

SYNOPSIS ➤ Quality Improvement Organizations (QIOs) are private organizations that contract with the federal government's Centers for Medicare and Medicaid Services (CMS) to improve care quality in nursing homes, home health care agencies, and other health care organizations. While their focus has traditionally been strictly clinical, many QIOs are amending their approach in nursing homes, encouraging organizational and management practices that support direct-care workers and other caregiving staff. This issue brief describes how and why QIOs are altering their tactics, becoming potential partners for others working to improve care quality in long-term care by improving the quality of direct-care jobs.

Quality Improvement Organizations: Recognizing Direct-Care Workers' Role in Nursing Home Quality Improvement

As project director for long-term care at MPRO, Michigan's Quality Improvement Organization (QIO), Renee Beniak is charged with helping long-term care providers improve their performance on publicly reported clinical outcomes measures. Initially she concentrated on disseminating clinical guidelines and best practices information, but her experiences led her to believe that more was needed.

"I have become more and more convinced over the last year or so that, as a QIO, just focusing on the clinical side is not sufficient," says Beniak. "If we're going to make a transformational change in complex situations like residents developing pressure sores, we need to include culture change as well. The whole organization has to get involved in making an improvement."

The key to effective quality improvement in nursing homes, Beniak says, is involving certified nursing assistants (CNAs). "You can make what you think is the absolute best plan in the manager's office, but frontline workers are the ones that can tell you if your plan has even a chance of working," she says. "It seems much wiser to get them involved up front rather than issuing a memo and telling them, 'You must fit into this slot.'"



Renee Beniak

In their initial long-term care work, as in their work with hospitals and doctors' offices, QIOs worked primarily with physicians and licensed nurses to improve clinical practices. That remains the emphasis in their home health initiative, for which QIOs train agency staff on how to implement outcomes-based quality improvement methods.

In nursing homes, however, QIOs have found that clinical practices such as pressure ulcer reduction and pain management cannot be significantly improved without the involvement of the CNAs who provide the great majority of the hands-on care.

THE ABCs OF QIOs

There is a QIO for each of the 50 states as well as the District of Columbia, Puerto Rico, and the Virgin Islands. All help various federal and private clients monitor and improve the quality of the health care they deliver. Their biggest client is Medicare.

CREDITS: This issue brief was written by Elise Nakhnikian, Communications Specialist for the Paraprofessional Healthcare Institute (PHI). It was edited by Debra J. Lipson, Deputy Director of Better Jobs Better Care, at the Institute for the Future of Aging Services, and by Karen Kahn, PHI's Communications Director.



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—David Gifford
MD, MPH
Chief medical officer and director of inpatient quality improvement for Quality Partners of Rhode Island

The QIOs' work for Medicare started in 1982, when they were called peer review organizations. They monitored the quality of care delivered to Medicare beneficiaries and guarded against waste of Medicare money, primarily by reviewing patient records. Many QIOs still do these so-called utilization reviews, though not necessarily for Medicare — most, for instance, perform utilization reviews or oversee quality for state Medicaid programs. Meanwhile, the primary focus of their Medicare work has shifted to quality improvement.

Medicare now contracts with QIOs to educate beneficiaries and to help providers and practitioners improve care quality. Working collaboratively with providers, they provide practice guidelines, checklists, and other clinical information to those who request their assistance, helping them to develop more effective systems and protocols. They may also offer guidance or training as needed.

Initially, QIOs worked only with acute-care hospitals, managed care organizations, and physician offices. In August 2002, Medicare-certified nursing homes and home health care agencies were added to that mix as part of the scope of work, which defines the activities that QIOs must perform under their three-year contracts with the federal government.

The QIOs are expected to work on three areas as part of the Nursing Home Quality Initiative (NHQI) during the 2002 to 2005 period covered by the current (seventh) scope of work. First, each QIO must offer help to all nursing home providers in its state, by distributing educational materials, conducting training, and providing other general assistance. Second, each QIO must work closely with a smaller group of at least 10 percent of the state's nursing homes, helping them improve care quality. While facilities are expected to volunteer, QIOs solicit suggestions for facilities

Quality Measures for Nursing Homes

The quality measures on the websites for Nursing Home Compare (www.medicare.gov/NHCompare) and Home Health Compare (www.medicare.gov/HHCompare) are part of CMS' effort to track care quality. These measures are only a small part of the data reported to CMS every year by Medicare- and Medicaid-funded providers, but they track key functions. Their listing on the federal government's websites has increased their importance — both to consumers, who consult them when looking for a nursing home or home health agency, and to providers, who stand to gain or lose clients based on their scores.

The long-term nursing home measures are:

- Percent of residents whose need for help with daily activities has increased
- Percent of residents who have moderate to severe pain
- Percent of high-risk residents who have pressure sores
- Percent of low-risk residents who have pressure sores
- Percent of residents who were physically restrained
- Percent of residents who are more depressed or anxious
- Percent of low-risk residents who lose control of their bowels or bladder
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents who spent most of their time in bed or in a chair
- Percent of residents whose ability to move about in and around their room got worse
- Percent of residents with a urinary tract infection

The short-stay nursing home measures are:

- Percent of short-stay residents with delirium
- Percent of short-stay residents who had moderate to severe pain
- Percent of short-stay residents with pressure sores

that could benefit from assistance from ombudsmen, consumers, survey agencies, and other long-term care stakeholders. Most of the homes chosen for the first stage of the nursing home quality initiative are performing at or above average on state surveys, but more lower-scoring homes may be added in later. Participating providers and QIO staff in each state choose three to five quality measures to focus on.

The third line of work is beneficiary education in long-term care, which consists mainly of increasing public awareness and understanding of the 14 quality measures listed on Nursing Home Compare (11 for long-term and 3 for short-term stays) and the 11 on Home Health Compare (see **Quality Measures for Nursing Homes**), the websites CMS designed to help beneficiaries evaluate providers. Quality improvement efforts also revolve around these quality indicators.

Most QIOs had little involvement with nursing homes prior to the current scope of work and few had staff with experience in long-term care. As a result, most had to recruit and hire staff with this experience. CMS awarded a separate contract to Quality Partners of Rhode Island to provide technical assistance to QIOs across the country on the Nursing Home Quality Initiative.

A FOCUS ON THE DIRECT-CARE WORKFORCE

When Quality Partners of Rhode Island began their efforts to guide fellow QIOs in nursing home quality improvement, the team knew they would have to do more than distribute clinical guidelines. Chief medical officer and director of inpatient quality improvement for Quality Partners of Rhode Island, David Gifford, MD, MPH, recognized the need to focus on direct-care workers' role in improving care quality.

"If you train a group of staff, yet after six months half of them leave," Gifford says, "you have to spend time training an entire new bunch of people, rather than spending time working on making improvements." In addition to reducing turnover, he says, "The QIO program has recognized the need to include CNAs in the teams that are addressing clinical conditions. When the CNAs are involved, the teams tend to be more creative and to come up with solutions that are more effective than when the CNAs are not involved.

"For instance, a lot of the QIOs have been working on pain management. One of the areas that nursing homes have focused on is non-pharmacological programs for managing pain, particularly for some of the individuals who have dementia. I'm not saying that if someone has a broken leg you give them aromatherapy, but there are many chronic aches and pains in the elderly that are annoying to the patient. If you can mitigate these aches without medication, that's valuable, given the side effects of many pain medications in the elderly.

"We have seen the aides who are involved coming up with very creative programs to address the residents' pain, such as putting warm blankets on people, giving them a shower instead of a bath or a bath instead of a shower, and using music therapy or aromatherapy. They have developed comfort boxes for residents, where music, aromatherapy, tactile therapy, or other things that appeal to a specific resident are gathered together and placed in a box at foot of the bed for use when they complain of pain."

To help providers who want to solicit input from CNAs and other frontline workers, Quality Partners has piloted two training sessions. The first, on team building, helps managers improve their supervisory techniques. It covers basics like how to work as a team and how to run effective meetings. "Those may sound like simple things, but a lot of people don't know how to do them," says Marguerite McLaughlin, project coordinator for Quality Partners' nursing home quality improvement initiative.

The second teaches medical directors, administrators, and directors of nursing a more inclusive style of leadership, encouraging them to convene staff at all levels to address poor outcomes by finding root causes in systems rather than finding fault with individuals. Teaching modules for that program were made available to all other QIOs this year.

As part of its national technical assistance effort, Quality Partners of Rhode Island also has piloted a workforce retention project with six national nursing home chains. In September 2004, members of the QIO's technical expert panel and faculty will begin teaching methods of training and supervision aimed at improving retention to staff development managers, charge nurses and other CNA trainers from a number of homes in each chain.



The Evidence Behind the Practice

In setting the course for QIOs to follow in assisting hospitals and nursing homes, CMS's Dr. McGann and Dr. Gifford of Quality Partners of Rhode Island base their approach on evidence of the relationship between staff retention and satisfaction and quality of care, or on what works to improve staff recruitment and retention. While some of the studies focus on nurses, the findings are generally applicable to nursing assistants in long-term care.

- *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004), by the Institute of Medicine, presents evidence on the link from insufficient staffing and inhospitable work environments to poor outcomes for residents and patients. It points to organizational transformation, work design changes, and other management reforms in hospitals and nursing homes as solutions to the problem. www.nap.edu/books/0309090679/html/
- *Roles of Senior Management of Quality Improvement Efforts: What Are the Key Components?* This article by E. H. Bradley and colleagues, which was published in the January-February 2003 issue of the *Journal of Healthcare Management*, defines senior managers' key roles and activities in quality improvement initiatives in eight acute-care hospitals, compiling elements that serve as a useful checklist for those involved in quality improvement efforts. www.ache.org/pubs/jhmtoc.cfm
- *Evaluation of the Wellspring Model for Improving Nursing Home Quality* (2002), by Robyn Stone and colleagues, describes the Wellspring model of nursing home quality improvement and evaluates outcomes in its initial years of operation, finding significant improvements in care quality. The report also explores broader implications and potential applications of the model. www.cmwf.org/programs/elders/stone_wellspringevaluation_550.pdf
- *The Business Case for Work Force Stability*. A 2002 white paper by the Voluntary Hospital Association shows the impact of high turnover and vacancy rates on hospitals' financial health and quality of care, highlighting the relationship between employee satisfaction and retention and the impact of both on patient satisfaction. <https://www.vha.com/research/workforce/public/>
- *Tomorrow's Work Force: A Strategic Approach*. Another Voluntary Hospital Association paper published in 2002, this examines the causes and solutions for what it describes as "health care workforce shortages that are unlike any that have gone before." Based on a literature review, best practice research, and organizational assessments by the VHA, it outlines a systematic solution consisting of five parts: a strong leadership platform, healthy cultures, work design for staff satisfaction and optimal care, effective human resources processes, and growing the next generation of health care workers. <https://www.vha.com/research/workforce/public/>

CMS SUPPORTS ATTENTION TO DIRECT-CARE WORKERS

Recognition of the link between staffing levels and skills and quality care outcomes is not new to QIOs, points out Dr. Paul McGann, the medical officer in charge of the Quality Improvement Group in CMS's Office of Clinical Standards and Quality. The work done by QIOs in acute-care hospitals, he says, illustrated the link between the stability of the licensed nursing staff and the quality of care in hospitals (see **The Evidence Behind the Practice**).

In addition, seminal studies published in the last year or so have shown definitively the contribution of staffing levels to patient outcomes in the acute care setting. For example,

Linda Aiken and her colleagues at the University of Pennsylvania School of Nursing¹ found that hospitals with fewer nurses per surgical patients had a greater risk of dying than those with higher ratios of nurses to patients. Nurses with the highest patient-to-nurse ratios (8:1) were twice as likely to suffer job-related burnout and to be dissatisfied with their jobs as those in hospitals with the lowest patient-to-nurse ratios (4:1).

Thanks in part to that research, says Dr. McGann, "We're already convinced that raising

¹"Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," *Journal of the American Medical Association*, v. 288, no. 16, October 23/30, 2002, pp. 1987-1993.



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MD
CMS Office
of Clinical
Standards
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the bar for the quality of working conditions for nursing staff radically affects the quality of care. We're more interested in how to do that." In nursing homes, he adds, that means focusing on the direct-care workforce.

Long-term care settings are different than acute care, Dr. McGann explains, because of their reliance on direct-care workers. CNAs are to nursing homes what RNs and LPNs are to hospitals, providing the bulk of the hands-on care. "A lot of our educational efforts are directed at direct-care staff, but if there's an 80 percent CNA turnover in a nursing home, you're almost setting yourself up not to succeed: You give your program in January and by November you're going to have to start over again. If we could reduce turnover to 20 percent, we think that would have a significant impact on quality." As a result, CMS is encouraging QIOs to focus on ways of reducing nursing staff turnover during their next scope-of-work cycle.

ORGANIZATIONAL CULTURE CHANGE: HOW QIOs CAN HELP

As important as reducing turnover among direct care workers is to quality, Dr. Gifford and McLaughlin of Rhode Island's QIO and some within CMS have begun to believe that long-lasting improvements can only come from a wholesale transformation of the nursing home culture. (See **What is Culture Change?**)

At the start of the QIOs' long-term care work, says McLaughlin, "CMS felt that we'd see a greater success story for each nursing home by improving clinical systems. I think what

we're finding is that that if our focus is all clinical and all data, we're not really affecting people. So we proposed that we hook people up with culture change initiatives, getting nursing homes to introduce a more resident-centered model."

Dr. Gifford agrees that CMS is intrigued by the notion of culture change as a route to dramatic quality improvement, though he cautions that his QIO and CMS are looking for models with demonstrated links to improved resident outcomes. "It's not clear that resident-centered culture will result in improved clinical outcomes such as pressure ulcer rates," he says, "but it's something the QIOs are looking at, because if it's effective, it could be a better way to improve quality than just training nursing homes about strategies to reduce pressure sores or pain. If [traditional nursing home culture] is part of the root cause, shouldn't we be addressing it?"

Gifford cites the results from programs such as Wellspring (see **The Evidence Behind the Practice**) and other culture change initiatives, which have demonstrated improvements in resident quality of care outcomes by combining both clinical practice and management changes. Wisconsin's QIO, MetaStar, won a CMS contract to spearhead a study of the Wellspring model to determine which elements, if any, are linked to rapid improvement in quality of care measures. Factors studied by MetaStar include staff empowerment, permanent assignment of care teams to individual residents, and staffing levels. "We recently expand-



What is Culture Change?

Getting Started, A Pioneering Approach to Culture Change in Long Term Care Organizations, published by the Pioneer Network (www.pioneernetwork.net), defines the organizational cultures that imbue long-term care as "complex, encompassing system-wide attitudes, values, and practices that influence how people live and work together."

In most nursing homes, author Susan Misiorski notes, "the pervasive culture is 'institution-centered.' The norms that govern daily activity are influenced by the hospital/industrial model of care, placing the locus of control with the facility leadership and staff.

This approach views residents as patients who are sick and unable to care for themselves; daily practices are organized for the efficient operation of the facility, rather than the physical, social, and spiritual needs of the residents."

The aim of culture change is to create environments that are person-centered rather than institution-centered, transforming a facility into a true home for its residents. In order for that to happen, decisions must be made whenever possible by the residents and those closest to them. And that means freeing direct-care workers from rigid schedules and heavy workloads so they can respond to individual needs and wishes.

ed the study because we're getting such good information," says CMS's McGann. "We hope this data will feed into larger efforts."

One of the main elements of the Wellspring model, McGann notes, are the interdisciplinary Care Resource Teams that are charged with learning about best practices and new developments in clinical practice and then helping to incorporate them into their facilities' care routines. CNAs are included on each of these teams, so observing how they work and measuring their success is one way to test the theory that meaningful inclusion of direct-care workers makes quality improvement efforts more effective.

In Michigan, where BEAM (Bringing the Eden Alternative to Michigan) has been encouraging nursing homes to adopt the Eden Alternative for years, MPRO — the state's QIO — finds that homes that are at least partially "Edenized" are more likely to succeed because direct-care workers are more empowered to implement changes. As a result, MPRO is encouraging the spread of the Eden Alternative. Everyone on the QIO's NHQI team has been certified as an Eden associate, and BEAM held two four-hour Eden intensives this year for MPRO staff and staff from the nursing homes they work with.

Kansas' QIO, the Kansas Foundation for Medical Care, has tapped into that state's thriving culture change movement. "With so many of the homes involved in culture change, a lot of the quality improvement work is taking place in [nursing home] neighborhoods with the whole team involved," says Kim Lawton, project manager of the Kansas NHQI. "Pressure ulcers are a good example. In one of the homes here, CNAs on the QI team identified a Medline pocket tool that let them draw a picture of where on the body skin breakdown was found, date it, and print it out. They gave a copy to the charge nurse, a copy to the DON, and put a copy in their book." It improved communication and prevented the ball from dropping. Many of the homes Lawton works with, she adds, enlist the help of senior aides or CNA peer mentors to answer questions, gather feedback, and marshal support for new ideas when implementing change.

Much of the state's impetus for culture change emanates from the Kansas Department on Aging, which has created training modules that the QIO uses on how to embark on culture

change. Lawton and the co-leader of Kansas' NHQI team, Communications Specialist Mapu Lemanua, help administer the agency's coveted PEAK awards, which are presented every year to nursing homes that have made significant progress in culture change.

Medical Review of North Carolina (MRNC), North Carolina's QIO, has taken a different tack to addressing the role of direct-care workers in quality improvement. MRNC was asked by the state's Better Jobs Better Care (BJBC) coalition to help measure the performance of home care agencies, nursing homes and adult care homes in implementing workplace practices that affect the recruitment and retention of direct-care workers.

Starting this fall, MRNC will begin developing measures of the best workplace practices selected by the coalition, which include balanced and safe workloads, staff empowerment, peer mentoring programs and management support for workers. "We were approached because of our experience with data collection and quality improvement work with nursing homes and home health agencies," says Jill McArdle, RN, manager of healthcare quality assessment for MRNC. After the measures are developed, MRNC staff will conduct on-site assessments of selected providers and send the results to the state, which will determine whether they are eligible to receive special licensure designation.

Ultimately, those who earn the special license may qualify for higher reimbursement rates or labor enhancement funds. In the short term, the special licensure can be used by qualifying organizations as a marketing tool to recruit employees and consumers, while also providing goals and best practices to support the development of a stable, high-quality direct-care workforce.

ON THE HORIZON

The QIOs' eighth scope of work starts next August 2005, but the planning is already well underway, and the focus on culture change appears to be intensifying. CMS has stated that in the next scope of work, QIOs will be expected to offer assistance to providers "to achieve transformational, rather than incremental, improvement through information technology, care process redesign, and *organizational culture changes*" (emphasis added).

CMS will likely ask QIOs to focus on specific



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Partnering with QIOs to Strengthen the Direct-Care Workforce

The efforts QIOs are making to improve care quality through improving job quality makes them a potential partner for others who are involved in similar work — and a powerful vehicle for disseminating best practices developed by BJBC coalitions, providers, and other organizations.

If you want to engage the QIO in your state on long-term care quality improvement and direct-care workforce issues, the first step is to get in touch with the group's Nursing Home Quality Initiative staff. Contacts in each QIO can be found at the American Health Quality Association's website, www.ahqa.org, by typing "QIO Nursing Home Quality Initiative Contacts" into the site's search engine. Each listing gives contact information and links to the organization's website, which includes sections for nursing home providers, home health providers, consumers, and others.

When you make contact, explain who you are and find out about the current priorities of your QIO's nursing home quality initiative. What is contained within their current scope of work with regard to long-term care organizations? Are they involved in any efforts to improve care quality by improving workforce practices? What have they learned in their work so far? Do they need partners or more information? What next steps have they planned?

Once you've covered the basics, you can explore ways of working together. Perhaps the QIO is seeking nursing homes to become part of the core group involved in the state's quality improvement initiative. Maybe a direct-care workforce coalition can disseminate some of its field-tested practice models or teaching materials through the QIO. Your group and the QIO can work on developing specific targets and activities for the 8th year scope of work. Or, who knows? You just might create something else that neither party could have developed on its own.



indicators that have a real impact on residents' quality of life, such as reductions in the rates of pressure ulcers and use of physical restraints and better detection and treatment of depression and pain. In addition, the eighth scope of work will probably step up efforts to ensure that quality improvement and culture change efforts result in "building workforce commitment" — meaning better staff retention.²

In preparation for this new emphasis, this summer, the American Health Quality Foundation, affiliated with the QIO membership association AHQA, sent QIO nursing home quality improvement staff two videos on culture change. One, which gathers insights from staff and residents of nursing homes engaged in culture change, was produced by consultant LaVrene Norton, who is helping Quality Partners of Rhode Island prepare for the next scope of work. The second video, which is expected to be sent out this fall, will provide guidance to QIO staff on how to help nursing homes begin the process of culture change.

Meanwhile, CMS has funded an 18-month culture change pilot study by Quality Partners of Rhode Island, which has enlisted 20 homes in seven states in an effort to improve the environment in nursing homes for both the residents and staff. As part of the project, Quality Partners will coordinate training sessions for 21 QIOs on the person-centered care model and other strategies to improve quality of life and clinical care for nursing home residents. Meanwhile, the Eden Alternative is hosting a special training session for all interested QIOs in August, and the Rhode Island group is reaching out to the Pioneer Network in an effort to coordinate its culture change efforts with them.

While much of the QIO work is focused on staff retention and organizational culture change, one QIO is working on a project to evaluate staffing quality measures that would be appropriate for public reporting. By March 2005, Colorado's QIO, the Colorado Foundation for Medical Care, will be reporting on the results of an 18-month, CMS-funded study to develop better ways of reporting on nursing home staffing information on Nursing Home

²For a description of CMS' framework for the eight scope of work, see www.cms.hhs.gov/qio/2s.pdf

Compare. The goal of the project is not to recommend changes in minimum staffing levels or specific staff ratios, but rather to find more accurate and meaningful ways of reporting staffing information to the public. In conjunction with researchers at the University of Colorado, University of Missouri, and Abt Associates, the Colorado Foundation is searching for better ways of capturing staff data - i.e. through payroll records, rather than relying on self-reports by nursing facilities. With the assistance of a technical expert panel, the group will present options to CMS on how best to configure a staffing quality measure.

David Gifford has some advice for nursing homes engaging in quality improvement. "Historically, programs tend to be rolled out from the top down," he says. "We try to empha-

size that leadership should tell their staff: 'Here's the goal.' Leadership then needs to focus on how to get the team of aides and nurses and activities people and others on the floor to reshape their work environment to achieve that goal."

If Gifford and the other QIO staff are lucky, CMS will take a similar approach, giving them the goal to strive towards while leaving the details of getting there to each QIO, working with individual nursing homes and other long-term care organizations in the state, and involving other community organizations as appropriate. That flexibility should help QIOs reach their potential to become valued consultants and partners in efforts to improve direct-care workers' jobs and care quality across all long-term care settings.

Resources

To help nursing homes and home health agencies improve care quality, QIOs often collect resources or create tools. The following is a sampling of websites, many hosted by and for QIOs, which offer resources free of charge:

MedQIC (www.medqic.org). Hosted by CMS to support QIOs and Medicare-funded providers, the website offers a number of clinical resources as well as links to quality measures, literature and other tools.

Institute for Healthcare Improvement's website (www.ihl.org), which will be merged with MedQIC's website later this year, has information about successful quality improvement efforts in health care organizations. On staffing, for example, see "Improvement, trust, and the healthcare workforce," which emphasizes the value of teamwork and work redesigns, *Lessons from the Baldrige Winners in Health Care*, descriptions of field-tested initiatives, discussion groups, and more.

American Health Quality Association. From this organization's website (www.ahqa.org) you can link to a num-

ber of useful pages for long-term care providers, such as www.ahqa.org/pub/219_1014_4353.cfm

Kansas Foundation for Medical Care. The Nursing Home Quality Initiative section of the website (www.kfmc.org/providers/Nursing%20Homes/nhproviders.html) includes numerous tools for assessing and improving key quality measures.

Ohio KePRO. The Nursing Home Quality Initiative section of this website (www.ohiokepro.com/providers/nursinghome.asp) houses tools to help in assessing and treating pain, pressure ulcers, and more.

MetaStar. The Nursing Home Quality Initiative section of the Wisconsin QIO's website (www.metastar.com/professional/nhqi.asp) includes guides to pain and pressure ulcer management and a train-the-trainer manual on quality improvement through teamwork in the nursing home setting.

Colorado Foundation for Medical Care. The nursing home section of this website (www.cfmcc.org/nhqi/index.htm) includes materials just for CNAs.



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