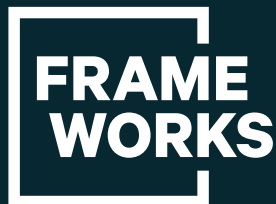


Communicating About Nursing Home Care: Findings and Emerging Recommendations

March 2022

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The
John A. Hartford
Foundation

A Strategic Brief in partnership with The John A. Hartford Foundation.

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Introduction

In the early months of the COVID-19 pandemic, as millions of Americans were quarantining in their homes and thousands of businesses had closed their doors, news outlets began to report on how the virus was affecting nursing homes.¹ Accounts of families struggling to move their loved ones out of nursing homes and of care workers actively working, gripped the nation and granted nursing homes nearly unprecedented attention in the media and popular discourse. Research shows that, as of October 2021, COVID-19 has claimed the lives of nearly 200,000 people living and working in nursing homes—amounting to roughly one-third of the total death toll in the United States.² But while the pandemic may have put nursing homes in headlines, the problems affecting nursing homes, the residents they serve, and the care workers that staff them existed long before COVID-19. Rather, these issues—including systemic underfunding, ineffective regulation, and insufficient staffing—have long inhibited access to high-quality, affordable care that supports the wellbeing of an aging population.

This moment prompted recognition of the need for a better conversation about nursing homes and nursing home care. Effectively communicating about nursing homes is crucial to generating public support for the structural reform necessary to bring about lifesaving changes in how nursing homes exist and operate—and to do that, we need to start by understanding how the public thinks about nursing homes right now. This brief will offer takeaways about public perceptions of nursing homes as well as some initial recommendations for communicators.

Advocates tell us that nursing homes can and should provide dignified and comfortable care to older adults and people with disabilities. However, our findings indicate that right now, the public views nursing homes as a last-resort option for care of older adults, intended mostly to triage various health concerns rather than support the overall wellbeing of older people. The public understands nursing homes to be cost-prohibitive for many older people, but views this issue as intrinsic to our health care system and thus beyond the reach of policy intervention. And when people look at care workers, they don't tend to see a workforce operating under stressful conditions that can and should be alleviated through policy reform. Instead, they see people who are inherently unmotivated and unconcerned with the welfare of nursing home residents. When it comes to thinking about how to fix these issues, the public often defaults to

reactive solutions that address individual problems with nursing homes after they manifest—not the preventive reforms that advocates tell us are essential to proactively support the wellbeing of nursing home residents.

This strategic brief identifies a set of preliminary findings on how members of the public think and reason about nursing homes. Based on in-depth, qualitative research, we offer strategies to help navigate these ways of thinking, providing preliminary recommendations about how to address challenges and take advantage of opportunities.

The brief is grounded in research conducted by the FrameWorks Institute, in partnership with The John A. Hartford Foundation, to examine how the public and those in the field think about nursing home care. This research is part of a larger project to develop an effective communications strategy for the issue. Further research will be needed to identify the most effective ways of framing nursing home care and build on the recommendations offered in this brief.

I. Methods Overview

What Are We Trying to Communicate?

To develop an effective strategy for communicating about nursing homes in the United States, it's necessary to identify a set of key ideas to get across. To do this, FrameWorks researchers conducted a series of interviews, supplemented with a review of existing literature and a feedback session with researchers and advocates in the field. Below, we summarize the key ideas that emerged from this process, which represent the core points that need to be effectively communicated and the solutions that the field wants to build support for through communications.

Public Thinking about Nursing Homes

To explore the public's thinking about nursing homes in the United States, researchers at FrameWorks conducted 20 one-on-one, two-hour-long cognitive interviews with members of the public. These interviews consisted of open-ended questions designed to elicit participants' deeply held beliefs and patterns of reasoning about nursing homes. For these interviews, FrameWorks recruited a diverse sample of participants with variation along multiple demographic and ideological dimensions: age, gender, race and ethnicity, educational background, income, employment status, and political views. The interviews were analyzed to identify implicit ways of thinking about nursing homes and a range of related topics relevant to the field, including aging and care work. The descriptions in this brief characterize the underlying assumptions that structure specific patterns of reasoning.

II. Research Findings

This section of the brief outlines our findings on how the public thinks about nursing homes. For each finding below, we outline core ideas from the field, discuss findings on the public’s assumptions, and offer initial recommendations. Communicators can start using these recommendations right now, with the caveat that further research is needed to identify more specific, evidence-based framing strategies to move public thinking in the right direction.

Finding #1: The public sees aging as a period of inherent and inevitable decline.

What the field wants to communicate:

- The aging population is rapidly growing, with a greater and greater proportion of Americans requiring long-term care.
- Older people deserve dignity, respect, and autonomy throughout their experiences of care.

What the public brings to the conversation:

The public looks at aging as a process of deterioration.

People tend to view aging as an inevitable decline in cognitive and physical health. Frequently, people expressed this line of thinking by comparing the human body to a “machine” that breaks down and ceases to function with time. People reason that the medical concerns associated with aging will not stop or get better. Rather, as someone ages, their health follows a linear and predictable downward trajectory. The public assumes that caring for an older person involves triaging various medical issues—a focus which can obscure other needs, such as emotional or social aspects of their wellbeing.

People tend to associate growing older with a gradual loss of agency and personal autonomy.

Relatedly, the public often equates any level of assistance an older adult receives with *dependence* on the care of others. According to this thinking, the older one gets, the more they “need” from other people. This is based on the aforementioned perception that as one ages, they will continually develop more and more health issues that build on one another. From this perspective, assistance required by an older person is never temporary or just a small part of their life. Rather, it is synonymous with lacking agency and translates into an ever-compounding erosion of personal autonomy in all facets of their life.

What this means for the field:

Given that the public views aging as synonymous with decline, **it may be difficult to explain how older people can thrive as they age when given the right support.** If aging is perceived as inherently and inevitably negative, people may assume that the wellbeing of an older person cannot be helped or supported. Similarly, the perception that older people will inevitably become sicker and more dependent on others may lead people to downplay the agency of older people, leading to paternalistic attitudes.

Furthermore, when aging is perceived as a process of deterioration that happens “within” a person, people may lose sight of **the role of environment in aging.** This could make it more difficult for people to understand how structural factors, including socioeconomic status, experiences of discrimination, and access to health care, can impact wellbeing among older adults as they age.

Recommendations:

Prior FrameWorks research on aging may offer guidance to communicators when it comes to combatting the negative perceptions of aging.³ Our existing framing strategy includes the following recommendations:

- **Highlight the role of environments in aging, providing specific examples of how structural factors play into someone’s wellbeing as they age.** Similarly, provide concrete examples of the ways in which society can support health and wellbeing for older adults.
- **Draw attention to the opportunities that aging can bring, even if a person is experiencing significant challenges, in order to avoid the negative perceptions cued along with it.** For instance, framing aging as a process of “building momentum”—that is, people gain valuable wisdom and experience as they age and thus become more capable of helping society move forward can help the public view aging in a more positive light.⁴ Talk about how this can occur in the context of nursing homes.
- **Use the value of *Justice*** to explain the importance of supporting the wellbeing of older adults as a matter of inclusion and equity.
- **Be sure to emphasize aspects of an older person’s life other than their medical concerns.** Give specific examples of the emotional and interpersonal needs of older people.

Finding #2: The public assumes that responsibility for care rests with an older adult's family.

What the field wants to communicate:

- Nursing home staff should communicate with family members about care and ensure adequate opportunities for visitation and involvement in the care being delivered.⁵
- Families should be a part of the decision-making process when it comes to nursing home care.

What the public brings to the conversation:

The public assumes that being cared for by one's family is the best possible form of care.

When thinking about care of older adults, the public views being cared for by one's family as the "ideal" scenario. They assume that older adults' families are most suited to provide care based on their emotional closeness, something that a "stranger" cannot provide. In interviews, participants consistently mentioned that family can "care for" and "love" an older person in a way that they need and deserve as they age. In contrast, people assume that any form of care that comes from outside the family (from nursing homes to in-home care) is less preferable because care workers lack the same "connection" with the older person that their family intrinsically has.

The public holds an older adult's family responsible for providing care for them as they age.

People assume that not only are families the best possible caretakers, but that they are *obligated* to provide care to older family members. This rests on the assumption that older adults cannot make informed decisions about their own care, leaving the responsibility to others.

In past FrameWorks research, we have observed that people hold similar views when it comes to childhood development: namely, that parents fundamentally and exclusively shape how well children do in life.⁶ The public applies a similar lens to the care of older adults, assuming that one's family can and should be primarily responsible for an older person's wellbeing. These perceptions of familial responsibility also draw on and reinforce paternalistic attitudes toward older people, with the public often assuming that older adults don't—and shouldn't—have a role to play in decision-making about their own care.

The public also understands that family should play a key role in care even when their loved one lives in a nursing home. When people discussed what it takes for an older person to do well in a nursing home, they often stressed the importance of one's family, from coordinating about medical care with nurses to advocating for their wellbeing with administrative staff. This largely parallels the field's perspective on the importance of family involvement in care. However, while the field views the family's role as collaborative with, but distinct from, the role of nursing home staff, the public's focus on the role of a family in care sometimes appeared to come at the expense of understanding what nursing home staff can and should do. Medication

schedules, day-to-day activities, and other aspects of living at a nursing home were often spoken of in terms of a family's responsibility to "check up" on their family member, rather than the role of staff in facilitating care on a day-to-day basis.

Nursing homes are perceived as a last-resort option after family care has proven untenable.

People tend to think of nursing home care as an inferior alternative to family care that is only chosen as a "last resort." In other words, older people "end up" in nursing homes because their family cannot—or will not—care for them. Importantly, people also assumed that when someone is in a nursing home, it is not because *they* chose to be there, but because their family "put" them there. This perspective on nursing homes manifested in a general sense of pessimism and fatalism, with people arguing that no one would want to be there. They often listed out more "preferable" alternatives—including family care, "retirement homes" or assisted living, home-based care, and so on.

What this means for the field:

While the public is aligned with the field in seeing a central role for family in nursing home care, the public's focus on familial responsibility threatens **to crowd out a role for nursing home staff**. This may lead people to downplay both the skills and responsibilities of nursing home staff.

There is also a danger that the emphasis on familial responsibility may obscure society's responsibility for older adults. The public may **conclude that the wellbeing of older adults is a "family" issue rather than a societal issue** for which we hold collective responsibility.

Additionally, because people look at nursing homes as places where no one would want to be, **they are often fatalistic** about their capacity to improve the wellbeing of older adults.

Recommendations:

- **Explain the role of staff and family members in the care process.** Discuss the ways in which person-centered care from staff can also fulfill residents' emotional needs when done correctly. Ensure that discussions of family involvement in care also highlight the role of nursing homes and their staff, and explain how they each hold unique roles but work collaboratively to provide quality care.
- **Situate care as a societal responsibility rather than a family one** in order to break down the perception that families are wholly responsible for the wellbeing of older adults.
- **Explain the agency that a resident can and should have in their own care in order to combat paternalism.** Make residents the "subject" of the sentence rather than the object, and give specific examples of the range of choices older people make about their own care (for instance, choosing their daily routine or schedule of activities at a nursing home).

- **Talk about all nursing home care as part of a spectrum of options for long-term care** to combat the perception that nursing homes are the “worst” of all possible options. Explaining the role that nursing homes play in this spectrum may help people understand how nursing homes can be the *best* choice for a family rather than one that is only ever chosen when no other options are available.

Finding #3: The public sees nursing homes as an impersonal medical environment, not as a “home.”

What the field wants to communicate:

- Nursing homes function as a home for residents and therefore should provide the privacy and comfort associated with a home.
- Nursing homes should support holistic wellbeing, including the nonmedical needs of residents.
- The care of older adults should be “person-centered” and recognize the humanity and individuality of each person.

What the public brings to the conversation:

Nursing homes are thought of as only medical facilities.

When describing a nursing home’s purpose, people tend to focus on the various medical concerns older people are presumed to face. Similarly, the public assumes that older people’s daily routine in a nursing home revolves around constant medical interventions—receiving medical treatments, being “checked on” by nurses, etc.. In this way, the public concludes that nursing home care is about addressing the various manifestations of physical and cognitive “deterioration” thought to characterize an older adult’s life.

This tendency draws on a narrow view of health and wellbeing documented in past FrameWorks research. Rather than thinking of health as multifaceted wellbeing across social, emotional, and physical dimensions, people tend to conceptualize health as the absence of illnesses, medical issues, and other “problems.” Our analysis indicates that when the public thinks about nursing homes, they apply this “medical” understanding of health care. While nursing homes do function in part as medical care facilities for a population with complex health care needs, this focus may obscure the other important activities that nursing homes can and do facilitate for their residents.

Nursing homes are often contrasted with “real homes.”

Using this medicalizing lens, people tend to look at nursing homes as impersonal spaces that don't rise to the level of a “home” for residents. Instead, people think of them as a “room” that someone stays in. These places cannot be “home,” the thinking goes, because they are less comfortable and lack personal touches. Instead, they were described as “hospital rooms” or “facilities.” People often compare nursing homes to “real homes” and conclude that nursing homes are undesirable places to live.

People assume that “routines” in nursing home are imposed rather than chosen.

People often characterized nursing homes as “prisons” or “dungeons,” and assumed that residents have little to no personal autonomy once they are in one. This was particularly evident when people described residents' daily routines. While the public has some capacity to understand that people engage in a variety of different activities at a nursing home, some of which are aimed at fulfilling social and emotional needs, they assume that residents have little to no say in determining which of these activities they participate in. Rather, the public reasons that nursing home staff impose a standard schedule of activities upon all residents without their input. For instance, participants described staff creating and “overseeing” a “regimented” schedule for an entire home. People also tended to assume that such a schedule is rigid and applies across the board to all residents (for example, everyone eats meals at the same time and does the same recreational activities at the same time). Once more, this was often contrasted with the benefits of living in one's own home and choosing a schedule of daily activities.

What this means for the field:

When the public thinks of nursing homes as a medical facility, it is impossible for them to consider them “homes,” **creating fatalism around the prospect of a nursing home ever feeling truly comfortable and personal to residents.**

This medicalizing perspective also causes people to **lose sight of aspects of wellbeing that move beyond physical health. Instead, people view the care of older adults as a form of triage for various medical concerns** rather than a social and emotional process in which the older people themselves have agency. This will make it harder to explain the role of nursing homes in supporting all aspects of wellbeing, and **may entirely obscure the concept of person-centered care.**

Furthermore, explaining that nonmedical activities do occur in nursing homes may be insufficient to help the public view nursing homes as a true “home” given the perception that these activities are imposed.

Recommendations:

- **Describe the range of different activities at nursing homes other than just medical interventions**, including aspects of nursing homes that are comfortable, personal, and feel like “home” to residents.
- **Highlight the autonomy of residents** in choosing what they would like to do on a daily basis.
- **Emphasize that nursing home care can and should be individualized** to the needs and wants of each older person.
- **Explain that nursing homes should support wellbeing by providing examples** and explanations of nonmedical activities that take place in nursing homes.

Finding #4: The public views “caring” as an innate characteristic rather than a learned skill.

What the field wants to communicate:

- Nursing home staff are underpaid and carry a heavy workload, and often have limited access to benefits and training. This is both unfair to workers themselves and it undermines the quality of care at a nursing home.
- Staff who work in nursing homes are often treated as less skilled and are valued less than staff with comparable positions and skills in other sectors of the medical field.
- Nursing home staff need greater access to training designed to meet the unique demographic, cultural, linguistic, and care needs of the populations they serve. This includes providing the nursing home workforce with training on person-centered care.

What the public brings to the conversation:

The public’s *ideal* care worker is a “caring” and “loving” person— traits which are perceived as innate rather than teachable.

When the public thinks about the “ideal” care worker, they tend to emphasize characteristics like active listening, compassion toward others, and empathy. From the public’s perspective, a care worker’s success is measured by the emotional connection they forge with their residents. Importantly, our interviews demonstrated that people understand these traits not as skills achieved through training and practice, but as intrinsic qualities that one either “has” or “doesn’t have.” For instance, people often said that to succeed at care work, one must be a “certain type of person”—for example, one with a great capacity to care for and be patient with older adults. Thus, it appears that what qualifies a care worker in the public’s mind is not their skills, but who they are as a human being. Because caring can’t be “learned,” people cannot be trained to do care work, nor can they learn on the job. This logic obscures other factors that play into the ability of care workers to succeed at their jobs.

People assume that nursing homes are inherently undesirable places to work and thus are bound to attract “bad” employees while struggling to retain “good” ones.

The public tends to reason that most of the people who *actually* work at nursing homes are not the ideal “caring people” mentioned above, as these people would not want to remain in their job if given other options. Instead, people tend to characterize staff as intrinsically “bad” employees who are inherently lazy, unmotivated, and dispassionate about residents. If anyone is “good” enough to do anything else, the thinking goes, they will soon move on to a better environment. Thus, much like the “good” characteristics of ideal care workers are thought of as intrinsic and immutable, the presumed “bad” qualities of actual employees are used to essentialize them and make categorical statements about their worth as people and their inability to improve at their jobs.

The public has some ability to understand the role of workplace conditions in staff performance, but this line of reasoning still frequently lays blame on care workers rather than conditions.

Unsurprisingly, the perception that a person’s individual personality is the ultimate determinant of their quality as a care worker leads many people to assume that little can be done to support nursing home workers. While some people argued that it is important to improve working conditions at nursing homes—a perspective that the field shares—this was not used as a reason to support existing staff and enable them to perform more effectively. Rather, improving working conditions is seen as a way to attract “better” workers to replace the “bad” ones. From this point of view, the current workforce by and large cannot be helped, only replaced with the higher-quality workers that would be attracted by higher pay and improved working conditions.

Racial and gender stereotypes shape the public’s perception of care work.

It is important to recognize that gendered and racialized perceptions of *who* makes up the nursing home workforce likely structure stigmatizing attitudes toward their “quality.” Experts notes that devaluation of and disregard for the labor conditions of the direct care workforce in nursing homes is at least partly due societal racism, xenophobia, and sexism. Past research has demonstrated, for instance, that wages tend to be lower in occupations where women (and Black women in particular) are disproportionately represented.⁷⁸ While direct instances of these attitudes did not show up as clearly in our research, our findings are consistent with these conclusions.

What this means for the field:

The belief that the care workforce’s strengths and shortfalls are primarily determined by their own personalities may cause the public to downplay **the role of structural reform** (for example, better pay and benefits). If staff are inherently “bad” or “good,” it stands to reason that various forms of training and support will do little to improve their performance.

When communicators advocate for improving working conditions at nursing homes, the public may interpret this as an attempt to hire “better quality” employees. Thus, if not explained, such statements may **reinforce existing biases about staff**. Likewise, because stereotypes of care workers and their inherent “quality” both draw on and reinforce racist, sexist, and xenophobic assumptions about staff, the negative assumptions about the work are likely inseparable from assumptions about the people who do it. Thus, efforts to reframe care work must be attentive to broader conversations about racial and gender equity.

Recommendations:

- **When communicating about the emotional responsibilities and skills of staff, be sure to emphasize that these are learned skills** that can be taught and improved.
- **Highlight the expertise of staff (medical, administrative, etc.) alongside their other characteristics.** Be specific about the rigorous training necessary to achieve this expertise and its importance in the day-to-day responsibilities of staff.
- **Explain in detail how training, better wages, and improved working conditions impact the quality of care** in nursing homes.
- **Contextualize nursing home work within broader narratives and conversations about racial and gender justice.** Link efforts to reframe care work with the larger movement for a just and equitable society.

Finding #5: The public recognizes that nursing home care is expensive and can often be cost-prohibitive, but concludes this is simply “the way things are” in our health care system.

What the field wants to communicate:

- Nursing homes are out of the price range of most Americans, and public funding through Medicare/Medicaid is insufficient to provide all residents with adequate care given that neither program is designed to fund long-term nursing home care. Medicare only funds short-term stays, and Medicaid only sets in once recipients have essentially exhausted all their money.
- Increasing and restructuring Medicaid funding to allow payments to fully compensate for the cost of care would help make nursing homes more affordable for Americans. Additionally, Medicaid should invest in paying high rates for nursing homes that are geared toward person-centered care (for instance, smaller or community-oriented homes).
- Expanding the budgets of nursing homes would make a significant difference in quality of care by improving training opportunities, increasing staff capacity, and providing homes with resources that support residents’ wellbeing.

What the public brings to the conversation:

People use consumerist thinking to conclude that quality nursing home care will only ever be available to the wealthy.

Throughout interviews, people spoke about health care in general—and nursing homes specifically—as a consumer good that is sold to the public. From this perspective, health care is a “product” and patients are “customers”; what one can afford determines how good their care will be. While we found that people were largely critical of this model of health care, they nonetheless appeared to accept it as “just the way things are” and seemed to have little faith that it would ever change.

Using this logic, the public tends to heavily focus on cost when thinking about nursing homes. They reason that there is a quality spectrum of nursing home care, with more expensive nursing homes providing better care and cheaper ones providing worse care. Any form of nursing home care that is publicly funded is assumed to be at the lowest end of this spectrum. In fact, public funding is almost universally seen as an indicator of low-quality care. While this understanding does in some ways overlap with how the field views nursing home prices and quality, the public takes for granted that health care will always be this way, and thus is not able to see that solutions are possible or even desirable.

Nursing homes are thought of as profit-seeking businesses.

In keeping with the viewpoint that health care is a consumer product, many participants explicitly described nursing homes as a “business” with a primary goal profiting off of its “customers.” From this perspective, nursing homes are more concerned with making money than providing high-quality care for residents. Using this logic, people concluded that nursing homes are often willing to cut corners if it means saving money, and that the lower a resident’s income, the less nursing home staff will be concerned with their wellbeing.

What this means for the field:

While the public understands that the cost of nursing homes can be prohibitive for many families, they have little hope that this can or will change. Thus, **they will likely have difficulty seeing how policy solutions can make high-quality nursing home care more accessible.** Additionally, the stigma associated with publicly funded nursing homes may make it difficult for people to understand how funding from the government can be part of the solution.

The perception that nursing homes are a “business” also threatens to **undermine perceptions of nursing homes as places that can support the holistic wellbeing of residents as human beings rather than customers.** Furthermore, this perspective entirely obscures the existence of nonprofit nursing homes.

Recommendations:

- **Focus on the steps for ensuring that nursing home care is financially accessible** in order to generate a greater sense of efficacy around solutions. For instance, explain the inadequacy of current programs and outline the changes that can and should be made to allow public funding to support long-term stays at high-quality homes.
- **Pair critiques of the current state of nursing home costs with solutions** to avoid reinforcing fatalism. Even if there are no easy or simple solutions to making nursing homes financially accessible, talking about actionable steps and outlining a plan is necessary to help combat the belief that nothing can be done.

Finding #6: The public does not see discrimination against nursing home staff as an issue, and while people have some capacity to reason about how discrimination may impact nursing home residents, their focus is interpersonal rather than structural.

What the field wants to communicate:

- Nursing homes with higher Black populations are more likely to experience low quality of care and have their Medicare programs terminated due to quality issues when compared to homes with higher proportions of white residents.⁹
- Residents of color experience consistent inequities in quality of care once they are in nursing homes, including not receiving timely care (from routine shots to hospitalization), and they self-report a lower quality of life.
- Women, people of color, and immigrants are disproportionately represented in the nursing home workforce. Racism, sexism, and xenophobia lead to the devaluation of direct care workers and their labor.

What the public brings to the conversation:

The public tends to assume discrimination is not a problem in nursing homes.

Generally, the public appears to have difficulty reasoning about the extent to which inequity exist in nursing homes, insisting that there is no reason to believe people would experience different outcomes or be treated differently on the basis of their identity. Across interviews, participants tended to resist the notion that racism, sexism, homophobia, and other forms of discrimination factor into residents' experiences in nursing homes. When directly asked about whether some factors (race, gender, etc.) might impact a resident's quality of care, participants mostly answered that this either would not happen or explicitly argued that any instance of discrimination would result from one individual "bad" or "biased" staff member mistreating a resident.

When it comes to nursing home staff, this pattern is even more pronounced. Most interview participants—even those who had been able to identify how nursing home residents might be impacted by discrimination—were not able to understand or explain how staff might face obstacles on the basis of their race, gender, socioeconomic status, and/or national origin (among other factors). Even when asked directly about staff experiences, participants would often continue talking about whether or not *residents* of minoritized backgrounds experience disparities in quality of care.

When the public thinks about discrimination, they tend to assume it happens between individual people rather than systemically.

To the extent that the public *does* recognize discrimination in nursing homes, they assume it is a rare person-to-person occurrence rather than something that is fundamentally built into the way nursing homes exist and operate. People would suggest that individual nurses and other staff members who harbor biases might treat residents unfairly, but that these instances are rare. The public thus tends to attribute all instances of discrimination to a few “bad apples” on staff who directly interact with residents.

The one exception in this pattern of thinking came when people spoke about nursing home residents with disabilities. Many participants were able to understand that nursing homes may not be set up to support residents with disabilities. In interviews, they speculated that staff may not “understand” how to support someone who had a “mobility issue” or “physical condition”. Of note, this reasoning was mostly applied to physical disabilities, and nonphysical disabilities were very rarely mentioned.

When thinking about how to address discrimination, people tend to focus on catching individual bad actors rather than instituting systemic, preventive reform.

Reasoning about discrimination as an interpersonal issue leads the public to think of solutions in terms of penalizing individuals rather than acknowledging and repairing systemic issues. For instance, a commonly suggested remedy was “increased oversight” and more “watchdogs” to keep an eye out for mistreatment. While this does at least indicate an ability to reason about the role of policy in nursing home care, it suggests a reactive rather than preventive solution. It also continually places blame on a few individuals rather than a system. If the focus is on catching isolated instances of abuse, people will likely struggle to understand the merit of broader and more proactive reforms, such as equitably distributing funding across nursing homes regardless of geographic location, implicit bias training for staff, altering the Medicaid reimbursement structure, and providing immigrant staff with the opportunity to obtain visas and a pathway to citizenship.

What this means for the field:

The public **has difficulty understanding that discrimination occurs beyond interpersonal interactions**, leading them to miss how racism, sexism, xenophobia, and other forms of bias impact nursing home residents and workers. This may cause people to lay disproportionate blame on staff who interact directly with residents (for example, nurses) and also leads them to miss the necessity of systemic reform.

The invisibility of discrimination against nursing home staff **poses a significant barrier to explaining how staff themselves can be impacted by systemic inequity and discrimination**, and will make it more difficult for the public to understand and support solutions, including policies that provide targeted support for some staff members (for example, immigrant or undocumented staff) or restructure federal funding in ways that would provide more reimbursement to direct care workers.

Recommendations:

- **Emphasize the structural nature of inequitable treatment beyond an individual resident's experience.** Explain that “discrimination” means more than interpersonal mistreatment. Rather, it means that the very way nursing homes are set up and their standard practices create consistently worse outcomes for some residents (residents of color, residents with first languages other than English, residents with disabilities, etc.) as well as members of staff. Provide examples of how specific policies and practices discriminate.
- **Connect individual instances of discrimination—which the public is able to understand—to broader patterns** that extend beyond just the staff who interact with nursing home residents on a day-to-day basis.

Endnotes

1. For the purposes of this project, “nursing home” refers to a live-in residence for people whose medical needs cannot be met by at-home care or assisted living. They can serve as long-term homes for older adults and people with disabilities or as short-term stays for people with rehabilitation needs.
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The John A. Hartford Foundation, based in New York City, is a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. For more than three decades, the organization has been the leader in building a field of experts in aging and testing and replicating innovative approaches to care. The Foundation has three areas of emphasis: creating agefriendly health systems, supporting family caregivers, and improving serious illness and end-of-life care. Working with its grantees, the Foundation strives to change the status quo and create a society where older adults can continue their vital contributions. For more information, visit johnahartford.org and follow [@johnahartford](https://twitter.com/johnahartford).

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March 2022

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FrameWorks Institute & The John A. Hartford Foundation. (2022). *Communicating about Nursing Home Care: Findings and Emerging Recommendations (a FrameWorks Strategic Brief)*. Washington, DC: FrameWorks Institute.

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