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Title of Project: Quality Factors in Nursing Home Choice

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Dates of Project: 9/30/00 to 08/31/04

Federal Project Officer: Denise Burgess

Acknowledgement of Agency Support: Agency for Healthcare Research and Quality (AHRQ)

Grant Award Number: R18 HS10926-03

Structured Abstract

Quality Factors in Nursing Home Choice

Purpose: Develop and evaluate information strategies to assist consumers use of quality factors in making Nursing Home (NH) choices.

Scope: Although quality indicators for NHs exist in the public domain, few consumers understand how to access and interpret them. What information do consumers need and value in NH choice?

Methods: A descriptive qualitative design determined information consumers and healthcare providers (HCP) valued in NH choice. A descriptive comparative design determined reliability and validity of publicly available quality data.

Results: Qualitative interviews were conducted with 65 NH residents, family, and HCPs from eight urban and rural institutions; 71% percent were White, 21% were Hispanic, and 8% were African American. In the comparative design, CMS data on quality indicators and NH staffing as well as state NH survey citations and staffing data were evaluated. Correlational analyses determined the best publicly available data.

A three-part instrument, the *Nursing Home Choice Tool*, 7was developed: I. First Steps in Choosing a NH; II. NH Quality Report Card; and III. NH Tour Guide. Seven quality domains identified in qualitative interviews were incorporated: environment, food and dining, staff-resident-family relationships, quality care, safety, family involvement, and administrative issues. The instrument was evaluated for content and format by nine focus groups with 50 consumers and HCPs. Parts I and III were rated positively, but Part II, report card, needs refinement. Consumers valued quality-of-life factors in NHs; these findings were incongruent with the science-based quality indicators in the public domain.

Key Words: nursing home, consumer preferences, quality factors, nursing home choice

Purpose

The purpose of the investigation was to develop and evaluate information strategies to assist consumers and providers to use quality factors in making nursing homes choices.

Specific Aims

1. Determine what information consumers use, need, and value in selecting a nursing home.
2. Determine what information healthcare providers use, need, and value in discussing nursing home choices with consumers.
3. Determine what information currently in the public domain (e.g., HCFA-MDS, state survey citations, staffing) can be used to help assess nursing home quality from the consumer and provider viewpoints.
4. Create a tool or prototype report card that incorporates information from Aims 1, 2, and 3 that can be used to assist consumers when choosing a nursing home.
5. Examine consumer and provider responses to the tool or prototype report card, specifically the quality indicators, usefulness, completeness, cultural appropriateness, and format.

Scope

Background

As the U.S. population ages and as individuals with chronic illnesses live longer, older persons will make numerous transitions into and out of various sectors of the healthcare system. Of persons aged 65 and older, it is predicted that 43% will use a nursing home at some point in their lives (Gabrel, 2000). The number of centenarians in the U.S. is rapidly increasing beyond initial projections. In addition, nursing home utilization is increasing among ethnic elders due to changing cultural norms, economic adversity, decreasing discrimination, and changes in the availability of community supports (Mui & Burnette, 1994). For example, research shows increased use of nursing homes by Hispanic elders when employment and economic strains limit families' abilities to provide care at home (Magilvy, Congdon, Martinez, Davis, & Averill, 2001). Both long- and short-term nursing home stays are a reality for many older persons and their families.

For consumers, the healthcare community, and the public, quality of care is a primary issue in nursing homes and has been a significant concern for the past two decades. Although quality indicators for nursing homes have been identified and exist in the public domain, few consumers understand how to access these indicators and know how to interpret their content or usefulness. Whether consumers use quality indicators to make value-based decisions in choosing a nursing home is unknown.

Context: Quality of Care In Nursing Homes

The process of nursing home choice requires that consumers have access to information about quality of care, appropriateness, cost and availability. Entry and admission into a nursing home are frequently made under urgent conditions because of increasingly shorter acute care stays, an exacerbation of complex chronic illness, and limited availability of family support (Congdon & Magilvy, 1998; Congdon & Magilvy, 2001; Magilvy & Congdon, 2000). Although the healthcare community has recognized the need for consumer information related to choice of providers, health plans, hospitals and other facilities, choice, quality, and decision making related to nursing homes remain an under-studied area. Developing useful, meaningful, and understandable information on quality indicators in nursing homes and exploring strategies to disseminate this information to consumers and healthcare providers together has been a high priority for our research.

The quality of nursing home care has been of significant long-standing concern to society. Since the mid-1970s, nursing homes have undergone increasing scrutiny, and this inspection has continued into the 2000s. A study released by the Institute of Medicine (1986) encouraged Congress to pass the Omnibus Reconciliation Act (OBRA) in 1987 that mandated certain nursing home reforms (Wunderlich, G.S. & Kohler, P.O. 2001). Although modest gains in nursing home quality have resulted from OBRA, these reforms have been only partially implemented and are cause for continued concern (Kovner, Mezey, & Harrington, 2000; Quadagno & Stahl, 2003; Weiner, 2003).

In 1987, the Health Care Finance Administration (now CMS) mandated the collection of a standardized set of data about all residents in long-term care facilities that use Medicare or Medicaid reimbursement. These resident assessments (known as the Minimum Data Set – MDS) are performed upon admission and annually thereafter with updates on a schedule determined by time and a change in the condition of the resident (Morris et al., 1990). The MDS captures indicators of individual clinical status that reflect pathologic changes accompanying very old age, and it records physical and mental disabilities that could conceivably be minimized by high-quality care.

Using the MDS information as indicators of quality of care, long-term care researchers developed a set of Quality Indicators (QI) (Zimmerman, et al., 1995) and later risk-adjusted measures (Arling, Karon, Sainfort, Zimmerman, & Ross, 1997). The risk-adjusted QIs were intended to provide nursing homes with a benchmarking process for quality assurance and to guide state survey visits. Examples of the indicators of quality care in nursing homes include indicators of physical care, such as rate of restraint use (physical and chemical), pressure sore prevalence, urinary tract infections, pain, injuries, hospitalizations, functional decline; staffing issues, such as ratio of staff to residents, consistency, turnover, training, supervision, competence; environmental concerns, such as cleanliness, odors, noise, privacy, food, furnishings, lighting; and nature of communication, such sensitivity to residents' likes and needs, family involvement, attitudes of staff, positive verbal and nonverbal communication, disposition of decision making. The recent accumulation of research using the CMS-mandated MDS

has begun to demonstrate that nursing home quality can be assessed using this information in a valid and reliable manner. Suggestions for use of the MDS information in improving the quality of care include improving the efficiency of state survey processes, offering models of best practice, guiding quality improvement efforts, and disseminating publicly to inform consumers. However, potential nursing home consumers do not know about or often use these data.

General agreement exists that the quality of nursing homes should be raised and that high-quality care is more than simply the absence of negative outcomes and regulatory deficiencies, but disagreement exists over the definition and assessment of the concept (Davis, Sebastain, & Tschetter, 1997; Kane, 2003; Noelker & Harel, 2000; Wiener, 2003). Nursing home quality is multidimensional, and current strategies for measurement place too little emphasis on the dimensions of quality that are meaningful and useful to consumers and their families and even to healthcare providers. Some experts contend that no meaningful progress can be made to improve quality until quality indicators have been accurately and systematically identified. To accomplish this goal, data must be collected from multiple sources, including interviews with consumers, families and providers in concert with other data sources, such as the MDS, public domain sources, and community resources. We believe that understanding the dimensions of quality nursing home care, including the perspectives from consumers and providers, is critical before information strategies can be developed to assist them in the use of quality factors in making nursing home choices. It is our opinion that quality should include both "quality of care," which refers to the technical competency of medical services (Weiner, 2003), and "quality of life," which means features as consumer choice, dignity, respect, comfort, relationships, spiritual and cultural well-being, and a sense of security (Noelker & Harel, 2000).

In a variety of healthcare arenas, report cards have been developed to integrate concise quality assessments to help consumers choose health plans, insurance, providers, and hospitals. Multiple examples exist in both the public and private sectors, including the National Commission for Quality Assurance (NCQA) and the Consumer Assessment of Health Plans (CAHPs). Criticisms of the report card movement to assess quality and assist consumer decision making included that report cards often rely only on administrative or medical records. Furthermore, quality is defined in a very narrow manner, often in negative rather than positive terms. At the time of writing the grant, the report card initiative had not been extended to selection of nursing homes. The report card movement gained momentum with health plan assessments (CAHPs), the goals of which are to develop and test questionnaires that assess health plans and services. They produce easily understandable reports for communicating survey information to consumers and evaluate the usefulness of these reports for consumers in selecting health care plans and services. Initial evaluations of these report card initiatives have raised questions about their effectiveness in terms of helping consumers make choices.

Despite initial implementation issues, use of consumers' judgments can be helpful in informing others and identifying opportunities for quality improvement (Clancy, 1999). However, we must learn how to increase the relevance of quality information to

consumers and make it more comprehensible to those from different cultural and educational backgrounds (Clancy, 1999). The Agency for Healthcare Research and Quality (AHRQ) has been especially interested in quality of healthcare services and long-term care and is to some degree driving the report card initiatives. These initiatives have helped us begin this process, but the time has arrived to involve consumers in developing information that is useful, valued, needed, and delivered in a consumer-friendly format.

To address some of the issues identified in the state of the science around quality in long-term care, we assembled a multidisciplinary team of investigators with expertise in long-term care and outcomes research. The purpose of our investigation was to develop and evaluate information strategies to assist consumer use of quality factors in choosing a nursing home. The setting of the investigation was eight nursing homes, five urban and three rural, through which we sampled a total of 65 participants, including healthcare providers, nursing home residents, and family members. Also sampled were 50 participants in nine focus groups, including healthcare providers and consumers. The aims of the project were 1) to determine what information consumers and healthcare providers use and value in making NH choices; 2) to determine what information in the public domain can be used to assist consumers to assess NH quality; and 3) to create and evaluate a tool to assist consumers in choosing a NH. The focus of the study was on selecting a nursing home once the placement decision has been made.

Methods

A combination of research designs was used in the study. A descriptive qualitative design was first employed to determine information consumers and healthcare provider (HCP) use and value in nursing home (NH) choice. Then, a descriptive comparative design was used to determine reliability and validity of publicly available quality data. Each design will be described separately, with discussion of methods followed by description of results.

Qualitative Descriptive Study

To pursue an understanding of the experiences of nursing home decision making, and to identify information about quality and other factors valued in the decision process, a qualitative descriptive design informed by ethnography was utilized. The ethnographic nature of the design facilitated the description of key cultural and environmental contexts of the nursing home selection process, including nursing home setting, rural and urban environment, and cultural/ethnic preferences.

Face to face audiotaped interviews were conducted with 65 rural and urban nursing home residents, family members, and healthcare providers in Colorado. Twenty-two of the participants were nursing home residents with a mean age of 82; 25 were family members of nursing home residents; and 18 were healthcare providers. Seventy-one percent of the participants were White, 21% were Hispanic, and 8% were

African American. Most participants were women (75%) and resided in urban areas (60%).

The participants were recruited from five urban and three rural nursing homes selected to ensure diversity of size, ethnic/cultural diversity, socioeconomic status, and rural or urban setting. Because family members were more likely than residents to make the choice or selection of a nursing home, the sampling plan allowed for oversampling of family members compared with residents. Healthcare provider participants included nursing home administrators, nurses, certified nursing assistants, social workers, hospital discharge planners, physicians, or aging services specialists experienced in helping older persons and their families select nursing homes. The study was approved by the Colorado Multi-Institutional Review Board.

Ethnographic, semi-structured audiotaped interviews were conducted at a time and place convenient for the participants. Most interviews were 30-45 minutes in length and took place in the nursing homes or in the offices of the professional care providers. Examples of interview questions included the following: "Tell me how you chose this nursing home?" and "What information was useful in helping you choose?" We asked how they had received or would like to have received this information. We also asked, "What information do you wish you would have had to make the choice?" HCPs were asked how they assisted their patients in choosing a NH.

Interview data were analyzed following qualitative data analytic techniques (Coffey & Atkinson, 1996). Three team members conducted the interviews, reviewed transcripts of the taped interviews, and, using *Atlas ti* to facilitate data management and organization, analyzed the interview data. Data were first coded for content, process, or impressions and then examined more and reduced into broad categories and finally into specific domains. The final consolidation of domains involved the entire research team. Trustworthiness of findings and rigor of the study were addressed following the guidelines of Lincoln and Guba (1985). Credibility and confirmability were addressed using multiple sources of data generated by three investigators; member checking with selected participants, peer debriefing with the full research team, and focus groups held during the later part of the study. A detailed log of all study activities and decisions was maintained, addressing dependability of data; applicability or transferability was enhanced by a thick description of findings. The data analysis (1) clarified the process consumers used to select a nursing home, (2) identified key criteria for screening potential choices, and (3) identified the information or domains that consumers considered most important when selecting a quality nursing home.

Results

Once a decision was made for nursing home placement, participants described a similar process. First a healthcare provider, typically a hospital social worker, presented them with a list of facilities. When the list included more than three facilities, they often experienced confusion and frustration with the process and desired assistance with screening or shortening the list of homes. Finally, a decision was made, most often by a family member of the resident with or without visiting the nursing home.

Most families reported receiving from hospital discharge planners or social workers a list of 4-10 nursing homes in urban settings, or 1-4 nursing homes in rural settings, from which to make a selection. Discouraged by the long lists, families recommended developing a "short list" based on specific criteria. Identification of the reasons for nursing home placement was the first criterion (e.g., rehabilitation, skilled care, Alzheimer's care, hospice, or respite care). Other screening criteria included location, religious/cultural preferences, size of the facility, and payment sources accepted. Using these criteria, screening questions that consumers could use to narrow their list of nursing homes were suggested.

The participants then described the information they most valued and needed when choosing a NH for themselves or a family member. These findings were presented in seven domains: Nursing Home Environment; Food and Dining; Staff, Resident, and Family Relationships; Quality of Care; Safety and Security; Family Involvement in Care; and Business and Administrative Issues. We will describe each domain, as this information will be essential in informing the state of the science in this area.

Nursing home environmental factors were the first and most often cited by the participants. Convenient location, community connection, religious and cultural environment, and physical surroundings were emphasized repeatedly throughout the interviews. Location was highly valued by participants. A social worker who frequently advises families on nursing home selection told us: "I tell the family … to place the resident as close as possible to your home or work…because they are going to have to monitor the care." Participants valued specific physical environment characteristics, including reasonable control of unpleasant odors, an orderly appearance, a pleasant feeling, a restful environment, privacy, and roommate compatibility. A frequent comment from consumers was that "it should feel homey." Environmental features held the dominant position in the selection of a nursing facility. Before considering other important features, participants wanted to make certain that the environment was compatible with their preferences, culture, values, and lifestyle.

Food and dining were important considerations. Participants voiced the importance of visiting the prospective nursing facility at mealtime and noting the appearance and cleanliness of the dining room, choice of menu, food that looked and smelled appetizing, residents being assisted with eating, and the presence of family members at mealtime. The availability of nutritious snacks, options for special diets, a variety of choices, and ethnic and cultural food preferences were deemed important for quality of life. Consumers preferred the dining room to be social, nicely decorated, and located away from care activity.

Both consumers and healthcare professionals discussed *relationships* between staff and residents, between staff and family members, and among staff members. The manner in which staff members treated and approached residents and families was considered crucial. Family and residents preferred a friendly, gentle, attentive, and respectful manner that exemplified caring and dignity. Respectful, friendly staff interactions and the ability of staff to coordinate and work together were considered

indicative of the quality of care. One family member asserted, "I would like to see how the staff work with each other, too. If there's a lot of animosity between staff members, that comes out in the care that they give the resident."

The *quality of care* received by residents (e.g., nursing services, medications, safety, rehabilitation services) was consistently identified as a valuable factor in nursing home choice. However, care was conceptualized differently than is typically represented in many nursing home quality-of-care indicators. Although participants discussed interventions such as hygiene, pain control, and patient safety, they clearly conceptualized care as having dimensions beyond tasks, skills, and safe procedures. A family member explained:

> "We never knew what a nursing home was and now we know what a nursing home is – it takes love to care for the elderly. It takes love and compassion…to be a good nursing home."

Many discussed practical aspects of what they considered "good" care – basic hygiene, appropriate medication administration, therapeutic activities such as rehabilitation, assistance with eating, and appropriate and timely response to resident needs. Quality-of-care issues were primarily quality-of-life issues as described by these participants. They acknowledged the complexity of care in a nursing home, especially comfort, sensitivity to resident needs, and respect for human dignity.

Family members and residents needed to feel confident that residents are *safe and secure*. Families wanted ample evidence that residents are well supervised and not left alone for long periods. It was also important to family that the neighborhood was relatively safe. Participants recommended that consumers look for efforts made by the nursing facility to protect residents who might wander or fall, such as secured units, locked doors, adequate hallway railings, low beds, unobstructed walkways and halls, sufficient lighting, and intact carpet or floor tiles.

The *family involvement* domain reflects the value of family members being physically present, monitoring nursing care, and actively delivering assistance in daily care activities. Family monitoring of care was considered a realistic worldview of the current healthcare environment. Participants held realistic expectations of the long-term care facility, as reflected by this family member:

> "Consumers need to know that a nursing home is not a hospital. They don't have the staff here or the resources to give you the kind of care that they have in the hospital and the type of attention. So they need to understand that the care will be different and that you will expect to be doing some things for yourself. Families will have to help more."

Participants who were involved in care appeared to be more satisfied with their selection and the perceived quality of the facility.

Participants recognized the impact of *business and administrative issues* on the nursing home setting and incorporated this information into their selection process. Others learned after the fact that the nursing home had serious administrative or financial problems. Investigating the financial status of the nursing home was recommended. Consumers and healthcare providers were astutely aware of the tentative financial status of many long-term care facilities, acknowledging that some nursing homes had experienced bankruptcy. Participants considered stability in ownership and low management turnover to be essential to quality of care and a secure environment.

Comparative Analysis Study

The domain analysis and qualitative descriptive portion of the research provided the team with information on which to base development of a screening tool and a tour guide for families in the decision-making process. The construction of a report card, however, involved compilation and analysis of publicly available information on quality in nursing homes. The quantitative portion of the research used a correlational design to evaluate CMS data on quality indicators and nursing home staffing as well as state data on NH survey citations and NH staffing. The purpose of the analyses was to determine the reliability and validity of the publicly available data. Reliability was assessed with stability of indicators across time and comparisons of two sources of data measuring the staffing indicator. Validity was assessed by determining the similarity between empirical inter-relationships among indicators and hypothesized relationships. Two hypotheses were written for this portion of the research;

1. If QI are true indicators of quality of care, they will be interrelated.
2. If nurse staffing is related to quality of care provided, the indicators of nurse staffing should be related to indicators of quality.

Once data were obtained from state and national sources and were cleaned and prepared for analysis, a series of comparative and correlational analyses was conducted. Findings of these analyses addressed the two hypotheses and described the stability and validity of the publicly available data. Moderate to high levels of stability were found in the quality indicators and staffing indicators; however, some indicators were more stable than others.

The average values for staffing variables were similar for the CMS data for Colorado and the staffing data collected quarterly by the state. The staffing indicators from CMS for 2000 correlated highly with the staffing values obtained directly from all NHs by the state regulatory agency for 2000. These correlations ranged between .502 and .762 for the five staffing indicators (total hrs / resident day, RN hrs / resident day, licensed hrs / resident day, percent of hours licensed, and percent of hours from RNs only). These analyses show moderate stability and agreement between the two data sources, providing some evidence for data reliability.

The percentile placement of NHs on five of the quality indicators thought to be most indicative of nursing care was assessed across the two halves of 2000. Moderate stability was also evident in these indicators. The Spearman rank correlation for each of

the five indicators were as follows: .626 for urinary tract infections, .528 for weight loss, .853 for tube feeding, .570 for pressure ulcers, and .812 for behavior affecting others. The NH percentiles for the quality indicators were not intercorrelated. Therefore, the hypothesis was not supported.

Analyses of the impact of staffing on quality were done using both the CMS quality indicators and the state survey citations for Care Quality and Substandard Care. After controlling for resident illness severity with the percent Medicare residents, and including both total hours / residents and percent licensed hours, multivariate analyses indicated that NHs with higher total hours of care had higher rates of urinary tract infections and pressure ulcers. Nursing homes with higher percent of care hours provided by licensed nurses had lower levels of new fractures and higher levels of urinary tract infections. The investigators recognize that the causal order is ambiguous in these analyses. The relationships between staffing indicators and problems with the quality of care, as indicated by survey citations, were not consistent but showed general trends, indicating that NHs with higher percent RN care hours had fewer citations for Care Quality and for Substandard Care.

Final product:

During the study, the CMS released their new website, called *Nursing Home Compare*. This publicly available site encouraged consumers to search nursing homes by state and county and compare their selected homes on variables such as quality indicators, staffing data, and survey citations. This site lent support to the validity of items that we selected for the report card portion of our instrument while leading us to wonder: if consumers were able to obtain this information alone, to what degree would the report card be needed?

In the final part of this research, our team, with the assistance of a graphic designer, developed a three-part ,consumer-oriented instrument, the *Nursing Home Choice Tool*. The instrument, as described in the following discussion, was then evaluated with a series of consumer and HCP focus groups, revised twice, and discussed again in focus groups.

Part I, the screening tool, *First Steps in Choosing a NH*, was designed to help families clarify their needs and values and narrow the list of nursing homes to three. Six screening questions are asked: reason for moving to a NH and care needs; location; religious/cultural environment; size, payment sources, and options; and continuity of care with their own HCP.

Part II, the *NH Quality Report Card*, based on the comparative analysis, includes a report card designed to be completed by a professional healthcare provider or by a family member with professional assistance, using publicly accessible data. Included on the report card is information on staffing, key and important deficiencies as cited on NH surveys, and quality measures from CMS. The three selected NHs are compared with

each other and with state and national data on staffing and eight CMS quality measures. The deficiencies in key categories are identified.

Part III, the *Nursing Home Tour Guide*, incorporates the seven domains identified in the domain analysis. Several items are listed under each domain to direct the consumer in assessing specific aspects of the nursing home. The guide encourages consumers to record their impressions of each NH visited on a single tool using an easy checkmark format.

Once the tool was developed, we evaluated the tool in a series of focus groups. The focus groups were held over a period of a year, during which we made several revisions of the instrument. The focus group evaluation included nine focus groups with a total of 50 participants held to determine the validity, feasibility, and usefulness of the NH Choice Tool. The nine groups consisted of 32 consumers and 18 healthcare providers (separately) in rural and urban environments. The members discussed the content, format, readability, understandability, and appearance of the tool and made many helpful suggestions. Overall, participants were very enthusiastic about the NH Choice Tool and believed it would be an excellent educational tool as well as facilitate families making a selection of the best nursing home for their family member.

An interesting finding of the focus group and interview analyses was the incongruities between consumer-identified factors and the established quality indicators found in the literature and CMS work. The consumers mentioned quality of life (QOL) variables as essential in the selection of a NH and did not mention many of the quality measures reported by nursing homes to the state and federal governments. For example, although some QOL variables were similar to quality of care variables, many were more related to the environment, safety, family involvement, and staff relationship aspects of NH care. Also, participants did not mention areas such as skin care, use of restraints and psychotropic medications, and rehabilitation outcomes that are part of the quality indicators from CMS. In addition, the information in the public domain was found to be confusing to the participants in focus groups. Likewise, the information was found to be variable in validity, reliability, and accessibility as determined by our comparative analysis. The focus group participants also questioned the reliability and accuracy of data on the report card, wondering about the sources of information and ways in which it was collected.

Limitations:

The Nursing Home Choice Tool is in an early phase in development, and more testing is needed to determine its usefulness and outcomes for families engaged in choosing a nursing home. The qualitative portion of the study, though not generalizable, provided in-depth information on factors consumers wanted and valued in choosing a nursing home. However, the purposive sample was limited to persons in a western state; a wider national sample might provide additional information. The report card development took place at same time as the CMS Nursing Home Compare project (www.medicare.gov/nhcompare) was published on the web. Therefore, we revised our

report card to reflect the information now becoming available in the public domain. Additional work is needed on this section of the instrument, with the possibility of using the Nursing Home Compare website instead of a separate report card.

Discussion

Many stakeholders have entered the arena of consumer information and education about selection of healthcare facilities and providers. Societal demands are driving this movement. Consumers have a growing interest in long-term care as the population ages and families are engaged in helping their older members transition into this environment. Information on quality and selection of nursing homes is becoming more available. For example, the federal government has created a website directed at consumers to assist them in making nursing home selection, called Nursing Home Compare (www.medicare.gov/nhcompare). The CMS published a *Guide to Choosing a Nursing Home* (CMS 2002). Other researchers, including a team of nurse researchers (Rantz, Popejoy, & Zwygart-Stauffacher, 2001), are publishing books on this topic.

In 2001, the Institute of Medicine published an extensive study of the current status of the quality of long-term care. Also examined were improvements in quality of long-term care services since the 1986 IOM report (Wunderlich & Kohler, 2001). Five categories of recommendations were identified for improving quality across long-term care settings: 1) access to appropriate services; 2) quality assurance through external oversight; 3) strengthening the workforce; 4) building organizational capacity; and 5) reimbursement to improve quality of care. This landmark study has many implications for future nursing research in cost and quality of long-term care. The US Congress recently entertained legislation calling for minimum requirements for nurse staffing in nursing facilities that receive payments under Medicare or Medicaid. Issues around nursing home quality are definitely in the news, in the minds of consumers, and in the minds of legislators.

Although the quality indicator initiative is embedded in all these publications, we believe that consumers have not yet made the connection between quality and choice. Harrington and colleagues emphasized a need for consumer materials to be comprehensive, accurate, and reliable to allow consumers to make informed choices (Harrington, O'Meara, Kitchener, Simon, & Schnelle, 2003). If the information is not reliable and valid, consumers are left to make decisions based on incomplete or inaccurate information (Mukamel & Spector, 2003). We would add that hallmarks of quality in long-term care are in need of more investigation and dissemination to consumers.

We therefore believe that a need is indicated for consumer education on quality factors in choosing a nursing home. Our research and the literature indicate that consumers don't distinguish well between quality-of-care indicators and quality-of-life measures. When questioned, they valued quality-of-life factors over the technical or medical aspects of quality of care. Evaluation of effectiveness, usefulness, and outcomes

of the decision process is essential to the state of the science. We believe that the dissemination of consumer-oriented quality and nursing home selection materials needs to be initiated sooner in the long-term care transition trajectory. Residents of retirement living centers and assisted living facilities may likely be the next consumers of long-term care. Perhaps the process of assisting consumers and their families to make long-term care choices should begin in these pre-nursing home facilities. Nurses are well positioned to guide consumers to make future life decisions in an environment of quality of care. By raising consumer awareness and use of quality factors, the long-term care system will be encouraged to improve quality of care and outcomes related to quality of life.

Conclusions, Implications, Significance

We believe this project is significant for a number of reasons. First, the qualitative descriptive portion of the study brought the voice of consumers to the foreground, allowing their interests, values, and concerns about choosing a nursing home to be heard. We now understand what information consumers want to receive and in what format prior to making a nursing home choice. A strength of this research was the inclusion of a mix of culturally diverse Hispanic, African American, and White (non-Hispanic) urban and rural older persons and their families. During the project, we developed a consumer-friendly, brief, and informative instrument not only to help consumers choose a nursing home, but also to educate them in the availability of information on quality factors in nursing home care. Consumer education is a continuing need as the aging population increases.

Another strength was the use of focus groups to evaluate the instrument and assist with determining the most appropriate content and the most acceptable format for presenting this information. The consumers in the focus groups evaluated Part I, *First Steps in Choosing a Nursing Home,* and Part III, *The Nursing Home Tour Guide*, very positively. The tour guide portion of the instrument was rated especially high. Part II, *Nursing Home Quality Report Card*, however, needs more refinement, with the potential for including the Nursing Home Compare website in place of the constructed report card. Although the overall instrument needs to be tested by consumers, early indications are that it would be useful to families poised to make a nursing home choice.

In conclusion, our focus group members, both healthcare providers and consumers, were very positive, and the participants requested copies to use and share with their families and clients immediately. Therefore, we believe that consumer interest in healthcare quality is high and the need for information is strong, particularly in this area of selection of nursing homes. Additional development of this instrument and testing of it regionally and nationally could lead to the expansion of this tool into other long-term care settings and populations, specifically assisted living and other residential models of care.

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