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# Quality of Care and Profitability in Not-For-Profit Versus For-Profit Nursing Homes

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# **QUALITY OF CARE AND PROFITABILITY IN NOT- FOR-PROFIT VERSUS FOR-PROFIT NURSING HOMES**

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# QUALITY OF CARE AND PROFITABILITY IN NOT-FOR-PROFIT VERSUS FOR-PROFIT NURSING HOMES

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## ABSTRACT

*Nursing home residents across the United States rely on quality care and effective services. Nursing homes provide skilled nurses and nursing aides who can provide services 24 hours a day for individuals that could not perform these tasks for themselves. Not-for-Profit (NFP) versus For-Profit (FP) nursing homes have been examined for utilization and efficacy, however, it has been shown that NFP nursing homes generally offer higher quality care and greater profit margins compared to FP nursing homes. The purpose of this research was to determine if NFP nursing homes provide enhanced quality care and a larger profit margin compared to FP nursing homes. Benefits and barriers in regards to financial stability and quality of care exist for both FP and NFP homes. Based on the findings of this review, it was suggested that NFP nursing homes have achieved higher quality of care due to a more effective balance of business aspects, as well as prioritizing resident well-being, and care quality over profit maximization in NFP homes.*

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## INTRODUCTION

Nursing homes provide skilled nurses and nursing aides who can provide services 24 hours a day for individuals that could not perform these tasks for themselves (Robinson, 2014). The difference between Not-for-Profit (NFP) and For-Profit (FP) nursing homes is that NFP facilities do not pay financial obligations such as federal income taxes and property taxes Grabowski and Stevenson (2008). On the other hand, FP nursing homes are owned by either private investors or shareholders and is therefore part of a company that sold stock to raise revenue to expand the facilities' activities (The Medicare Newsgroup, 2014).

Quality of care may be measured in a variety of ways. One of the most widely used approaches to quality measurement in healthcare is the conceptual framework of Avedis Donabedian (1966). This model of structure, process, and outcomes has impacted healthcare in multiple ways (CMA, 2011). Structural factors are easy to use and access, however, nursing homes can meet these measures but not necessarily provide quality care. For example, it is important to have high staffing numbers but the quality of the staff is more imperative in a nursing home. Process quality indicators reflect on the nursing homes and can be an advantage or disadvantage depending on ownership. In addition, if a vaccination is provided to the resident of the nursing home or not is a good example of process quality indicators. Different plans such as how medication is distributed to reduce errors or toilet plans to reduce bowel accidents with residents are placed into effect and may provide efficient and effective ways of process quality indicators. Process quality indicator plans increase quality of nursing homes while increasing effectiveness of staff. Outcome quality indicators in NFP and FP should reflect on structure, process and provide good health outcomes if appropriate care is provided. According to the authors, outcome quality indicator plans analyze quality of care; however, it is important to take in consideration external and genetic factors that can render outcome results (Castle and Ferguson, 2010). Therefore, the Donabedian model serves as a guideline for coordinating/delivery of care in an attempt to work hand in hand with the three related concepts (Kobayashi, Takemura and Kandra, 2011; Mor et al., 2009).

At the time of placement in a nursing home, residents are often unaware of factors such as ownership (NFP or FP) or the types of resources the facility may or may not have (Alliance for Advancing Nonprofit Health Care, 2011). For example, one nursing home may be equipped with up to date or better technology versus another nursing

home facility. In addition, technology has greatly improved and continues to mature and develop to enhance quality of care in nursing homes (Magan, 2013).

Profitability is, not surprisingly, a top focus for FP nursing homes: the profit margin for FP nursing homes treating Medicaid patients in 2010 was 21%, compared to NFP nursing homes treating Medicaid patients (Young, 2012). Clearly, profitability is not a top focus of NFP nursing homes (Alliance for Advancing Nonprofit Health Care, 2011). Magan (2012) noted that NFP nursing homes in New York state had less frequent hospitalizations, higher staffing levels, lower patient acuity, fewer deficiencies (shortages per 100 beds) and more discharges to the patient's home than did FP nursing homes. In 2012, the number of nursing homes nationwide increased to 15,700 with an estimated 1,383,700 residents (Harris-Kojetin et al., 2013). The ownership status of nursing homes varies: NFP nursing homes rely on philanthropy and other government funding. In contrast, FP nursing homes are generally more focused on stock prices and benefiting shareholders (Span, 2012).

## RESULTS

### For-Profit Financial Trends

A 2010 Department of Health and Human Services study (DHHS, 2010) of Medicare payments to skilled nursing facilities between 2006 and 2008 revealed that FP nursing homes used substantially more ultra-high therapy Resource Utilization Groups (RUGs) than did NFP nursing homes. The higher the RUG classification, the higher Medicare pays (DHHS, 2012). Overall, regardless of ownership status, the rate of classifying and obtaining reimbursements for ultra-high therapy RUGs increased from 17% in 2006 to 28% in 2008 in FP nursing homes, but FP nursing homes were "far more likely ... to bill for higher paying RUGs" (DHHS, 2010, p. 11). In addition, 32% of patients in FP homes were categorized in the highest RUGs compared to 18% of NFP nursing homes, and patients in FP nursing homes had longer average lengths of stay than patients in NFP nursing homes. These differences among types of SNF ownership did not appear to be the result of differences in SNFs' beneficiary populations: the average age and the distribution of ages of nursing home patients over the period of the study changed only minimally, and the top 20 diagnoses at admission remained constant (DHHS, 2010). It should be noted that FP nursing homes owned by large chains were the most likely to bill for higher paying RUGs that were nursing facilities owned by NFPs, and in those cases where FPs purchased NFPs, the billing by the FP nursing homes purchased by large chains changed soon after the NFPs were acquired (DHHS, 2010), while the performance of these nursing homes whose ownership changed deteriorated (Grabowski and Stevenson, 2008).

### Overview of Selected NFP Financial Statements

The balance sheet for 2013 year from the Overton County Nursing Home of Livingston, Tennessee was examined. On a \$10 million balance sheet, only \$4.5 million accounted for liabilities. In addition, the payer mix/credit risk was much more balanced between Medicare, Medicaid, and private pay. This balance made the nursing home significantly less susceptible to fluctuations by one payer. The Overton home also had an operating loss of \$425,604 (Jobe, Hastings & Associates, 2013).

The financial statements of the Alice Byrd Tawes Nursing Home of Crisfield, Maryland was also analyzed. The nursing home showed an operating profit of \$214,219 in 2010, an important indicator of financial stability. The overall position of cash and cash equivalents improved from 2009 to 2010 by \$150,383. A new building increased assets and liabilities by nearly \$9 million (Independent Auditor, 2010). Although the organization's overall financial position appeared respectable, a heavy population of Medicaid patients leaves it susceptible to changes in Medicaid policy, and was noted in the "concentration of credit risk" - gross charges for Medicaid represented \$4,114,139 out of \$5,313,886 or 77.4% of charges coming from Medicaid utilization (Independent Auditor, 2010).

### Organization Ownership Effects on Structure and Performance

Schlesinger and Gray (2006) in a review of over 50 studies of nursing homes, analyzed and compared selected dimensions of performance, including economic performance, quality of care, and accessibility for unprofitable patients. These authors reported that NFP nursing homes had better outcomes across all dimensions. Further, they concluded that FP homes are typically run at lower costs and are potentially more efficient than their NFP counterparts; however NFP homes have been associated with higher quality of services. In a study of nursing homes in Minnesota,

Ben-Ner and Ren (2008) found that FP nursing homes delegate less decision-making power to employees, provide more incentives and fewer fringe benefits, and monitor patients less. They also found FP nursing homes were more efficient, and provided similar levels of service elements that observable to their customers but lower levels of less-well observable elements.

### **Profit Status and Quality of Care**

Process-based indicators such as inappropriate use of restraints, audit deficiencies for restraint use, catheterization rate, tube feeding rate, and inappropriate usage of psychoactive drugs were reviewed by Hillmer et al. (2005). NFP homes were found to provide higher quality of care when evaluated on both process-based and outcome-based indicators. Both FP and NFP have received audit deficiency citations for inappropriate restraint use, but this review of the literature indicated that there was increased use of restraints in FP homes, as well as increased inappropriate use of psychoactive drugs. The research also noted that that lower staffing rates in FP homes were associated with detrimental outcomes for residents. The increased inappropriate use of restraint rates in FP homes has led to higher morbidity and mortality rates.

### **Staffing levels and Quality of Care**

Staffing levels in regards to FP and NFP nursing homes is considered to be a significant predictor of quality of care (Harrington et al., 2012). A 2011 University of California at San Francisco-led analysis (Fernandez, 2011) and a Harrington et al. (2012) report assessed the staffing and quality of the U.S' ten largest FP nursing home chains. These ten FP chains operate over 2,000 nursing homes nationwide, as well as control an estimated 13% of the nation's nursing home beds. The FP chains assessed were found to keep labor costs at a minimum in order to increase profits; therefore not prioritizing quality of care (Fernandez, 2011).

Staffing levels and quality deficiencies were compared at the FP chains to NFP homes. In data gathered from 2003 to 2008, these FP chains had lower levels of RN staffing as well as lower staffing hours than NFP homes. These chains were considered to have the sickest residents, however the combined total nursing hours were 30% lower than their NFP counterparts. The top ten FP chains were also significantly below the national average for LPN staffing, and were also cited for over 36% more quality deficiencies and 41% more severe deficiencies than NFP facilities. These deficiencies included failure to alleviate pressure sores, injuries, inspections, mistreatment of residents, and poor sanitary conditions (Harrington et al., 2012).

McGregor et al. (2005) also assessed FP and NFP staffing levels. Nursing homes that composed 76% of British Columbia's total facilities were selected, 109 NFP and 58 FP. The average number of hours per resident day was higher in NFP facilities for direct care and support staff for all facility care levels. Direct staff included RNs, LPNs, and resident care aids. In comparison to FP ownership, NFP was characterized by an estimate of 0.34 more hours per resident day for direct-care, as well as 0.23 more hours per resident-day for support staff. The authors concluded that public funds used to provide care to frail elderly patients in nursing homes purchased significantly fewer direct-care and support staff hours per resident per day in FP nursing homes than in NFP ones.

--- insert Figure 1 here ---

Figure 1 shows that NFP status is associated with higher staffing as well as higher average numbers of direct and support care hours per resident day. Lower staffing levels and average hours were consistent in FP homes, due to the implication that lower staffing levels were a viable option to maximize profits in a system with fixed costs (McGregor et al., 2005).

### **For-Profit Homes and Chain Status**

Chain participation allows the costs of network participation to be distributed over multiple facilities, making the profit advantages of FP nursing homes available for use in other areas and activities; e.g., transfer learning among different facilities (Elliot, 2007). FP chain participating homes have been heavily debt-financed with stakeholder pressures for short-term profitability, and base managerial decisions on financial priority at the expense of care quality (Kitchener et al., 2008). In addition, FP homes have been generally less concerned about competition in regards to quality of care because they are enabled by resources to conduct marketing campaigns in order to attract patients.

Lastly, FP homes typically have more attorneys and funds to battle regulatory deficiencies, enabling poor quality to have less of an impact on them.

## DISCUSSION

The results of this literature review suggested the advantages and efficiency of NFP nursing homes across multiple dimensions. The literature review supported the overall better performance of NFP over FP nursing homes. Higher staffing levels at NFP facilities have resulted in better quality of care and lower mortality rates. Research indicated that NFP homes prioritize quality of care and support resident payments at their own expenses.

The financial aspects of nursing home facilities have also contributed to the quality of care delivered. Research has indicated that FP nursing homes have an advantage over NFP facilities in the fact that they acquire additional resources, such as funds from stockholders and other outside entities. These funds have proven advantageous over competitors in some aspects, but have also shown to be harmful in others. The vision of the FP homes in regards to high profits often results less concern regarding quality of care. FP nursing homes have attracted residents with marketing campaigns instead of enticing potential residents with optimal quality of care.

Although the FP nursing homes have access to capital to cover their neglect to the attention of quality in care, this financial advantage is not enough to keep FP homes ahead of NFP homes across all dimensions. As a result, the quality of care that the NFP nursing homes offer, such as efficient staff levels to care for resident's needs, and proper medicine distribution, exceeds the additional resources FP nursing homes obtain and thus NFP residents are more likely to stay long-term in a nursing home.

U.S. health system implications are essential in complying with certain recommendations in order to battle the inappropriate billing trends of FP homes. For example, stakeholders such as the Centers for Medicare and Medicaid Services (CMS) should take additional precautions to monitor all Medicare payments to FP facilities, increase the monitoring of FP homes that bill for higher level RUGS, and conduct follow ups on FP homes that have been identified as practicing questionable billing. In addition, the CMS should consider changing the methods for determining how much therapy is needed to ensure correct payments. Further recommendations include that the CMS should increase the use of its fraud prevention system, encourage compliance with new therapy assessments, and conduct more reviews of FP claims.

## CONCLUSIONS

Benefits and barriers in regards to financial stability and quality of care exist for both FP and NFP homes. Based on the findings of this review, it was suggested that NFP nursing homes have achieved higher quality of care due to a more effective balance of business aspects, as well as prioritizing resident well-being, and care quality over profit maximization in NFP homes.

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Figure 1. Mean Hours per Resident-day for Individual Job Classifications, by Facility Level and Type of Ownership (data from McGregor et al., 2005)

