The nursing home problem in Florida was characterized as a debate over quality of care and the rapid increase of lawsuits against nursing homes that led to a decline in the availability of affordable liability insurance. The staff for Florida’s Task Force on Availability and Affordability of Long-Term Care analyzed lawsuit and quality-of-care data from one county in Florida and quality-of-care data statewide to understand the relationship between the two sides of the argument. Analyses showed support for both positions and a middle-ground policy position was achieved. The subsequent nursing home reform legislation and implications for the future of long-term care in Florida are discussed.

Key Words: Long-term care, Nursing homes, Assisted living facilities, Litigation, Liability insurance, Quality of care

In May 2000, the Florida Legislature established the Task Force on Availability and Affordability of Long-Term Care (Task Force). The challenging mission of the Task Force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes, the impact of lawsuits against nursing homes and other long-term care facilities, and financing long-term care. The Task Force received staff support from the Florida Policy Exchange Center on Aging (FPECA), which prepared a comprehensive report with policy, program, and fiscal recommendations based on research and public testimony. The focus of the debate in Florida was over the quality of care in nursing homes, the rapid increase in lawsuits against nursing homes since the mid-1990s, and the declining availability of nursing home liability insurance. These issues constituted the “nursing home problem” that had been on the legislative agenda for several years before the Task Force was appointed. Legislation addressing the problem passed in 2001. The delay in a legislative response to these issues was caused by a highly divisive struggle between the nursing home industry and the trial lawyers over the definition of the problem—excessive quality of care deficiencies versus out-of-control litigation—and the most effective legislative response to it: tighter regulation versus tort reform.

The legislature, with the help of the Task Force, achieved a middle-ground position in the form of Senate Bill (SB) 1202, which was signed into law on May 15, 2001 and provided something for both camps by requiring more stringent regulatory standards and procedures, increasing nursing home staffing standards, and placing caps on punitive damages along with other tort reform measures. This article summarizes the review of the literature and data analyses conducted by FPECA staff and the subsequent nursing home reform legislation. We conclude with a discussion of the policy implications arising from the legislation and the larger context of long-term care policy and politics. Our purpose in reporting research findings in a forum article is to show how the analyses conducted for the Task Force supported legislation and how the legislation may ultimately affect long-term care reform. Forthcoming research provides a more detailed examination of...
the analyses summarized here and examines multyear predictors of nursing home deficiencies in Florida (Johnson and Hyer, 2002), predictors of lawsuits (Johnson et al., 2002), and a ten-year review of lawsuits against nursing homes (Hedgecock, Oakley, Johnson, Salmon, Polivka et al., in preparation).

Nursing Home Quality of Care

Quality of care in nursing homes is a multidimensional construct that includes structure, process, and outcomes (Donabedian, 1966, 1980) and is affected by the nature and scope of quality indicators (QIs) and how indicators are operationalized and interpreted (Wunderlich & Kohler, 2001). Resident satisfaction is a critical quality-of-care indicator, but is not routinely collected (Kane, 2001) and, given the 6-month timeframe for the Task Force, was not addressed by FPECA staff. Many Task Force members, a priori, stated that poor quality of care was because of too few staff and resulted in higher deficiencies. This regulatory definition of quality of care was likely because of the availability of deficiency data and was commonly used by advocates and legislators. In fact, the Florida legislature passed House Bill 1971 in 1999 to provide $32 million in new Medicaid dollars to increase direct care staff (through hiring and staff retention incentives). The State’s Medicaid agency, the Agency for Health Care Administration (AHCA, 2002), published deficiency data in its quarterly Nursing Home Watch List and was planning to rank nursing homes based on total deficiencies in its Nursing Home Guide to inform consumers about nursing home performance (AHCA, 2002). At the time of the Task Force, the Health Care Financing Administration (HCFA; now the Centers for Medicare and Medicaid Services [CMS]) released its study that examined the effects of nurse staffing and found that quality of care (defined by several clinical outcomes) was seriously impaired when nursing homes were staffed below HCFA minimum staffing levels at that time (2.0 certified nursing assistant [CNA] hours per resident day [hprd], .75 registered nurse [RN] and licensed practical nurse [LPN] and .20 RN; HCFA, 2000). The Task Force members’ compelling interest in deficiency and staffing data focused staff research on this definition of quality of care. Staff included structural indicators, such as ownership and percentage of residents who are on Medicaid, as well. The policy and research literature that address deficiencies, staffing, and these structural variables are briefly reviewed next.

Deficiencies

CMS defines the standards that nursing homes must meet to participate in Medicare and Medicaid programs, and contracts with states to hire survey staff to certify that homes meet these standards during an annual survey. Violations of the health or safety regulations result in deficiencies and are included in the Online Survey Certification and Reporting (OSCAR) database. The OSCAR data are published annually and are the basis for the comparisons across states and indicate changes within states over time (Harrington, Carrillo, Thollaug, Summers, & Wellin, 2000). Citations, facility characteristics, resident characteristics and conditions, and staffing information are available for research purposes.

Deficiencies are limited as a proxy for quality of care because of underreporting or false negatives (U.S. General Accounting Office, 1998), the inconsistent enforcement of standards (U.S. Office of the Inspector General, 1999), the wide range in resources available for state enforcement (Walshe & Harrington, 2002), and the fact that staffing predicts only 1% of variance in total deficiencies when it is found to be important to quality of care (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000). Improvements in assessing quality of nursing home care are expected to be more reliable with the use of QIs (Zimmerman et al., 1995). For example, in a recent study of the validity of QI measures for chronic care residents, the following items were recommended: prevalence of an in-dwelling catheter, bladder/bowel incontinence, urinary tract infections, inadequate pain management, pressure ulcers, late-loss activity of daily living (ADL) worsening, ADL and locomotion worsening, improvement in walking, and worsening bladder continence (Morris et al., 2002). CMS now publishes these QIs in Florida and five other states to inform residents and their families about quality of care in long-term care facilities. Harrington, Zimmerman and colleagues (2000) recommend that the relationship between QIs, Minimum Data Set (MDS) data, and survey deficiencies be tested to improve our understanding of correlates of nursing home quality.

In 1999, Florida ranked both higher and lower than the national average in the ten most commonly cited deficiencies (Figure 1; Harrington, Carrillo, et al., 2000). Florida received more citations in the areas of food sanitation, care planning, dignity, and care plan assessments than most other states. Florida received fewer violations than the national average and was among the top 20 states for quality of care, accidents, accident prevention, pressure sores, housekeeping, and assistance with functional impairments. Over time, the percentage of residents in Florida with severe conditions, such as contractures, increased from a low of 16.5% in 1993 (not displayed) to 18.3% in 1999, but remained below the national average (24% in 1999; Harrington, Carrillo, et al., 2000). The percentage of residents with physical restraints in Florida had significantly decreased since 1993 and was lower than the national average in 1999 (7.4% vs. 10.9% for the nation). At the same
time, the percentage of Florida nursing homes cited for inadequate staffing increased from 5.6% in 1993 to 12.4% in 1999 (Harrington, Carrillo et al., 2000).

**Staffing**

Research is consistent regarding the impact of the number of registered nurse staff on the quality of resident care, but there is also a significant relationship between levels of LPNs, CNAs and resident outcomes involving intensive levels of personal care (Harrington, Carrillo et al., 2000; Harrington, Zimmerman et al., 2000; Health Care Financing Administration, 2000). CMS (2001) released the first comprehensive analysis of the impact of different staffing mix on patient care outcomes. The authors acknowledge that the mix of RNs, LPNs, and CNAs in nursing homes varies widely, and obtaining accurate measures of specific nurse staffing was difficult. However, using Medicaid cost reports and nurse researchers, the authors found hospital transfer rates for avoidable conditions was clearly linked with CNAs, LPNs, and other licensed staff. The convincing evidence indicated that adequate nursing—both licensed and nonlicensed—was necessary to assess and care for residents with high-risk chronic conditions. Similarly, the CMS report was the first large-scale study to confirm the relationship between all levels of nurse staffing and incidence of pressure ulcers, refuting Cohen and Spector (1996) who found no relationship between total staff intensity and resident outcomes. The labor-intensive efforts needed to reposition patients required CNAs, but the skill needed to assess, treat, and supervise nonlicensed staff required licensed staffing. Consistent with earlier research (Cohen & Spector, 1996; Spector & Takada, 1991), functional improvement is related to licensed staff. Improvement in resisting ADL assistance, a quality of interpersonal relationships between staff and residents, is related to RN staffing. Others have found that inadequate staffing and supervision led to serious dehydration of residents (Kayser-Jones, Schell, Porter, Barbaccia, & Shaw, 1999), and RN staffing improves nursing home care on a range of outcomes (Anderson, Hsieh, & Su, 1998; Bliesmer, Smayling, Kane, & Shannon, 1998; Castle, 2000).

In 2000, Florida’s minimum staffing levels for nursing homes were 1.7 CNA hour and .6 RN plus LPN hour. Nine percent of nursing homes were below the minimum for CNA staffing, and 1% were below the RN plus LPN staffing minimum (Alan Eddy, AHCA Medicaid Analyst, personal communication). Using HCFA minimum staffing standards at that time, 45% of Florida’s nursing homes were below the CNA staffing level (2.0 hour), and 16% were below the RN staffing level (.20 hour). Florida’s staffing was better than the nation, which reported 54% below the CNA minimum and 31% below the RN minimum.
Table 1. Predictors of Quality Deficiencies in Nursing Homes

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Coefficient</th>
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<td>-.82</td>
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<td>Medicaid ratio</td>
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<tr>
<td><strong>Case-Mix</strong></td>
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<td></td>
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<tr>
<td>Eating dependency ratio</td>
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<td>.08</td>
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<td>Incontinence ratio</td>
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<td>Bed/chairfast ratio</td>
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<td>.48</td>
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<tr>
<td>Tube feeding ratio</td>
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<td>-.228*</td>
</tr>
<tr>
<td>Rehab patient ratio</td>
<td>3.53</td>
<td>1.71</td>
</tr>
<tr>
<td>Dementia ratio</td>
<td>-3.16</td>
<td>-2.32*</td>
</tr>
<tr>
<td><strong>Deficiencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication errors</td>
<td>.25</td>
<td>5.86*</td>
</tr>
<tr>
<td>Cited for low staff</td>
<td>6.25</td>
<td>8.99**</td>
</tr>
<tr>
<td>Acquired pressure sores ratio</td>
<td>1.84</td>
<td>2.37*</td>
</tr>
</tbody>
</table>

*Note: Dependent variable—number of quality deficiencies (quality of care + quality of life). N = 654 nursing homes. R² = .23.

*Source: Online Survey Certification and Reporting (OSCAR).
*p ≤ .01; **p ≤ .05.

**Residents on Medicaid**

To some extent, the lack of consensus on ownership status may be because of the difference in the number and percentage of Medicaid residents. In Florida, for-profit nursing homes are more likely to have residents who are on Medicaid. Higher proportions of Medicaid recipients in a nursing home—an indicator of lower resource availability and excess demand—are associated with lower levels of RN staffing (Nyman, 1988; Zinn, 1994). For many states, Medicaid reimbursement is focused on lower costs, not on the quality of care, and Medicaid is a proxy for poorer care presumably because reimbursement is low (Harrington et al., 2001; Nyman, 1988). Facilities in such areas may have less incentive to compete on the basis of quality as evidenced by higher levels of state survey violations. Adequate reimbursement levels are a necessary, but not sufficient condition for quality. Finally, Hirth (1999) argues that areas with higher not-for-profit market share may encourage competition based on quality because of differential preferences of often poorly informed consumers to use not-for-profit ownership as a substitute indicator for quality. Evidence has been found for such preferential choice (Hirth, 1993; Spector et al., 1998).

**For-Profit and Not-for-Profit Ownership**

Ownership type may influence the quality of care provided to nursing home residents. For example, not-for-profit facilities consistently have more staff at all nursing levels than for-profit facilities with the greatest difference in RN levels (CMS, 2001; Cohen & Spector 1996; Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2001; Kanda & Mezey, 1991). Insofar as not-for-profit or for-profit ownership status encourages higher skill mix among the nursing staff, it also encourages quality. Staff philosophy, an important aspect of institutional mission influenced by not-for-profit status, also appears to influence care quality (Anderson & Lawhorne, 1999).

The evidence regarding the relationship of nursing home ownership and clinical care outcomes is more mixed. Not controlling for size, for-profit nursing homes were more likely to have poor quality of care, compared with not-for-profit nursing homes (Harrington et al., 2001). For-profit nursing homes were also more likely to receive deficiencies for the use of restraints (Aaronson, Zinn, & Rosko, 1994; Castle, 2000), have a higher percentage of decubitus pressure ulcers (Aaronson et al., 1994) and mortality for private-pay residents (Spector, Selden, & Cohen, 1998). Not-for-profit nursing homes were more likely to have reduced adverse outcomes (Spector et al., 1998) and fewer hospitalizations (Freiman & Murtaugh, 1993). Yet, others report that ownership type has little overall consistent effect on quality (Castle & Shea, 1988; Porrell, Caro, Silva, & Monane, 1998).

**Predictors of Nursing Home Quality in Florida**

To examine further the relationship between staffing, clinical deficiencies, for-profit status, and ratio of Medicaid residents on nursing home quality, a multivariate analysis was conducted using 1999 cross-sectional OSCAR data for Florida. We hypothesized that nursing homes would have fewer quality deficiencies against them if (1) the facility met minimum HCFA staffing levels; (2) were not-for-profit; (3) had fewer residents on Medicaid; and (4) had fewer poor quality outcomes, such as in-house pressure sore development. Because the validity and reliability of OSCAR staffing deficiency data have been questioned (Harrington, Zimmerman, et al., 2000; Wunderlich & Kohler, 2001), we used the low staffing citation as a staffing compliance indicator.

Our dependent variable is labeled quality deficiencies. It is based on OSCAR data that include 185 standards in 17 categories each with many deficiencies (U.S. Office of the Inspector General, 1999). The standards were categorized by others into three groups: quality of care, quality of life, and administrative (Harrington, Zimmerman, et al., 2000). Surveyor discretion affects how a particular deficiency is classified (Harrington, Zimmerman, et al., 2000; U.S. Office of the Inspector General, 1999). Therefore, for our purposes, we combined the quality of life and quality-of-care deficiencies as categorized by Harrington and colleagues because they (1) more thoroughly covered areas of concern to the Task Force (e.g. resident rights and quality of
care) and (2) together corrected for any discretion by the surveyors. For instance, all deficiencies are recorded, but the same deficiency may have been coded by different surveyors in two or more areas that, in the abbreviated classification scheme, would force them into either quality of care or quality of life. If we disaggregated the analysis, we would lose relevant deficiencies. In a times-series analysis (not displayed here), we determined that combining these two categories accounted for more variance ($R^2 = .15$ vs. $R^2 = .09$ with quality of care alone). Other researchers measured quality as the total combined quality of life, quality of care, and administrative deficiencies or disaggregated them (Harrington, Zimmerman, et al., 2001) but did not combine the two, as we have done here.

One structural variable (ratio of Medicaid residents) was associated with higher deficiencies (Table 1). All of the deficiency variables (medication errors, inadequate staffing, and ratio of acquired pressure sores) were associated with quality deficiencies in a nursing home. Two variables that measured the relative acuity levels of residents (case mix) were associated with lower quality deficiencies. The ratios of residents who receive tube feeding and who have some form of dementia decreased the number of quality deficiencies. Not-for-profit status was not associated with quality deficiencies.

There are two problems with using OSCAR quality deficiencies as an outcome variable. First, quality deficiencies represent a minimum standard and are not representative of all the dimensions of quality outlined by Donabedian (1966; 1980). Second, quality deficiencies include the low staff citation variable in the multivariate model. It is used here as a predictor variable because it is a better indicator of failure to meet overall Florida staffing standards than other options available in the OSCAR data that were highly correlated with the low staffing citation indicator. As mentioned earlier, disaggregating deficiencies into quality of care and quality of life deficiencies produced a less robust model, compared with combining these deficiencies. Future research will examine how process and structure measures relate to the scope and severity of deficiencies and use longitudinal rather than cross-sectional data.

The multivariate model supports the hypothesis that being cited for failure to meet minimum staffing levels is related to higher quality deficiencies. The importance of staffing is supported by other research (Anderson et al., 1998; Castle & Fogel, 1998; CMS, 2001; Harrington, Koven, et al., 2000; Harrington, Zimmerman, et al., 2001). For example, Harrington, Zimmerman, and colleagues (2000) found that lower RN staff levels and lower CNA hours predicted total deficiencies, but LPN hours were not related to deficiencies. They also found that facilities with more incontinent residents and residents with pressure sores had more quality deficiencies, which is partially supported here. Increasingly, the evidence indicates that the clinical skill mix for frail and ill nursing home residents, geriatric training of staff, and use of best-practice knowledge is critical to the quality of nursing home care (Harrington, Koven, et al., 2000; Stone et al., 2002).

Our model also supports the hypothesis that nursing homes serving more Medicaid residents will have higher quality deficiencies. This may be from lower reimbursement and therefore a lack of resources to pay for adequate staffing (Harrington et al., 2001; Nyman, 1988). At the same time, there was no support for the hypothesis that not-for-profit nursing homes will have fewer quality deficiencies when controlling for other structural variables and case mix. In another analysis (not shown here), the interaction between for-profit status and ratio of Medicaid residents did not improve the model fit ($R^2 = .22$), but the interaction approached significance ($p = .07$), although the ratio of Medicaid residents continued to be one of the strongest indicators of deficiencies.

Although Florida was worse in some deficiencies and better in others, compared with the rest of the nation, Florida was among the worst for low staffing. Our analysis supported the importance of nurse staffing at all levels, provided evidence that higher staffing is linked to fewer quality deficiencies, and led to recommendations for higher mandated staffing levels. Our analytic model also raised concerns about the Medicaid reimbursement rate to care for elders and supported the for-profit nursing homes' argument that the Medicaid formula and rates needed to be revised. This argument was supported by a separate panel on the Medicaid reimbursement rate.

### Nursing Home Litigation

The second major issue that constituted the nursing home problem was the perception there was a high level of litigation against nursing homes in Florida that was driving up the cost and availability of liability insurance. The research on the prevalence, causes, and costs of lawsuits against nursing homes is scant (Kapp, 2001; Williamson, 1999), but is reviewed here followed by a brief description of two research studies conducted for the Task Force that looked at the prevalence and cost of lawsuits in a representative county and tests a model for predicting the causes of lawsuit activity.

### Prevalence of Lawsuits

For the most part, the numbers of nursing home lawsuits is known through jury verdicts that represent 1% of all lawsuits. In some cases, insurance companies and actuaries have provided data about a number of lawsuits. St. Paul Fire and Marine Insurance Co. closed 2,500 nursing home claims nationwide from 1988 through 1992, and 4,200 such claims between 1993 and 1997 (Hawryluk, 1999).
Cost of Lawsuits

Jury verdicts for nursing home lawsuits over an 8-year period showed that average awards increased 120%, from $238,285 in 1987 to $525,833 in 1994 (Felsenthal, 1995). The majority of nursing home lawsuits are settled out of court and are not included in national databases of jury verdicts. High-profile jury awards in nursing home lawsuits are one reason lawsuits are settled out of court. The awards have reached as high as $250 million (Hawryluk, 1999) and have been attributed to the perception of nursing home indifference (Bennett et al., 2000), jury members’ experience with aging parents in nursing homes, or their concern about their own future use of long-term care (Moss, 1998). In fact, 20% of plaintiffs were awarded damages in nursing home lawsuits, compared with 5% of plaintiffs in other personal injury suits.

The average size of a nursing home litigation claim in Florida, according to actuaries who represent the for-profit industry, was $278,637 in 1999, which was 250% more than the average claim in the other states ($112,351; Bourdon & Dubin, 2001). For-profit nursing homes in Florida had 4 times as many claims filed against them than the rest of the nation, and the average loss per annual occupied bed in Florida was $12,700, which was 12 times more than the average loss cost in the other 49 states ($1,050; Figure 2; Bourdon & Dubin, 2001).

Nursing Home Lawsuits in Florida

Nursing home lawsuits in Florida began to increase around 1997 because of trial attorneys’ perceptions that there was inconsistent and weak enforcement of federal and state nursing home regulations and a need to punish facilities for wrongful actions (Williamson, 1999). Infringements of the Resident Rights statute (Florida Statutes §400.022–400.023) was the primary cause of action. The statute created a different burden of proof for nursing homes than those found under malpractice law. Malpractice law requires the plaintiff to show that the care provided within the nursing home was done so in a negligent manner. Lawsuits brought under the Florida Resident Rights statute requires that the nursing home proves that it did not violate the resident’s rights as defined by the statutes. Criteria for attorney fees associated with nursing home lawsuits are explicitly defined in a manner different than found under malpractice law (Williamson, 1999). The effects of the increased lawsuits on nursing homes were: (1) insurance carriers required nursing homes to settle cases even if faci-
ilities were in compliance with regulations; (2) nursing homes were increasingly portrayed negatively; (3) jury verdicts increased because of negative publicity; (4) operating funds were reduced and affected hands-on care and resident services; and (5) nursing home closures increased (Williamson, 1999). There was also a perception that nursing homes were at higher risk of being sued because of increased acuity of residents who were discharged earlier from hospital stays.

There is no statewide database of lawsuits filed against Florida nursing homes. A systematic review of the record-keeping systems of Florida’s 20 circuit courts revealed that two courts provided easily accessible, computerized public records systems. One court was in a county with just three nursing homes and the other was the Circuit Court of Hillsborough County, which had 35 nursing homes. Hillsborough County was comparable with the state average on a number of variables related to access to long-term care options (e.g., the ratio of nursing home and assisted living beds per 65+ population, and allocations for home- and community-based alternatives).

From 1991 to 1995, 87 lawsuits were filed against 35 nursing homes in Hillsborough County. The Tampa Bay area (Hedgecock et al., 2002). From 1995 to 2000, 369 lawsuits were filed, representing a four-fold increase. The Sun Sentinel (Lamendola, 2001) and South Florida Sun-Sentinel (Groeller, 2001) newspapers conducted a study of circuit court data in south and central Florida, and found that 924 lawsuits had been filed against 241 nursing homes between 1996 and 2000, which represented a 157% increase over the 5-year period and a 300% increase in central Florida alone. Statewide, there were 67 jury-tried lawsuits in 10 years. Of these, four were from Hillsborough County (1% of all lawsuits in Hillsborough County). Plaintiff defense attorneys believe that 1% or less of all lawsuits against nursing homes go to trial. If this is the case, then there were an estimated 6,700 lawsuits statewide during this 10-year period.

Every year from 1995 through 2000, an average of 61.4% of nursing homes in Hillsborough County had at least one lawsuit. The size of the claims (for those that were not sealed) averaged $283,667 in the early 1990s and $484,680 in the late 1990s. This level of lawsuit activity is one of the reasons that 9% of nursing homes in Florida were entirely without liability insurance as of February 1, 2001. This was up from 1% in June 2000. The last admitted insurance carrier (one that is regulated by the Department of Insurance) announced that it was ending its liability coverage for long-term care facilities in February 2001 (Oakley & Johnson, 2001).

According to public testimony given during Task Force hearings, the remaining unregulated insurers were offering premiums that were 100% to 1,000% above rates last paid by many providers. Assisted living facilities (ALFs), which are required by statute to hold liability insurance, were told by insurers to give up their Extended Congregate Care (ECC) or Limited Nursing Service (LNS) licenses in order to receive liability insurance. ALFs are required to hold an ECC or LNS license to accept residents who are covered by Medicaid. Without an ECC or LNS license, these ALFs would have to discharge many residents who would be forced to move to nursing homes (Oakley & Johnson, 2001). Continuing Care Retirement Communities (CCRC) experienced a 74% increase in their premiums in 2000 (the average increases in 1998 and 1999 were 15%). Because CCRCs are required to have 15% of their operating costs (including expected liability insurance costs) set aside in a reserve fund, this trend, if continued, could place them in financial jeopardy, or at least necessitate major increases in charges to residents (Oakley & Johnson, 2001). Just as Task Force members decided a priori that nursing home quality was directly related to staffing, there was also a belief that nursing homes in Florida were sued more often because they were of poorer quality than other states. It was thought that for-profit nursing homes would be sued more often because they were motivated by profits rather than caring for their frail residents. We used a similar model for predicting quality deficiencies to predict total lawsuits with a few modifications. We added three deficiency variables: acquired contractures, unplanned weight loss, and total F-tag deficiencies. The first two variables were added because they were considered important by Task Force members. Total quality deficiencies were added here to indicate that a facility is not meeting minimum standards and thus may be open to more lawsuits. Here, we hypothesized that nursing homes would have more lawsuits filed against them if they (1) had more financial resources available to them (for-profit), (2) were exposed to more risk (bed size), and (3) had more deficiencies. A database of OSCAR and lawsuit data for 31 nursing homes that were in business from 1996 to 2000 was used in this analysis. Data were analyzed using a lagged lawsuit variable as a regressor to examine the effects of last year’s lawsuits on the current year’s litigation against the home. One structural variable, the number of beds, was associated with higher lawsuit activity (Table 2). No other variables, including both case-mix (acuity of residents) and deficiencies, were associated with higher lawsuits.

Data on lawsuits were mostly limited to one county in the state of Florida. Although the county was representative, it is also the location of one law firm that has a national reputation for bringing lawsuits against nursing homes. Even so, the volume of lawsuit activity in this county allowed for a better analysis of the relationship between structure, process, and outcome indicators, and the number of lawsuits against a nursing home. Statewide data on lawsuits was limited to extrapolating from the
statewide jury verdict reporter and newspaper reporting.

Nursing home size was the only predictor of lawsuit activity and may be because of increased exposure to potential lawsuits. On the other hand, for-profit status, ratio of Medicaid residents, or deficiencies do not determine whether or not a nursing home will be sued. The documented sharp increases in lawsuit activity in the latter half of the 1990s gave credence to the concern that there was a high level of litigation against nursing homes (Williamson, 1999). With average settlements of $295,667 (19% of lawsuits in early 1990s) to $483,000 (81% of lawsuits in late 1990s), the estimated 6,700 lawsuits against nursing homes during the past decade may cost the industry 2.9 billion dollars. The flight of the insurance industry is not surprising, given these potential costs. Our findings supported the initial concern by the nursing home industry and the legislature that there was a notable increase in lawsuit activity, and it was not explained by quality deficiencies in nursing homes.

Policy Response

The Governor and the Florida legislature responded to the staff research and recommendations and to pressures from interest groups representing the nursing home and ALF industry, the trial lawyers, and consumer groups. Soon after the Task Force completed its report in February 2001, the Governor provided an initial set of recommenda-

Table 2. Nursing Home Litigation Predictors

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<thead>
<tr>
<th>Predictor</th>
<th>Coefficient</th>
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<td>Total F-tag deficiencies</td>
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</tr>
</tbody>
</table>

Note: Dependent variable—number of lawsuits. N = 28 nursing homes. z" < .000. Source: Online Survey Certification and Reporting and Hillsborough County Circuit Court Database. **p ≤ .01.

Table 3. Major Provisions of Florida Senate Bill 1202

Addressing Quality of Care for Nursing Homes

New Staffing Mandates

1. Increased the CNA minimum staffing from 1.7 (hprd) to 2.3 hprd by January 1, 2002, to 2.6 in 2003, and to 2.9 by 2004.
2. Increased licensed nursing to 1.0 hprd effective 2002.

Improved Florida’s Ability to Deny or Revoke Nursing Home License

1. Mandated that the Agency shall revoke or deny a license if the licensee or controlling interest operates a facility that has had: (1) two moratoria for substandard quality of care within any 30-month period; conditionally licensed for 180 days; cited for two Class I deficiencies; or (2) is cited for two Class I deficiencies in separate surveys within a 30-month period.
2. Allowed the denial, revocation, or suspension of a license for any applicant, licensee, or controlling interest for a demonstrated pattern of deficient practice; failure to pay final order fines; exclusion from Medicare/Medicaid; or for an adverse action by a regulatory agency.

Increased Number of Surveys

1. Mandated a survey every 6 months for 2 years for facilities cited for a Class I deficiency or two or more Class II deficiencies from separate surveys within a 60-day period or three or more substantiated complaints, resulting in either a Class I or Class II deficiency within 6 months.
2. Imposed an additional $6,000 fee for the 2-year period, with one half due after the additional 6-month survey.

Risk Management

1. Mandated a Risk Management program and Risk Manager in each facility.
2. Required risk management policies and procedures; adverse incident reporting within one business day, and a written report to the Agency within 15 calendar days after a full investigation.
3. Required an annual report to the legislature on nursing home adverse incidents by county and types of liability claims filed based on adverse incidents.

Increased Training for Nursing Home Staff and Surveyors

1. Increased the annual CNA training from 12 hours to 18 hours and specified the content.
2. Required new nursing home surveyors to observe a nursing home.
3. Required that at least 30% of surveyor continuing education credits be in geriatric care.
4. Mandated increased dementia training for all staff.

Note: A full listing of all of the quality-of-care provisions in Senate Bill 1202 may be retrieved from http://www.leg.state.fl.us/session/index. CNA = certified nursing assistant; hprd = hours per resident day.

The Gerontologist
Among the many reforms in SB1202, the bill increased staffing minimum standards over the next 3 years that would place Florida with the highest staffing levels in the nation if other states do not follow suit (Table 3). Nursing homes are required to increase CNA staffing from 1.7 hpd to 2.9 hpd by January 1, 2004. This is higher than the CMS minimum or preferred staffing levels (HCFA, 2000). Licensed nurses will also be increased. CNAs will be required to increase their continuing education units from 12 to 18 hours a year, and dementia training is mandated for all staff.

SB1202 provides AHCA the means to revoke or deny licenses to nursing homes much sooner than previously allowed. Surveys with a pattern of deficiencies will be surveyed more often and will pay a fine for additional surveys. Nursing homes will be required to have a risk management program with a certified risk manager in each facility.

SB1202 created a new negligence standard for filing residents’ rights lawsuits, limited add-on attorneys’ fees, reduced the statute of limitations on most lawsuits, and placed caps on punitive damages but not on compensatory damages (Table 4). It should be noted that nursing homes are responsible for paying punitive damages, whereas insurance companies are responsible for compensatory damages. The lack of relief to insurance companies for compensatory damages may reduce the overall impact on insurance costs. Given the complexity and urgency of the issues at stake and the many competing forces confronting the legislature, the decision not to limit compensatory damages reflected the limits of what was achievable in a contentious political environment.

SB1202 was one of the most comprehensive nursing home reform packages ever passed by the legislature. Its first year costs were $76 million in additional funding for nursing homes and may cost more than $300 million when fully implemented. The fact that the legislature was able to pass tort reform in combination with the nursing home quality-of-care measures described earlier, with strong bipartisan support (Senate voted 38-0 and House voted 112-8), was surprising to many veteran observers of the Florida Legislature.

Table 4. Major Provisions of Florida Senate Bill 1202 Addressing Tort Reform for Nursing Homes

<table>
<thead>
<tr>
<th>Standard for Filing Lawsuit Against Nursing Home</th>
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<tbody>
<tr>
<td>1. Created a negligence standard for filing residents’ rights lawsuits.</td>
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<tr>
<td>2. Defined burden of proof for bringing a lawsuit against a nursing home.</td>
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<tr>
<td>3. Created pre-suit notification process similar to what is in effect for other health care providers.</td>
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<tr>
<th>Attorneys’ Fees</th>
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<tbody>
<tr>
<td>1. Limited add-on attorneys’ fees to $25,000 for lawsuits that can be solved through an injunction or administrative remedy.</td>
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<tr>
<td>2. No limits on contingency fees for a plaintiff’s lawyer.</td>
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<tr>
<th>Statute of Limitation</th>
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</thead>
<tbody>
<tr>
<td>1. Reduced statute of limitation from 4 years to 2 years; allowed for extensions of up to 6 years from date of injury when information was concealed to prevent discovery of injury.</td>
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<table>
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<tr>
<th>Punitive Damages</th>
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<tbody>
<tr>
<td>1. Allowed for continued recovery of punitive damages in cases involving intentional misconduct or gross negligence.</td>
</tr>
<tr>
<td>2. Placed limits on punitive damages at the greater of three times the amount of compensatory damages awarded to each claimant—or the sum of $1 million.</td>
</tr>
<tr>
<td>3. Provided for punitive damages at the greater of four times the amount of compensatory damages awarded to each claimant—or the sum of $4 million.</td>
</tr>
<tr>
<td>4. Provided for no cap on punitive damages when it is determined that the defendant had a specific intent to harm a resident, and that harm occurred.</td>
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<tr>
<td>5. Divided punitive damage awards equally between the claimant and the Long-Term Care Facility Improvement Trust Fund.</td>
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<th>Administrative</th>
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<tr>
<td>1. Required resident or resident’s legal representatives to serve a copy of a complaint alleging a violation of a nursing home or assisted living facility resident’s rights to the Agency.</td>
</tr>
<tr>
<td>2. Eliminated the possibility of bringing residents’ rights lawsuits against a nursing home or assisted living facility under Florida’s elder abuse law.</td>
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</table>

Note: A full listing of all of the quality-of-care provisions in Senate Bill 1202 may be retrieved from http://www.leg.state.fl.us/session/index

Discussion

Florida’s long-term care system has become too dependent on nursing home care and that has greatly limited the capacity of consumers to receive care in home- and community-based alternatives, which remains the major failing of long-term care policy in Florida and most other states. However, nursing homes, ALFs, and other forms of residential care will continue to play major roles in a more rational and consumer-responsive long-term care system than presently exists. The question then becomes, “How do you ensure their existence and achieve the highest quality of care feasible, given finite resources, and preserve the right to sue?”

SB1202 addressed this question by providing significant tort protection (caps on punitive damages, a negligence standard, and removal of automatic attorneys’ fees) for nursing homes and ALFs, by imposing more stringent regulatory and staffing standards, and by providing the necessary funding for their implementation. Whether or not these initiatives will be sufficient to mitigate litigation and make liability insurance available on an affordable basis is an empirical question we will not be able to answer for at least another year or two, although an estimated tail
of more than 3,000 existing claims may be 2 to 4 years long, and may, in itself, substantially limit the availability of insurance (Hedgecock & Salmon, 2001).

The costs of the quality-of-care initiatives, mainly the nursing home staff increases, may significantly constrain the state’s ability to expand home- and community-based services. In fact, Florida’s continuing heavy reliance on nursing homes makes the state more vulnerable to litigation/liability insurance crises than states that have developed the capacity to serve a far greater percentage of those requiring long-term care in home- and community-based programs. Failure to expand home- and community-based services at an accelerating rate over the next several years would represent a major policy setback and create the conditions for an even deeper long-term care crisis in the years ahead as Florida’s already large population of older persons grows steadily larger (currently, 19% are 65+; by 2010, 25% are expected to be 65+).

SB1202 also imposed a moratorium on the construction of new nursing home beds over the next 5 years that may help offset the additional costs of increased staffing and give the state enough fiscal leeway to spend substantially more on home- and community-based services than it did over the previous 10 years to create a more balanced, consumer-responsive, long-term care system. This will, however, require major changes in methods of funding and delivering long-term care services—changes designed to target enhanced home- and community-based services more rigorously to those at greatest risk of requiring nursing home care.

Policymakers are counting on a significant improvement in the quality of nursing home care resulting from their investment in increased staffing and the legislation requiring more stringent regulation. The new staffing levels, although higher than any other state at this time, will still be lower than the new recommended staffing levels for licensed staff (1.3 RN-LPN [CMS, 2001], .70 LPN, 1.15 RN [including administrative hours; Harrington, Kovner, et al., 2000]).

Beyond the conventional, quality-of-care regulatory issues, however, advocates, researchers, and policy makers need to begin addressing quality-of-life issues in nursing homes. Enhancing the quality of life in long-term care has been a major motivating force in the development of less restrictive, more consumer-oriented home- and community-based programs for 20 years. We have been negligent, however, by overlooking the need to humanize the nursing home environment, as well. Creating conditions designed to maintain and nurture autonomy, privacy, dignity, and affectionate ties should have as high a priority in the development of nursing home policy and day-to-day practices as it has historically in the creation and operation of home- and community-based services. This represents the next frontier in the evolution of nursing home care, and we should address it with at least as much resolve and moral commitment as we have the regulation of quality of care.

If the tort reform provisions of SB1202 fail to contain litigation costs and make liability insurance affordable, policy makers will probably be confronted with urgent demands for more tort reform measures, including caps on compensatory damages and lowering the new punitive caps. There may be more interest in developing a large, comprehensive state-run joint underwriting association. The political climate within which these events would unfold, however, may be just as unsympathetic to the interests of the nursing home industry as it has been for the last several years. It is impossible to predict how this scenario, if it were to emerge, would play out. One strong possibility, however, is that policy makers would respond by combining support for more tort reform with support for not-for-profit nursing home providers in the form of various incentives, including insurance subsidies, elimination of certificate of need restrictions and other incentives. In many quarters, including the media, for-profit providers are viewed as having an inherent conflict of interest (profits vs. care) and are often invidiously compared with not-for-profit nursing homes, many of which are operated by faith-based organizations and benefit from a greater reservoir of trust within the community and the perception that they provide a higher quality of care, even though they have been almost as likely to be sued as for-profit facilities. The efficacy of this approach, however, would depend on successfully addressing several limiting factors, including the following.

Not-for-profit providers constitute only 17% of the nursing homes in Florida and have been a shrinking percentage for several years. Reversing this trend would take time and would probably require substantial incentives well beyond the relatively marginal incentives most often mentioned, including assistance with high liability insurance costs. For-profit providers serve a much higher percentage of Medicaid recipients than the not-for-profit providers (70% of residents in a for-profit nursing home are on Medicaid). One major reason for this discrepancy is that not-for-profit providers’ costs are higher (often substantially higher) than Medicaid reimbursement rates and as long as there are a sufficient number of private-pay residents able and willing to pay for what they perceive to be a higher quality of care and quality of life in not-for-profit facilities, there is little reason to cut their costs to serve a higher number of Medicaid recipients. (The for-profit providers also claim that their costs are higher than Medicaid pays.) In short, the state would probably have to increase its Medicaid nursing home expenditures substantially to attract more not-for-profit providers. This would be difficult, given that the nursing home budget has already grown by more than 100% since 1992.
There is no clear evidence that the for-profit provider community is interested in substantially expanding their operations. Providing nursing home care is an extremely demanding enterprise, with multiple constituencies that often have inconsistent, if not opposing, agendas. Furthermore, for-profit providers have been sued at an accelerating rate in Florida over the last few years (68% had been sued by June 2000) and are not likely to consider expanding, absent a qualitative reduction in litigation and the return of affordable insurance. Few doubt that the quality of nursing home care would benefit from a greater presence of mission-driven, faith-based providers governed by an ethic of care. Their expansion, however, is as contingent on a predictable, affordable business environment as would be required for proprietary providers.

The most immediate effect of the litigation and liability insurance crisis on the availability of home- and community-based services may be the pressure from insurers on ALFs to give up or not apply for the ECC license. The ECC license was created by the Florida Legislature to allow ALFs to serve more impaired residents with higher levels of health care needs than can be admitted to or remain in facilities without the license. The major purposes of the license are to provide a community—residential alternative to nursing homes and to enhance opportunities for residents to age in place. In short, ECC-licensed facilities, in combination with assisted living Medicaid waiver funding, are intended to play an essential role in the future growth of Florida’s underdeveloped home- and community-based, long-term care system. The loss of this option through the withdrawal of affordable insurance for ECC-licensed facilities would greatly limit the state’s capacity to create a more balanced and cost-effective, long-term care system and expand the range of choice available to long-term care consumers.

The debate over litigation and nursing home quality should not take our eye off the prize of long-term care reform that most fundamentally entails expanding the ability of consumers to choose from an array of community-based services and community–residential programs and improving the quality of care in nursing homes. The Florida Legislature took a major step in this direction with the passage of SB1202 in 2001, which may be interpreted as Phase I of long-term care reform in Florida. Phase II will require a sustained multiyear effort to increase the availability of home- and community-based services and create a far more balanced long-term care system than currently exists.

References


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