JAMDA 24 (2023) 581–582

JAMDA

journal homepage: www.jamda.com

Editorial

Handling With Care: Attending to Staff Burdens in Implementation of Quality of Care Initiatives in Nursing Homes

Arif Nazir MD, CMD *, Paul R. Katz MD, CMD

Department of Geriatrics, Florida State University, College of Medicine, Tallahassee, FL, USA

Despite repeated calls for improving the quality of care in nursing homes (NHs) over the past several decades, progress remains slow and at times erratic. Although funding and staff recruitment, training, and retention at times appear to be intractable challenges, we believe that our current approach to clinical quality improvement (QI) is also seriously flawed.

Most NHs continue to adhere rigorously to the established, onerous, and ever-changing regulatory standards that mostly represent an outdated carrot and stick approach to QI. Many of the regulations usurp precious resources, distract from person-centered needs, and exacerbate staff burdens, putting to question the value of these standards.[1,2] Beyond the regulatory structures, policy makers and other advocates have offered other strategies to improve quality of care, but their impact has been questionable, both on quality and staff workload. For example, the much awaited report from the Medicare Payment Advisory Commission in June 2021 showed that the Centers for Medicare & Medicaid Services (CMS) investment into the value-based purchasing program, which required many resources and considerable staff time, was deeply flawed and did not help improve quality.[3] Similarly, the impact of the CMS campaign to counter the use of antipsychotics for residents with dementia that took a lot of staff time and focus has been questionable at best.[4] In the editorial that follows, we contend that QI approaches in NHs need to be turned on their head by accounting for staff burdens and organizational readiness to change while taking lessons from implementation science and pragmatically designed trials.

A recent report by the Nursing Home Quality Committee of the National Academies of Sciences, Engineering, and Medicine (NASEM), in an attempt to implement good quality of care approaches, puts forth a set of familiar recommendations.[5] Although laudable, it is unclear how meaningful change will occur given similar efforts in the past and in the current context of significant workforce and financial constraints. Possibly overstated, but such efforts bring to mind Einstein's definition of insanity—doing the same thing but expecting different results.

Despite these challenges, we recognize and applaud several recent efforts to improve clinical quality. Some of these include an increase in NH telehealth utilization, clarification of the infection preventionist role in NHs while strengthening infection control monitoring and reporting processes, and attempts to automate resident monitoring using remote technologies. These changes are expected to improve quality but will likely add to the staff burdens.

NHs represent complex adaptive systems where staff are continuously exposed to and respond to unpredictable and burdensome scenarios, making many "rational" interventions unimpactful and unsustainable.[6] For example, not receiving clear discharge instructions from a hospital for a new patient add significant and unpredictable strain on the staff. Similarly, Internet outages, which happen frequently in rural settings, often add barriers in compliance to electronic health record–driven protocols. Hence, it is not a surprise that NH quality initiatives face several uphill challenges and that many well-designed interventions fail to show sustained results.

The lack of significant impact of apparently rational and well-designed interventions such as the INTERACT program and the SMART campaign demonstrate that initiatives that need to add to or modify workflows for already stretched staff may not result in a sustained benefit. Neither the randomized trial of the INTERACT program, aimed to guide staff to lead collaborative interventions to prevent avoidable hospital transfers, nor the SMART campaign, a state-level initiative designed to add deprescribing interventions to workflow of the staff, reached statistical significance for impact.[7,8]

Researchers for the above-mentioned interventions and others often cite NH operations and staff-related causes for lack of an impact. Such explanations (eg, lack of staff engagement, NH leadership instability, staff's noncompliance with protocols or inadequate staffing) inadvertently present the operational and clinical staff in a negative light. With so much at stake for us to succeed in QI initiatives, it is critical that we seek better understanding of NH implementation challenges, particularly in the context of staff burdens, so we can aim to address them in a more collaborative way.

We propose, first and foremost, to be cautious before simply assigning the blame for failure for a sustained impact to the overstretched staff. The NH setting already receives an unfair share of negativity in the lay media.[9] Second, we need to learn from our consistent failures and rethink future QI interventions, using the lessons from implementation science and pragmatic design. For example, "Agile implementation" promotes a pragmatic approach by emphasizing an understanding of the unique culture and diversity of a setting before instituting a system-level change. The approach recommends a loop of "sprints" and evaluations in order to create "minimally standardized procedures" that have in-built flexibilities

The authors declare no conflicts of interest.

* Address correspondence to Arif Nazir, MD, CMD, BrightSpring Health, Louisville, KY 40222, USA.

E-mail address: anazir@shcmedicalpartners.com (A. Nazir).

https://doi.org/10.1016/j.jamda.2023.03.025

Table 1
Recommendations to Improve Pragmatic Trials and Achieve Evidence-Based Change in Long-Term Care Practice and Policy: Revamp, Respond, Reframe, Reach

Revamp the academic mindset and enterprise	• Develop practice-based evidence • Change the academic mindset and academic process to one of quality • Maximize nimble funding opportunities
Respond to what is known about content and process	• Draw from existing knowledge regarding the topic in the context of implementation • Think systemically when implementing a new intervention • Build the knowledge base related to the topic in the context of implementation
Reframe the partnership paradigm	• Be purposeful in identifying partners • Begin the collaboration before the proposal is written • Collaborate to change care practices that are not pragmatic
Reach 3 key parties toward 3 key goals when communicating	• Communicate to organizations to change care • Communicate to the public to drive awareness and create urgency • Communicate to academics to promote science

responsive to staff needs. One team used this approach to enhance the adoption of person-centered processes in a large NH. The team showed success by focusing on iterative approaches to improve the uptick of the processes and to include staff and resident preferences in each iterative phase.[10]

The value of agile methodologies and pragmatic designs that incorporate ongoing iterations in any implementation process based on feedback from those that are impacted were highlighted in the proceedings and recommendations from a recent comprehensive seminar on meaningful pragmatic trials. The seminar put forth an excellent overview of NH implementation challenges and provided recommendations for the adoption and sustaining of a change in the real world[11-13] (Table 1).

As physician leaders experienced in NH implementation (successful and failed), we support these recommendations and urge researchers and policy makers dedicated to NH QI to help usher in a new era of QI that accounts for staff burdens and organizational readiness.

We envision that this new era will be different in several ways. In this era, we will transition from implementing evidence-based medicine to *practice-based evidence*, turning the QI model on its head. Instead of emerging from academic centers, research ideas will emerge from seemingly impactful outside-the-box concepts that are already implemented, for example, the Green House project.[14] This new era will set a precedence of adequate funding for the staff engaged in implementation, not just relying on gift cards or "champion" labels for reimbursing the overstretched staff and operational teams. Finally, formal assessment of the organizational readiness will be the norm in this new era. Such an assessment before starting a quality initiative, and then repeating it periodically, is a must to ensure that the QI efforts are not counterproductive.[15] If urgent interventions are needed to address serious quality issues for NHs that may not be ready for drastic change, external resources could be deployed with great results, as was seen with the deployment of strike teams during the pandemic in many states.[16]

Several efforts are already providing a glimpse of a more collaborative future for NH implementation efforts. Most notable include efforts by the Moving Forward Quality Coalition whose main objective is to oversee implementation of highest priority recommendations from the NASEM report. The Coalition is already engaging multiple stakeholders, particularly frontline operational and clinical leaders and patients and families, to come up with pragmatic solutions.[17] Also, notable is the Moving Needles initiative, a 5-year cooperative agreement between AMDA—The Society for Post-Acute and Long-Term Care Medicine and the Centers for Disease Control and Prevention.[18] The initiative is working with frontline staff in a handful of NHs to understand the barriers staff face for successful vaccinations and are very cautiously coming up with efficient workflows to address them.

We are in exciting times when there is exceptional motivation to transform care in the NH settings. But we need to remember that any change will burden staff, risking a decline in quality, and amplify staff shortages. It is crucial that implementation scientists partner closely with operational and clinical leaders in the frontlines to ensure that well-meaning interventions are designed with extreme attention to staff burdens. Let us together commit to the era of new implementation.

References

1. Nazir A, Steinberg K, Wasserman M, et al. Time for an upgrade in the nursing home survey process: a position statement from the Society for Post-Acute and Long-Term Care Medicine. *J Am Med Dir Assoc*. 2020;21:1818–1820.
2. Marek KD, Rantz MJ, Fagin CM, Krejci JW. OBRA '87: Has It Resulted in Positive Change in Nursing Homes? *J Gerontol Nurs*. 1996;22:32–40.
3. MedPac. Evaluating the skilled nursing facility value-based purchasing program (June 2021). Accessed March 17, 2023. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch4_medpac_report_to_congress_sec.pdf
4. When less is more, but still not enough: why focusing on limiting antipsychotics in people with dementia is the wrong policy imperative. *J Am Med Dir Assoc*. 2019;20:1074–1079.
5. National Academies. The National Imperative to Improve Nursing Home Quality Honoring Our Commitment to Residents, Families, and Staff (2022). Accessed March 15, 2023. https://www.nationalacademies.org/our-work/the-quality-of-care-in-nursing-homes
6. Nazir A, Arling G, Katz PR. Incentivizing nursing home quality and physician performance. *J Am Med Dir Assoc*. 2012;13:91–93.
7. Kane RL, Huckfeldt P, Tappen R, et al. Effects of an intervention to reduce hospitalizations from nursing homes: a randomized implementation trial of the INTERACT program. *JAMA Intern Med*. 2017;177:1257–1264.
8. Abrahamson K, Unroe K, Lieb K, et al. Lessons Learned From Implementation of the Indiana SMART Campaign to Reduce Nursing Home Polypharmacy. *J Am Med Dir Assoc*. 2020;21:140–141.
9. Nazir A, Zimmerman S, Meyer ML. No one cares when planes don't crash: the message for long-term care. *J Am Med Dir Assoc*. 2019;20:583–585.
10. Abbott KM, Hulshult A, Eshraghi K, et al. Applying agile methodology to re-engineer the delivery of person-centered care in a nursing home: a case study. *J Am Med Dir Assoc*. 2022;23:1442–1447.
11. Resnick B, Zimmerman S, Gaugler J, et al. Pragmatic trials in long-term care: research challenges and potential solutions in relation to key areas of care. *J Am Med Dir Assoc*. 2022;23:330–338.
12. Levy C, Zimmerman S, Mor V, et al. Pragmatic Trials in Long-Term Care: Implementation and Dissemination Challenges and Opportunities. *J Am Geriatr Soc*. 2022;23:339–344. Also published in: Journal of the American Medical Directors Association; and Geriatric Nursing.
13. Zimmerman S, Resnick B, Ouslander J, et al. Pragmatic trials and improving long-term care: Recommendations from a national institutes of health conference. *Geriatr Nurs*. 2022;44:288–292.
14. Zimmerman S, Resnick B, Ouslander J, et al. Pragmatic trials and improving long-term care: Recommendations from a national institutes of health conference. *J Am Med Dir Assoc*. 2022;23:323–327.
15. Levy C, Au D, Ozkaynak M. Innovation and Quality Improvement: Safe or Sabotage in Nursing Homes? *J Am Med Dir Assoc*. 2021;22:1670–1671.
16. CMS.gov. Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19 (July 2020). Accessed February 10, 2023. https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19
17. Moving Forward Nursing Home Quality Coalition. Accessed March 16, 2023. https://movingforwardcoalition.org/
18. Moving Needles A CDC Funded Initiative. Accessed March 18, 2023. https://movingneedles.org/about/