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Editor's Introduction

In most cases, the chapters of The Robert Wood Johnson Foundation *Anthology* focus on recently or nearly completed activities. In this way, we are able to provide timely reports of emerging findings. Every year, however, at least one chapter takes a look back at a long-finished program; this allows us to assess outcomes through a longer lens. This year, the *Anthology* looks back on the Teaching Nursing Home Program, an effort the Foundation funded between 1982 and 1987 to improve the quality of nursing home care and the clinical training of nurses by linking nursing schools with nursing homes.

The program was based on the model of educating physicians whereby medical residents get on-the-job training by caring for patients in teaching hospitals. If this model enhanced the skills of young physicians and improved the care of patients, why, Foundation staff members asked, wouldn't the same be true if nursing students received on-the-job training in nursing homes?

As told by *New York Times* editor and frequent *Anthology* contributor Ethan Bronner, the story of the Teaching Nursing Home Program is not one of a uniformly successful initiative. Maintaining relationships between nursing schools and nursing homes turned out to be more difficult than expected; nursing homes had less money than did hospitals; and geriatrics was not an attractive field for many new nurses. Although the program's use of quantitative measures contributed to later evaluations of home health agencies' performance and many of the program's alumnae attained great stature in the nursing profession, teaching nursing homes are today the exception rather than the norm.

While teaching nursing homes may no longer be a priority of the Foundation, its interest in nursing and in services for the elderly continues. The Foundation has \$173 million in active grants aimed at strengthening the delivery of care for chronically ill individuals, a large proportion of whom are elderly. And improving the quality of the nursing workforce and of nursing services is one of the eight Foundation priority areas that the board of trustees adopted in January 2003.

In 1980, Bruce Vladeck shook the nation when he published his book *Unloving Care: The Nursing Home Tragedy*, which chronicled government failure and rapacious private profiteering in an industry that had exploded during the 1960s.¹ With Americans living longer and increasingly spending time in nursing homes of widely varying quality, the book called for a restructuring of care for the elderly.

The Robert Wood Johnson Foundation was eager to play a role, and from 1982 through 1987 funded the Teaching Nursing Home Program. Inspired by the success of teaching hospitals, the program aimed at improving nursing home care by linking the homes with nearby schools of nursing. The five-year, \$6.7 million program sought to teach nursing students hands-on geriatrics while bringing rigor and research to the nursing homes.

The Teaching Nursing Home Program was modest by Foundation standards and, at best, was also modest in outcome. Some consider it to have been a failure. Launched in the Foundation's classic style as a pilot, with the hope that it would be picked up and replicated by other foundations or the federal government, or both, the Teaching Nursing Home Program ended with no takers at the time and was not renewed by the Robert Wood Johnson Foundation. Of the eleven schools of nursing and the dozen nursing homes from around the country that participated in the program, none directly follow the model anymore. As Patricia Patrizi, a former assistant director of the program and now an evaluation consultant to foundations, put it, "It was a model based on improved medical care when what was really needed was improved social care. This was a time when cost containment was central in health care, and the program advocated a kind of Cadillac model that was bound to fail."

Alan Cohen, a professor of health policy and management at Boston University and a former vice president at the Robert Wood Johnson Foundation in the 1980s, said the program had little impact on the field, adding, "I think it comes down to one fundamental question that always is raised when you talk about a new approach to health care delivery: Who is going to pay for it? Where will the money come from so there will be incentives for more nursing homes to adopt the model? Frankly, I don't think there was clear-cut evidence that would have suggested to payers such as the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and state Medicaid programs that this was really worth replicating."

Yet in the field of geriatric nursing, the Teaching Nursing Home Program is honored as a pioneer. While it is viewed as a program that suffered from unfulfilled promise, it is also viewed as a program that made a

difference in a number of areas. For example, the concept of linking research and nurse training with nursing homes remains alive in a nation where the very old are the fastest-growing segment of our population. There are, today, several new teaching nursing home programs on university campuses in places like Lubbock, Texas, and Lexington, Kentucky. Their administrators say they were inspired by the first program. In addition, there are nearly six thousand nurse practitioners—registered nurses with advanced degrees—in geriatrics, 80 percent of whom work in nursing homes, and such a development was one of the program's aims. Those nurse practitioners gather data on such factors as pressure sores and incontinence using the methods developed by Peter Shaughnessy, a professor of geriatric medicine at the University of Colorado Health Sciences Center and one of the leaders of the program evaluation team, among others. Nursing students at many schools, which have historically offered no exposure to geriatrics, now spend at least a small portion of their training in that area. This is not solely a direct result of the Teaching Nursing Home Program, of course, but the program is often cited when the training is discussed. Home health care for the elderly, which has exploded in importance, is now often judged and rated using approaches developed by Shaughnessy and based partly on his work in the program. Finally, a core of geriatric nursing specialists who launched the Teaching Nursing Home Program have fanned out to hospitals, nursing schools, and nursing associations, and continue to spread the techniques, the results, and the spirit of the pilot program.

“There is no poster child for the elderly in our society,” observed Marla Salmon, dean of the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta and a trustee of the Robert Wood Johnson Foundation, in reflecting on why programs like the one for teaching nursing homes did not enjoy wide support. “We are ambivalent about nursing homes because they remind us of our vulnerability. The Teaching Nursing Home Program was fundamental, however—a paradigm shift. It sought to operationalize care for the elderly, and it provided a model for improving health care in nursing homes that is still widely discussed.”

Although Emory was not one of the eleven participants in the program, it is one of the beneficiaries because it has set up a program based on the model. All Emory nursing students put in some time at one of two nursing homes on campus—something their predecessors twenty years ago did not do—and Emory has become a center for innovative geriatric care. At the A.G. Rhodes Nursing Home in Wesley Woods, Jennifer Reardon, a nursing student who plans to go into pediatrics, spent two days working with what are today often called “maturing adults,” meaning the aged. In the shining, welcoming chambers of the nursing home, Reardon helped a one-hundred-year-old resident with exercises by placing weights on

her feet and arms and attending to her other needs. Reardon's supervisor was Jean Pals, a nurse-educator with the division of geriatric medicine at Emory University.

During a break, Pals discussed with Reardon and two other students the differences between treating a thirty-five-year-old and an eighty-five-year-old. One is likely to have a strong family support system, the other is not; one is likely to have a strong immune system, the other is not; one is likely to go home after the treatment, the other may already be home. None of the students training under Pals that day planned to be a geriatric nurse. But they are still young and focused on the problems of youth. Nobody, Pals says, is born to geriatrics. Nonetheless, even their brief exposure opened a world to them. One day, when they are older, their interest in the aged may well increase.

"Like most students, I had the image that a nursing home was a place where people go to die," remarked Camille Louisy-Oladele, who was training with Reardon. "It's smelly and people can't walk and all you do is go around changing bedpans. Now I see that it doesn't have to be that way, that there are people who get better and who do leave. And we also see what kind of difference we can make in a place like this."

Emory is one of the few facilities (though their numbers are growing) in the country where no physical restraints are used on residents. As explained by Dr. Ted Johnson, director of the Atlanta VA Medical Center Nursing Home Care Unit and assistant professor of medicine at Emory University School of Medicine, in the past nursing homes have often been places where residents sat in diapers, tied down through restraint vests. Now the beds in his facility do not even have simple bars.

This is partly due to the work of Elizabeth Capezuti, who until recently held the Wesley Woods Chair in Gerontological Nursing at Emory. Capezuti, who emerged from the Teaching Nursing Home Program group in the 1980s, focuses her research on how to increase the dignity and the comfort of nursing home residents. She has been working with bed manufacturers to improve the way nursing home beds function. Through the Emory Center for Health in Aging, she has also focused on patient falls. Working with Dr. Joseph Ouslander, the founding director of the center, Capezuti helped develop a program for resident safety, within a so-called culture of safety. Since there are today more nursing home beds in the United States than hospital beds, and since those over age eighty-five make up the fastest-growing segment of the American population, such rethinking of nursing home care is vital. It is a shift anticipated by those who conceived the Teaching Nursing Home Program two decades ago, when few others were as focused on the care and health of aging people as they are today.

THE BIRTH OF THE TEACHING NURSING HOME PROGRAM

The idea of a teaching nursing home came from Linda Aiken, who arrived at the Robert Wood Johnson Foundation in 1974 as a program officer after having been a postdoctoral fellow at the University of Wisconsin–Madison. From the start of her career, she had been interested in the evolving professional roles of nurses and their connections with patient outcomes. She was struck by the growing number of nursing home scandals and the clear need for high-level care in these homes. They may be called “nursing” homes, she noticed, but nursing was not their strength. With nursing homes becoming such a growing part of the health care picture—their numbers doubled from thirteen thousand in 1963 to nearly twenty-six thousand in 1982—she asked herself how to improve them.

Given Aiken’s background—a nurse who had gone back to school for a master’s degree and a doctorate—she thought the way to fix the problem might be to build links between nursing schools and nursing homes. She drew inspiration from a similar and successful arrangement during the 1960s involving public and veterans’ hospitals on the one hand and medical schools on the other.

“Back in the 1960s, there was an acknowledgment that public hospitals and those of the Veterans Administration (now the Department of Veterans Affairs) were substandard,” Aiken recalled. “They couldn’t get good doctors and nurses, and they were filled with scandals. The solution that was found was to affiliate those hospitals with medical schools and teaching hospitals. It was a highly successful plan. Today many VA and public hospitals are as good as any in the country.”

Aiken asked herself why the same would not work for nursing homes. Most such homes really had no capacity for providing therapeutic care, and so doctors had no real interest in working there. She figured that if nurses could be brought in, doctors might be more willing to join them. That might reduce some of the problems, like bedsores and routine dispatch to hospital emergency rooms that cause disruption and discomfort for the residents.

Another factor in nursing homes had drawn her attention. It was becoming increasingly clear that such facilities had two very different sets of residents—long-term ones and those who would leave after some weeks or months. A 1976 paper of which she was coauthor in the *Journal of the American Geriatrics Society* found that 43 percent of nursing home residents stayed for less than six months.²

There was also another issue—what Aiken considered the worrying isolation of academic nursing from real care. She thought nursing education would be dramatically improved through an association with nursing

homes and suspected that the more manageable size of nursing homes would be easier for the nurses than huge hospitals.

THE PROGRAM IN OPERATION

Having gained the approval of the Robert Wood Johnson Foundation's board, Aiken and her colleagues set up the program, which was cosponsored by the American Academy of Nursing and administered by the University of Pennsylvania's School of Nursing. Fifty-three schools applied to participate in the program, and eleven were accepted. They were Georgetown University and Catholic University in Washington, D.C.; the State University of New York at Binghamton; Rutgers University in Newark, New Jersey; the University of Wisconsin in Madison; Case Western Reserve in Cleveland; the University of Cincinnati; Rush-Presbyterian–St. Luke's Medical Center in Chicago; Creighton University in Omaha, Nebraska; the University of Utah in Salt Lake City; and Oregon Health & Science University in Portland. Each school chose one nursing home affiliate except Creighton, which chose two. The projects had varying start-up dates in 1982. Each nursing school had a slightly different history and status. Five were privately endowed, six publicly funded. All offered a graduate program in nursing. Six of the graduate programs offered a major in gerontological nursing (one was a geropsychiatric program), and three offered a subspecialty or minor in it. Before the Teaching Nursing Home Program, all but two of the schools had some formal or informal agreement with their affiliated nursing homes for clinical placement of students.

The twelve nursing homes that participated were also diverse, but had one trait in common: they provided a higher than average level of care. Some were recognized leaders in their areas. All except one were nonprofit. Eight were freestanding, four hospital-based.

The program's administrators at the University of Pennsylvania School of Nursing set objectives for four areas: to increase quality of care; to increase interest in geriatrics at the school of nursing; to improve staff development; and to ensure financial survival beyond Foundation funding. Each pairing of school and nursing home outlined strategies in all four areas.

The main aim in quality of care was to improve the physical and psychological well-being of residents. There were programs in bladder and bowel training to combat incontinence, a skin care program to reduce the number and severity of decubitus ulcers, or bedsores, and activities to prevent falls and monitor drug use. Many programs entailed rewriting nursing protocols and developing interdisciplinary approaches to care. In one case, a registered nurse assumed twenty-four-hour responsibility for a group of

residents. On the psychosocial side, group activities for residents were developed. Three projects formed residents' councils to advocate for residents' rights and to increase participation. An additional goal was to decrease the rate at which residents were sent to emergency rooms and outside hospitals. While this became important for residents, it proved to be less so for the nursing homes. In many cases, nursing homes are reimbursed by Medicaid for "bed holds"—that is, for a portion of the time a resident is hospitalized—thereby actually giving them an incentive to use emergency rooms more, not less.

The goals of increasing interest in geriatrics at the schools of nursing and improving staff development were to be met by adding faculty members trained in gerontology, stepping up research in the field, and building the number of students ultimately interested in going into it. Some projects offered adjunct or clinical faculty appointments to nursing home staff members (although in many cases, staff members lacked the needed academic degrees to qualify). As Joy Smith, the recently retired director of nursing at the Providence Benedictine Nursing Center in Mount Angel, Oregon, put it while the program was going on, "This forces the staff to reexamine their practices because they are demonstrating them for students. I hear staff saying, 'The students are coming and we have to watch our procedures.'"³ Since one of the biggest problems of nursing homes is frequent staff turnover, an important goal regarding staff development was retention. One indirect path toward this was staff training and development as well as career counseling. The theory was that increasing staff knowledge and skill would lead to greater job satisfaction.

To help the program survive beyond the years of the pilot project, negotiations were begun with state agencies. Calculations were made on how to share costs between the nursing homes and the schools. In a few cases, participants were able to increase the Medicaid reimbursement rate for their nursing home affiliate by demonstrating improved care.

No pilot project is ever easy, but from the outset the Teaching Nursing Home Program ran into difficulties. The first might best be described as a culture gap between the academic nursing schools and the more rough-and-ready nursing homes. Nursing home staff often seemed to resent the outsiders, viewing them as intruders who thought they knew better and who were going to create unnecessary work. Meanwhile, many faculty members were typically unfamiliar with the regulatory difficulties in nursing homes and the small profit margin on which they operated. Relations eased after the first year or two in most cases and were even harmonious in some cases.

A second problem was frequent staff turnover. One teaching nursing home had six different administrators over three years, while another had four. Many others had at least one change at the top. Each new arrival needed to be oriented to the project. Joint appointments also proved complicated, since many nursing home staff members did not have the needed academic credentials for even adjunct appointments. Moreover, the nursing professors found that their heavy clinical responsibilities at the nursing homes conflicted with their need to pursue teaching and research for tenure. In addition, many of the faculty members had nine-month appointments at the school, whereas their nursing home responsibilities were for a twelve-month year.

Ultimately, the Robert Wood Johnson Foundation did not renew the five-year grant. “We needed another four to five years of funding,” says Mathy Mezey, who was the director of the program at the University of Pennsylvania, where she was also a professor of nursing. She now runs the John A. Hartford Institute for Geriatric Nursing at New York University. “If we had gotten it, we would have helped to stabilize good partnerships. We would have positioned them more centrally in their communities. We also tried, but failed, to get several states to have several nursing homes as models for the state.”

Many foundation grants are not renewed. In this case, a combination of skepticism toward the model and changes within the Robert Wood Johnson Foundation itself were the likely cause. David Rogers, the president, left, and many of those closest to him who followed him out the door, including vice presidents Linda Aiken and Robert Blendon, were among the program’s biggest supporters. Former Foundation vice president Alan Cohen points out that by the late 1980s, the Robert Wood Johnson Foundation was seeking to move support services for the frail elderly out of institutions and into the community. He also felt that tacking the evaluation onto the project later, rather than making it an integral part from the beginning, may have undermined the program’s chances for demonstrating success.

Other factors in the late 1980s clearly didn’t help. The nation was entering a period of economic recession. Managed care was settling into the health industry, leading to severe cost cutting. There was also another in a series of periodic nurse shortages. And despite increased attention to gerontology, it was still a stepchild in the health field. Sources of support for faculty members at nursing schools also began to shift, making them more grant dependent. And while geriatric nurse practitioners began to be reimbursed through Medicare for their work in skilled nursing facilities at a rate of 85 percent of that of physicians, Medicaid remained the

main source of funds for most nursing homes. Teaching nursing homes did not offer Medicaid ways to cut its costs.

THE RUTGERS COLLEGE OF NURSING'S EXPERIENCE

In many ways, the experience at Rutgers was emblematic of the program.⁴ The Rutgers College of Nursing originally chose two county nursing homes to be its partners—the Long-Term Care Division of Bergen Pines County Hospital in Paramus and a second home that was on the verge of decertification. But as the program was about to start, it became clear that including the second home was not feasible. It was dropped. Bergen Pines was a large facility with 571 beds, located on a 1,300-bed campus in an affluent suburb in northern New Jersey. It had established a name for itself as a leader in nursing care.

Lucille Joel, professor and director of clinical affairs at the Rutgers College of Nursing, was chosen to run the program, and one of the conditions imposed on the nursing home was that she serve as one of its two associate directors. This was the only case in the program where a faculty member was given direct authority rather than an advisory role in the home. Joel recalls that while Rutgers chose Bergen Pines for its quality, what she and others saw when they entered the facility was well below their expectations.

“There were more urinary catheters than there should have been, more bowel problems, more bedsores, more people dependent on nurses' aides for eating,” she said. “We also had not been prepared for how difficult many of the cases were. The residents were more disabled, more compromised than those in private sector homes, yet the reimbursement was the same as in those other homes. That actually led us to work with the county on a class action suit to get the state of New Jersey to increase reimbursement to the county homes. We were able to get more reimbursement per day for the county homes.” That led to an additional \$1.5 million coming to the home.

There were other accomplishments. Just two faculty members were involved in gerontological nursing in early 1982, but the number rose to six in 1983 and to twelve in 1986. In addition, some twenty-nine student and faculty research projects in gerontology were completed during the project, and twenty-five publications were produced. Among the research projects was the development of an instrument to diagnose depression in the nonverbal elderly.

The project's leaders realized within a year, however, that their clinical proposal was too ambitious. It was nearly impossible to have an impact on all 571 residents at one time. As a result, two residential units of sixty beds each were set apart from the rest of the home to serve as experimental centers. Once strategies

there proved effective, they were to be moved out beyond the units to the entire nursing home. One problem with that approach was that it took away the possibility of comparing the results at Bergen Pines with other nursing homes used as control groups, which had been the original intent of the evaluation.

Within the first year of the program, clinical results were persuasive in the 120 experimental beds. Among the residents in those beds, there was a 50 percent decrease in bedsores, a 23 percent decrease in the use of physical restraints in one unit, a 25 percent decrease in the use of enemas, and 18 percent fewer acute care transfers than in the previous year. Such results were typical of many other participants in the Teaching Nursing Home Program.⁵

By the end of the second year, there was a further 7 percent decrease in bedsores, 10 percent less use of physical restraints, 13 percent less incontinence, and 17 percent fewer residents on psychotropic drugs. Similar results were found in the following two years.

But by early 1987 nearly all the documented gains either had begun to reverse or were entirely reversed. For example, in 1987 barely more than 6 percent of the residents were able to feed themselves, compared with 27 percent in 1986. The use of physical restraints had increased to 75 percent, compared with 59 percent in 1986 and 64 percent in 1985.⁶

What led to the decline? It is hard to say, but it may have had to do with a decision by the county administration to award a management contract to an investor-owned corporation in the hope of reversing long-standing deficits. Nonprofessionals were substituted for licensed nurses as positions opened. The new managers also declined to give Rutgers faculty members an equal role in running the facility. As Lucille Joel recalled later, "When the corporation came in, they cut us off from information and instituted their own changes, including reducing registered nurses and other key personnel. They refused to listen to us about anything."

Rutgers withdrew from Bergen Pines, choosing to finish up its Teaching Nursing Home Program years working with the Daughters of Miriam Center for the Aged in Clifton, an eight-hundred-bed religiously affiliated home with multiple levels of care. Rutgers faculty members did not have any direct control over this home. Their role was purely advisory, focusing on areas of staff development, quality assurance, research, and long-term planning and programming. That relationship continued for a decade.

Although other participants in the Teaching Nursing Home Program did not face such a rupture with their homes, the Rutgers experience exemplifies the program's fortunes. There were, as in most of the nursing homes, tough relations at first, followed by encouraging results, good clinical research, and increased involvement in gerontology on the part of nursing students and faculty. Nonetheless, the project was unable to demonstrate that it could be a money saver for homes that operate on narrow margins. And the link between college and nursing home was an often difficult and ultimately unsuccessful one.

As Joel summed it up, "From the beginning of the Rutgers program, nothing was easy." Contract negotiation was beset by a series of misunderstandings and deficiencies in the art of compromise on the part of both institutions. The academic interests of faculty members predominated over any responsibility for clinical care, and administrators in the home were hesitant to give any authority to individuals who were external to their own system. Only mutual respect and trust between nursing leaders in both arenas allowed the basic philosophy of the project to prevail and to find permanent protection in the resulting affiliation agreement.

One account of the Rutgers experience noted lack of mutual trust, but pointed out other obstacles: "The lingering mistrust between education and service and the hurdles of contract negotiation that this created seem small compared to the entrenched attitudes toward the aged, most particularly the institutionalized aged. Undergraduate students were less than exuberant about a clinical placement in the home. Staff members were blind to the fact that there could be more quality of life for residents, and proceeded with their usual infantilizing approaches to care."⁷

In conclusion, Joel said that change was "slow but glorious" and would have continued if there had not been a rupture with the new management. "Experience with clinical programs, staffing, and resident classification systems reinforced the conviction that there were models for care of the institutionalized, frail elderly that we had yet to explore," she said.

EVALUATION OF THE PROGRAM

That is how many people involved in the Teaching Nursing Home Program felt when it was over—that it had been reasonably successful for both home and college and had opened vistas onto new areas and methods in the expanding field of gerontology. But since the program had not been renewed, it was unable to fulfill its potential. Others were far more skeptical of its value. Some nursing home staff

members and outside evaluators considered the program flawed in concept and the wrong model for the field.

The program did show signs of success, but in a somewhat less clear-cut fashion than its advocates had hoped. And given the costs involved in maintaining such a program, the likelihood that it could serve as a model nationally was bleak. This is mainly because evaluation of the project could not be systematic, since it was added after the project had begun. This meant that the collection of baseline data was done retrospectively and often incompletely, and the use of control group nursing homes, against which the results of changes that had taken place within the program sites could be compared, was partial.

Peter Shaughnessy and Andrew Kramer of the University of Colorado Health Sciences Center were chosen to be the program's evaluators. Beginning their work in late 1983, after the Teaching Nursing Home Program had been going for a year, they were given an advisory committee of other evaluators whom the Foundation had turned down for the grant. This made for some unusual tensions. And they were urged to look only at what they called the "big picture"—functional change and hospitalization rates—and not to get bogged down in clinical details.

Their advisory committee and the federal government's Health Care Financing Administration, which was brought in as a cofunder of the evaluation, were most focused on reduced hospitalization and increased rehabilitation. But Shaughnessy and Kramer worried that neither category would produce clean results. Moreover, when rehabilitation among the frail elderly occurs, it is not easily attributed to any one factor. So the evaluators pushed to expand the sources of evaluation by gathering data on less spectacular matters such as urinary tract infection, congestive heart failure, and distribution of psychotropic drugs. They were worried that the program's virtues would not be evident from research based purely on the so-called big questions. As Kramer put it, "We were concerned that you might not be able to make the bedridden walk with a teaching nursing home."⁸

The evaluators found six nursing homes located in the same states as those of the Teaching Nursing Home Program that had similar traits and compared them with six of the program participants. This was fine as far as it went, but it created some problems. First, it meant that the six other program nursing homes were not evaluated with the same care. In addition, baseline data were collected only retrospectively from nursing home records and were not as comprehensive or as exact as the data obtained during the intervention period.

As Alan Cohen, who arrived at the Robert Wood Johnson Foundation in late 1984, put it, “When they brought the evaluators in well after the beginning of the implementation of the program, they put them in a really tough position. There was a tendency on the part of many of the evaluators to try to use process measures as proxies for some of the outcomes. Because the evaluation budget was constrained, they couldn’t go out and collect primary data to get at some of those outcome questions that the Foundation staff wanted answered.”

The data that the evaluators did collect were impressive. Hospitalization rates in the first three months—meaning the chance of a resident being sent to a hospital at least once within three months of arrival—were different between the two groups of homes. There was a drop of 7 percent among the experimental group compared with an increase of 4.9 percent in the control group. That makes a mean difference of 11.9 percent. That pattern continued throughout the first year, although it was more pronounced for short-stay and Medicare patients than for long-stay and Medicaid patients. There was also a significant drop in the number of days spent in the hospital by the Teaching Nursing Home Program residents, down from 3 days to 1 day over six months and from 3.4 days to 1.3 days over twelve months.⁹ The two main reasons for the decline in hospitalization were thought to be programs that enhanced or stabilized activities of daily living and the involvement of nurses in the planning of care.

There were also 20 percent fewer bedsores in the teaching nursing homes than in the control homes and a 22 percent reduction in bowel incontinence, as well as marked improvements in stabilization of bathing and ambulation. Physical restraint was down, as was the use of psychotropic medication. As the evaluators wrote in a 1995 review, “nursing home quality improvement through affiliation with schools of nursing is possible and warrants consideration on a more widespread basis.”¹⁰

Mathy Mezey, the program’s former director, said the hope was that all these data showing improvements would lead to the spread of the program. “We all hoped, certainly, that the model of the teaching nursing home would be a sustaining one and be encouraged in a number of ways; and that the states would designate certain teaching nursing homes, the federal government would grant some waivers for teaching nursing homes, and the industry itself would see the advantages,” she said. “None of that was really accomplished within the five years of the project.”

Peter Shaughnessy, a leader of the evaluation team, said that in retrospect more should have been made of the program’s success so that Congress and the federal government would take up the program where the

Robert Wood Johnson Foundation left it. “Whose job is it to take the bit in their teeth and run with it on this program from the standpoint of its national value?” he asked. “We didn’t see it as our job. Now that I look back on it, I can kick myself—even though we didn’t have funding to do any more—for not trying to squeak out more at the margin in order to better communicate the message, ‘OK, health care society, this is important, don’t overlook it’ and in a constructive way beat people over the head with the fact that you can’t overlook this.”

Joan Lynaugh, associate director of the program at the University of Pennsylvania School of Nursing and now a retired professor of nursing, said the project was probably a long shot from the start. “We tried to convince policymakers that this would make care cheaper, but that was hard to demonstrate,” she said. “On the other side, we were trying to drag schools of nursing into this by bribing them and then making a big fuss over the results. The faculty were uninterested and unmotivated. It was hard to get them to redirect their interests and carve out space in the curriculum. Gerontology has never been as sexy as critical care or oncology nursing.”

Patricia Patrizi, the former assistant director of the project, said that improving health care in nursing homes was not the main problem, since so many nursing home residents are demented. “You are really talking about maintenance,” she said. “It doesn’t take a whole lot to improve bedsores. It is simply about moving people. The key is inclusion of family and improved social setting.”

THE PROGRAM IN RETROSPECT

Interestingly, although funding for the Teaching Nursing Home Program stopped over ten years ago, geriatric nurse specialists continue to recall it with pride. May Wykle, dean of the Frances Payne Bolton School of Nursing at Case Western Reserve University, said her school no longer had a program link with the nursing home—the Margaret Wagner House, now called the Kethley House—but that it continues to have a formal affiliation agreement, and both undergraduate and graduate nursing students have clinical experiences there.

Wykle, who was the site’s project director under the Teaching Nursing Home Program, believes that the nursing home was improved by the school’s involvement with it two decades ago. “The end result of the Teaching Nursing Home Program was that we improved the quality of care there, and it is now considered one of the best nursing homes in the Cleveland area,” she said.

Others disagree, however, saying that the nursing home had been a top facility before the involvement of her faculty. In any case, nursing students continue to train at the home—something they did not do before the program.

Today there is a growing group of researchers focused on the needs of the elderly, people like twenty-seven-year-old Laura Wagner, who emerged in some sense from the Teaching Nursing Home Program environment. Wagner is working toward a Ph.D. in nursing at Emory University after studying for her registered nursing degree at Case Western and becoming a nurse practitioner at Penn. Wagner worked as a nurse practitioner at a nursing home in Columbus, Ohio, and helped change the way emergency room transfers were carried out there. Now, for her doctorate, she is focusing on falls in nursing homes. Her mentors are largely graduates of the Teaching Nursing Home Program.

Some involved in care for the elderly believe the Teaching Nursing Home Program was one factor that helped focus attention on a series of quality-of-care issues like bedsores, incontinence, safety, mental health, and the use of physical restraints. Today some of the nursing homes formerly involved in the program are moving to a restraint-free environment. That is the case at Kethley House, according to May Wykle.

Another change to which the program contributed is the increased use of nurse practitioners in nursing homes. Debbie Gunter, who works for UnitedHealthcare, which owns Evercare, is part of a group of 40 nurse practitioners who cover a set of nursing homes in the Atlanta area. Evercare started in Minnesota, spread to more than a dozen states, and now has 350 nurse practitioners working around the country. Gunter says that she and her colleagues collect data routinely on such things as bedsores, catheterization, psychotropic medication, restraints, and falls. They pay close attention to such issues as palliative care to help people end their lives in comfort and dignity, surrounded by family or friends, without aggressive medical intervention.

“We try to help our residents make more appropriate life choices whether they have six weeks or six years left,” she said. “Unlike in the past, most people today will die of chronic diseases. Our society’s challenge is helping people live with those chronic diseases. In many cases, the nursing home is not a place they will visit and leave. It is their home. So we don’t want to send them to hospitals when they get sick. We want to treat them. It is bad for the frail elderly to be sent around to other places. So our role has

increased and will continue to do so. The Teaching Nursing Home Program taught everyone the value of high-level, humane care in the nursing home. We're continuing that tradition."

The program's legacy does not rest only in the likes of Debbie Gunter, however. Geraldine Bednash, executive director of the American Association of Colleges of Nursing, said her members had been expressing renewed interest in establishing teaching nursing homes.

"I believe the growing awareness of the need to improve the nursing care dynamics in long-term care settings and the interest in having more meaningful learning opportunities in these settings are coming together to create the potential for some new efforts here," she said. "I am not able to say that anything is in place yet, but we will begin these efforts in earnest."

Meanwhile, even without an organized effort, a few new teaching nursing homes are starting to appear on the horizon. In Lubbock, Texas, for example, Texas Tech University Health Sciences Center has established a \$15 million facility with 120 beds, half of them for people needing skilled nursing services and the other half for people with Alzheimer's and other dementia-related illnesses. Students do clinical and research work there. Certified nurse assistants, the core of nursing home staff, are being trained there as well. Social work, law, nursing, pharmacy, and medical students work in an interdisciplinary fashion to develop programs for what they call "healthy aging," said Ana Valdez, associate dean for undergraduates at Texas Tech University Health Sciences Center. She said the original Teaching Nursing Home Program served as the inspiration for the setup.

Finally, the evaluation of the Teaching Nursing Home Program played a role in sharpening the way care of the elderly is evaluated. Peter Shaughnessy of the University of Colorado said that in 1995 the Health Care Financing Administration, responsible for overseeing Medicare and Medicaid, funded a national demonstration project to improve care in fifty-four home health care agencies using an outcome-based quality improvement methodology. In 1999, the Centers for Medicare & Medicaid Services adopted the data set that underpins the methodology for the nation's seven thousand certified home health care agencies and, as of 2003, required its use as the basis for reporting the performance of the nation's certified home health care agencies.¹¹ As Shaughnessy put it, "It is important to note that the outcome measure system for this quality improvement program has its origins in the outcome measure research done on the Teaching Nursing Home study."

Given that teaching nursing homes were a low-cost, and today only dimly remembered, Foundation pilot project of the 1980s, their legacy, all told, is not a bad one.

Notes

¹ Vladeck B. *Unloving Care: The Nursing Home Tragedy*. New York: Basic Books, 1980.

² Aiken LH, Mezey MD, Lynaugh JE and Buck CR. "Teaching Nursing Homes: Prospects for Improving Long Term Care." *Journal of the American Geriatrics Society*, 1976, 33(3), 96–201.

³ Quotation from "A Perspective of Hope," a 1987 documentary produced by B. Achtenberg, C. Mitchell, and S. Shaw.

⁴ For a comprehensive look, see Joel LA and Johnson JW, "Rutgers—The State University of New Jersey and Bergen Pines County Hospital." In N. R. Small and M. B. Walsh (eds.), *Teaching Nursing Homes: The Nursing Perspective*. Owings Mills, Md.: National Health Publishing, 1988, pp. 211–237.

⁵ Shaughnessy P, Kramer A, Hittle D and Steiner J. "Quality of Care in Teaching Nursing Homes: Findings and Implications." *Health Care Financing Review*, Summer 1995, pp. 55–83.

⁶ Joel and Johnson (1988).

⁷ *Ibid.*, pp. 228–229.

⁸ Quoted by Dexter Hutchins in an unpublished interview for the Robert Wood Johnson Foundation in 2000.

⁹ Shaughnessy, Kramer, Hittle, and Steiner (1995).

¹⁰ *Ibid.*, p. 69.

¹¹ Shaughnessy P, Crisler K and Schlenker R. "Outcome-Based Quality Improvement in the Information Age." *Home Health Care Management and Practice*, Feb. 1998, pp. 11–18.