback on current practices from a nonregulatory

entity (e.g., the Quality Improvement Organization), and peer-to-peer learning about RCC implementation strategies. However, the foundation of the pilot was the promotion of RCC during the annual recertification survey. Indeed, two primary rationales for the pilot were that 1) resident-centered care is at the heart of OBRA '87, and 2) despite uncertainty about whether the current survey process performs optimally,⁸ regulation can be a powerful tool for change. In this context, the Rhode Island state survey agency emphasized existing elements of the survey process to support and, in some cases, compel the provision of RCC. The pilot required the SSA to reorient its focus somewhat; in particular, a pre-pilot survey found that nearly 90 percent of providers in the state felt that surveyors

Exhibit 3. Current or Planned Resident-Centered Care Initiatives

		No plans	Plan to do within next 5 years	Plan to do within next year	Currently implementing	Percent of facilities closer to implementation ^a	Pre–Post change ^b
Enable residents to determine own daily schedules	Pre-ICP	8.2%	18.4%	24.5%	49.0%		
	Post-ICP	4.3%	4.3%	19.2%	72.3%	44.7%	0.49*
Actively involve residents in decisions about their household, neighborhood, or unit	Pre-ICP	14.6%	10.4%	25.0%	50.0%		
	Post-ICP	2.1%	8.5%	29.8%	59.6%	39.1%	0.33
Break down larger units into smaller units (e.g., households, neighborhoods)	Pre-ICP	51.0%	12.2%	10.2%	26.5%		
	Post-ICP	36.2%	17.0%	19.2%	27.7%	27.7%	0.28
Include direct care workers and residents as formal part of senior management team	Pre-ICP	28.6%	10.2%	36.7%	24.5%		
	Post-ICP	21.3%	6.4%	38.3%	34.0%	40.4%	0.26
Implement consistent CNA assignment	Pre-ICP	2.0%	6.1%	14.3%	77.6%		
	Post-ICP	0.0%	0.0%	8.7%	91.3%	17.4%	0.26*
Implement “Bathing-Without-A-Battle” Techniques	Pre-ICP	4.3%	4.3%	38.3%	53.2%		
	Post-ICP	4.3%	2.1%	25.5%	68.1%	31.1%	0.18
Change dining experience (e.g., from tray service to family style or buffet)	Pre-ICP	10.2%	10.2%	28.6%	51.0%		
	Post-ICP	6.4%	8.5%	25.5%	59.6%	25.5%	0.15
Eliminate nurses’ stations	Pre-ICP	62.5%	14.6%	14.6%	8.3%		
	Post-ICP	69.6%	15.2%	6.5%	8.7%	8.9%	–0.11

^a Closer to implementation defined as having implementation of practice be more proximate in post-ICP period relative to the pre-ICP period (e.g., moving from “no plans” to “plan to do within next 5 years,” “plan to do within next year,” or “currently implementing”).

^b Pre–Post change based on movement of facilities across response categories between the pre-ICP and post-ICP periods (e.g., moving from “no plans” to “plan to do within next 5 years” moves one level, moving from “no plans” to “plan to do within next year” moves two levels, etc). A positive value reflects more proximate plans to implement in the post-ICP period relative to the pre-ICP period.

* This change is statistically significant ($p < 0.05$).

Results based on facilities that responded to pre-ICP and post-ICP surveys (N=49).

gave priority to quality of care over quality of life and residents' rights.⁹ To address this imbalance, the pilot included multiple hours of surveyor training and incorporated quality of life-related questions into the annual recertification surveys.

The pilot also utilized innovative approaches, in particular the integration of educational components into SSA-provider interactions and the involvement of the state's QIO. Importantly, these educational activities were scheduled outside of the survey time frame to comply with the prohibition of "consultation" between facilities and surveyors during the survey process.¹⁰ In addition to communicating the priorities and expectations of the pilot to providers in multiple forums, the SSA offered a range of resources relevant to implementing RCC. These included reference materials as well as interactive forums where providers could exchange ideas with each other and with the state's QIO about best practices. Reflecting limits to the SSA's role as educator (to reiterate, the SSA's role is to act as a regulator and not as a consultant¹¹), a key component of implementing these activities included collaborating with an entity—the QIO in this case—that could work with providers to identify feasible strategies for quality improvement. Indeed, quality improvement and quality assurance should be viewed as complementary tools that government can use to improve nursing home quality. The possibility of sanctions or closure for poor performance are important deterrents; yet, using an approach that is exclusively punitive may be particularly constrained in its ability to help providers identify root causes of problems and work effectively to address them.

Study Limitations. Our study has several important limitations. It focuses on the single state of Rhode Island and may not be generalizable. The SSA in Rhode Island has been relatively proactive in advancing RCC, and the QIO served as the national Nursing Home QIO Support Center from 2005 to 2008. Moreover, based on the Commonwealth Fund 2007 National Survey of Nursing Homes (from which many of our survey questions were adapted), Rhode Island facilities appear relatively advanced in their provision of RCC compared with national averages.¹²

These differences could imply that the positive changes observed over a relatively short time may be harder to achieve elsewhere. Conversely, one could surmise that the potential for positive change is even greater in states where RCC is not as well established.

Our findings are also limited by some features of our data collection. The findings are based on facility self-report. Given that providers in the state presumably had a greater awareness of the SSA's prioritization of RCC at the post-pilot survey, it is possible that some of the improvements reflected this altered perception and not real changes in practice. Results are based on the 53 percent of facilities that responded to *both* surveys; we are uncertain whether nonrespondents differed systematically from respondents. There also was no true control group to assess whether the pre-post differences we observed were due to unrelated time trends or to the intervention itself. For instance, even though 51 facilities in the state received a survey visit during the pilot period (and 41 did not), all facilities in the state were exposed to other components of the pilot, and communication among the nursing homes about SSA visits and expectations is extremely common.

Despite these limitations, our findings indicate a potential to spur provider change through a multi-pronged approach that focuses on the regulatory process. Despite a small sample size, significant improvements were observed across most of the dimensions studied. Even if the changes we observed are reflective of providers recognizing the increased importance of these issues to the SSA, they convey that administrators became more aware of the notion that RCC is necessary to achieve regulatory compliance. What remains to be seen is whether these changes are sustainable in the absence of the pilot. Although surveyor training and provider education may have lasting impacts, it is unclear how attuned providers—or even the SSA—will remain to these issues, especially in difficult economic times. Ideally, elements of the pilot would be incorporated into the standard federal recertification survey process, provided sufficient resources are provided to do so.

CONCLUSION

Through regulations, technical assistance, and payment policies, government action can be a force for positive change in nursing home care. Rhode Island's Individualized Care Pilot made the regulator's role central to encouraging and requiring the provision of resident-centered care, but other mechanisms could be used as well. For example, following a recent recommendation by the National Commission for Quality Long-Term Care, state survey agencies could work iteratively with their QIO counterparts to help facilities address identified quality problems.¹³ Similarly, quality measurement could place greater emphasis on RCC

and its determinants. Efforts to assess resident quality of life and satisfaction signify progress in this area,¹⁴ as do efforts to document facility practices that are consistent with RCC.¹⁵ If measurement of RCC continues to advance, publicly reporting these measures to consumers could be a logical next step; incorporating the measures into a pay-for-performance framework would also be an option. Both steps could help create a market as well as a regulatory incentive to provide RCC. Ultimately, aligning the expectations of regulators, providers, and consumers around resident-centered care will help move us closer to fulfilling the promise of the Nursing Home Reform Act.

NOTES

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- ⁸ K. Walshe, “Regulating U.S. Nursing Homes: Are We Learning from Experience?” *Health Affairs*, Nov./Dec. 2001 20(6):128–44; and M. B. Kapp, “Quality of Care and Quality of Life in Nursing Facilities: What’s Regulation Got to Do with It?” *McGeorge Law Review*, Spring 2000 31(3):707–31.
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How the Individualized Care Pilot Evaluation Was Conducted

Administrators were asked to consult with clinical staff as necessary in answering survey questions. The pre-pilot survey was administered from September through November 2007, and the post-pilot survey from September through November 2008. We sent three e-mails to administrators and conducted three follow-up phone calls to encourage response. All responses were confidential, and respondents were assured that their answers would not be linked to other facility information nor shared with the state survey agency other than in aggregate.

Survey items were adapted from the [Commonwealth Fund 2007 National Survey of Nursing Homes](#) tool, which was fielded to measure the extent to which nursing homes nationally are practicing RCC.¹⁶ The questions asked about the extent to which residents have access to various elements of RCC, resident involvement in nursing home decision-making, and facilities' progress toward selected aspects of RCC. The post-pilot survey also included questions about the perceived impact of the pilot on facility practices.

Analyses compared pre-pilot and post-pilot survey responses for facilities that answered both surveys; we dropped responses from facilities that answered only one survey. We calculated the percent of all responses in each response category across the pre-pilot and post-pilot periods. We also calculated a pre-post change score based on the change in a facility's response to each question. To do this, we first assigned a numerical value to the response scale for each question. For example, in Exhibit 1, "not at all"=1; "sometimes"=2; "usually"=3; and "always"=4. Using these values, we then calculated a change score for each facility—for example, moving from "not at all" to "sometimes" is a change of 1, moving from "not at all" to "usually" is a change of 2, and so on. We then created a mean change score across all facilities and assessed whether it was significantly different from zero using a t-test.

In each of these analyses, a positive change reflects greater degrees of implementation or consideration of RCC practices in the post-pilot period relative to the pre-pilot period. As a sensitivity check, we compared changes that occurred at facilities that received a pilot survey visit to changes that occurred at facilities that did not. However, since all facilities received educational and other pilot-related communications from the SSA and since facilities generally talk with each other about SSA activities and expectations, we present results on all facilities that responded to both surveys, regardless of whether they received a survey visit during the pilot period.

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