Institute for Healthcare Improvement

Enhancing Quality Improvement Adoption in US Nursing Homes

Innovation Report
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This IHI innovation project was conducted from July to September 2022.

IHI's innovation process seeks to research innovative ideas, assess their potential for advancing quality improvement, and bring them to action. The process includes time-bound learning cycles (typically 30, 60, or 90 days) to scan for innovative practices, test theories and new models, and synthesize the findings (in the form of the summary Innovation Report).

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Institute for Healthcare Improvement

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Executive Summary

The COVID-19 pandemic exacerbated and illuminated quality failings in nursing homes, persistent equity issues, and the system- and policy-level factors that contribute to their endurance. To begin seeking ways to address these issues, the Institute for Healthcare Improvement (IHI) conducted a 90-day innovation project to identify key activities to increase adoption of effective quality improvement practices in US nursing homes.

To inform the work, IHI conducted a literature scan focused on quality improvement in US nursing homes and the Quality Assurance and Performance Improvement (QAPI) program; 20+ expert interviews; and a site visit to one high-performing nursing home.

This report summarizes the research findings and presents some recommendations for organizations seeking to work with nursing homes to improve quality.

Intent and Aim

The intent of this 90-day innovation project (conducted from July to September 2022) was to develop a theory of change about activities needed to increase adoption of effective quality improvement (QI) practices in nursing homes in the United States. To inform the work, the Institute for Healthcare Improvement (IHI) conducted a literature scan focused on quality improvement in US nursing homes and the Quality Assurance and Performance Improvement (QAPI) program; 20+ expert interviews (see Appendix A); and a site visit to one high-performing nursing home.

The innovation project sought to research the following questions:

- How can QAPI implementation and QI practices be improved in nursing homes?
- Can nursing homes improve quality by focusing on culture, trust, and will?
- What workstreams, staffing models, and other practical elements are needed to operationalize a robust quality improvement program within nursing homes?

This report summarizes the research findings and presents some recommendations for organizations seeking to work with nursing homes to improve quality.

Background

In 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) convened a national, interprofessional committee that researched and then later published a consensus study on US nursing home quality and safety. The study makes wide-ranging recommendations for improving the quality of care in nursing homes, noting, “The COVID-19 pandemic ‘lifted the veil,’ revealing and amplifying long-existing shortcomings in nursing home care such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and

deficiencies that result in actual patient harm. The pandemic also highlighted nursing home residents' vulnerability and the pervasive ageism evident in undervaluing the lives of older adults."[1]

There is a sense of urgency surrounding improving nursing home quality, particularly since the COVID-19 pandemic has exacerbated and shed light on quality failings in nursing homes. Two of the seven goals outlined in the 2022 NASEM report specifically relate to nursing home quality, as excerpted in Table 1.

IHI has an opportunity to lend its voice and unique perspective to this arena. This 90-day innovation project builds on IHI's work in two national initiatives to improve quality of care in nursing homes: the AHRQ/Project ECHO National Nursing Home COVID-19 Action Network and the Age-Friendly Health Systems COVID-19 Rapid Response Network for Nursing Homes.

Table 1. NASEM Report Goals and Recommendations Related to Nursing Home Quality[1]

Goal 5: Design a More Effective and Responsive System of Quality Assurance
Recommendations 5A • Ensuring that state survey agencies have adequate capacity, organizational structure, and resources for their responsibilities including monitoring, investigation of complaints, and enforcement; • Refining, expanding, and publicly reporting oversight performance metrics of state survey agencies; and • Using existing strategies of enforcement when states consistently fall short of expected standards. 5B Developing and evaluating strategies to improve quality assurance efforts, including: • Enhanced data monitoring to track performance and triage inspections; • Oversight across a broader segment of poorly performing facilities; • Modified formal oversight activities for high-performing facilities, provided adequate safeguards are in place; and • Greater use of enforcement options beyond civil monetary penalties. 5C Increased funding for the Long-Term Care Ombudsman Program to: • Hire additional paid staff; • Train staff and volunteers; • Bolster programmatic infrastructure; • Make data on programs and activities publicly available; • Develop metrics to document the effectiveness of the programs; • Eliminate cross-state variation in capacity; and • Develop plans for collaboration with other relevant state-based entities. 5D • Implementing strengthened oversight across facilities with a common owner; and • Denying licensure and imposing enforcement actions on owners with a pattern of poor-quality care across facilities. 5E • Elimination of certificate-of-need requirements and construction moratoria.

Goal 6: Expand and Enhance Quality Measurement and Continuous Quality Improvement

Recommendations

6A and 6B

- Addition of measures to Care Compare related to:
  - Resident and family experience; and
  - Weekend staffing and staff turnover by role.
- Increased weight of staffing measures within the five-star composite rating;
- Facilitation of the ability to examine quality performance across facilities with common ownership or management company;
- Improvement in the validity of Minimum Data Set-based clinical quality; and
- Additional testing to improve differentiation in the five-star composite rating.

6C

Developing and adopting new measures for Care Compare related to:

- Palliative care and end-of-life care;
- Implementation of the resident's care plan;
- Receipt of care that aligns with resident's goals, and the attainment of those goals;
- Staff well-being and satisfaction;
- Psychosocial and behavioral health; and
- Various structural measures (e.g., health information technology adoption and interoperability, emergency preparedness and response, financial performance, staff employment arrangements).

6D

- An overall health equity strategy for nursing homes;
- A minimum data set to identify and describe disparities;
- Measures of disparities to be included in a national report card;
- Culturally tailored interventions and policies; and
- Strategies to identify the types and degree of disparities in order to prioritize when action is needed, and promising pathways to reduce or eliminate those disparities.

6E

Developing state-based, non-profit, confidential technical assistance programs with an ongoing and consistent focus on nursing homes that include:

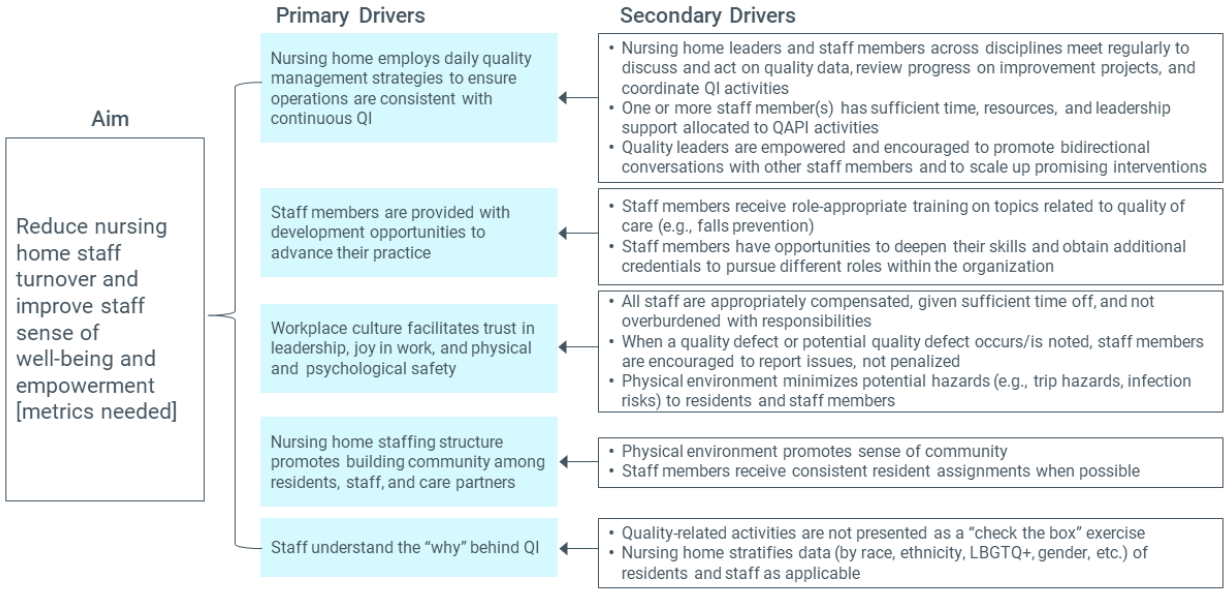
- Standards to promote comparable programs across states;
- Ongoing analysis and reporting of the effectiveness of services;
- Coordination with state surveyors and ombudsmen; and
- Partnerships with relevant academic institutions of higher education.

Results of the 90-Day Innovation Project

Theory of Change

Based on the literature scan and interviews with subject matter experts as part of this innovation project, IHI created a driver diagram representing the initial theory of change for factors that drive adoption of QI in nursing homes. The driver diagram was subsequently revised based on knowledge gained during the innovation project and the IHI research team's recommendation for the most practical aim (see Figure 1).

Figure 1. Theory of Change: Does Staff Well-Being Drive QI Adoption in Nursing Homes?



Existing QAPI Regulations and Daily Quality Management

An initial research question that the innovation project set out to answer was: In what ways are QAPI regulations counterproductive to QI activities in nursing homes? Interviewees, however, frequently stressed that the regulations are not directly contributing to the quality problem in nursing homes. On the contrary, prior to the nursing home industry being so highly regulated, it was more prone to care deficiencies. The QAPI regulations might be complicated and ripe for simplification, but the regulations themselves are not the main impediment to QI in nursing homes.

However, a consequence of a system that penalizes infractions rather than investigates them as potential learning opportunities can inadvertently result in what one interviewee provocatively termed a "surplus of safety." In essence, nursing home administrators and staff members are so focused on avoiding citations and safety risks that they make compromises when it comes to residents' sense of autonomy, well-being, and quality of life. This phenomenon also has implications for nursing home staff well-being.

Leadership and Culture Attributes

Engaged and empowered leadership and staff in addition to a robust and resilient culture of safety and inquiry are fundamental components for continuous QI in nursing homes. This commitment to developing and sustaining a transparent and quality improvement-oriented culture must be maintained even in times of crisis and constraint, when it might naturally be assumed that leadership, culture, and staff development should take a backseat to the pressing day-to-day demands. Several interviewees noted that times of strain are, in fact, the most critical moments to invest in organizational culture and staff development.

A 2022 article summarizing “positive deviant” leadership and staffing strategies in Missouri long-term care facilities drew a similar conclusion: “Leaders were persistent and consistent in their communication, making sure every staff member’s every question was answered. They were flexible with staff about time off for family needs and generous in supporting staff when they or their family had COVID-19. Caring for staff, going the extra mile to support them, and being flexible with staff’s situations generated reciprocity. Staff, in turn, took the extra shifts to cover for workmates and pitched in to make each day work. Leaders’ commitment generated staff’s commitment... When COVID-19 ravaged nursing homes, these positive deviants were already in a stable, positive place, unlike most of their counterparts. They all practiced transformational leadership styles, sound clinical approaches, and relationship building with staff. They stepped up during COVID-19 by heightening their practices, educating themselves, testing their leadership skills, and trusting their instincts so that they could ensure their residents were well cared for and the staff they worked alongside were safe.”[2]

Developing Staff, Building Community, and Emphasizing Why QI Matters

Interviewees also emphasized that nursing homes are already inundated with materials designed to help explain quality concepts and QAPI regulations; they aren’t looking for another toolkit or infographic. IHI also perceived a note of caution related to bringing a “what’s good for the goose is good for the gander” attitude to work with nursing homes — staff members tend to be wary of academics or consultants who arrive to “fix” an organization without acknowledging its particular challenges and strengths. One interviewee noted that nursing homes are often highly capable of “n of 1” interventions — staff members are skilled at identifying ways to innovate at the individual patient level. Where nursing homes struggle is scaling up those interventions to larger groups. Hospitals, by contrast, typically have the opposite challenge: starting small and then scaling up. Nursing homes frequently serve as long-term homes for residents, providing more time to build relationships with staff members. This relationship-building can contribute to more person-centered care, as staff members truly get to know residents with whom they interact on a regular basis.

Health Policy Impact

We cannot neglect the particular challenges facing nursing homes due to US health care system writ large and the health care policy landscape. Individual nursing home residents might well be impacted by social determinants of health and/or inefficient health care policies; for example, they might be transferred to a nursing home when they pose a financial risk to hospitals (which, being Medicare-covered, reimburse at higher rates than Medicaid-eligible nursing homes) or when they don’t have the support or means necessary to be cared for at home.

Recommendations

The recommendations, informed by the research and an updated theory of change, are intended to serve as guidance to organizations seeking to work with nursing homes to improve quality.

- Test ways to improve quality by building will, trust, and culture. Consider training programs that find a way to include Certified Nursing Assistants (CNAs), despite staffing challenges.
- Teach improvement through relevant nursing home-specific content. Make QI tangible and accessible by embedding methods like small tests of change into lesson plans related to clinical challenges that are specific to nursing homes (e.g., reducing antipsychotic use, pressure ulcers, falls). Be realistic about constraints on nursing home staff members' time and the need to maintain focus on practical improvements to daily workflow that immediately promote efficiency.
- Play to nursing homes' strengths. As discussed above, nursing home staff often excel at developing long-term interpersonal relationships with residents, given the nature of the care they provide. This introduces an opportunity to undertake QI in partnership with residents, families, and/or care partners.
- Explore partnerships with regulatory bodies such as the Centers for Medicare & Medicaid Services Division of Nursing Homes and/or the state survey system.

Conclusion

The physical, cultural, and regulatory structure of nursing homes today results in extremely high staff turnover and in some cases a "surplus of safety" for residents, at the expense of well-being, purpose, autonomy, and community for both. Enabling continuous quality improvement in nursing homes requires investing attention in leadership, culture, and consistent operations. Interventions in these areas will require intensive technical assistance and/or expert consultation — toolkits and general guidance documents are insufficient.

Appendix A: Expert Interviews

Name	Organization
Joelle Baehrend, MA	IHI
Paulo Borem, MD	IHI
Lisa Bridwell	Telligen
Rachel Broudy, MD	Ariadne Labs
Penny Cook, MSW	Pioneer Network
Jerald Cosey, HFA	American Senior Communities
Marla DeVries	The Green House Project
David Gifford, MD, MPH	American Health Care Association
Nell Griffin, EdM, CHC, CPHQ	Telligen
Kate Hilton, JD, MTS	IHI
Kevin Little, PhD	Informing Ecological Design, LLC
Joanne Lynn, MD, MA, MS	The George Washington University
Catherine Mather, MA	IHI
Mary Ousley, RN	PruittHealth
Jane Pederson, MD, MS	Stratis Health
Vibeke Rischel, RN, BA, MHSc	Danish Society for Patient Safety
JoAnne Reifsnyder, PhD, MBA, RN, FAAN	University of Maryland School of Nursing
Susan Ryan	The Green House Project
Tetyana Shippee, PhD, JD	University of Minnesota
Christina Southey, MSc	SoutheyC Consulting
Lynn Wilson, MS	IPRO
David G. Wolf, PhD, MSJ, MSOL	Lynn University College of Business and Management

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