



PROMOTING QUALITY IN NURSING HOMES: THE WELLSPRING MODEL

Susan Reinhard and Robyn Stone
Institute for the Future of Aging Services
American Association of Homes and Services for the Aging

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Introduction

The quest to improve the quality of care in the nation's 17,000 nursing homes is a continuous struggle. The last two years have produced an almost constant stream of congressional hearings, government reports, administration initiatives, media stories, and editorials about nursing home quality. Not since the late 1980s, when the Institute of Medicine issued its groundbreaking report and Congress enacted the nursing home improvement sections of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), has this kind of attention been focused on nursing homes. What sets the present debate apart is that it is occurring in a labor market so tight that many states report that they cannot hire or retain the staff they need to provide adequate care.

Success in improving the quality of nursing home care will require a combination of strategies. These include:

- developing and implementing model practice systems at the provider level;
- establishing quality assurance systems internal to nursing homes;
- strengthening nursing home staff;
- improving regulatory standards—through development of appropriate outcome measures, for example—and tightening their enforcement; and
- changing the Medicare and Medicaid reimbursement systems.

This report describes one nursing home–based initiative that is striving to improve quality through model clinical practice systems and changes to the prevailing culture in nursing homes. Preliminary evidence suggests that Wellspring Innovation Solutions, Inc., an initiative developed by an alliance of 11 nonprofit nursing homes in Wisconsin, offers a promising approach to improving the well-being of nursing home residents by improving care and reducing staff turnover. Before examining the core elements of the Wellspring model and their applicability to other nursing homes across the country, it is important first to lay out the key issues in nursing home quality and current research into quality improvement.

Issues in Nursing Home Quality

Concerns about the quality of nursing home care and ineffective government regulation of facilities date back at least 30 years. OBRA '87 raised quality-of-care standards for homes that participate in Medicare and Medicaid and strengthened federal and state oversight. Following the law's implementation, several studies found evidence of improvement in nursing home care, including a decline in the use of physical and chemical restraints, reduced prevalence of dehydration and pressure ulcers, and less frequent use of catheters.¹

Despite these improvements, studies indicate that many nursing homes continue to provide inadequate care. The U.S. General Accounting Office has found that one-fourth of nursing facilities have serious deficiencies that have caused actual harm to residents or placed their health and safety at risk. Many of these homes have had repeated serious deficiencies.² Even when problems were identified, state and federal enforcement policies were not effective in ensuring that they were corrected and remained corrected.

There is growing awareness among nursing home directors, state and federal regulators, consumer advocates, and others that staff shortages and insufficient staff training are at the root of the problem.³ High turnover in nursing home staff—currently at 40 to 75 percent nationally and as high as 500 percent in certain facilities—makes it difficult to attract, train, and retain an adequate workforce.⁴ Staff turnover among certified nursing assistants (CNAs), who are at the front lines of nursing home care, is particularly detrimental to overall quality of care.⁵ Instability in the CNA workforce means that residents are constantly receiving care from new people who often lack experience and knowledge of individual residents. In such an environment, continuity of care is compromised. The cost of training new staff, moreover, drains resources from resident care.

Low pay and hard work have always been obstacles to hiring and retaining qualified staff in nursing homes. Near-full employment and stiff competition for entry-level workers in the last decade have exacerbated the situation. With far less physically demanding and less emotionally draining jobs in plentiful supply, the job of nursing assistant has limited appeal.

Even with future downturns in the economy, the challenge of improving quality of care and staff retention will undoubtedly grow as the U.S. population ages. The anticipated five-fold increase in the proportion of the population age 85 and older in the next 30 years indicates soaring demand for long-term care down the road. At the same time, there will be fewer workers to meet the needs of the disabled elderly population.

Without significant changes in employee incentives and the work environment, nursing homes will continue to encounter difficulties in recruiting and retaining committed paraprofessionals.

Research in Quality and Workforce

Nursing home quality has a number of components that interact to affect residents' health, functional status, and quality of life. Over the past 20 years, researchers have attempted to understand better how policy (i.e., regulation and reimbursement), clinical interventions, management practices, and individual worker, resident, and family characteristics account for variation in nursing home quality. While the literature is equivocal on the relative impact of each of these domains, clinical and management practices appear to be most responsible for the outcomes experienced by nursing home residents.⁶

There have been a plethora of small studies assessing the impact of specific clinical interventions in the nursing home setting. Research has demonstrated the efficacy of a range of clinical practices in treating or preventing major conditions associated with quality problems, including urinary incontinence, malnutrition and dehydration, pressure ulcers, falls, and depression.⁷ Much of the literature has focused on interventions specifically targeted to the needs of residents with Alzheimer's disease or related dementias.⁸ Clinical guidelines produced by the Agency for Healthcare Research and Quality and professional organizations are available to help providers improve practice in nursing homes.

The research suggests, however, that effective implementation of good clinical practice requires an ongoing commitment on the part of providers and their staff to use the knowledge and tools that have been developed in the field. Several studies have demonstrated that the successes of clinical interventions observed in a research experiment are short-lived if they are not adopted by the provider organization and integrated into daily practice. It is not enough to have research-based clinical guidelines. There has to be a strong management structure and approach that ensures that these guidelines and clinical interventions are implemented on a daily basis on the front-line of care.

Research into the relationship between quality and organizational or workforce factors has been largely anecdotal. Most of this work has simply described various management or job redesign efforts, training activities, and financial and nonmonetary reward programs. A few empirically based studies, however, have identified several important factors related to staff satisfaction and lower turnover rates. In an early study of several nonprofit nursing homes in Philadelphia, Waxman and colleagues found that the strongest predictor of lower turnover rates was the organization's management style.⁹

Nursing home employees who were given greater autonomy expressed more job satisfaction and were more likely to remain at the facility.

In the most ambitious study to date, Banaszak-Holl and Himes looked at factors determining turnover among certified nursing assistants in 254 facilities in metropolitan areas of 10 states.¹⁰ The authors examined the effect of intrinsic rewards such as job satisfaction and sense of belonging, and extrinsic rewards such as wages and benefits. The elements of job design, including the extent of CNA involvement in resident care planning and assessment, in-house training, and workload, were also examined. Finally, the study looked at ownership status (commercial, nonprofit, or public), average number of beds, proportion of residents insured by Medicaid, and strength of local economy.

Not surprisingly, Banaszak-Holl and Himes found that local economic conditions had the strongest positive effects on turnover rates. But one of the most important findings was that nursing homes in which mid-level managers were receptive to their nursing assistants' advice, or at least discussed care plans with aides, reported turnover rates one-third lower than in nursing homes without this management philosophy. Furthermore, homes where CNAs were involved in the care plan meetings experienced turnover rates 50 percent below those of other facilities. Turnover rates were not affected, however, by greater CNA involvement in resident assessments.

The researchers conjectured that CNA involvement in care planning meetings might give aides a greater sense of responsibility for and authority over actual resident care. Simply involving CNAs in resident assessments is not sufficient. The frontline workers must be able to observe a direct link between the information they provide on residents and the subsequent tasks undertaken. The study underscores the importance of formal communication channels between management and paraprofessional staff and the value of group problem-solving.

Other studies have underscored the importance of including CNAs in care planning and demonstrating the link between interventions and resident outcomes. Schnelle and colleagues, for example, developed and evaluated the effects of a clinical, data-driven incontinence reduction program in eight nursing homes.¹¹ The CNAs were trained in reducing incontinence in their residents and were involved in both data analysis and ongoing program management. They were able to track their own successes and failures in alleviating incontinence in those residents for whom they were responsible. The study found that in seven of the eight facilities, residents experienced significant increases in dryness and maintained this improvement for a six-month period.

McMallion and colleagues, meanwhile, developed a nursing assistant communication skills program to help improve the care of residents with dementia.¹² The researchers observed a significant improvement in the well-being of residents who were cared for by the CNAs participating in the program. They also observed a reduction in turnover rates among the CNAs who had received training. These CNAs reported feeling more empowered and better able to communicate with the residents in their charge.

Given the challenges of addressing quality-of-care and workforce issues in nursing homes, it is crucial to examine systematically models that can work in the real world. Those that combine effective practices identified in research studies with tested quality-improvement methods used in business and industry can offer new opportunities to change the way care is delivered to residents.

Continuous Quality Improvement

The systematic search for quality improvement is well documented in the Total Quality Management and Continuous Quality Improvement movements.¹³ The health care industry discovered the quality improvement framework in the late 1980s, when providers began to base quality-improvement efforts on the systematic collection and analysis of clinical data and the application of tools and processes to change delivery and outcomes of care. Most initiatives were developed in acute care settings; much less attention was directed to organizations providing long-term care. Many nursing home managers and clinicians now recognize the quality paradigm,¹⁴ but large-scale implementation of policies and programs that would radically transform organizational culture has not yet occurred.¹⁵

The individual worker is fundamental to the quality-improvement paradigm. Staff at each level of an organization must understand the processes that relate to specific outcomes the organization values—that is, all members need to see how their work affects the end products. Quality improves when employees understand the data used to measure outcomes, are able to make necessary changes in the way they perform their jobs, and can reexamine data to see if their changes have made a difference.¹⁶ Critical to the quality-improvement paradigm is an organizational culture that stresses staff involvement in quality monitoring and empowers staff to alter work activities as needed.

The Wellspring Model

While there is a dearth of literature addressing quality improvement in nursing homes, some providers are putting the ideas discussed above into action. One example comes from Wisconsin, where an alliance of 11 nonprofit nursing homes has initiated a quality-improvement model known as Wellspring Innovative Solutions, Inc. Founded in 1994 to

position its members within an increasingly competitive health care environment, the alliance aims to ensure that its members use best practices to deliver high-quality care at an affordable price. Wellspring operates under the assumption that providing excellent care is cost-effective, and that an initial investment in setting up a data-driven quality-improvement system will benefit member nursing homes in the long run. For the past six years, Wellspring facilities have been collaborating with one another to create an organizational culture dedicated to resident-centered care. According to their own data analysis, Wellspring members have made substantial progress in improving quality, training and retaining staff, and redirecting resources to care-related activities.

The 11 facilities in the Wellspring consortium differ somewhat from other nursing homes in Wisconsin. The Wellspring homes are slightly larger than the other Wisconsin facilities, the percentage of private-pay residents in the Wellspring homes is higher than other facilities in the state, and they have a lower percentage of residents whose care is covered by Medicare.

The Wellspring model has six core elements (see Table 1). First is the formation of an alliance of nursing homes whose top management makes quality of resident care a daily priority. In launching their collaboration, the chief executive officers of each of the 11 independent nursing homes formed a board of directors and contributed to the alliance's overall costs, including the salaries of an executive director and a geriatric nurse practitioner (GNP), staff training expenses, and data analysis. The program's developers believe an alliance of three to 12 nursing homes is critical to successful implementation.

Table 1
The Wellspring Model of Quality Improvement: Six Key Elements

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- An alliance of nursing homes with top management committed to making quality of resident care a top priority
 - Shared services of a geriatric nurse practitioner (GNP), who develops training materials and teaches staff at each nursing home how to apply nationally recognized clinical guidelines
 - Interdisciplinary "care resource teams" that receive training in a specific area of care and are responsible for teaching other staff at their respective facilities
 - Involvement of all departments within the facility and networking among staff across facilities to share what works and what does not work on a practical level
 - Empowerment of all nursing home staff to make decisions that affect the quality of resident care and the work environment
 - Continuous reviews by CEOs and all staff of performance data on resident outcomes and environmental factors relative to other nursing homes in the Wellspring alliance
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All Wellspring facilities implement the program's fundamental components. Nevertheless, each facility maintains its independence and has some unique features, such as innovative architectural designs, creative use of recreational programming to include community-dwelling residents, and integration of plants and pets into the nursing home environment and resident life.

The most important shared resource is the GNP, who conducts staff training and oversees the application of nationally recognized clinical guidelines in seven areas: physical assessment, elimination/continence, behavior management, skin care, accident prevention/restraint reduction, restorative care, and nutrition. An eighth module on management has been added to the Wellspring program to help management staff in all departments learn to adopt a coaching and mentoring style that is consistent with empowering frontline staff.

Under the leadership of the GNP, staff training starts with a two-day off-site session on one of the seven areas for "care resource teams" made up of various staff members from each of the 11 facilities. Nursing assistants play a prominent role in these interdisciplinary care resource teams, which also include dietitians, activity specialists, housekeeping, and other departmental staff. A nurse coordinator participates in all of the clinical modules and serves as the daily coach in implementing them.

During the training session, the care resource teams learn how to assess residents, collect data, apply clinical practices, audit the care they give, and develop an organizational plan for how they will bring back what the teams have learned to the other staff at their facilities. The GNP visits each facility three months later to reinforce what the teams have learned, and conducts a one-day workshop for team members six months after the initial training. Staff are able to network across facilities to share information about what works and what does not work in their daily practice. The training process, schedule, and networking are repeated for each of the eight clinical and management areas, with different care resource teams formed for each. The GNP is also available for emergency troubleshooting. This follow-up and reinforcement appear to be essential in changing the practice of staff.

The Wellspring model is particularly compelling because of its attention to the day-to-day work of frontline staff, particularly the CNAs. The stated philosophy is that top management sets policies for quality, and the workers who know the residents best decide how to implement those policies. All employees participate in decisions that affect their work and the care of the residents they serve. For example, frontline workers may be

given the authority to decide which bathtub to purchase within budget guidelines, or how best to alert other staff about residents who are prone to falls without embarrassing such residents. Staff members have permanent assignments so that they really get to know residents with whom they work on a daily basis. In some facilities, staff are able to work with their peers to create schedules that accommodate individual preferences for time off.

Care resource teams collect and use data to assess and compare resident outcomes within and across Wellspring facilities. This data-sharing appears to foster a degree of healthy competition as well as pride in the care provided. It also encourages staff to think critically.

Continuous review of performance data on resident outcomes and environmental factors related to those outcomes is at the core of the Wellspring model. All staff are involved in this review, and data are reported and compared across the 11 facilities. The CEOs, directors of nursing, nursing care coordinators, and GNP meet quarterly to share and review each facility's clinical and environmental data, learn from each other's successes and failures, and share resources to support significant quality-improvement activities. No other examples of this kind of multiorganizational focus on continuous clinical outcome evaluation can be found in the literature.

The Wellspring Model at Work

During site visits to several Wellspring facilities, staff described how they use data about falls and urinary incontinence to change their practice, and how management allows them to make decisions that result in better resident outcomes. While comparing incidence data on falls in Wellspring facilities, management discovered that one facility had a higher rate than others and started to search for factors that might explain the difference. When the information was shared with staff, including CNAs, one aide noted that falls occurred most often in the late afternoon on one side of the building. It appeared that the sun's glare was blinding residents, making them more prone to falls. The solution? Lower the blinds around sunset. According to the facility's data analysis, this simple action immediately led to fewer falls.

Evaluating the Wellspring Model

Preliminary empirical evidence suggests that the Wellspring model may be producing improvements in quality. Yet because it is a multifaceted approach, implementation is not easy, according to top management. Aside from initial start-up costs in hiring the GNP and developing data systems and training programs, there can be "psychic costs" associated with broad organizational change. Mid-management nurses and staff who are accustomed to a certain level of authority can sometimes be stumbling blocks to creating an

environment in which CNAs and other front-line staff have a more substantive role in resident care and purchasing decisions.

With support from The Commonwealth Fund, an evaluation of the Wellspring model is currently being conducted by a team of nationally recognized experts in long-term care led by the Institute for the Future of Aging Services at the American Association of Homes and Services for the Aging in Washington, D.C. This research team will delineate the component parts and quantify the potential effects on resident outcomes, resident satisfaction, employee satisfaction, and facility finances. The work will examine how the model operates in each facility and consider whether any demonstrated success is tied to the uniqueness of these facilities. The most important question will be the extent to which the Wellspring approach can be replicated with diverse populations of nursing home residents and workers.

Even without a formal evaluation, providers in several parts of the country are convinced that Wellspring offers a practical way to improve resident care, and they are interested in replicating the model.

Summary

Success in improving the quality of nursing home care will come not from one strategy but from a combination of strategies. The Wellspring model offers a promising approach that addresses the need for improved clinical practices as well as a strengthened frontline workforce.

More information about the Wellspring approach is available online at www.wellspringis.org, or by calling 920/833-1833. For information about the Wellspring evaluation, please contact the authors at 202/508-1207 (Susan Reinhard) or 202/508-1206 (Robyn Stone).

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#386 *Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment* (June 2000). Sarah Greene Burger, Jeanie Kayser-Jones, and Julie Prince Bell, National Citizens' Coalition for Nursing Home Reform. In this report, the authors describe the high rates of malnutrition and dehydration that occur in U.S. nursing homes, then suggest ways these rates could be reduced.

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#348 *Long-Term Care in New York: Innovation in Care for Elderly and Disabled People* (September 1999). Susan Raetzman and Susan Joseph. This issue brief reviews the programs New York has established to improve the delivery and effectiveness of care to New Yorkers with long-term care needs.

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#284 *Facts on Medicare's Home Health Benefit and Recent Policy Changes* (June 1998). Harriet L. Komisar and Judith Feder, Georgetown University Institute for Health Care Research and Policy. This fact sheet examines the effect of the Balanced Budget Act of 1997 on the provision of home health care under Medicare.

#283 *Repeal of the Boren Amendment: Potential Implications for Long-Term Care* (June 1998). Barbara Bolling Manard and Judith Feder, Georgetown University Institute for Health Care Research and Policy. This policy brief analyzes how repeal of the Boren Amendment—a provision of the Medicaid program that established federal rules for states' payments to nursing facilities, hospitals, and other institutions—may affect access to and quality of care for elderly and disabled Medicaid beneficiaries.

NOTES

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