Nursing Homes: Introduction

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Nursing homes (NHs) provide one of the most dynamic practice settings available to clinicians today. In the last 20 years, NHs have evolved from providing custodial care to a blend of caregiving and sub-acute or post-hospitalization rehabilitation care. In decades past, nursing homes offered a common retirement path for physicians. Now, more—although not nearly enough—physicians are choosing a practice focusing on nursing home care early in their careers. Unlike a few decades ago, specialized education exists for nursing home care and management. With the increasing complexity of residents, NH staff deliver a more sophisticated and broader array of services meeting ever higher quality standards.

The evolution of NH services has proceeded in lockstep with regulation. Regulatory oversight has framed standards for care at the state and national levels, while payment for services has followed the lead of hospital care for the segment of patients using skilled services in the NH setting. Interestingly, even though the motivation for high quality care in these settings is great, the regulatory burden is high and not particularly conducive to creative reform. Instead, at the close of this last millennium, the process of reform has tended to be reactive to the regulatory process rather than proactive, and restrictive and system-centered rather than embracing individual-centered care.

Meanwhile, hospitals’ successful quality improvement movement serves as an example for a second-generation quality improvement initiative in NHs. This work began as part of Centers for Medicare and Medicaid Services (CMS) 7th Scope of Work (SOW). CMS first mandated a reporting system to try to capture quality of care under the “minimum data set” (MDS). Next, they funded the 53 state quality improvement organizations (QIOs) to add NH quality to their work, and reach out to the greater of 30 or 10% of NHs in each state to directly participate in the QIO programs. Quality Partners of Rhode Island (QPRI) and collaborators at Brown University lead the national QIO Support Center (QIOSC) for this effort. The Support Center was started under the leadership of David Gifford, MD, MPH, currently Director of the Health Department for RI. The MDS provided a key measurement tool. Measurable successes in the areas of focus have been demonstrated, especially in the management of pain and reduction in use of restraints. An important lesson of the 7th SOW was that quality improvement requires effective changes at the management level, as well as at the resident care level. In other words, the culture of care and management is important to clinical outcomes. The 8th SOW includes assessments of depression, pain, restraints, pressure sores, as well as measures not captured by the MDS, including satisfaction of staff, residents and their families, and NH staff turnover.

CMS this past September raised the bar again for quality measures by launching the “Advancing Excellence in America’s Nursing Homes” campaign. This program enlists NHs to volunteer in setting improvement goals. As an “un-funded mandate,” now almost 10% (1400) of the nation’s long-term care facilities have enrolled, and continue to enroll at a steady rate since the September launch. One of the successes associated with enrollment is the recognition by these individual facilities that quality care ultimately costs them less rather than more resources, and the campaign and QIOSC provide support through the Local Area Networks for Excellence (LANES). Many of the LANE “convenors” happen to be the state QIOs, and for Rhode Island this is again led by the QPRI team which continues as the state QIO and national NH QIOSC. Physicians, facility staff, trade associations, facility residents and their families also have the opportunity to individually sign on and become informed, but the Campaign is really targeted for facility leadership and facilities to sign on and commit (www.nhqualitycampaign.org). NH “commitment” means individually setting targets for improvement, and to learn and implement changes, facilitated through use of the linked educational resources, and tracking these over time. There is no regulatory hazard for failing to achieve targets and reporting is anonymous (i.e., success is reported in aggregate), which should motivate facilities to set their targets to try to achieve these results, and not be left behind by the national movement.

We have learned from the past decade that as quality care improves in NHs, the setting provides an ever better practice environment for all levels of providers - from the bedside care given by certified nursing assistants to midlevel providers, physicians, and administrators. As the environment and process of care improve, so does the high rate of staff turnover that plagues the NH industry. Even better, the people who live in these facilities and their families are getting increasingly personal care that is less invasive, safer, and focused on quality at all levels. You will enjoy the articles in this issue. They address the challenges but also the revolution of quality care, regulation and finance. You will learn where and how to educate yourself to provide the care you would expect for yourself, and the barriers and opportunities to achieve that level of quality.

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Stefan Gravenstein, MD, Consultant: Amgen, Orthobiotech, Merck, Protein Sciences, Glaxo-Smith Kline, SanofiAventis, Diagnostic Hybrids, NIH, American Medical Directors Association, Quality Partners of Rhode Island.