



New Horizons *policy forum*

a Village Care of New York publication

Do Nursing Homes Have a Place in Long-Term Care Reform?

by: Arthur Y. Webb, Herbert H. Fillmore, Louis J. Ganim and Allison Silvers

New Horizons policy forum is a series of articles presented from the perspective of practitioners of care. In this forum, you will find a discussion of significant issues that impact older adults in our society, as well as a dialog on making sense of public policies and translating them into practice.

Village Care is embarking on a radical transformation of its current services into a system of care that will serve more seniors in a more efficient manner, and as we head down that road this policy forum will offer an opportunity to share with others the many choices and pathways that are confronted.

The forum is a way to enliven and enrich the debate about long-term care in our state. We invite others to submit outside commentaries for inclusion after a review by Village Care of New York. To inquire about submitting a paper for publication, please send an email to policyforum@vcny.org.

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Much has been said and written about long-term care reform and the efforts going on across the country to create new service paradigms for adults with chronic care needs and for those whose frailties and disabilities demand constant, intensive and ongoing care and services.

Indeed, the authors and Village Care of New York, the operator of two skilled nursing homes, have embarked on undertakings that would transform the nature of institutional care, diminishing its significance as the mainstay of long-term care. Village Care's intent is to downsize, or "rightsize," its skilled nursing capacity and shift the primary locus of care to at-home and community settings.

Heretofore, it wouldn't be taken as accurate to say that America has a love-hate relationship with its nursing homes. Rather, ask just about anyone "The Question," and his or

her response will be (ready, all together now): "I don't ever want to go into a nursing home." Yet, that shouldn't be taken necessarily as a loathing for the nursing home, although no doubt there is some. The real culprit likely is a sense of dread: entering a nursing home is seen by most everyone as the loss of one's independence, and, moreover, raises a specter of finality.

Nursing homes, however, have been changing over the past decade.

Many have focused on rehabilitation services, and oftentimes, as is the case with the authors' own geriatric nursing home, there is considerable turnover as patients come for short stays and return home, or to some other community setting, where they receive temporary or ongoing home care and other supportive services. Nursing home environments, too, have evolved, as reconstructions have ripped out traditional settings such as

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nurses' stations in favor of open, neighborhood concepts. Also, nursing home providers have developed specialized residential programs and units, particularly for those with dementia and Alzheimer's disease, and have focused on end-of-life services and palliative care.

Much of this innovation has taken place in not-for-profit settings.

Even before all that, even given an apparent disdain by the American populace for the nursing home concept and the dread that accompanied the prospect of a skilled nursing facility being one's "last stop" on this earth, countless families have shared an appreciation and were thankful for the presence in their communities of nursing homes. This has been especially true of those facilities that they can "trust." Such highly valued places are seen as somewhere a loved one can go and receive reliable care from a dedicated and devoted staff in a safe environment.

Those of us in the not-for-profit world understand that such trustworthy nursing homes are more often the rule rather than the exception, imperfect as this long-term care solution may be.

Today, as the public becomes more aware of the changes occurring in the traditional nursing home setting, there are indications that there may be less antipathy.

A recent poll of New York residents revealed some interesting views. The poll found an overall "favorable" rating of 67 percent for nursing homes, with 28 percent of New Yorkers holding a strongly favor-

able opinion – better even than for assisted living and continuing care retirement communities.¹

Village Care's two skilled nursing facilities are Village Nursing Home with 200 beds and Rivington House – The Nicholas A. Rango Health Care Facility with 206 beds for persons living with HIV/AIDS.

Village Nursing Home is part of a New York State-authorized demonstration that will replace the existing facility with a new Village Center for Rehabilitation and Nursing, a 105-bed, state-of-the-art facility that will focus on short-stay rehabilitation services (63 beds) and will also provide end-of-life/palliative care (42 beds). This demonstration will shift and expand capacity to community settings with the establishment of a Program of All-inclusive Care for the Elderly (PACE), a Medicaid Assisted Living Program, Care Advocate services serving as point-of-entry and an expanded Long-Term Home Health Care Program. Village Care already has available two adult day health centers, a primary care clinic, senior walk-in storefronts for information and referral, a Certified Home Health Agency and a licensed home care program.

As all those efforts reach fruition, it will mean that in three-to-five years, Village Care's SeniorChoices programs will nearly double the number of older adults it serves, from some 3,000 annually now to more than 5,600. Significantly, Village Care will be serving more than 400 additional individuals with a skilled-nursing

1 "Long-Term Care Survey of New York Voters, November 14-17 2007," Continuing Care Leadership Coalition presentation.

level need than it does today, with most all of that additional capacity coming in consumer-desired and preferred at-home and community settings.

Over the past two decades, Village Care has pursued a strategy of building systems of care that look to offer services in the least restrictive and most appropriate setting, first in its efforts for persons living with HIV/AIDS and more recently for older adults.

While there are also innovative pursuits being explored in the Network of AIDS Services, this paper focuses on the SeniorChoices demonstration and the role and needs of an institutional setting within broader long-term care reform.

SeniorChoices moves the nursing home from an “end-point” in the long-term care system to one of several integrated care options that together ensure the right service at the right time in the right setting. Not only has Village Care has been calling for long-term care reform for many years, it has sought to lead by example. This demonstration is the culmination of that effort: long-term care reform at a neighborhood level. (Village Care has produced *Reform in Motion*, a paper reflecting the goals, accomplishments and lesson learned in the demonstration process, which can be accessed on our website at www.vcnj.org/reforminmotion.)

Here, we now examine the ongoing role of the nursing home and what these facilities need as they continue to exist and evolve even as the broader long-term care reform movement takes hold. Nursing facilities

have long played a vital role in the health and social care system for society’s most vulnerable citizens and serve as an important safety net for a significant number of people for which there exists no reasonable, adequate or accessible alternative at this time. New York State has recognized this, and the current administration in Albany has stated that long-term care reform is a priority, creating opportunities for true improvements while at the same time paying attention to the continuing needs of the many existing skilled nursing facilities in the state, which serve nearly 100,000 persons. How this will all play out in the next few years is still uncertain, but this paper examines the continuing role of nursing homes and what they need, and suggests policy options for sustaining them at a level where high-quality care is provided in a caring environment.

The Evolution of Nursing Homes

Today’s skilled nursing facilities can trace their origins to the 19th Century system of poorhouses, which served the role of sheltering and caring for people who were unable to care for themselves. With the passage of the Social Security Act, society recognized in law a new social contract with the poor, and, as a result, for-profit and not-for-profit custodial homes proliferated, being able to provide better quality sleeping accommodations, food and clothing than the poorhouses. At about this same time, more attention was being paid to convalescence, and many custodial homes began to employ nurses to gain access to this market. The addition of nurses to custodial homes was also advanced with

the social reform and women's organizations that were powerful at the time.

Beginning in the 1940s and taking root in the 1950s, states began to license nursing homes and require attention to a set of standards, as well as providing funds for building such facilities. Then, as is more widely recognized, the passage of Medicare and Medicaid in 1965 brought an influx of additional funding. These programs truly defined the modern nursing home, through the myriad requirements with which the facilities needed to comply in order to become certified to receive payments. This regulation and inspection process was solidified with OBRA 1987, and continues today. It did indeed help to improve the quality of the nursing homes.

Modern nursing homes got a major stimulus in the 1970s in New York with the advent of state bonding, creating the basic buildings for many New York State facilities. At that time, the efficient building standard was the "medical model" with all the attributes of hospitals – such as nursing stations and 40-bed units. Reimbursement systems were created to support this model and pay for the debt service. Today, many of these same homes are at the end of their useful lives, needing an infusion of new capital to meet their current roles.

An Unshakable Nursing Home Stigma?

There remains a long history of negative stories and claims that has continued to feed the overall displeasure our society holds for these institutions. The most striking examples may be found in

the mid-1970s, starting with a *New York Times* exposé of unethical practices in nursing homes and the Moreland Commission's investigations revealing remarkably poor care in certain facilities.

Yet, over 30 years later, and with now a long history of stringent regulations, inspections and improvements, nursing homes are still largely the target of public scorn. In fact, in a large study of seriously ill older adults, 29 percent indicated that they would rather die than enter a nursing home.² A Kaiser Family Foundation survey found that only 12 percent of Americans strongly agree with the following statement: "Nursing homes provide high-quality services for people who need them."³

Despite this, we know that countless frail and disabled persons are helped and well-served by nursing homes. While public surveys reveal a mixed reaction, nursing home resident satisfaction surveys tell a different story:

- » Press-Ganey reports that across its 127 nursing homes, residents rate their nursing care at 84 (out of 100).⁴
- » Ohio, one of only a few states to provide public access to statewide resident satisfaction results, had an

2 "Surrogate and physician understanding of patients' preferences for living permanently in a nursing home," Mattimore, et. al. *Journal of the American Geriatrics Society* 45, no.7 (1997).

3 "Update on the Public's View of Nursing Homes and Long-Term Care Services," *The Henry J. Kaiser Family Foundation*, December 2007.

4 "Nursing home residents rate their care providers," *Extended Care Professional News* January 2002

overall satisfaction rate of 91 percent, with over 150 facilities rating at 95 percent or higher.⁵

In the November 2007 survey of New York voters, over two-thirds do believe that the caregiving staff are dedicated and genuinely concerned about the welfare of the residents.⁶

Clearly, people are having positive experiences in nursing homes.

Even with so many positive experiences, there has not been a single year of outspoken support for nursing homes or the role they play in our society. Perhaps one might say that the best years in New York State – from 2002 to 2006 – were years of considerable support and success using Medicaid funding for worker retention and recruitment, and for quality improvement. In New York State, the legislature supported and passed a “re-basing” policy that was intended to gradually “lift all boats” with an infusion of Medicaid funding over many years. Indeed, during this time of support, nursing homes on the average showed improvement in a number of indicators, from work force stabilization to steady gains on national indicators.

The irony through these “supportive” years was the simultaneous annual targeting of nursing home Medicaid cuts by two governors, Pataki and Spitzer. Why does this happen? Why don’t nursing homes enjoy the same prestige and value that hospitals

do? Is the underlying problem of nursing homes driven by ageism and fear? Our society hates the thought of growing old and nursing homes are perhaps the symbol of inevitable deterioration, as opposed to the healing promise of hospitals, physicians and even pharmaceutical companies.

Will the Baby Boomers Change the Stigma?

Some of us hold out hope that the Baby Boomers might bring about respect or celebration of growing old. While the natural phenomenon of aging is something even the Boomers can’t alter, they could change public attitudes and policy. This, however, remains to be seen.

For many years now, most pundits and researchers (who most likely are Baby Boomers themselves) have convinced themselves that their generation or age cohort would fix nursing homes as they believe they created the Internet. The argument goes: because they have demonstrated their resolve over the years, they will not accept status quo and consequently will change the traditional nursing home. By demanding choice, independence, quality care and privacy, and accepting nothing less, nursing homes will have to change or go out of business. This generation is having similar effect on various customer products and services, so why not nursing homes?

Here’s another, more realistic assertion: The Baby Boom generation will not have much influence on nursing home quality or advancing new models.

Will the Baby Boomers Change the Stigma?

5 www.ltcOhio.org/consumer

6 “Long-Term Care Survey of New York Voters, November 14-17 2007” Continuing Care Leadership Coalition presentation.

Baby Boomers' Influence on Nursing Home Quality

We at Village Care get calls all the time asking for references, not for the “best of the best” but for “what home can I trust?” or simply “do you have a bed?” They do not ask what homes provide superb quality-of-care, or what facility’s care model has proven better outcomes. They often simply appreciate that nursing homes are available, and that they can select one where they feel that their parent or loved one will be “safe.”

The reality is that a cohort of Baby Boomers, just as others before them, will likely require the nursing home-level of care for ongoing custodial care in the face of self-care disability. In spite of their long impact on society in general and their role in their parents’ care and decision-making, Baby Boomers have not really influenced the nursing home care model.

- » Boomers have long held the reins of power, but all we see from them is a cry for cost-containment and a generalized railing on about quality. No constructive agendas or national philosophical debates among our leaders have emerged on the issue of long-term care. A previous New Horizons policy report examined some of the quality issues; it can be accessed at www.vcnny.org/policyforum.
- » Boomers are too consumed with the current life styles and demands and not focused on changing nursing homes. They look for convenience, not excellence.
- » Boomers are building senior living communities or, as some might call them, “camps.” Indeed, they will do

everything possible to create alternative living arrangements to avoid nursing homes. And they are also using their wealth to pay for home-based alternatives.

- » Nonetheless, there will be those individuals for whom home-based care or assisted living will prove at some point incapable of meeting the complex needs of a frail, disabled individual who seeks comfort and a good quality-of-life. At that point, the option of a residential skilled nursing setting makes sense.

It’s likely that Baby Boomers, or their families, will seek out nursing home care at some point, but only as a last resort. Given that, there seems little probability, or hope, that the surging Baby Boom generation will lend its considerable hand to changing or reforming long-term care and the public perceptions that are held for such care.

The Current Role of Nursing Homes

All that being said, we’re left with the conclusion that nursing homes currently play an important role in our society for frail and disabled individuals, and the likelihood is that they will continue to be called upon to play that role for the foreseeable and indefinite future. This is in spite of the perennial attacks on them from both funding and perception perspectives and regardless of the stigma they carry.

What, then, are the key functions of nursing homes that are not readily available else-

where in the health care of social service systems? We see four critical elements:

1. Nursing Homes provide custodial care for those who are disabled and need 24-hour supervision, largely paid for by Medicaid. The average length of stay for this population is 2.4 years, serving primarily women, almost half of whom are over age 85. Some estimate that over 65 percent have some form of dementia, with an ever-increasing percentage with end-stage Alzheimer's disease. In keeping with their history, nursing homes are providers of last resort for individuals unable to care for themselves, and for families unable to care for their loved ones. They offer safe and secure housing and supervision for some 100,000 New York citizens each day.
2. For more than a decade, many nursing homes have been transitioning to being providers of short-term rehabilitation and post-acute continuing care, with Medicare being the primary payer, and now with a growing share of managed care plans controlling those Medicare dollars. This role fills a key, otherwise unmet need in disability and illness recovery – cost-effective restorative care for those individuals (often, older adults) unable to tolerate the rigor of strict rehabilitation facilities.
3. There are many special care facilities or units within nursing homes that offer care to children, those living with HIV/AIDS, ventilator-dependent individuals, head trauma victims and, in some cases, persons with developmental disabilities. This role is a sub-set of the

custodial care role, but providing services for individuals and families who often have no available or appropriate alternatives.

4. Many nursing homes also serve as a “hub” for an array of community services for the nursing home-eligible, including medical day care, various home health care programs and assisted living programs. These services are used to substitute for the old “HRF,” or health-related facility, nursing home care, allowing individuals to remain at home.

Despite the clarion calls for alternatives and increasing support for home and community-based options, few substitutes are emerging in sufficient numbers or capacity, not to mention cost-effectiveness, that can care for the frailest and most disabled among us. Even in the face of a diminishing reliance on nursing home care and a declining capacity, combined with still-growing alternatives, we face a significant policy challenge in making the remaining nursing home capacity acceptable both in improved quality and environment. We must find a way to change the perception of nursing homes and gain an appreciation for the continued role they will be playing in long-term care, even in the midst of major reform.

Exploring Different Perspectives and Policy Options

We see three prisms through which to view the nursing homes. Each prism reveals different policy options.

The Current Role of Nursing Homes

A “Public Good” Prism

Government and the public established years ago, especially with the advent of Medicaid in 1965, that people who are poor or disabled should have access to a certain level of care and that public funding would be made available for that purpose. This funding is presumably set at levels deemed to be sufficient for safe and secure residency.

Some might call this “satisficing,” meaning that government pays just enough – what’s sufficient – to satisfy the public’s sense of protection while simultaneously requiring compliance with minimum standards. Government then polices compliance – a classic public good model. Within the context of fiscal responsibility, government feels justified to target annual cost containment attacks to bring it in line with this “just-enough” funding while it simultaneously demands increasing efforts for compliance to achieve levels of care that provide satisfactory quality care, which the public can measure.

The irony is that government – starting with President Reagan, and later pursued with aggressive and unrelenting efforts in New York by Governor Pataki – promoted deregulation and market-based approaches to other public utilities such as hospitals, energy and airlines. This puts the responsibility more squarely on providers, and loosens the tie to government support, opening political opportunities for cuts in that support. Nursing homes stand out as one of the areas of health care that does not lend itself to market-basket approaches because of the very fact that it is serving the

most vulnerable in our society, therefore a public good. The casual observer might expect that nursing homes would be shielded from any attacks because of whom they serve but, to the contrary, they are always in the sights of budget cutters.

The primary goals that are highlighted in the public good prism are uniformity and conformity with standards, enabling consumers to have clear expectations for care that can be met by all providers.

Policy Options within a Public Good Prism:

- » Achieve stable levels of funding that are predictable and relate to the cost of care within a “just-enough” framework.
- » Use new and different funding options to “lift all boats” to that same level of service and cost of care.
- » Expand the pool of long-term care funding to encompass both nursing home and community-based services. This will lead to shifting money to a paradigm in line with the needs of individuals, which is an integral part of the public good.
- » Coordinate government and provider activities to support work force initiatives to train, attract and retain qualified workers, the backbone of providing an appropriate standard of care.

A “big lift,” but appropriate within a public good framework, is for society to re-define the standards of sufficiency to be more than just basic care. Clear quality goals and pri-

orities would then follow, which perhaps would establish new approaches to quality assurance, such as national accreditation standards and contracting awards. All of this must be accompanied by sufficient funding to make it succeed.

A “Medical Care” Prism

In response to changing epidemiological and external health service market trends, nursing homes are evolving as health care settings meeting a greater and growing range of medical needs, demanding increasing skill and sophistication levels. An example of state government policy that had a resounding effect on the role of nursing homes was New York’s 1990s policies and reimbursement methodologies that encouraged post-hospital Medicare admissions to nursing homes for short-term rehabilitation and sub-acute care.

Today, there are more rehabilitation and recovery services provided along a greater spectrum of needs, such as stroke recovery, cardiac rehabilitation and joint replacement recovery. The medical establishment is sending more patients to nursing homes who are being treated with highly sophisticated medication regimens, requiring specific pharmacy and nursing skills. Moreover, a growing percentage of individuals seeking nursing home placement have serious mental illness and problematic behavioral issues that nursing homes must care for – without resorting to excessive use of pharmaceuticals and restraints. Studies of the healing process also point to the role of the individual in his or her own health and recovery, making obvious the need to partner with the consumer and hearing and heeding his and her preferences in seeking

to achieve the best possible medical outcome.

The primary goals that are highlighted in the medical care prism are building capabilities to ensure high quality of care and positive clinical outcomes. But the medical care prism also reveals new challenges beyond the funding/regulation issues seen in the public good prism. For example:

- » Shortages of LPNs and RNs make recruitment and retention issues severe in many nursing homes. Shortages will become even more severe as more clinically compromised residents require more nursing hours; some studies recommend an increase to more than four hours per resident-day, up from an average of just over three hours currently.
- » Shortages are not the only problem, as new skills are needed along with the money for re-training and paying more highly skilled workers. These funds are currently just not available.
- » Finding physicians who are geriatricians or with experience in serving primarily seniors is extremely difficult and will remain so given the trends in medical education as well as the lack of financial incentives to pursue this specialty.
- » Care is being provided in settings originally built for simpler custodial care, and often in physical plants that are more than 30 years old.
- » Funding is limited for nursing homes to respond better to consumer preferences for more home-like envi-

ronments and settings that promote privacy and dignity with person-centered care.

In short, nursing facilities are being pushed by the public, by the medical establishment and by government to provide heightened levels of care while they are not robust enough in staffing or infrastructure to respond to such demands. While elected officials and advocates rail at the level of quality of care – not without some justification – the reality is that nursing homes are what they are. Nursing homes remain a necessary albeit ill-fitting response to the growing need for care for cost-effective, post-acute care. With funding restraints and shortages of medical personnel, nursing homes will be hard-pressed to transform to match these demands.

Policy Options within a Medical Care Prism:

- » Pay-for-performance policies can encourage capacity-building, but because of significant inequalities in current capacities, we suggest that structure and process investments first lead the way. This was examined in a previous New Horizons policy paper, available at www.vcny.org/policyforum.
- » Establish specific investment funds for the infrastructure required for this clinically complex and variable care. Electronic medical records (EMR) and communications systems are key to quality assurance.
- » Coordinate the deployment of best practices in clinical care. These

should be built into the EMR systems as well.

- » Establish specific investment funds for worker training in clinical care competencies and electronic record-keeping and communications.
- » Create incentives for medical, nursing, therapy and pharmacy schools to expand geriatric skill training. Further, create incentives for these professionals to accept employment in nursing homes.
- » Create quality measures and payment incentives to reward excellence in transitioning patients from the nursing home and back into community care.
- » Create incentives to promote the link between “person-centered care” and high quality outcomes.

A “Business” Prism

Most nursing homes do everything they can to sustain themselves and continue to operate. A business prism helps us to understand the operational, financial and efficiency pressures they face.

According to the New York Association of Homes and Services for Aging, more than 50 percent of the state’s nursing homes have negative operating margins. Since 2004, 21 nursing homes in New York have closed, with many more near the point of “going under,” according to NYAHSa.

Most nursing home business practices are based more on a manufacturing model of production where repetitive tasks are the

norm, not individualized, variable treatments. The organization of work revolves around completing assigned tasks on a shift basis. Residents are highly regimented to fit into schedules that fit the workflow of staff, not the variability of resident needs. Floors are designed to maximize workflow, not to meet privacy or independence. Funding is shaped by formulas that severely restrict the flexible use of resources.

The skilled nursing business is extremely capital and labor intensive. Capital reimbursement has lagged behind the realities of capital costs, and labor costs continue to outpace trend factors. Other industries facing high capital or labor costs have gone overseas, substituted capital with labor, or otherwise made changes in the production function, options not available to nursing homes by virtue of the “human” needs of patients and by regulatory requirements.

One might say that the business model is extremely efficient given the resources and requirements it must operate within. These business practices are becoming outmoded, however, and are severely limited in adjusting to the demands revealed in the medical care perspective. This “efficiency” may simply be the positive spin on an industry that is constantly in a state of fragility, if not a stage of near collapse, and any precipitous change in government funding or dramatic new requirements unaccompanied by financial support could be the tipping point. Unlike almost any other business model, the nursing home business model is a transparent one. At some point, a “doing more with less” policy will fail.

Under a business model, fair prices for care can – and should – be accurately calculated, and providers can – and should – be held accountable to achieve fair standards of care in conjunction with fair reimbursement levels. This is in keeping with the “public good” imperative.

The primary goal that emerges through the business prism is to enable nursing homes to manage their resources so they can best compete across efficiency and customer service. Unlike the public good prism that requires the “lifting of all boats,” or the medical care prism that requires significant capacity-building, the business prism suggests more of a deregulation approach, and assumes that nursing homes will find their own profitability and customer base, and maintain the safety net.

Policy Options within a Business Prism:

- » Enact changes to reimbursement methodologies that increase financial flexibility. Re-examine the validity of direct, in-direct and non-comparable limitations, and allow providers to use interest income to stabilize operations without an offset from reimbursement. Revisit the basic models for recognizing capital and establishing risk adjustment.
- » Create multi-year budgets for facilities that demonstrate a consistent level of quality and fiscal responsibility. This would achieve predictability of financing as opposed to annual funding machinations.
- » Re-balance the payment negotiation playing-field by considering legal

avenues for “collective bargaining” by nursing homes with managed care companies. This will enable a movement from destructive below-cost price-setting to a focus on procuring quality and outcomes, within regulated boundaries on both sides.

- » Create opportunities to gain access to capital for those able to afford it. (The state recently establish new bed caps for capital that will significantly help homes replenish their facilities.)

Conclusion

The role of nursing homes today in our society remains both vital and varied, and it is likely to stay that way for the foreseeable future. A single framework is simply insufficient to understand the needs and options available for long-term care reform. This is not surprising, as we are spending nearly \$7 billion on nursing homes in New York State, paying for 35 million patient days in over 650 homes. A “one size fits all” is clearly out of the question.

It is imperative that government be clear as to what it wants from nursing homes – and what officials are willing to let go by the wayside – and then pursue policy as consistently and predictably as any government can. Again, predictability is often more valuable than the annual rituals of give-and-take politics, which serve more to preserve the status quo and less to achieve reform and quality.

For government to take responsibility for the future of growing demand, having a consistent approach to creating policies and incentives is a must. Additionally, providers will need sufficient lead time to restructure

their operations to bring them in line with public policy. Creating the right incentives for change becomes crucial.

There is a major caveat: providers and consumers must be brought in to build a consensus around the key principles that will guide long-term care.

If government is to be driven solely by spending limitations or some view of “affordability,” then it should adopt one of the three paradigms outlined here and pursue it with specific investment and consistency.

On the other hand, if government believes that nursing homes will continue to play a vital role in health care in the foreseeable future even within the context of reform, then it should work together with providers and consumers on a policy path that stabilizes nursing home services and respects their role.