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Racial Disparities in Nursing Facilities— and How to Address Them

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INTRODUCTION

Recent years have seen an increased—and overdue—focus on structural racism within the United States. Broadly speaking, the focus on “structural” racism—as compared to legal or explicit racism, for example—responds to ongoing disparities that statistically tend to favor white Americans over persons of color and specifically over Black Americans. In structural racism, the structures of society—in health care, housing, employment, and other facets of life—benefit white individuals over persons of color regardless of supposedly colorblind policies and procedures. Formal segregation in housing, employment, and education is clearly illegal,¹ for example, yet the “whiteness” of a neighborhood, school, or other institution tends to correlate with increased prosperity, support, and success.²

Like any American institution, the U.S. system of long-term services and supports (LTSS) is not immune from structural racism. This paper first reviews relevant research into disparities in nursing facility care, then evaluates the implications of that research. The paper concludes with five policy recommendations on how to improve nursing facilities and home and community-based services in order to better and more equitably meet the needs of older Americans.

RACE-BASED DISPARITIES IN NURSING FACILITY QUALITY OF CARE: AN OVERVIEW OF THE RESEARCH

Numerous studies have shown that Black nursing facility residents are more likely than other populations to receive poor nursing facility care. The majority of these studies have looked at data across facilities, noting an increased likelihood that Black residents reside in low-quality facilities. A smaller number of

studies look at data *within facilities*, finding generally that Black residents receive poorer care than the facility's other residents. As outlined below, a review of available research demonstrates racial disparities in admissions to nursing facilities, resident hospitalization rates, staffing levels, other quality measures, and COVID-19 infections and deaths.

“80% of Black patients were admitted to only 28% of nursing facilities and these facilities provided poorer quality of care.”

Admissions to Nursing Facilities

One research strategy, for example, focuses on admissions—whether a Black hospital patient is statistically more likely to be admitted to a low-quality nursing facility. In general, the research reveals segregation akin to the residential segregation that is endemic in American neighborhoods. Facilities, like residential neighborhoods, are often heavily segregated, with persons of color disproportionately living in a relatively small subset of facilities. A 2018 study, for example, using a data set of hospitalized Medicare beneficiaries, found that nursing facility admissions correlated with race. A full 80% of Black patients were admitted to a subset of only 28% of the nursing facilities; similarly, 80% of Latino patients were admitted to 20% of the facilities. Furthermore, these admissions correlated to quality of care disparities. Poor quality—as measured by rehospitalization rates, discharge-to-the-community rates, and Medicare star ratings—was more prevalent in facilities with higher percentages of Black residents, although “associations between quality indicators in [Latino] majority facilities were more complex.”³

Similar studies on facility admissions have reached essentially the same conclusion: that Black individuals are more likely to be living in lower-quality facilities. In 2004, a study found that Black individuals generally were admitted to nursing facilities with an above-average number of deficiencies, and this correlation persisted after controlling for differences between residents.⁴ Also, in 2006, a study reported that Black hospital patients were more likely than white patients to be admitted to nursing facilities in the lowest quartile of quality. The same study found a similar disparity among patients without high school degrees, compared to high school graduates.⁵

Finally, a 2021 report concluded that Black individuals were less likely to be admitted to high quality nursing facilities, and the disparities were not completely explained by financial and clinical status. That being said, race-based disparities were decreased in states that made supplemental Medicaid payments for residents with dementia.⁶

Hospitalization of Nursing Facility Residents

Other studies look for correlation between facility quality and resident race through other methodologies. In measuring quality, one subset of studies focuses on the facility's hospitalization rate. Though an individual hospitalization may or not be appropriate or advisable, depending on the circumstances, an excessive *rate* of hospitalization may indicate that a facility has been providing inadequate care or has not dedicated sufficient resources to address certain resident conditions. In a 2008 study, Black residents in general were less likely than white residents to be hospitalized, and this held true for both younger and older nursing facility residents. Among residents with severe impairments, however, Black residents were more likely than white residents to be hospitalized. Also, the likelihood of hospitalization varied with the percentage of Black residents in the facility—regardless of a resident's race, the likelihood of hospitalization was greater in those facilities with a higher percentage of Black residents. Overall, the researchers noted the “striking” differences between Black and white residents, “particularly among the most impaired.”⁷

Another study of hospitalizations found that Black residents had a higher likelihood of being rehospitalized within the first 30 and 90 days of a nursing facility stay. A “considerable portion” of the disparities were attributable to resident and facility characteristics, but disparities persisted even after multivariable adjustments. To explain the disparities, the authors noted the likelihood of Black residents being housed in “resource-poor” facilities that did not meet residents’ health care needs. Regarding resident-specific disparities, the researchers added that Black patients “tend to desire more aggressive and life-sustaining medical treatments than do White patients,” and that conversations with physicians and facility staff also tend to be less productive for Black patients.⁸

A similar study considered white, Black, and Latino nursing facility residents, finding higher hospital readmission rates for the Black and Latino residents. The authors concluded that approximately 30% of the disparity for Black residents was attributable to within-facility disparity, although no similar within-facility disparity was observed for Latinos. Consistent with these data, readmission rates for all populations decreased as the percentage of white residents increased. To explain the data, the authors cited the lesser quality of the facilities with fewer white residents, along with disparities in the quality of residents’ communications with physicians, rates of advance health care planning, and preferences regarding hospitalization.⁹

In many of these studies, one ongoing issue is distinguishing between-facility disparities from those disparities that occur within a facility. One additional study of hospitalizations found the between-facility disparities to be more consequential. Overall, Black residents tended to be admitted to nursing facilities with poor performance, limited resources, and high rehospitalization rates. Because disparities mostly related to the facility, both Black and white residents had high rehospitalization rates within nursing facilities with higher percentages of Black residents. Similarly, both Black and white residents had similar rates of potentially-avoidable rehospitalization within each cohort of facilities with a comparable Black-resident percentage.¹⁰

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Nursing Facility Staffing Levels

Within studies of disparities, another common measure of quality is a facility’s staffing levels.¹¹ One study examined staffing levels over a ten-year period, finding 1) an overall rise in registered nurse (RN) staffing levels, but 2) generally lesser RN staffing levels in facilities with larger populations of residents of color, even after multivariable adjustment. Furthermore, nurse aide staffing levels demonstrated similar race-based disparities, with higher nurse aide levels in facilities with high percentages of white residents, compared to facilities with high percentages of residents of color. On the other hand, facilities with a higher concentration of residents of color had higher levels of licensed practical nurses (LPNs) compared to facilities with high levels of white residents, although this disparity tended to disappear after multivariable analysis. So while total licensed nursing levels were relatively equal across both facilities with higher and lower concentrations of residents of color, facilities with a higher concentration of residents of color utilized less skilled LPNs more and had a lower nurse skill mix than facilities with a lower concentration of residents of color.¹²

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In the same vein, another study of staffing levels showed that majority-white facilities had registered nurse levels that were 34% and 60% higher, respectively, than majority-Black and majority-Latino facilities. Furthermore, these disparities were not entirely accounted for by variables including the residents’ medical conditions, the facility’s percentage of Medicaid-eligible residents, and whether the facility was in an urban or rural environment.¹³

Additional Quality Measures

Due in large part to extensive information provided by the Minimum Data Set—a standardized resident assessment process used by every nursing facility—researchers are able to measure nursing facility quality through a variety of measures. One study on racial disparities examined five quality measures: three measures based on types of interventions provided, and two measures drawn from resident outcomes. Overall, the study found consistent negative disparities in quality of care for Black residents. These disparities were mitigated but not eliminated by adjusting for a facility’s financial resources and percentage of Medicaid-eligible residents.¹⁴

Another study considered four separate quality measures: the use of physical restraints, catheterizations, antipsychotic medication, and feeding tubes. For each measure, the study found disparities between white and Black residents; after a multivariable analysis, however, white-Black disparities remained only in regard to the feeding tube use.¹⁵ Another study on disparities examined quality under three separate metrics: inspection deficiencies, staffing levels, and financial viability. Under each of these measures, Latino residents were found more likely to be residing in a low-quality facility.¹⁶

A study on pressure sores found racial disparities both within *and* between facilities. Black residents suffered higher pressure sore rates than white residents within both facilities that have higher and lower percentages of Black residents. Facilities with higher percentages of Black residents tended to have lower levels of nurse staffing and nurse aide staffing, along with a greater reliance on Medicaid and relatively higher rates of pressure sores across all resident populations, compared to facilities with lower percentages of Black residents.¹⁷

Another study found that Black residents were more likely than white residents to be subject to physical restraints.¹⁸ A study based on antipsychotic use found disparities in relation to Medicaid eligibility but not the resident’s race (Black or white).¹⁹

Consistent generally with these findings, a study on quality of life found race-based disparities from facility to facility, and also within facilities. Compared with white residents in primarily-white facilities, residents of color reported a lower quality of life regardless of the facility’s racial makeup.²⁰ On the other hand, a study of clinical care and quality of life found minimal race-based disparities, some in favor of white residents and others in favor of Black residents.²¹

COVID Infections and Deaths

As has been widely noted in the media, Black and Latino communities throughout the country suffered disproportionately from the COVID-19 pandemic, whether measured by case counts or deaths. Relevant factors include the residential segregation discussed above, along with the fact that Black and Latino employees were relatively less likely to be able to telework to avoid COVID infection.²²

Similar disparities were observed within nursing facilities. In general, a greater percentage of Black or Latino residents correlated with increased numbers of COVID infections and deaths. As causal factors, researchers cite poor quality of care, facility size, and prevalence of COVID-19 in the surrounding community.²³

EVALUATING THE RESEARCH ON NURSING FACILITY DISPARITIES

Research evaluating disparities in nursing facility care frequently notes the intersection of race and financial resources (or the lack thereof). One frequently-cited paper posits that nursing facility care is a “two-tiered system,” with the lower tier consisting of mostly Medicaid-eligible residents. This lower tier has fewer nurses, lower occupancy rates, more health-related deficiencies, and a high percentage of Black residents.²⁴ As multiple reports have noted, Black and Latino residents are more likely to be Medicaid eligible, and research shows correlations between the percentage of Medicaid-eligible residents and the likelihood that the facility provides a poor quality of care.²⁵

Related to financial and race-based disparities are disparities attributable to residential segregation. Although formal residential segregation is illegal,²⁶ informal segregation often is more rule than exception across the United States.²⁷ This segregation correlates to disparities in many facets of life, including but not limited to health care, education, employment, and multiple social determinants of health.²⁸ In general, majority-white neighborhoods are more prosperous than others, based on the financial resources available to residents and the community. In turn, nursing facilities in those neighborhoods are more likely to be majority-white, with greater financial resources, less reliance on Medicaid reimbursement, a relatively more-healthy resident population, and better quality care. The opposite is true within communities of color.²⁹

That being said, many race-based disparities cannot be explained away by pointing to Medicaid reimbursement rates, preexisting residential segregation, or other factors. As discussed above, race-based disparities often persist even after controlling for resident-specific factors other than race.³⁰

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Also, the design of some studies makes Medicaid concerns less relevant. For example, in a study discussed above, the data set was drawn from the hospital patients who were discharged to nursing facilities under *Medicare* reimbursement.³¹ Thus, the disparities observed in that study are less likely attributable to financial discrimination, and more likely the result of racial bias and residential segregation.

Likewise, within-facility disparities generally are more likely to be attributable to racial bias and discrimination rather than to financial discrimination.³² Although the disfavoring of Medicaid-eligible residents exists in a facility’s day-to-day operation—particularly when compared to care received by a facility’s Medicare-reimbursed residents—the within-facility comparisons are less affected by the type of payment source discrimination that occurs in admission decisions.³³

RECOMMENDATIONS

The following recommendations aim to address the documented racial disparities in nursing facilities. The recommendations are not intended to be comprehensive, but rather serve as a jumping off point to improve access, quality of care, and quality of life for persons of color, at both systemic and facility levels. More is needed to root out and address long-standing racial disparities in nursing facilities and across the entire

long-term services and supports infrastructure. For one thing, increased comprehensive and intersectional data collection and reporting is essential to measure the effectiveness of these recommendations and to identify ongoing disparities and develop policies and strategies to address those disparities.

ELIMINATE PARTIAL MEDICAID CERTIFICATION

As discussed above, racial disparities often are tightly intertwined with discrimination against Medicaid-eligible residents. Accordingly, one positive step to address race-based disparities is to eliminate partial Medicaid certification in nursing facilities.

Under partial certification, only certain rooms are certified for Medicaid, which allows a facility to cap its number of Medicaid-eligible residents. In practice, partial Medicaid certification allows a facility to collect the “preferred” payment source—the resident’s life savings, for example, in a private-pay scenario—and then evict the resident when the resident needs to switch to Medicaid coverage, simply because the resident is residing in the “wrong” room.

From a purely financial perspective, facilities may consider partial certification to be a positive. But Medicaid-eligible residents suffer when they are treated as undesirable and disposable. Some states have chosen to require full certification, but many others allow partial certification.

This problem could be rectified legislatively at the federal level by deleting “distinct part” language from the Medicaid Act, thus requiring full-facility certification from those facilities that seek Medicaid certification.³⁴ This change would require full certification across the country.

No one forces nursing facilities to apply for Medicaid certification. But if a facility chooses Medicaid certification, it is only fair that Medicaid reimbursement be an option for each and every one of the facility’s Medicaid-eligible residents. This would allow more Medicaid residents, who are disproportionately people of color, to stay in nursing facilities when they must transfer to Medicaid coverage.

IMPROVE NURSING HOME STAFFING

The adequacy of nursing facility staffing is universally recognized as a significant factor in residents’ health outcomes. This has an impact on racial disparities: as noted above, facilities with higher percentages of residents of color tend to have less staffing and less skilled staffing, with a generally poorer quality of care. The federal Centers for Medicare & Medicaid Services (CMS) currently is considering several initiatives to improve nursing facility staffing. A recent Request for Information solicits information on methodologies to implement mandatory staffing levels nationwide.³⁵

Improved staffing levels would improve care provided in all facilities, including facilities with a higher percentage of residents of color. A relatively large impact would be seen in the underperforming facilities where residents of color disproportionately reside, since higher quality facilities with a higher percentage of white residents are more likely to already maintain appropriate staffing levels.

ENSURE GREATER CULTURAL COMPETENCY WITHIN NURSING FACILITIES

Quality of life disparities based on race can be addressed in part by improving facilities’ cultural competency. Current regulations and guidelines have taken small steps in this direction, but much more

needs to be done. The average facility today has done little to provide a more welcoming environment for Black, Latino, and other residents of color.

Current regulations and guidance have taken initial steps to incorporate cultural competence. For example, services under a resident's care plan must be "culturally-competent,"³⁶ and care plan interventions for activities must include "resident's choices, personal beliefs, interests, ethnic/cultural practices and spiritual values, as appropriate."³⁷ Interventions for "psychosocial adjustment difficulties may include ... arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices."³⁸ Food of course is an important element of culture and health; accordingly, menus must "[r]eflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups."³⁹ A resident who for 85 years has eaten primarily Vietnamese food, for example, or Mexican food, will feel isolated and somewhat insulted if served generic facility meals.

To improve facilities' cultural competence, government surveyors should issue citations for failure to comply with cultural competence standards. In addition, cultural competence should be emphasized in the facility training and in technical assistance provided by Quality Improvement Organizations and others. Cultural competence should be understood as a necessity rather than a theoretical best practice.

IMPROVING TRAINING FOR NURSING HOME STAFF, INCLUDING IMPLICIT BIAS TRAINING

As discussed in this paper, within-facility disparities suggest racial bias as a contributing factor. For example, studies have shown Black nursing facility residents experiencing lower quality of care as measured by increased antipsychotic administration, less productive communications with staff, and reduced access to fall prevention activities.⁴⁰ This problem could be addressed by improving training for nursing facility staff, including training on recognizing and addressing implicit bias.

Under federal law, nurse aides must receive a minimum of 75 hours of training across a variety of areas including communication and interpersonal skills, infection control, safety and emergency procedures, and respecting residents' rights and promoting independence.⁴¹ Advocates have raised concern that these training requirements are too low, particularly since nurse aides provide the bulk of the care for residents. A report by the Institute of Medicine concurs, recommending that the federal minimum hours of training be raised to 120 hours.⁴²

Of course, the content of those 75 (or 120) hours is critical. Currently, the required topics do not include implicit bias. Although evidence shows that implicit bias contributes to poor care, there are limited studies on the effects of implicit bias training in facilities, due in part to the lack of standardized implicit bias training programs.⁴³ This should be rectified by developing implicit bias training for use in facilities as part of the required training for nurse aides, nurses, and other facility staff members as well.

BEYOND NURSING FACILITIES: IMPROVED ACCESS TO HCBS

One response to inadequate nursing facility care is simply to provide more access to care outside of a nursing facility. Necessary care often can be received at home through Medicaid Home and Community-Based Services (HCBS). Furthermore, of course, receiving care at home is a common preference among disabled and older people.⁴⁴

A large impediment to accessing HCBS is an ongoing institutional bias within the Medicaid program. Most prominently, under Medicaid law, nursing facility care must be offered to all qualifying Medicaid beneficiaries, while states have an option to provide HCBS and can arbitrarily cap enrollment in HCBS programs.⁴⁵ The result is a patchwork of HCBS programs within states and wide variation in the availability of HCBS across states, leading to inequities in who can receive HCBS and who has no option but to receive care in a nursing facility setting.

To address institutional bias, Medicaid should require coverage of HCBS as a mandatory benefit on par with nursing facility coverage. Such a mandatory entitlement would provide expanded opportunities for older adults of color to receive long-term care outside of nursing facilities. Short of making HCBS a mandatory benefit, increased federal funding for HCBS like that provided under the American Rescue Plan for one year should be extended beyond one-time funding.⁴⁶ Specifically, federal and state governments should incentivize diversion and transition programs, such as the Money Follows the Person program, and implement additional policies to connect individuals to HCBS, utilizing strategies to ensure these services are equitably available based on race and other factors.

CONCLUSION

Numerous studies have found harmful disparities in the nursing facility care received by residents of color. Now is the time to target and reverse these disparities. Eliminating partial Medicaid certification and increasing staffing levels would benefit residents of all racial backgrounds, with especial benefit to residents of color. Increased cultural competency, along with training in implicit bias, would improve both quality of care and quality of life for residents of color. Finally, HCBS improvements would better enable residents of all racial backgrounds to receive necessary care outside of nursing facilities, which would particularly benefit older adults of color, who are more likely otherwise to reside in low quality nursing facilities.

ENDNOTES

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- 2 See generally Kriston McIntosh et al., Brookings Institution, *Examining the White-Black Wealth Gap* (Feb. 27, 2020).
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- 15 David Grabowski & Thomas McGuire, *Black-White Disparities in Care in Nursing Homes*, Atl. Econ. J., Vol. 37, No. 3, at 299, 307-12 (Sept. 1, 2009).
- 16 Mary Fennell et al., *Elderly Hispanics More Likely to Reside in Poor-Quality Nursing Homes*, Health Affairs, Vol. 29, No. 1, at 65, 70-71 (2010).
- 17 Yue Li et al., *Association of Race and Site of Care with Pressure Ulcers in High-Risk Nursing Home Residents*, JAMA, Vol. 306, No. 2, at 179, 182-84 (July 13, 2011).
- 18 Kimberly Cassie & William Cassie, *Racial Disparities in the Use of Physical Restraints in U.S. Nursing Homes*, Health and Social Work, Vol. 38, No. 4, at 207 (Nov. 2013).
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