# Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs

**Susan C. Eaton**

**April 1997**

**Keystone Research Center High Road Industry Series, #1**

For additional copies of this report contact:

**412 North Third Street, Harrisburg, PA 17101**
**Phone: 717/255-7181 Fax: 717/255-7193 Internet: KeystoneRC@aol.com**

## The Keystone Research Center

The Keystone Research Center (KRC), a non-partisan think tank based in Harrisburg, conducts research on the Pennsylvania economy and labor market. This research documents current conditions and develops innovative policy proposals to improve state economic, labor market, and social performance.

## Author

**Susan Eaton** is a doctoral student in Industrial Relations and Organizational Studies at the Sloan School of Management, Massachusetts Institute of Technology. She holds a master's in Public Administration (MPA) from the Kennedy School of Government at Harvard and an A.B. from Harvard-Radcliffe.

Ms. Eaton's research and publications have dealt with nursing home and home health care, work organization and productivity, work-family issues, and clerical work.

With this report, the Keystone Research Center inaugurates its **High Road Industry Series**. Each study in this series will seek to illuminate the dynamics of competition in Pennsylvania in a particular industry. Based on this analysis, each report will outline the role of public policy in encouraging "high road" business strategies that will raise productivity, quality, and service, and create good jobs. Over time, by accumulating understanding of a wide range of sectors, Keystone hopes to crystallize for Pennsylvanians a clear vision of a prosperous and equitable future.

## Acknowledgments

The author is grateful for the cooperation and assistance of managers and hourly employees at the anonymous Pennsylvania and California nursing facilities visited for this report, as well as representatives of industry associations, resident advocacy groups, and unions.

The author appreciates the research assistance of Amy Chin, Anne Liu, and Lesley Nearman. Stephen Herzenberg contributed important ideas, editing, and research to the report. The county nursing home report and the policy section are largely based on Stephen Herzenberg's contributions. A number of other individuals donated their time to review the report or related work before publication:

- William Bordner and Jean Volpetti of the Pennsylvania Department of Health, Nursing Homes Division;
- Liz Capezuti of the Institute on Aging at the School of Medicine at the University of Pennsylvania;
- Kathy Cubit of the Coalition of Advocates for the Rights of the Infirm Elderly;
- Professor Larry W. Hunter of the Wharton School of Management at the University of Pennsylvania;
- Chris Klejbuk of the Pennsylvania Association of Non- Profit Homes for the Aging;
- Mary Jane Koren of the Philadelphia Geriatric Center;
- Pat Konhaus of the Pennsylvania Association of County-Affiliated Homes;
- Joy Mitchell of the Pennsylvania Directors of Nursing Association;
- Jim Ryan of the District 1199C Training and Upgrading Fund;
- Mark Smith of the Service Employees International Union;
- Mike Wilt and Nancy Rorem of the County Commissioners Association of Pennsylvania;
- Members of the MIT Industrial Relations Seminar.

In addition to the Keystone Research Center, support for the research on which this report is based was provided by the U.S. Office of Technology Assessment, Professors Lotte Bailyn and Tom Kochan at MIT's Sloan School of Management, and the Radcliffe Public Policy Institute.

The authors retains responsibility for the final product.

Executive Summary ........ 5

Introduction ........ 9

*Organization of the Report* ........ *12*

1. The Evolution of the Nursing Home Industry ........ 13

2. Nursing Homes: From Places to Die to Regenerative Communities ........ 15

*The Roots of Diversity in Quality of Care* ........ *15*
*Low Quality, High Quality and Regenerative Models* ........ *18*
*How Prevalent are Low Quality, High Quality, and Regenerative Models?* ........ *20*

3. A Closer Look at Low-Quality Nursing Homes ........ 23

4. Three High-Quality Pennsylvania Facilities ........ 32

*Example 1: A Quaker Home* ........ *32*
*Example 2: A Jewish Home for the Aged* ........ *34*
*Example 3: A County Facility* ........ *35*

5. National Examples of Regenerative Nursing Homes ........ 38

*Example 1: The Eden Alternative* ........ *38*
*Example 2: Providence/ Mt. St. Vincent* ........ *39*

6. Policy Recommendations ........ 41

*Recommendation 1. A Pennsylvania Quality Care Council* ........ *42*
*Recommendation 2. Promote Research, Education, and Information Dissemination to Expand Regenerative Care* ........ *44*
*Recommendation 3. Health Department Survey Reform to Discourage Low-Quality and Promote High-Quality Care* ........ *45*
*Recommendation 4. Modify Reimbursement Formulas to Promote Higher Quality Care* ........ *47*
*Recommendation 5: Paraprofessionalize Nurse Aide Work* ........ *47*
*Summing Up* ........ *51*

7. Endnotes ........ 53

8. Bibliography ........ 60

# Executive Summary

"The central question for the future is: Will the Pennsylvania long-term care industry be dominated by approaches that deliver quality care and provide quality jobs?"

Nursing homes and the rest of the long-term care industry, which provide the elderly and disabled with assistance performing basic activities of daily living, are critically important to the quality of life and employment in Pennsylvania. Almost 100,000 residents live in Pennsylvania nursing homes alone. More than 110,000 individuals work in the not-for-profit, government, and for-profit facilities in the state. Many thousands more work or receive care in personal care homes, assisted living environments, and home care. The long-term care industry will grow dramatically over the next several decades as the baby boom generation ages and a rising share of the population becomes very old.

This report documents the wide variation that exists in the quality of care for residents and the quality of jobs for workers in long-term care. The report explores the close links between quality jobs and quality care, and the public policies necessary to improve both in a time of shrinking public resources. For two reasons, the report focuses most on Pennsylvania nursing homes: nursing homes today account for most long-term care delivered outside the family, and more research has been conducted on nursing homes. Nonetheless, since increasing amounts of care are delivered outside nursing homes, the policy analysis addresses the long-term care industry as a whole.

The central question for the future is: will the Pennsylvania long-term care industry be dominated by approaches that deliver quality care and provide quality jobs? Or will it be dominated by approaches that deliver poor care at the expense of customers and workers?

- In a **positive scenario**, creative public policy would foster the spread of high quality care, improving the quality of life for older Pennsylvanians, and the quality of jobs for those delivering care.

- In an **alternative, negative** scenario, funding cuts and a relaxation of regulatory oversight would exacerbate uneven quality for the less affluent throughout the long-term care industry. Ad-hoc, legislative responses to the all-too-predictable horror stories would do little to prevent neglect and abuse. Such responses would do nothing to realize the potential that exists for improvement.

### *Policy Recommendations*

The basic character of nursing homes and long-term care in Pennsylvania in the future are not fixed by resource constraints or “the market.” Which scenario will more closely describe reality depends on choices that will be made by Pennsylvania’s citizens and legislators. To choose better care for its elder residents, better jobs in long-term care, and greater peace of mind for all who know that they or their kin may one day need care, Pennsylvania should adopt the following public policies:

- **Publish an annual Pennsylvania “Consumers’ Report” for long-term care** that includes information on human resource indicators critical to care quality (e.g., workforce turnover) as well as easily understandable information on health and quality of life indicators;

- **Modify Act 185 to convert an existing stakeholder Council on Long-term Care into a “Pennsylvania Quality Care Council”** (PQCC). The Quality Care Council should oversee a comprehensive effort to transcend low-quality care. To strengthen its commitment to policies that promote better care and better jobs, the PQCC should have strong representation of advocates for those who receive care and of workers who deliver it.

- **Increase research and educational activities** to raise the visibility of better models of care delivery and to better understand the possibilities for improving quality without raising costs;

- **Increase fines for serious deficiencies** identified by Health Department surveyors, but also **make surveys a more effective vehicle for spreading high-quality practice**;

- **Modify reimbursement formulas to promote improved quality of care**, to reward low turnover and good human resource practices, and to focus management attention on resident quality of life.

- **Require providers to pay their workers at least health care benefits plus $8.58 per hour** (for a full-time worker, this hourly wage generates annual income equal to 110 percent of the poverty level for a family of four). While still short of a real “living wage,” this would reduce turnover and improve continuity of care for frail elders, at modest cost to the state.

- **Encourage the creation of paraprofessional associations of aides** with members drawn from across the continuum of care settings, from the nursing home to people’s own homes. Paraprofessionalization would increase aide status, training, and peer mentoring and translate directly into better care. Paraprofess-ionalization is all the more important because the expansion of care in decentralized settings removes customer-worker interaction from regular oversight by peers and supervisors. Creating organizations of aides with the power to help constructively reshape long-term care could be accomplished by innovative legal reform to directly promote occupational association. Paraprofessionalization might also be encouraged by better protecting workers’ rights to form unions in individual homes (these unions could then link up into broader, occupational associations).

*Research Findings*

The analytical and empirical basis for the policy recommendations was derived from extensive interviews and observation in seven Pennsylvania and 13 California nursing homes plus quantitative survey evidence. This research revealed enormous diversity in the quality of care driven by variation in wages, workforce experience, and the way managers and corporations organize work. Findings from the Pennsylvania homes visited illustrate the wide range in care quality that exists. In these homes:

- **Quality of Care**: The number of corrective actions homes required by Department of Health surveyors at each home ranged from 0 to 66 in 1995.

- **Wages**: Average nurse aide hourly wages ranged from $6.00 to $10.00.

- **Workforce Experience**: The share of employees with at least three years tenure ranged from 19% to 80%. At homes with higher workforce turnover, state government surveyors typically required many more corrective actions.

The body of this report presents a framework for understanding the diversity of nursing home care in Pennsylvania, positing the existence of three basic types of facility: low quality, high quality, and regenerative. In characterizing these types, the reports highlights two powerful forces, economics and "care philosophy." These two factors reinforce each other. Improving quality of care requires addressing both.

- **"Low quality" homes** provide care that does not meet even minimum standards of quality defined by the government. Managers at such homes typically recruit aides with minimal training and pay them only a little over minimum wage; they do not assign sufficient staff to meet residents' individual needs; and they provide little training or support. High turnover arising from poor compensation and difficult working conditions regularly interrupts residents' relationship with individual aides; homes, as a result, lose much worker knowledge of residents so critical to good care. Many house a high proportion of residents whose care is paid by Medicaid funds, and managers often blame poor quality care on insufficient funding. While it is true that Medicaid offers relatively low rates and that reimbursement does not depend on providing any given degree of quality, this report stresses that lack of funding is not the only, or even the main, reason for the low quality of care offered.

- **"High quality" homes** typically meet or exceed government standards for providing individualized care, and they are cleaner, better staffed, more pleasant places for elders to reside. These homes are characterized by lower staff turnover and managers provide more support, training, supervision, and higher wages for employees. Some high quality homes cater more to private-pay populations or rely on charitable contributions to pay for higher staffing levels and better wages and benefits than low-quality homes. Other managers simply do a better job of organizing work and resident care, saving money by such measures as reducing medical problems (e.g., bed sores), and preventing injuries to residents and aides through good staffing and supervision.

- **Regenerative homes**, the most innovative, are those in which managers and staff seek to reconceptualize aging as another stage of growth and life. They challenge the traditional assumptions that resident decline will be progressive and irreversible, and that nursing homes are "places to die." Workers in these homes help residents recover their independence, and enjoy as high a quality of life as is possible given their chronic conditions. More experimentation and evidence is needed to make reliable estimates of the cost of regenerative homes. Initial evidence shows that by raising the status and skill of aides, streamlining administrative staff, cutting over-medication, and promoting independence, some regenerative homes cost no more than low-quality homes.

Variation in care quality exists within ownership segments and even within individual chains. Research suggests, however, that administrators and nursing directors in not-for-profit facilities tend to be more open to challenging traditional philosophies of care.

In Pennsylvania and the United States as a whole, no one currently knows what fraction of providers fit into each of these three categories. Quantitative research that has been conducted does show that many homes in Pennsylvania and other states are poor and few are good.

- 66 percent of Pennsylvania homes (slightly better than the national average of 70 percent) are "out of substantial compliance" with the requirements of the major federal nursing home statute (the Nursing Home Reform Act);

- based on visits to dozens of homes and reviews of thousands of inspection reports nationally, Consumer Reports concluded in 1995 that "many facilities range from inadequate to scandalous, and…good ones are hard to find."

- in more than 80 percent of homes surveyed in Massachusetts (by Wharton Professor Larry Hunter) fewer than half of the nurse aides had more than three years experience. For reasons explained in the text, typical Pennsylvania homes probably have workforce experience as low or lower than in Massachusetts.

This report is addressed to a variety of audiences: policy makers, managers and employees, advocates and families of long-term care recipients, regulators, and members of the public. The report is written to be accessible to people with varying levels of familiarity with long-term care. Sometimes this means simplifying technical language, or referring interested readers to more technical research. Keystone offers this report as a resource to spark a much-needed debate which can lead to better care for Pennsylvania's elders and disabled, and to better jobs for its workers.

# Introduction

"In 1994 in Pennsylvania, 96,408 people lived and 110,878 worked in 731 licensed nursing facilities...These numbers will grow."

The lives of an increasing number of Americans are touched by the long-term care industry, which includes home health care, assisted living, and nursing homes.[1] More than 1.7 million individuals live in nursing homes alone. In 1994 in Pennsylvania, 96,408 people lived in 731 licensed nursing facilities, more than in all but four other states (Pennsylvania Department of Health 1994; HCFA 1994). In Pennsylvania, 55,000 people live in 1,600 personal care homes, and uncounted more live in "assisted living" facilities (which remain undefined in the state as of this writing).[2] More than two million employees work in U.S. nursing homes, and 110,878 worked in Pennsylvania facilities as of 1994.

These numbers will grow. The Pennsylvania population aged 65 and over is projected to increase 22% by 2020 to 2.35 million (PANPHA 1996a). The Pennsylvania population 85 and over will increase 73 percent between 1990 and 2010 (PICLTC, no date).

Nationally, 75% of nursing homes are owned by private, for-profit firms. In Pennsylvania, for-profit firms own 44% of homes, private not-for-profits make up 48% of homes, and county governments own 8% of facilities. County-owned homes are typically larger, averaging 300 beds and containing 18% of the total number of licensed beds (PANPHA 1996b:13). County homes also care disproportionately for the poor. Some public facilities contract out management or are privatizing.

Public funds pay for the majority of nursing home care nationally, including 72.5% of care in Pennsylvania.[3] Pennsylvania ranks third in the U.S. in total funds spent on nursing facility services for Medicaid residents, with 30% of the Medical Assistance budget, or $1.7 billion, allocated to the care of nursing facility residents (Pennsylvania 1995:4447). Including Medicare reimbursements, government funding to nursing homes nationally nearly doubled between 1986 and 1991[4] (PANPHA 1996:13).

Jobs in the long-term care industry typically are "low-wage, low-skill" jobs. Nationally, front-line caregivers (nurse aides) in the mid-1990s earned only an average of $6.06 per hour and comprised 85% of all nursing staff (Wunderlich, *et. al.* 1996: Table 6.6, 161). In Pennsylvania, aides earned a little more, about $7.00 an hour on average. This is still less than a

poverty-line income for a full-time worker in a four-person family.[5] Many nursing home staff are not covered by health insurance.[6] Pensions are rare.[7] Turnover rates nationally are extremely high, averaging more than 100% annually for nurse aides, 56% for registered nurses, and 27% for administrators (Wunderlich, *et. al*. 1996:160). Nursing homes are more dangerous places to work than coal mines or manufacturing plants. Lost-time injury and illness rates in nursing homes are twice the national average for private industry at 17 cases per 100 workers in 1993 compared to 8.5 overall (Wunderlich, *et. al*. 1996:163).

Despite decades of public criticism, the overall quality of care provided to residents remains abysmal in too many facilities (for evidence, see Chapter 3). Most people go to great lengths to avoid nursing homes. Some think of them as "places to die." Still, not all nursing homes fit the dominant low-quality pattern. In some homes, residents are cared for with thoughtful individualized care. In a small number, elders are actively encouraged to regain greater independence, to continue their psycho-social growth and development, and to remain in control of their lives. In such settings, working conditions, wages, and quality of working life for employees are far better, this report shows, than in the lower-quality homes.

Data obtained from six of the Pennsylvania homes visited illustrate the wide variation in care and job quality in nursing facilities (Table 1). In one high quality home state surveyors found no deficiencies. The survey of another home listed 14 pages of deficiencies requiring 66 corrective actions. Most deficiencies concerned inadequate hygiene or cleanliness, and failure to develop and carry out "care plans" for residents suffering from weight loss, pressure sores or missed medications. The share of staff with more than 3 years' service varied from only 19% in the most problematic home to 80% of employees in the no-deficiency home. Average nurse aide wages varied from $6.00 at the problematic home to more than $10.00 at a better one. Nursing homes with the higher-paid, longer-service employees generally required fewer corrective actions (Figure 1).

***This report seeks to explain these divergent outcomes and to understand how worker and resident conditions are linked,*** drawing on original research in Pennsylvania and California, and on secondary literature covering other states. Based on this understanding, the report identifies policies that would enable higher quality care and jobs to become the norm rather than the exception as long-term care expands.

The field research for this study included direct observation, interviews, and case studies in seven nursing facilities in Pennsylvania and 13 in California.

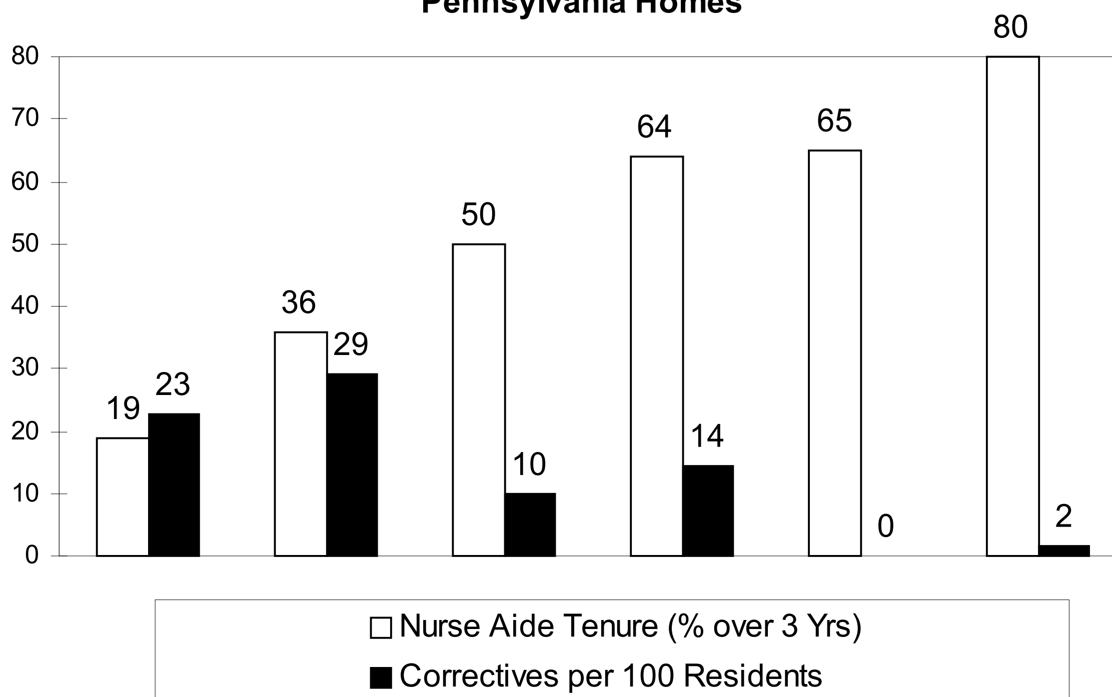
**Table 1**
**A Statistical Profile of Six Pennsylvania Homes**

| | *NFP/FP Mgt* | *FP* | *County* | *NFP1* | *NFP2* | *NFP3* |
|---|---|---|---|---|---|---|
| *Beds* | 180 | 241 | 154 | 240 | 140 | 120 |
| *# of Employees* | 240 | 180 | 190 | 270 | 180 | |
| *Managers' Tenure (Years)* | Adm 1<br>DON 1 | Adm 5<br>DON 1 | Adm 5<br>DON 10 | Adm 10<br>DON 1 | Adm 10<br>DON 1 | Adm 15<br>DON 14 |
| *Aides with > 3 Years Tenure (%)* | 19 | 36 | 50 | 64 | 65 | 80 |
| *Aide Average wage/Hr.* | $7 | $6 | $9 | $10 | $8 | $10 |
| *All Nursing Staff, Avg. Wage/Hr.* | $10.16 | $10.55 | $12.50 | $14.27 | $11.92 | $13.77 |
| *New Aide Training (Days)* | 5 | 2 | 15 | 2-3 | 10 | 10-15 |
| *1995 Net Income* | ($1,200,000) | $500,000 | (300,000) | $300,000 | ($70,000) | ($20,000) |
| *Occupancy* | 83% | 94% | 97% | 96% | 89% | 97% |
| *Deficiencies* | 3 | 8 | 7 | 4 | 0 | 1 |
| *Corrective Actions* | 31 | 66 | 15 | 33 | 0 | 2 |
| *Administrator Salary* | $150,000 | $150,000 | 50,000 | $90,000 | $60,000 | $60,000 |
| *DON Salary* | $50,000 | $50,000 | 45,000 | $60,000 | $50,000 | $50,000 |
| *Contributions* | 0 | 0 | 0 | $91,000 | $160,000 | $421,415 |
| *Medicaid beds (%)* | 67% | 77% | 90% | 66% | 42% | 70% |

1. The table reports corrective actions as well as deficiencies because one deficiency may include multiple violations. The number of corrective actions which homes agree to take in response to surveys gives a rough indication of the severity of the deficiency.
2. Financial figures are rounded to avoid identifying the homes.
3. Aide denotes Nurse Aide; NFP denotes not-for-profit; FP denotes for-profit; DON denotes Director of Nursing.

Sources: 1995 Medicaid Cost Reports and Author's Field Interviews

One hundred and eighty-six interviews were conducted with workers, managers, residents, corporate officials, resident care advocates, union representatives, academic experts, and state regulators and policy makers. The interviews lasted from 15 minutes to two hours, averaging about 30 minutes. One hundred and seventy-seven hours of field observation were completed on site visits. The sites were drawn from a non-random sample of facilities, chosen to represent a variety of size, ownership types, resident mixes, and geographic locations. They included 10 private for-profit, one county-owned, and 9 non-profit homes (of which 2 were managed by for-profit companies), 10 chain-owned and 10 free-standing facilities, 11 union and 9 non-union facilities. High quality "best practice" facilities as identified by resident advocates and other industry experts were deliberately over-sampled.




The report focuses on nursing homes: that is where the majority of long-term care outside the family gets delivered. In addition, much more quantitative research has been conducted on nursing homes. Since increasing amounts of care will be delivered outside nursing homes, however, the policy analysis addresses the long-term care industry as a whole.

***Organization of the Report***

Chapter One of the report provides a brief history of the nursing home industry. Chapter Two explains why some homes are bad while others are so much better. It summarizes the economic pressures and managerial philosophies that shape the industry. These generate the three distinguishable types of homes labeled low quality, high quality, and regenerative. Chapter Three examines the low-quality pattern closely . Chapter Four describes three high-quality Pennsylvania facilities. Chapter Five paints a picture of two homes which have begun to realize a "regenerative" *model without raising costs above those of typical facilities*. Chapter Six outlines policies that might permit Pennsylvania to spread high-quality and regenerative care models. Because of Pennsylvania's large elderly population, what happens here could provide a model for other states.

# 1. The Evolution of the Nursing Home Industry

The two main precursors of today's nursing homes were almshouses for the poor unable to work because of age, and religious charitable private care homes, often set up for elderly widows within ethnic communities. The industry expanded as a private sector employer after 1965, with the adoption of Titles 18 and 19 of the Social Security Act, now known as Medicaid and Medicare (Fein 1989: 110).[8] These programs created benefits for those recovering from hospital stays but not able to be cared for at home, and those who were poor and required long-term care. The mentally ill elderly were placed in nursing homes after the 1960s as they were "de-institutionalized" from state hospitals.

At first regulation was minimal, except in the area of safety. Fire regulations, for example, eliminated older boarding houses and led to the creation of the now-typical low-rise facilities with wide corridors and fire doors (Kane 1994: 292). During Richard Nixon's presidency, regulatory changes permitted a new category of homes to employ very few licensed nursing personnel. Nursing homes also were made eligible for low-interest small business loans. As a result, a large number of "mom and pop" facilities started (Maas, *et al*. 1996). For-profit chains also acquired nursing homes, in part to take advantage of reimbursement policies, which then treated real estate debt favorably (making operating some homes worth more to new owners than old).

Influential publications, including Tender Loving Greed (Mendelson 1974) and Unloving Care (Vladeck 1980) documented financial scandals and exposed shocking conditions (see also U.S. Senate 1974). Public outcry led to Senate hearings and a 1986 Institute of Medicine study, which documented problems with quality, regulation, and reimbursement practices (U.S. Senate 1986; Institute of Medicine 1986). Under the leadership of the National Citizens' Coalition for Nursing Home Reform (NCCNHR), a coalition of consumers, advocates, residents, unions, and some industry representatives mobilized in favor of federal regulatory reform. In 1987, the Nursing Home Reform Law (known as OBRA) passed. OBRA increased standards for quality, required individualized care, improved registered nurse staffing, and mandated limited training of aides. The Act was phased in over seven years, with full regulations not complete until 1995, and the first financial penalties for noncompliance yet to be paid in Pennsylvania.[9] The first formal evaluations of OBRA's impact are now being finished in selected states. Most experts agree that the law has had positive effects.

"… Most nursing home admissions are brief but the few … long admissions account for most utilization. More than 80% of nursing home residents are female...as are 90% of nursing home workers."

Compared to many industries, nursing home ownership is highly dispersed. The three largest chains (including Beverly Enterprises with 633 homes and Vencor-Hillhaven, Inc. with 280 homes) together own or manage 8% of the total nursing home beds, and the ten largest own 15%.[10] Observers suggest that regional and local chains of 15 to 50 nursing homes may represent the future of the industry.

Some nursing homes are also being purchased by health care networks seeking to provide full services to customers. Some hospitals are acquiring nursing homes to cut the costs of caring for patients who no longer require acute care (e.g., are recovering from surgery). In Pennsylvania, 113 of the state's 737 licensed long-term care facilities are hospital-owned. Because of shorter hospital stays, nursing home residents today are more likely to be acutely ill and to require more intensive nursing care than in the past. In addition to their physical ailments, more than half of all nursing home residents suffer from Alzheimer's Disease or some other form of dementia.

Nursing homes are reimbursed by Medicaid and Medicare for providing a basic minimum level of services. Rates are often fixed per day of care, although case-mix systems, which vary reimbursement based on the condition of residents, are increasing in popularity. Pennsylvania adopted case mix in 1996. Because of joint federal-state funding and administration, 56 different state and territorial systems of Medicaid reimbursement exist. Facility and chain percentages of patients with different payment sources vary widely. Vencor-Hillhaven, for instance, has 55-60% Medicaid-dependent residents, 25-30% private-pay, and 15% Medicare and other HMO patients on average (Eaton interview 1994). Manor Care, another major chain, has only 30% Medicaid patients. Some private homes have 80% or more Medicaid patients, and are known as "Medicaid mills." The industry average is about 67%. County homes in Pennsylvania average 90% Medicaid patients.

Some for-profit nursing home chains make money through ancillary services like pharmacies or occupational therapy.[11] Beverly Enterprises makes greater profit on its drug subsidiary than on its Medicaid patients. Hillhaven, Inc. was also the second largest rehabilitative services company in the United States before its 1994 merger with Vencor, which then employed 3,000 occupational, physical, and other professional therapists. Vencor-Hillhaven provides rehabilitation services to its own nursing homes, to other facilities, to managed care networks, and to companies seeking rehabilitation services. One Pennsylvania for-profit chain collected fees for trips to the hospital, the cemetery, or anywhere in between, since it owned all of the relevant transportation services.

# 2. Nursing Homes: From Places to Die to Regenerative Communities

### *The Roots of Diversity in Quality of Care*

In analyzing nursing homes, this report highlights the impact of two powerful forces, economics and "care philosophy." These two factors reinforce each other. Improving quality of care requires addressing both.

***Economics:*** Government reimbursement for nursing homes is essentially independent of quality. Many nursing home operators trying to make a profit — and some of those constrained by a county or not-for-profit budget allocation — see every dollar spent on more staff, or more training, or better food, as raising costs and cutting revenues.

The lack of basic economic incentives to improve care is compounded by high average occupancy rates (91.5% in the United States and 92.7% in Pennsylvania in 1994.)[12] High occupancy rates stem from "certificate of need" requirements, which restrict the creation of new beds as a way of containing the cost to the state of long-term care.[13] High industry-wide occupancy means that even low-quality homes tend to be full.

"Consumer voice" is also weak in nursing homes. Fifty percent of residents can not make their needs known or communicate requests for better treatment because they are disoriented or suffering from dementia. Some residents may fear retaliation, or that the situation will worsen if they speak up.[14] Families, when they visit, may find it difficult to discern what goes on when they are not there. Since visits can induce feelings of guilt, and since they cannot easily move their kin to a better home, families may prefer not to see problems or feel that all homes are equally bad. They may be unable to pay for better care. Some residents may have no family members to visit, or a distant family.

By contrast, homes that depend heavily on private payers or charitable contributions have a greater incentive to make themselves more attractive to visitors. Even in these homes, the difficulty of evaluating quality, residents' lack of power, and the limited alternatives and difficulty of moving residents limit the capacity of market forces to drive improvements in care.

***Care Philosophy***: How managers define or conceive of what nursing homes do also powerfully influences the nature and quality of care. Managers' conceptions are shaped by dominant views of aging in American culture. Americans tend not to think of aging as another stage of growth and development but as a period of steady, irrever-sible decline. They explain lapses of memory or minor mishaps, such as falls or accidents, by saying "he's getting old, you

Researchers estimated in 1992 that the risk that a 65-year-old will ever enter a nursing home is 35% (Dick, Garber and MaCurdy 1992). Most nursing home admissions are brief, but the few people who have long admissions account for most utilization. Median utilization for those admitted to nursing homes is only 6 months, although it is 3½ years in Pennsylvania county homes. More than 80% of nursing home residents are female as are 90% of nursing home workers.

# 2. Nursing Homes: From Places to Die to Regenerative Communities

***The Roots of Diversity in Quality of Care***

In analyzing nursing homes, this report highlights the impact of two powerful forces, economics and "care philosophy." These two factors reinforce each other. Improving quality of care requires addressing both.

***Economics:*** Government reimbursement for nursing homes is essentially independent of quality. Many nursing home operators trying to make a profit — and some of those constrained by a county or not-for-profit budget allocation — see every dollar spent on more staff, or more training, or better food, as raising costs and cutting revenues.

The lack of basic economic incentives to improve care is compounded by high average occupancy rates (91.5% in the United States and 92.7% in Pennsylvania in 1994.)[1] High occupancy rates stem from "certificate of need" requirements, which restrict the creation of new beds as a way of containing the cost to the state of long-term care.[2] High industry-wide occupancy means that even low-quality homes tend to be full.

"Consumer voice" is also weak in nursing homes. Fifty percent of residents can not make their needs known or communicate requests for better treatment because they are disoriented or suffering from dementia. Some residents may fear retaliation, or that the situation will worsen if they speak up.[3] Families, when they visit, may find it difficult to discern what goes on when they are not there. Since visits can induce feelings of guilt, and since they cannot easily move their kin to a better home, families may prefer not to see problems or feel that all homes are equally bad. They may be unable to pay for better care. Some residents may have no family members to visit, or a distant family.

By contrast, homes that depend heavily on private payers or charitable contributions have a greater incentive to make themselves more attractive to visitors. Even in these homes, the difficulty of evaluating quality, residents' lack of power, and the limited alternatives and difficulty of moving residents limit the capacity of market forces to drive improvements in care.

***Care Philosophy***: How managers define or conceive of what nursing homes do also powerfully influences the nature and quality of care. Managers' conceptions are shaped by dominant views of aging in American culture. Americans tend not to think of aging as another stage of growth and development but as a period of steady, irrever-sible decline. They explain lapses of memory or minor mishaps, such as falls or accidents, by saying "he's getting old, you

Most nursing homes do not challenge this view. They define the responsibility of front line staff in essentially custodial terms. Aides perform for and on residents a variety of tasks that the residents can no longer perform for themselves. In addition, most nurses and doctors approach long-term care using what has become known as the "medical model." Some tend to objectify the "patient," seeing her or him as a package of discrete medical problems and a mix of reimbursement strategies. Many discrete medical problems are treated through the use of drugs, or high-tech surgery, without adequate understanding of the cumulative effect of these interventions, or holistic consideration of how they affect quality of life. In some cases, the "cures" may be worse than the diseases (Friedan 1993, Chapters 13, 14). Under the surface, the preoccupation with curing discrete problems coexists with the assumption that old people cannot be cured.

The potential for reconceptualizing the care of the elderly in terms of supporting their functional independence and quality of life remains largely unexplored. Resident decline remains a self-fulfilling prophecy: people can decline because they are expected to, just as teacher expectations of students have a powerful effect on learning in schools.

Although there are good for-profit homes and low-quality not-for-profits, field visits and interviews with resident advocates and ombudspeople indicate that administrators and nursing directors in not-for-profit facilities tend to be more open to challenging traditional models of care. Some religious views of community and the elderly make not-for-profits affiliated with religious organizations receptive to reconceiving the goal of long-term care as fostering independence. A Quaker document, for instance, notes "the central Quaker belief that human life is sacred, and that all people, regardless of age, race, infirmity, economic status, or other circumstances, are to be treated with loving respect... (Quakers) share the belief that the later years of life are full of potential for love, growth, friendship, and contributions to others" (Friends, n.d.).

A study of 449 Pennsylvania nursing homes shows that not-for-profit (NFP) nursing homes have higher levels of care staffing than for-profits (FPs) (Aaronson, *et. al.* 1994: 782). Not-for-profits also have fewer pressure sores. The study concluded that: "NFPs produce significantly higher quality of care to Medicaid beneficiaries and to self-pay residents than do FPs. In consideration of the differences in self-pay payment rates, NFPs provide better value and are less likely to shift excess costs onto self-pay residents" (Aaronson *et. al.* 1994: 784).

### *Low Quality, High Quality and Regenerative Models*

The field research underlying this report identified three distinct types of nursing homes: low quality, high quality, and regenerative. Oversimplifying somewhat, these types can be related in a simple way to economic pressures and care philosophy. Table 2 shows the relationship visually. Low-quality homes dominate the most Medicaid-dependent segment of the industry. Perceiving little economic incentive to improve care, managers focus little attention on doing so. High-quality homes often serve a disproportionate share of the private pay market and include significant parts of the not-for-profit industry. They have an economic incentive to improve care

which will attract higher paying patients or more donations. Nonetheless, most of these homes do not challenge the traditional custodial/medical conception of nursing home service. Regenerative or growth-fostering homes challenge the assumption that the elderly are on a steady decline path. They typically perceive a regenerative philosophy as at least consistent with economical operation of the home because quality actually saves money as well as attracting

**Table 2**
**Types of Nursing Homes by Philosophy of Care and Economic Incentives**

| | | Philosophy of Care: Custodial or Medical | Philosophy of Care: Regenerative or Growth-fostering |
|---|---|---|---|
| Economic Incentives | Independent of Quality | Low-Quality Facilities | |
| Economic Incentives | Dependent on Quality | High-Quality Facilities | Regenerative Facilities |

Table 3 describes the human resource (HR) practices, work patterns, quality of care, and other defining characteristics of the three types. While these are intended as "ideal types" (Weber 1947), and few pure "regenerative" models exist today, the typology captures patterns in work and care systems observed in practice.

**Table 3**
**Three Models of Nursing Home Work Organization**

| | *Low Quality* | *High Quality* | *Regenerative* |
|---|---|---|---|
| *Philosophy of Care* | Custodial- low end | Medical -high end | "Regenerative community" |
| *Most Common Ownership Characteristics* | Medicaid mills: for profit chain or "mom & pop" | Non-profit, religious and high-end, for profit chain | Non-profit, religious |
| *Cost structure* | Low to average (high profits in some chains) | Average to high | Too little evidence |
| *Patient load: day Nurse Aides* | Ten and up | Seven to ten (big activity staff) | Five to seven |
| *Work Patterns* | Aides work alone | More flexible, adaptive Some teams | Flexible teams, some "neighborhood" units |
| *Worker Input into Service Delivery and Quality* | Is discouraged or ignored | Welcome | Is built into work structure or neighborhoods |
| *Information on Residents Shared* | Little or not at all | Mostly | Totally |
| *Supervision and Control* | Emphasis on legal compliance | Emphasis on medical outcomes | Supports resident choice and growth |
| *Assumptions re: Workers* | They cannot be trusted to do their best | They want to do a good job | They are community members; like residents, they deserve respect |
| *Wages (nurse aides)* | $6.00 + | $8.00+ | $7.50+ |
| *Annual Turnover* | 60- 200% | 30-60% | 20-40% |
| *Career paths for Nurse Aides* | Little or none | Senior nurse aide; Scholarships | Cross-training Evolving |

***How Prevalent are Low Quality, High Quality, and Regenerative Models?***

How prevalent is each of our three types of nursing home in Pennsylvania? The short answer is that we do not know for sure. We hypothesize that the regenerative group accounts for a small number of homes, that high quality homes number less than one-third of the total, and that low-quality homes account for about two-thirds. But it would take expensive surveys to develop good estimates. Even then, complex questions of statistical methodology would leave significant room for debate.

Still, significant corroboration exists for our informed guesses. The best source at this point is a survey conducted by Wharton Professor Larry Hunter. In 1992 in Massachusetts, 156 nursing homes fully responded to a survey Hunter sent them on human resource practices. Only 20% of the homes Hunter surveyed had employed more than half of their nursing assistants for at least three years. This level of workforce experience is one critical indicator of regenerative or high quality homes (Table 4). At another 19 % of homes, between 40 and 50% of aides had three years or more experience. At fully 42 percent of homes, less than 30 percent of aides had three years experience at the facility.

**Table 4**
**Nurse Aide Experience in Nursing Homes**
**(Sample Size = 156)**

| *Share of Nurse Aides with More than 3 years Experience (percent)* | *Share of Homes in this Workforce Experience Range (percent)* |
|---|---|
| 0 - 20% | 19.5 |
| >20 - 30 | 22.7 |
| > 30 - 40 | 18.8 |
| > 40- 50 | 19.3 |
| > 50 | 19.7 |

(Source: Hunter, personal communication, 1997)

Hunter also considered how many of the 156 homes which supplied complete information had each of five "good job" practices: offering a tuition reimbursement program for nursing assistants, contributing to a deferred compensation (or pension) plan, offering a median wage significantly above the local industry average, providing the opportunity for significant wage advancement within the nursing assistant category, and providing nursing assistants with the opportunity for advancement into higher-paying job categories. *More than half of the homes had two or fewer of the "good job" practices*, while 27% had three or more, and fewer than 12% had four or five "good job" practices (Table 5) .

**Table 5**

**Number of "Good Job" Practices At Nursing Homes (range from 0 to 5)**
**(Sample Size = 156)**

| | |
|---|---|
| 0 | 21.2 % |
| 1 | 35.3% |
| 2 | 16.7% |
| 3 | 14.7% |
| 4 | 9.6% |
| 5 | 2.6% |

(Source: Hunter, personal communication, 1997)

Hunter used sophisticated statistical techniques to show that, in his sample, the number of good job practices explained a significant part of the variation in workforce experience.

For several reasons, Hunter's sample probably included a disproportionate number of good homes relative to Pennsylvania today. Just 29% of Massachusetts nursing homes sent back Hunter's survey. While the sample appeared representative of the industry (as measured by mix of residents, level of care, location, and the like), what researchers call "social response bias" may have led more homes with better practices and lower turnover to respond. In addition, the nursing home industry in Massachusetts has always been a high-reimbursement, high-wage state, leading employers to invest more in human resources.[15]

Our hypothesis that there are a high proportion of low-quality homes is also consistent with two other sources of information. The Consumer Reports series on nursing home choices published in 1995 (Lieberman 1995 a-e) used government surveys to construct an index of quality based on 69 health-related deficiencies. *None of the 43 chains evaluated had a score of more than 80 on a scale of 100, and only 12 scored higher than 60.* Most of the best scoring chains with significant operations in Pennsylvania were religious non-profits, the best of which was the Friends General Conference, a Quaker group with facilities in Pennsylvania (Table 6). Table 6 also shows the substantial variation within virtually all chain and religious organizations. With two exceptions, every organization shown in the table had at least one home in the "best homes" category and one home in the "worst homes" category.

Government inspection data, collected by state regulators and collated by the Health Care Financing Administration, also show *that approximately 70% of facilities – over two thirds — are "out of substantial compliance" with the requirements of the Nursing Home Reform Act, as of their last survey*. (HCFA-HSQB 1996, Bordner 1996; HCFA 1996).[16] Even in Pennsylvania, which did slightly better than the national average, two thirds of 1025 homes inspected over an 18-month period were not in substantial compliance.[17]

Of course, the number of deficiencies does not always closely predict the overall quality of life for residents. The policy section of this report recommends additional research and surveys to track human resource practices and quality of life, as well as health indicators. That would enable the state to learn more about the characteristics that matter to residents in nursing facilities.

**Table 6**
**Consumer Reports Ratings of 16 National and Regional Organizations with Nursing Homes in Pennsylvania**

| *Chain/Religious Affiliation* | *Overall Score (out of 100)* | *Share of Homes in Best Homes Category* | *Share of Homes in Worst Homes Category* |
|---|---|---|---|
| Friends General Conference | 78 | 32% | 5% |
| Episcopal (ESMA) | 77 | 26 | 2 |
| Church of the Brethren | 76 | 16 | 0 |
| Presbyterian | 69 | 27 | 6 |
| Catholic Health Association | 62 | 19 | 9 |
| The Evangelical Lutheran Good Samaritan Society | 56 | 15 | 7 |
| United Jewish Federation | 53 | 10 | 8 |
| Manor HealthCare | 53 | 12 | 9 |
| United Methodist Association | 51 | 14 | 11 |
| Beverly Enterprises | 50 | 12 | 9 |
| Lutheran (NALMA) | 48 | 12 | 11 |
| Hillhaven | 46 | 12 | 14 |
| American Baptist | 44 | 14 | 12 |
| The Multicare Companies | 28 | 11 | 20 |
| Unicare Health Facilities | 24 | 9 | 23 |
| Integrated Health Services | 22 | 10 | 26 |

Source: Consumer Reports, August 1995. Nursing home providers were rated using an index of average critical deficiencies per survey, adjusting for state variation. Critical deficiencies were based on 69 Federal standards that relate to residents' health and well-being. Of the 43 organizations Consumer Reports rated, the Table includes those the magazine called "national" and those it indicated operate in a region that includes Pennsylvania. The numbers for "overall score" were read off a bar chart and are therefore approximate.

# 3. A Closer Look at Low-Quality Nursing Homes

"Patients are supposed to get between 2 and 3 hours of nursing per 24 hours. But… each patient gets only an average of 21 minutes, with all the CNA's duties, even if they work fast… [The aides] are not taking breaks, they are not eating."

— Union Representative

Manufacturing assembly line jobs have been carefully analyzed and broken down to enhance efficiency. In stark contrast, few managers in low-quality nursing homes have systematically examined what aides do or thought about how they might do it better. Their implicit assumption: there isn't much room for improvement. Low-quality homes pay aides a dollar or two above the minimum, with few or no benefits, schedule too few staff, and rely on workers' socialized sense of obligation to residents to ensure that aides do their best to get their long list of tasks completed. Training is minimal; many managers assume that workers need only generic knowledge — how to clean, feed, lift, care -- acquired by virtually all women in the course of growing up. In low quality homes, workers receive little or no supervision on "how" to do the tasks which are required of them, no feedback on the effects of their work, and virtually no information about the specific condition of the individual frail residents for whom they care.

When interviewed for this study, most administrators and directors of nursing had few ideas about how to rearrange work to improve the quality of care, working conditions, or the overall environment. Most nursing home administrators did not receive extensive training in long-term care or management; very few are versed in innovative work methods. "We are nowhere near a high-performance work place," said one high-level manager for a major for-profit chain. "We are just trying to get beyond the warm body syndrome."[18]

When told about team nursing arrangements for aides in other facilities, several managers exclaimed, "Why, that's a very interesting idea!" but did not then ask about how it worked. Managers' primary concerns are keeping the beds full of paying patients, and coping with a variety of regulations including labor and employment laws, state and federal licensing require-

ments, the Nursing Home Reform Act, and others. They tend to blame the payers or the workers for poor care. The story told by one manager in a mediocre facility was: "The government just doesn't want to pay [for Medicaid patients], so what can we do?" A nursing director in the same facility said, "The staff... are an insurmountable challenge... We need a 'better class of people' here. They have lots of family problems. They have minimal education." While many managers bemoaned the quality of staff they can hire for just above minimum wage, only a few of the dozens interviewed seem to understand the life situations and work motivations of the front-line staff, and to build on these in a positive way in engaging them in caring work (see Tellis-Nayak 1989 for a view of workers' lives).

Housekeeping, dietary and laundry workers in nursing homes all play important roles in preparing food and supplies as well as keeping the facility clean and sanitary. Many housekeepers or dietary workers have relationships with individual residents they see and talk with in the course of their work. But because nurse aides provide 90% of all hands-on care in nursing homes, this report focuses on nurse aides and their interactions with residents, nurses, and others (Institute of Medicine 1986: 101). Figure 2 shows the organization chart for a typical, mid-sized nursing home, including administrative and nursing staff.

### The Story of "Arianne:" a typical nurse aide's working day

The following describes the work day of a nurse aide shadowed in a mid-sized nursing home. Despite the frenetic quality of the story, most nursing home workers would recognize that this is not a "bad day at the office" for Arianne (not her real name). It reflects a typical working day .

Arianne gets to the nursing home at 6:20 a.m., ahead of her co-workers so that she can find some clean linens which might not have been used up on the night shift. There are never enough clean linens, or gloves either. As frequently happens, they are short of staff again— not enough people were scheduled to work. Arianne is given an extra six patients on top of her regular 11 to get up before breakfast at 7:30. She starts rousing her patients, two to a room. She gets them sitting up, changes their diapers (half of them are incontinent and lying in wet or dirty sheets), washes their faces and bodies in warm water, shaves the men, and gets them into clean clothes if she can find them.

As she is waking her sixth patient, a charge nurse pages Arianne on the loudspeaker. "Call light on 12," she is told. She puts her patient back to bed and races to #12. She tries to lift Mrs. Cole, who is heavy, by herself, and slips and wrenches her back. She tries to calm Mrs. Cole, who is crying.

Arianne rushes to get the Hoyer lift, which raises patients with a crank and belt. It is not available. She brings a bedpan but it is too late, Mrs. Cole has soiled the bed. She cleans and dresses Mrs. Cole, then goes back to 6, only to be told by the irritable nurse that she is late in getting people to breakfast. She wheels and walks the eight residents who are ready, one by one, to the dining room, and gets trays for the rest. She already has a bad headache. As she is taking dirty linens to the cart, the nurse scolds her because she didn't stay in the dining room to help her "feeders" eat breakfast. She tries to explain, but is cut off. "One could have choked. Be sure to get Mrs. Miller dressed nice today, her son is coming later," says the charge nurse, as she wheels

the medications cart to the dining room. "Mrs. Miller will have to be re-dressed," Arianne says, as she struggles to get the rest of her residents up and dressed. "But she will be really pleased to be going out."

At 8:30 a.m. she has a 10-minute break, but can't take it. The rest of the morning she can't even go to the bathroom. Mrs. Shattner becomes severely ill and is sent to the hospital. Arianne feels badly, for she has become close to Mrs. Shattner, but she doesn't get a chance to hold her hand or talk to her before she goes. Even though she is sorry, she is also glad there is one less person to care for. She finally begins her lunch break at 11:00 a.m.

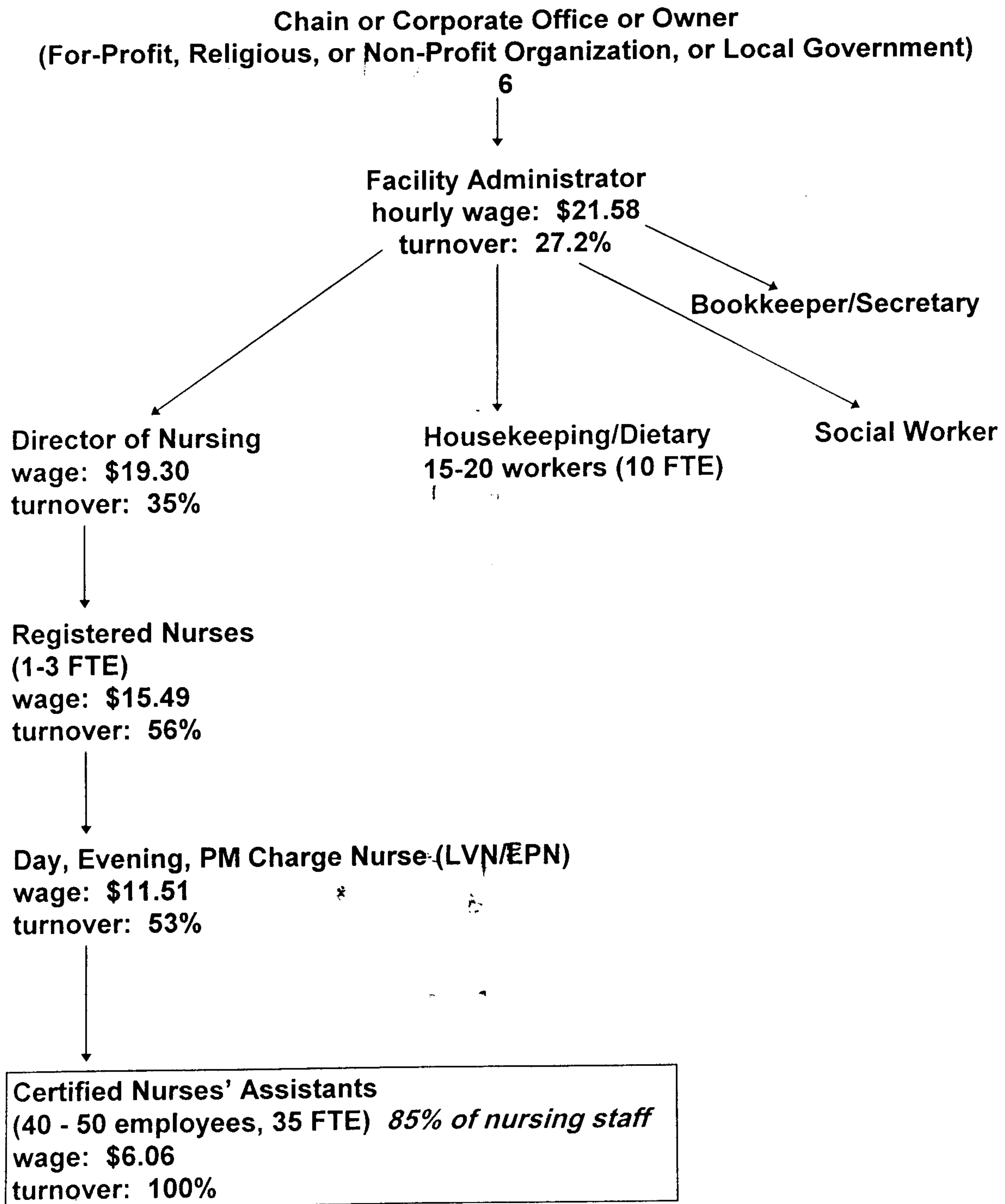
In the small, ammonia-smelling lunch room, her co-workers are talking about the new memo on the bulletin board. From now on, if you are sick either before or after your day off, you will get an automatic write-up. "Three write-ups and you are fired, even if you are sick in the hospital," says José. "Well, there are other lousy jobs out there." Arianne eats the leftovers she brought from home, and tries to get a little peace of mind in her 30 minutes. She will be taking all the residents, 17 of them this time, to the dining room for lunch.

Arianne knows that those who are in diapers will need changing again right after lunch. Next week is the state inspection, so she also has to fill in the documentation on everything she did in the last week. "If it's not documented, it didn't happen," says the director. Arianne understands why they need documentation, but isn't it better to take care of someone than to write down that you did it? Now she is trying to remember who had a bowel movement, and what they ate, and who had a bath. Each resident gets a bath a week, if there is time. Some hate the experience, and scream, so they are sometimes not bathed.

Getting residents to lunch, feeding them, changing them, and putting them down to nap takes the next two hours. From 1:30 to 2:30 p.m. she transports residents to activities and gives two baths, interrupting her work several times to answer call lights, though she can't leave someone alone in the bath. She asks for help, but is told no one is available. She can't talk to the residents who are used to seeing her for a few minutes every day, hearing about her children, and telling her about their grandchildren. At 2:30 she stops answering lights, and catches up on her documentation. She leaves the nursing home a little after 3:00 p.m., feeling exhausted, and catches the bus to her second job, a part-time nursing job in a nearby home where she works the 4:00 to 8:00 p.m. shift. By the time she gets home it will be 8:30 p.m. She will see her children and husband for a half hour before her husband goes to work the night shift at a nearby plant. Some months they don't have the same day off at all.

Arianne wants to go back to school at night to finish her G.E.D. She has been doing nursing aide work for eight years. But she can't manage school on top of two jobs. She also cannot afford health insurance with a 50% share plus co-payments and deductibles. She has been hoping for a promotion to rehabilitative aide, which pays 25 cents more than her $6.00 an hour, and requires less lifting and running. But there are 40 nurse aides in the 99-bed nursing home, and only one rehab aide.

***The role of aides in low-quality nursing homes*:** Work for a day shift aide in nursing homes includes waking, washing, toileting, and dressing eight to 12 patients, often before breakfast. She will feed them, change their beds, shower or bathe several residents, walk and toilet them as there is time, take




Source: Wunderlich, *et al*, eds. Institute of Medicine Report, 1996, Tables 6.5 and 6.6, pp. 160-161.

them to activities and to the lunchroom, lift and transfer them from bed to chair to shower to toilet and back to chair and bed, put them to bed for a nap, and record their vital signs, general condition, eating, and elimination patterns on a form. The average nursing home patient is unable to perform three or more activities of daily living (ADLs).[19] Aides also respond to unpredictable requests from residents, nurses, or administrators, and answer calls.

While many nursing home workers feel that they have nearly impossible jobs, they usually stay (if they do) because they like caring for old people. A significant number enter the industry having had experience caring for an elderly relative. They often develop warm relationships with their patients, and both can look forward to the interaction. The value of these relationships to residents is not always appreciated by nurses or doctors. These relationships represent a largely untapped resource for improving quality of care and worker responsibility levels.[20]

***Staffing***: In Pennsylvania, as nationally, nursing aides, patient care advocates, union officials and many managers see typical staffing levels as too low to provide high quality care. One chief executive of a proprietary Pennsylvania chain said that the expansion of home and personal care has increased acuity levels of those in nursing homes compared with 10 years ago. Staffing standards and reimbursement levels, he believes, have not adequately recognized the additional labor necessary with a less independent resident population.

Facilities must hypothetically have enough staff to "ensure resident needs are met," regardless of the specific hours standard. Some homes slip below the legal minimum (now 2.3 hours per patient day) because of predictable absences, vacations, or vacancies among the nursing staff. One Pennsylvania manager interviewed said she regularly staffed below the legal staffing standard on weekends. Based on its state Medicaid cost report, another Pennsylvania facility appeared to deliver 15,000 hours less nursing care than the annual minimum.[21] Since Department of Health nursing home inspectors do not routinely examine cost reports submitted to the Department of Public Welfare, endemic staffing violations may go unnoticed.

Most aides at low-quality homes say it is impossible to get everything done. Their concerns are the same in many workplaces — too much work, too many patients, not enough help or teamwork to accomplish the care safely, not enough supplies, insufficient recognition and respect, and too much paperwork. "It's a job," said one young worker. "But there's nothing to look forward to. You come to work, it's a heavy workload, and you try to get through." Another said, "there is not enough staff to help everyone."

In Pennsylvania, the required 2.3 hours of nursing care per patient day is lower than before case mix (because of the elimination of an "intermediate care" category for which the staffing standard was 2.6 hours). Moreover, the staffing standard includes all hours worked by any licensed or unlicensed nursing staff member — even if staff are getting supplies, in training, making a bed, or doing paperwork. A study at one *high-quality* home in Washington state (prior to its reorganization to address this problem) found that residents received direct care from staff for less than four percent of their waking day (about 36 minutes if residents sleep eight hours) . Residents spent only 3% of their day doing anything at all, and most of their time idle

and waiting (Providence Mt. St. Vincent 1994: 8). In California, a study by a local union negotiating committee at a more typical chain-owned home found that patients received about 21 minutes attention from aides over a 24-hour period.

***Supervision:*** Many nurse aides are left to swim— or sink— on their own. Indeed, many aides interviewed could not say who was their particular supervisor. Most supervising nurses have not done nurse aide work in years, if ever. None in low-quality homes visited was observed helping lift or clean a patient, or fetching an afghan, glasses, or dentures. Few offered ideas on how to do the work "better" or more efficiently.[22]

In the end in low quality homes, working faster is what many nurse supervisors recommend— "hurry up," or "didn't you do that yet?" are often heard on the floors. Another strategy is to look the other way when certain things do not get done. "I couldn't give showers because I had too many patients to take care of," said one nurse aide. "So my supervisor told me to write it down anyway because she had to show that it was done." Higher-level supervisors also admitted creating documentation for things that they had not done. They saw no alternative.

***Safety:*** Occupational injury and illness rates for nursing home workers are higher than for workers in mining and construction. Nursing home workers are injured at more than twice the rate of private sector workers generally. In nursing homes, 43% of all injuries are to the back and trunk (Personick 1990; SEIU 1994.) Injuries to nurse aides frequently occur while attempting to lift or transfer heavy patients.

Lower-quality facilities visited did not own lifts or did not keep them in working condition. Many aides described having to choose between helping a patient alone while risking injury, or trying to find others to help them while the patient waited, sometimes in discomfort or in need. "Back belts," which are in wide use, do not appear to prevent back injuries and may even give a false sense of security by supporting injured back muscles, according to union safety experts (SEIU 1994:23).

A religiously affiliated high quality facility and a county home in Pennsylvania, in contrast, invested in several different types of lifts, both mechanical and electric. Their injury rates have fallen substantially as a result. Most lifts require two persons to operate, so sufficient staffing and time are necessary if they are to be used properly. A third Pennsylvania administrator said that safety training and equipment pays back many times over, especially now that the facility is self-insured for workers' compensation.

***Workers' Lack of Involvement in Patient Care Decisions:*** In the typical nursing home, nursing aides are not included in resident care conferences, although OBRA requires that all care givers be included in care plan reviews. Some aides said they reported changes or concerns about residents to the charge nurse, only to feel they were ignored. Many are not included in discussions about medical conditions and treatment that would enable them to better interpret their residents' behavior. One aide read charts at night so that she would know what was going on with her residents.

***Training and the Importance of Resident-Specific Knowledge:*** The federal Nursing Home Reform Law (OBRA) requires aides to have at least 75 hours of training and to pass a written test.[23] Many facilities provide little on-the-job training or orientation beyond this. In the Pennsylvania facilities visited, initial orientation ranged from two days to 15 days before aides were given a full assignment to handle on their own. "Corporate cut it back from a week [to two days]," said a charge nurse in one for-profit facility. "I think it should be more."

Research shows that resident-specific knowledge is the most important in ensuring quality of life, safety, and adequate care.[24] While two people may have the same diagnoses (dementia, cataracts, arthritis), their exact comfort level, orientation level, needs and concerns, personality, and even their wheelchairs may be radically different. Perhaps the most difficult skill to learn is how to communicate effectively with individual residents. More than two-thirds of residents, even individuals without dementia, are sometimes in a state of confusion. Without knowing individual patients, one cannot know if moaning or crying is typical or indicates an emergency, if they need help feeding or prefer to feed themselves, even if slowly, or whether they need to be reminded of toileting.

The following examples from an interview illustrate the significance of aides' knowledge. One aide observed that a resident likes cool water on her back when being washed, but prefers warm water on her face. She also explained that a second resident's skin tears easily and a third cannot swallow easily, so she should be given only pureed food. While a swallowing difficulty would be listed on a resident's chart, these are inaccessible to aides. But an aide who knew about it would recognize the wrong diet being sent from the kitchen, and would not jeopardize the resident's health by trying to feed her solid food.

Because the knowledge most important in a nursing home for day-to-day quality of life is relationship-specific, it must be acquired over time. Turnover destroys it virtually completely. Yet low wages and difficult working conditions lead to turnover among nurse aides that averages more than 100% nationally. Turnover rises to 150% and even 300% in some homes. This reduces the quality of care dramatically.

The importance of positive relationships with aides is supported by the findings of a National Citizens' Coalition on Nursing Home Reform study conducted with 457 nursing home residents from 105 nursing homes in 15 cities (NCCNHR 1985). Residents said that "treatment with dignity, and staff attitudes" were the most important factor in their care, even ahead of stimulating activities and better food, and medical care. They wanted staff to be helpful, better supervised, oriented, and better trained — especially in specific care tasks, personal service tasks, basic nursing skills, human relations and psychological skills, and communication. Residents understand that people who work in nursing homes want to care for and help others. They thought that better pay and more career development would help attract and keep good people (NCCNHR, 1985: 1-12).

Training also can help aides deal with the stress of their jobs, and prevent abusive situations from developing. Excellent training is available from some advocacy groups, such as CARIE, which presents modules on handling resident and employee abuse, and on inter-cultural

communication and racism. CARIE's training programs for aides have won national recognition. One CARIE program is called "Ensuring an Abuse-Free Environment: A Learning Program for Nursing Home Staff." The eight-hour training program uses role plays and group brainstorming to help nursing assistants learn how to deal with difficult or violent residents without becoming abusive in return. Pilot tests at 14 facilities, including a follow-up six months later, showed definite positive changes in staff attitudes and behaviors, and a reduction in conflict experienced by aides (Pillemer and Hudson 1993). Carefully developed and tested programs, evaluated by groups that include aides themselves, could immeasurably improve the quality of care and jobs in the state.

In a well-organized facility, knowledge of residents can be transmitted from one aide to another through peer training, orientation, patient care committees, or team-work . However, this knowledge is rarely recognized or appreciated. As a result, in many facilities, nurse aides are "floated" from one area to another whether they know the residents or not.[25] But workers are not interchangeable. Residents come to trust and depend on certain individuals. The presence or absence of those individuals makes a difference.

**Unionization in Pennsylvania nursing homes**

In some low-quality nursing homes, poor compensation and unrealistic work standards generate collective anger that leads to employee attempts to form unions. In some higher-quality and county homes, unionization results because managers see a positive role for unions or respect workers' legal rights to organize. Overall, the private U.S. nursing home industry is roughly 10 to 11% unionized, about the same as other private sector industries. In Pennsylvania, a slightly higher percentage of private nursing home workers are unionized. Sixty-seven percent of Pennsylvania county homes are unionized. The Service Employees International Union (SEIU) represents 8,000 nursing home workers statewide. In the Philadelphia area, the Hospital Workers Union, District 1199C (an affiliate of AFSCME, the American Federation of State, County, and Municipal Employees), represents roughly 3,500 nursing home workers.[26] Nursing home unions usually represent the nursing aide, housekeeping, and dietary employees, and sometimes the Licensed Practical Nurses (LPNs) or Registered Nurses (RNs).

---

While they sometimes originate in response to low-quality practices, unions, once formed, often stabilize the workforce. They can, therefore, lead to improved quality. Hunter found that while 36% of employees in non-union Massachusetts nursing homes had three years' service or more, 54% of those at union homes did (Hunter, personal communication, 1997). Unions reduce turnover not only because of improved wages and benefits, but because they allow employees a "voice" and a chance to make things better instead of quitting (Freeman and Medoff 1984).

---

Some nursing home unions, recognizing their members' commitment to residents, have negotiated explicitly about care quality. For example, a 1995 national agreement between the Service Employees International Union and Grancare Inc. establishes innovative "patient care committees" in each home. In Philadelphia, management and District 1199C union activists at one higher-quality facility were establishing joint patient care teams. Other union agreements cover patient care through negotiations over workloads, rotations, and scheduling, as part of a labor-management or a safety committee. SEIU locals have negotiated staffing language and won management recognition for union "patient care representatives" in a variety of private and public

nursing facilities in Pennsylvania. These representatives will help to monitor conditions for all employees and residents, and communicate with management so as to address systemic or structural concerns rather than only individual issues.

### *Labor-management Conflict at Beverly*

Low-quality nursing homes often resist unionization and demands for wage and benefit increases because profitability depends on keeping compensation low. An ongoing conflict in Pennsylvania between Beverly Enterprises and the SEIU could be interpreted as an illustration of this. Beverly, which owns 42 homes in Pennsylvania, earns about 80 percent of its revenues from Medicaid and Medicare. Throughout the United States over the past 20 years, the National Labor Relations Board (NLRB) has issued multiple complaints against the company for illegally hindering employees' rights to form unions. In the current Pennsylvania case, the NLRB alleges that Beverly unlawfully fired striking workers and committed a variety of other labor law violations. As of this writing, the case remains under appeal.[27]

# 4. Three High-Quality Pennsylvania Facilities

Higher quality facilities typically serve a disproportionate number of more affluent patients, or they are not-for-profits that exist for the purpose of providing quality care for members of a particular group. Our three ideal types distinguish high quality homes from regenerative homes that explicitly break with conventional conceptions of care. In practice, homes may have elements of both ideal types, and exist on a continuum.

In the seven Pennsylvania homes visited, the highest quality homes based on observation and state inspections had the lowest turnover, while the lowest quality homes visited had the highest turnover. In most cases, the lowest-wage facilities had higher turnover. Yet some low-wage homes were high-cost facilities. Managers spent time compensating for gaps, dealing with hiring and orientation, and trying to prevent accidents.

The discussion below describes three Pennsylvania homes visited that combine high quality practices with movement toward a regenerative model.[28] Two of these homes serve more Medicaid residents than the industry average.

***Example 1: A Quaker Home***

One Pennsylvania Quaker facility visited has 120 residents, of whom 70% are Medicaid-dependent. It focused strongly on developing and supporting staff, on resident autonomy and dignity, and on building relationships with families and between staff and residents. It paid well, offered extensive benefits, staffed well, and gave aides more responsibility on their assignments. Managers built loyalty by supporting training and by helping readjust schedules to fit the needs of workers, and by chipping in to do the actual work. All these add up to a high quality facility with many feedback mechanisms to improve its performance. Eighty percent of employees have more than three years' experience at the facility. Nursing aides are assigned permanently to a group of seven or eight residents on days and a few more on evenings. Aides are called "care nurses."

The philosophy of the Quakers that health and dignity are paramount for all led the home to eliminate resident restraints early in the 1980s, years before reducing restraints as much as possible became public policy under OBRA. Because the Board of Directors believed it was inhumane to tie people up, or to medicate them into insensibility, staff developed ways to

avoid restraints while still providing appropriate care. One aide said, "They have a wander guard on their wrist, so if they go out the doors a buzzer goes off. But they have a right to wander around, and they will tell you, 'I have my right.'"

The care nurses have grown to like the long-term assignments, and have become attached to their residents. One said, "we used to rotate every two weeks. If someone had a red spot, or was starting a pressure sore, I might not notice. Now, every day after lunch when I put them to bed, I look for bed sores. They don't get bed sores here. No one has one." This is exceptional in any facility.

This facility's management also believes in developing staff skills. They want people to improve themselves and learn more. They offer tuition, paid up front, of $600 per semester, and include pro-rated tuition reimbursement for part-timers. In this one facility, a social worker began as a secretary. A medical records clerk began as a nurse aide. Several nurses' aides became nurses. One manager noted that the staff was "not a low-maintenance staff, but a high-maintenance staff. Nurses and managers need to prevent problems, and to build trust with employees."

In contrast to traditional facilities, managers helped directly with resident care. I observed the director of nursing listening to a resident who was having a difficult time. After a few questions, she told the resident, who was distressed at being unable to find her (deceased) husband, "You're a wonderful lady." The woman calmed, and smiled, saying "And you're a wonderful lady too." During a snowstorm, the administrator had helped out with the cooking. She also cleaned toilets if they were short. "Nobody's hands are too clean," say aides. "The bottom line is giving residents the best possible care." This nursing director spends 60% of her time with staff, finding that if she takes good care of the staff, the staff take good care of the residents. The administrator and nursing director know every patient and employee personally. Residents came into the director's office during interviews; the door is always open, and the atmosphere is welcoming, gentle, and humorous.

Aides took significant responsibility for resident outcomes in this facility. Aides were included in care planning meetings, which were held at the resident's bedside, with family members, the nursing managers, and the care nurse.[29] One aide explained that she had helped a resident recover from using a feeding tube to feeding herself — something a nursing director at a low quality home said was impossible— and helped others care for themselves as much as possible. She would do their washing when needed, or lay their clothes out, but sought not to treat her residents "like a baby." When I was introduced to residents, many listened intently only to the voice of the care nurse, and barely noticed my presence.

The administrator acknowledged financial stress. She was getting advice from a for-profit consultant about how to bill: their nurses had been doing certain procedures without billing for each one, as they are entitled to do. The managers survey residents regularly, with a sheet that has written and pictorial representations of possible feelings about programs, exercises, etc. The home has found that 81% of their residents talk with others, 87% say the staff smile at them, 90% feel they have privacy, and 78% identified one of the staff members as a friend.

One resident told me, "They take good care of us... I have [my care nurse] every day, except the one day she is off, and the administrator is lovely."

Finally, families played an important role in this facility. Each family is introduced to the care nurse, and given her phone number, so that any problems can be settled directly with the person who delivers primary care. The administrator also takes family phone calls daily, and made calls to families at the slightest change in the resident's condition. The staff hold a pre-admission meeting with families before residents arrive, to set expectations. "We are not going to make your mother into St. Theresa," said one staff member. "If she isn't already, that is."

This non-union home pays better than most others, starting trained aides at $7.76 per hour with a range of benefits including fully paid health insurance for workers. As one aide said, "If you pay $4.50 an hour, you're going to get $4.50 worth of work." This aide began at $5.50 an hour, 10 years ago. Aides found having their own concrete goals with residents (e.g. everyone should be walking and feeding themselves) challenged them and the residents, and made their daily work both more important and meaningful. The presence of adequate numbers of motivated and trained staff was important. One manager said vehemently, "2.3 hours of nursing care a day is a joke." This facility has a very low number of administrative staff and puts its limited resources into front line nursing personnel as a first priority.

Both managers and aides seem to love their work, though no one thinks it is easy. "It's hard work, but rewarding. This is the happiest job I've had," says one aide. Another said, "This is their home. We have to remember that," referring to the residents. So she gets them up in the order they prefer each morning. "We are community and family. We are all here together."

***Example 2: A Jewish Home for the Aged***

At one Pennsylvania Jewish Home for the Aged, the staff is paid well compared to some other area nursing homes.[30] Administrators give the predominantly non-Jewish aides and nurses education about Jewish cultural traditions. Each resident has a small colorful plaque with a photo and brief life story mounted outside her or his room. A longer version of the story is found in a notebook at each nursing station, open to nursing staff who want to read it. When each resident enters, a social worker reviews her or his life story with direct care staff. One aide told me of one resident's delight when she spoke to him about his life's work on the railroad, which she knew about from the book. The home has a staff council with representatives from every department and shift, which works to solve problems.

More than 180 residents, 55% of them Medicaid-eligible, live in units based on their acuity and need. The Home has had a geriatric psychiatrist for well over a decade; it views them as better at using drugs properly than general practitioners. The Home has a strong philosophy of providing meaningful activities and programs (including art, music, and religious expression) for their residents, visitors, and volunteers. Because they must raise money from the community, staff of the Jewish Home make it an open and welcoming place, with ample volunteer opportunities so that those who cannot give financially can give of their time, and so

that donors may see the effect of their gifts. Family members are welcome, and their involvement is solicited. The administrator says: "Families are an important constituency. We have always attracted the community— we have constant visitors. We are happy to have them. We never limited visitors' hours. Some are supportive, and some are critical. We formed a family support group, and a spouse support group. Some people stay in the spouse group even after their resident spouse has passed away. We also have a support group for newcomers, and a men's group, which watches and goes to baseball games together." The Home also features an intergenerational, award-winning puppet show. The facility had zero deficiencies on each of its last three state surveys.

Except for some floaters, this Jewish Home organized aides into two-person teams assigned permanently to a single unit. Within each unit, teams rotated periodically among sections. The teams meant that aides worked together with patients who were physically difficult to lift or emotionally difficult to attend, and that they could share their knowledge of the specific likes and dislikes of each patient. Because they came to know each resident of the unit, they could cover for each other in the event of vacations or unanticipated staff absences. One nurse aide was scheduled to every eight residents on days and one to nine on evening shifts. The Home held meetings at the beginning of each shift to report changes in resident conditions to incoming aides. It also encouraged employees to get continuing health-care related education, paying for half of it, helping with loans, and re-arranging workers' schedules to fit with school requirements.

Staffing levels permit close to 3.5 hours of care per patient rather than 2.3, and most aides describe the work as rewarding but demanding, especially when staffing ratios slip. They get a 10-day orientation when they start work (and must have long-term care experience), and then are assigned to a team for on-the-job orientation. Top-level staff screen potential aides, hiring less than one in every seven applicants; this selectivity can lead to delays in hiring. Managers say that new hires can learn skills, but not attitude or reliability. "Being able to take care of difficult elders in a compassionate way is most important," one said.

The director of nursing explains that most aides have been at the home at least several years. She supports the "team" system of nursing based on her experience in acute care hospitals (which more directors are beginning to have). At first, she says, the aides preferred working alone— but within a few months, they began to appreciate the "buddy" system, and the care improved. Fewer injuries occurred, and the home's quality standards improved. The Jewish Home also conducts training on a full-day schedule at least five times a year, finding that aides need ongoing training, especially as residents' conditions become more serious.

### *Example 3: A County Facility*

The Green Acres County Home in Gettysburg has 150 residents, 90% on Medical Assistance (Medicaid). The Administrator sees the mission of the home as fostering the independence and quality of life of residents. The facility runs a program to teach residents how to feed themselves. While it schedules meals at regular times, it informally accommodates some

residents' preferences for eating at other times. Green Acres has high levels of front-line and ancillary nursing staff. It pays wages close to the levels at the Quaker Home, while in a lower cost area. It offers good benefits which are available to all county employees. As in other good quality homes, the end result is a relatively experienced workforce.

Informed by her own religious convictions, administrator Pat Konhaus "looks at people, not the dollar as the bottom line." She sees this is "not necessarily the predominant thrust in this industry" and believes it distinguishes county from for-profit homes. She also sees the philosophy of her home as a natural outgrowth of the social mission county homes have to take care of the local indigent population.

Konhaus believes that nursing homes must aim to be "places to live, not places to die." The distinction between these two perceptions was crystallized for her by the reactions of her own family to the homes in which she has worked. While it disturbed her daughter to come to a nursing home, her son volunteered for a summer, showing up every morning. While her daughter could not look past all the capacities that the residents of the home had lost, her son instinctively saw the vibrancy that residents retained. Sharing her son's views, Konhaus says that she could not do her job if she looked at the home as a warehouse for people approaching death.

Given the chronic problems of many residents, Konhaus sees the goal of the home not as curing them, but as enhancing their capacity to enjoy life given their condition. For her, the traditional medical model brings with it an authoritarian element that sometimes undermines resident self-determination. Doctors can tell staff to deny a resident candy if they have a diabetic condition, while Konhaus would explain the consequences, but let the resident choose. A medical model may also call for patients to be woken to have sheets changed, she says, even when their comfort level might be enhanced by letting them sleep. (A recent survey at the home, however, found significant problems with pressure sores.)

To promote resident independence, the home employs physical and occupational therapists to teach people how to feed themselves and to restore functional independence in other ways. The dietary staff also supports residents' individual preferences, by making them a grilled cheese or egg sandwich if they prefer that to the regular menu.

The home employs one nursing aides for each of 5 residents on day shift as well as a unusually large number of LPNs (one for each five residents counting LPNs on all three shifts). Prior to case mix, the home was able to afford this: at that time, a mandated county contribution of about 5 percent of total cost supplemented state and federal reimbursement. In addition, the home has no profit, few frills designed to attract contributions, and a streamlined administrative staff paid less than in private for-profits. The home also spends all of its allocation each year on care. In the medium term, fiscal pressure may intensify on county homes due to the shift to case mix reimbursement.

The Administrator believes that to deliver quality care, front-line nursing staff must themselves be treated with respect. To increase continuity of care, the nursing staff at the home serve on one of three units (rather than rotating across the whole facility). To support nursing

aides, managers recently introduced a new entry-level "resident assistant" position. In many cases, resident assistants can respond to simple requests from more independent residents (e.g., to wheel them to an activity, get a blanket, or bring a pair of glasses), so that aides need not interrupt a feeding, cleaning, or bathing. This position also allows new recruits to find out whether their interest in "helping people" remains intact, once they understand what that means in a nursing home environment. If resident assistants leave, residents' lives are less severely disrupted than if aides do.

The administrator believes the Pennsylvania Association of County -Affiliated Homes (PACAH), of which she is the current president, plays a valuable role. PACAH holds annual state-wide and quarterly regional meetings for administrators. Attendees at these meetings see themselves as "in this together," not as competing with each other. Between meetings, they talk to each other periodically to seek advice.[31]

# 5. National Examples of Regenerative Nursing Homes

"One day…elderly residents were each given a choice of house plants to care for and were asked to make a number of small decisions about their daily routines. A year and a half later,,,these people were more cheerful, active, and alert than a similar… group in the same institution…Less than half as many of the decision-making, plant-minding residents had died as had those in the other group."

— Ellen Langer,
Mindfulness, 1989, p.1

The facilities described as "high quality" in Chapter 4 experimented with creative forms of work organization while providing good staffing ratios, higher than average pay, pre-hire screening, and ongoing training. Some facilities draw more explicitly on a new "paradigm" focused on creating a "regenerative" or holistic community in which residents continue to grow, develop, and learn. Often the initiator or leader of these programs came from outside the industry and fought an uphill battle against highly institutionalized beliefs about what a nursing home "is." As these models succeed in improving care and social and medical outcomes, as well as improving jobs for the staff, their lessons and visions must be shared with other providers.

***Example 1: The Eden Alternative***

At the Eden Alternative, a small-town nursing home in upstate New York, the residents include more than 200 birds, four cats, and two dogs. Dozens of plants, a child care center, a garden, and a visiting school-children's program also help create what founders Dr. William Thomas and his wife Judy call "a holistic environment." Thomas, a part-time faculty member at the State University of New York (SUNY), and a small-town doctor, used to hate his rounds at local nursing homes. The Eden Alternative (1990) describes his attempt to create an environment in which older (and younger) people could thrive. By offering older people the opportunity to play and interact with a wide variety of birds, animals and young people, the Thomases and their colleagues created a more healthful and generative community. One operating principle is that people need to give as well as receive care to feel valued and valuable (see also Langer, 1989). The Eden paradigm allowed them to care for animals, birds, and children as well as each other, rather than to only "receive" care.

At Eden, Thomas asked aides to make their own schedules. Immediately staff attendance improved as people worked out their responsibilities at home and at work for themselves. Thomas got rid of physical and chemical restraints, before the law required it, and found that residents who had been restrained began walking and talking again, with help. Compared to a nearby control facility, the Eden Alternative experienced reduced mortality and illness, as well as lower drug use and bills (Thomas 1990). The start-up financial costs were relatively minor. The entire cost of "Edenizing" the facility with animals, plants, and staff training can be done carefully for about $100 a bed, less than 1/300th of most facility's budgets for that bed currently. Thomas notes that "the biggest cost is changing your mind."

The Thomases have engaged in several projects to replicate and document results of facilities in upstate New York, New Hampshire, Missouri, and Texas (with help from the Institute for Quality Improvement for Long Term Care at Southwest Texas University, funded by the state legislature). They are working on a replication "technology" for such a holistic philosophy. In some states, including Pennsylvania, reimbursement impedes replication by penalizing facilities when residents become healthier or take less medication.[32]

### *Example 2: Providence/ Mt. St. Vincent*

At Providence/ Mt. St. Vincent, a Catholic long-term care facility in Washington State, another visionary leader and his colleagues are turning a traditional facility into a regenerative community rather than a place to die. This is the home in which, before a reorganization referred to earlier, residents received direct care for 3.2% of their waking day. Nurse aides spent two-thirds as much time completing paperwork as assisting residents. Residents spent only seven percent of their day interacting with staff, other residents, or visitors. Baseline measures of resident physical and cognitive capacities trended down after entrance to the home, as in most nursing homes (Mt. St. Vincent 1994). But Ogden noted that "Staff were doing exactly what they have been trained and were expected to do... We had committed and hard working staff forced to use an antiquated and stupid system" (Mt. St. Vincent 1994: 13).

Since this pre-study, care delivery on that unit has been reorganized so that five residents are supported by a single "resident aide." Activity planning, assistance with individualized food preparation, and some social and rehabilitation planning have been integrated into resident aide jobs, in conjunction with the residents themselves in each "Experimental Neighborhood." Each experimental unit was remodeled to include a living room, kitchen, and small dining room for each "family" rather than the usual institutional corridors. The aides' jobs were redefined to include talking with residents, attending to their requests for specific items as well as for companionship, and helping them to eat at times and meals of their choice rather than feeding everyone the same thing at the same time. This required that aides be cross-trained and licensed as food handlers, so they could help residents make a sandwich if that was what they preferred. Similarly, housekeeping staff were assigned to the same "neighborhood" unit and were cross-trained as nursing assistants so they could help with toileting, bathing, etc. at times when residents preferred rather than on an institutional schedule.

As the new job title suggests, managers redefined the aide's job to focus on what the residents wanted, not the nurses. They deploy licensed nursing staff as a clinical resource available on demand rather than as controlling figures responsible for each moment of the day. This allowed the home to substitute some resident aides for nurses at the rate of 2 to 1 (resident aides earned about $9 an hour and nurses about $18), and to provide more hands-on care staff without compromising quality of care. Eliminating some middle management jobs funded the designation of resident coordinators for a neighborhood (Boyd 1994).

Residents now spend 15% of their day (compared to 7% earlier) interacting with others, and 50% of the day (not one-third) engaged in activity of some kind. Residents' functional capacities improved, while they continued to fall in control groups. Medication dosages and usage declined significantly compared to the control setting. Infections also declined, as did "incidents" like skin tears or falls (Mt. St. Vincent 1994: 27-33). Many resident aides found their jobs more rewarding because they included more variety and required more judgment and skill (Eaton interview 1995).

Many changes were made in traditional assumptions about long-term care. The emphasis on resident choice also required helping resident neighbors to cope with disturbed and demented residents. Family support was crucial. Not everyone who had worked in the prior facility was able to adjust to the new paradigm of care. In some cases, Ogden had to hire people **not** trained in long term care to get beyond deeply embedded assumptions.

All of this was accomplished without additional cost aside from the initial remodeling, and the research and documentation effort. Longer-term health care costs could be reduced if overall resident health status improves as it did in this innovation (Boyd 1994).

# 6. Policy Recommendations

The long-term care industry is at a crossroads…Concerted efforts to spread regenerative care…could achieve both high quality care and better jobs.

Viewed in historical terms, the long-term care industry is at a cross-roads. In the next two decades, cuts in funding, increases in the number of long-term elderly, and more care delivery in hard-to-monitor dispersed settings could lead to new and widespread examples of neglect and abuse, accompanied by low-wage, high-turnover jobs. Concerted efforts to spread regenerative care models, paraprofessionalize care provider work, and creatively contain costs could achieve both high quality care and better jobs, with improved advancement opportunities. This section considers how to achieve better outcomes.

It is important to stress that, while adequate resources are absolutely essential to achieving a more positive scenario, significant quality improvement can come from spending resources more effectively. There are several reasons for this.

**Cutting workforce turnover lowers recruitment and training costs**. One industry source estimates that each new hire costs nursing homes $4,000. Assuming an annual wage of $12,250 (an hourly wage of $7.00, 35 hours per week, and 50 weeks per year) and a turnover rate of 100 percent for aides, turnover costs typical homes roughly one third of what they pay in wages. Lowering turnover by half — an achievable goal given the much lower workforce churning at higher quality homes — would by itself pay for a $1.14 per hour wage increase for aides.

**Quality Saves**. In U.S. manufacturing until the 1980s it was assumed that better quality would cost more. Today, managers in factories recognize that "quality is free," and indeed, it often saves money. Diagnosing the root causes of quality problems contributes to less scrap, less rework, higher customer satisfaction, and higher profits. In the vast majority of nursing homes, the potential for saving money through improved quality has barely begun to be explored. How much of the annual $3.26 billion cost of incontinence in nursing homes could be saved through more and better trained staff ? How much could be saved in workers compensation and medical costs through adequate staffing and ensuring that all homes have adequate lifting equipment and training for aides in how to use it? And how much of the billions spent on treating pressures could be saved by preventing them— with frequent turning, massage, mobility, and proper skin care.[33]

**Fostering Resident Independence Saves Money**. At present, excessive reliance on physical and chemical restraints contributes to high costs. It reinforces resident functional decline and dependence on staff to help with basic activities of daily living.[34] Fostering resident independence through regenerative practices, within assisted living settings as well as nursing homes, has untapped potential to lower the need for staff.

**Resources Could be Shifted from High-tech Medicine to Regenerative Long-term Care**. In principle, resources could be shifted towards life-enhancing long-term care and away from expensive, last-ditch efforts to cure particular medical problems in patients with multiple chronic disabilities. The hard part is finding a way of explicitly bargaining this trade-off. If this is not done, managed care organizations may end up developing rules rationing care for Medicaid as well as private pay recipients and pocketing much of the savings. Our recommendations below, including the creation of a stakeholder council committed to quality of care, should improve chances for constructive bargaining about how to move resources toward regenerative care and away from expensive end-of-life medical care.

**Enabling Families to Provide More Long-term Care**. The expansion of long-term care stems in part from the struggle by families to tread water economically through having both partners work full time. Families might be able to afford to take back a larger share of responsibility for caring for their elders if workers in the bottom half of the income distribution were able, once again, to share in the fruits of economic growth. Subsidized family leave for those engaged in elder or child care, or a 30-hour work week, might also give families more of the time and money they need to care for their kin. As this implies, the prospects for a more positive scenario in long-term care depend not only on policy in the industry itself. They depend also on state and national capacity to define a more equitable economic development path in general, one that recognizes quality of life in all its meanings as a central guiding principle.

In sum, the defeatist assumption that we cannot get better value for public investment in long-term care is simply wrong. We must challenge this assumption before it becomes a self-fulfilling prophecy. We must challenge the related assumption that, as the baby boom ages and the very old elderly population mushrooms, we can do no better than bad care, bad jobs, and high cost. The text and table below spell out in detail how *Pennsylvania can do better*.

***Recommendation 1. A Pennsylvania Quality Care Council***

**A.** To spearhead reform, the Pennsylvania legislature should modify Act 185 to reconstitute the Intra-Governmental Council on Long-term Care into a Pennsylvania Quality Care Council.[35] Act 185, passed in 1988, established the Intra-Governmental Council. To its credit, the Ridge Administration has recently revived it and made it an important public forum for information sharing and dialogue on policy. Its composition, however, would have to be modified to make it a more powerful and cohesive voice for quality care. The council now has 13 provider representatives, five resident advocates, and one employee representative, and six state government representatives.[36]

## Table 7
## Summary Of Policy Recommendations

| Recommendation | Actions |
|---|---|
| **1. Form a Pennsylvania Quality Care Council (PQCC)** | A. Modify Act 185 to establish a PQCC with stronger representation from resident advocates, residents and families, and workers who deliver care.<br>B. Develop a "Charter of Customer and Worker Rights and Responsibilities"<br>C. Develop a long-term industry strategic plan |
| **2. Promote Research and Information Dissemination to Promote High Quality and Regenerative Care** | A. Support research and dissemination of best practice<br>♦ *research and pilot programs on innovative approaches*<br>♦ *a Business-Quality Partnership Grant for dissemination*<br>♦ *meetings to discuss "best" and "standard" practice*<br>B. Conduct survey research on the human resources and quality connection<br>C. Develop an annual quality report card on providers |
| **3. Reform the Survey Process to Discourage Low-Quality and Promote High-Quality Care** | A. Increase fines for serious deficiencies to discourage low-quality models of care<br>B. Use surveys to promote learning about high-quality practice |
| **4. Change Reimbursement to Reward Quality** | A. Maintain higher case mix reimbursement after residents improve<br>B. Increase reimbursement for homes with low turnover<br>C. PQCC should conduct a general review of case mix |
| **5. Paraprofessionalize Nurse Aides In Long-Term Care** | A. Pay aides a living wage and health benefits<br>B. Improve training and credentialing; emphasize peer mentoring<br>C. Create career ladders that cut across all health care organizations in an area<br>D. Promote paraprofessional association<br>♦ *Strengthen protections for union formation in individual homes by: including information on labor-management disputes in report cards; prohibiting the state government from doing business with repeat labor law violators*<br>♦ *Pennsylvania should request jurisdiction over long-term care from the National Labor Relations Board and implement statutory changes to promote occupation-wide nurse aide associations as well as require first contract arbitration* |

To become a more effective vehicle for defining and implementing cost-effective, high quality care, a PQCC should have more representation from residents and their families, employees (aides, LPNs, RNs, DONs, other support staff, administrators) and individuals knowledgeable about industry best practice (ombudspeople and researchers). Stakeholders should lead the new Council. The new Council could be staffed by a new sub-unit of the Health Care Cost Containment Council and appropriated an annual budget of $1 million.[37] Organizations on the Council should donate their own time to the PQCC.

A Council with this composition should be able to create an industry consensus in favor of better care and better jobs.[38] It is, after all, difficult in open dialogue to advocate for the right to profit from high-turnover, low-wage strategies at the expense of both residents and workers. Moreover, much of the provider community, for-profits as well as not-for-profits, would prefer to be able to pay workers decent wages and benefits – and not have to deal with headaches of high turnover – as long as reimbursement is sufficient to permit this (see, for evidence, the box below which excerpts a statement by the Pennsylvania Association of Home Health Agencies).

**B.** To guide its efforts, the Council should develop and seek consensus support for a **"Charter of Consumer and Worker Rights and Responsibilities**."[39] Such a charter might commit employers and employees to helping all infirm Pennsylvanians recover physical and social capacities, when possible, and to providing personalized attention and dignity in daily life for those with irreversible incapacity.[40] It might commit employers and the government to pay workers a "living wage," with health benefits and an opportunity for training and advancement into higher paid occupations (see Recommendation 4A). It might commit industry stakeholders to search continuously for ways of improving cost-effectiveness without sacrificing quality.

**C. Develop a Long-term Industry Strategic Plan** After outlining its Charter, the new PQCC should develop a strategic plan that outlines how the stakeholders believe the industry can best achieve *all* the goals articulated in the Charter. This might foster less institutional delivery of long-term care in conjunction with a general embrace of "regenerative" approaches. The plan, however, would need to guard against an emerging presumption that competition and "consumer choice" will safeguard quality in community and home-based services any more than they do in nursing homes. Because the market does not ensure quality in long-term care, inadequate state oversight outside nursing homes could lead to widespread neglect and abuse.

In addition to the steps above, a new Quality Care Council could play a central role in designing and implementing many of the other policies outlined below.

***Recommendation 2. Promote Research, Education, and Information Dissemination to Expand Regenerative Care***

**A. Conduct Research and Disseminate "Best Practice**." Many nursing homes and home care services continue to operate on the assumption that the low-quality model is the

only option. To challenge traditional thinking, the Department of Aging could ask the PQCC to oversee research and small-scale pilots on innovative work systems and high-quality care. Dissemination of results to this fragmented industry (many nursing homes are small) should be a priority. Dissemination might be supported through a grant from the Department of Community and Economic Development's Pennsylvania Business-Quality Partnership Program to a coalition of some of the organizations on the PQCC. Substate regions might create local analogues to the state-wide Quality Care Council to identify local examples of "above standard," and "below standard" practice. These examples might fuel concrete dialogue about doing better that is of immediate relevance to administrators and DONs.[41] In addition to sponsoring researching on practices in other states, the Council might investigate long-term care in other countries, including how to promote deinstitutionalization without promoting neglect.

**B. Support Survey Research on the Human Resource and Quality Connection**. The Departments of Aging, Health, and Public Welfare should support additional large-sample survey research on the links between human resource indicators (employee turnover, satisfaction, staffing levels, etc.) and the quality of care (for a related recommendation, see CARIE 1995:12). As well as other hypotheses, such surveys could be used to test the hypotheses in this report about the existence of low-quality, high-quality, and regenerative nursing homes and their basic characteristics.

**C. Publish an Annual Long-term Care Consumers' "Report Card."** Market failures resulting from consumers' difficulty in evaluating quality of care in nursing homes contribute to the persistence of low-quality models and retard the spread of regenerative approaches. A Pennsylvania Quality Care Council should develop an annual consumers' report card on long-term care providers that would be accessible to the public. Debate within the PQCC would be important to ensure that the card provides as much information as possible but does not place an undue reporting burden on providers.[42] Published by the Department of Aging in cooperation with other agencies, a comprehensive report card could contain information on resident health and changes in functional capabilities (controlling for initial case mix), use of medication, staffing levels, turnover rates and staff experience levels, training, certification, and licensing of staff, as well as documenting equitable access to all clients to ensure non-discrimination. To publish a report care with this information would require a new short survey on human resource practices and additional surveys of long-term care providers outside the nursing home segment (The Intra-Governmental Council is currently surveying non-institutional providers about the information they track internally and would therefore be able to provide to the public. The Council has not asked if providers keep information on training, workforce experience, wages, benefits, or other human resource practices). This recommendation for "quality report cards" echoes proposals from advocacy groups (CARIE 1995: 12). Reports in each region should be publicly available at local facilities, agencies, and public libraries.

***Recommendation 3. Health Department Survey Reform to Discourage Low-Quality and Promote High-Quality Care***

Ideally, annual inspections of nursing homes by Department of Health surveyors would perform a dual function. They would help ensure a basic minimum level of quality in all homes. They would also use the training and experience of surveyors to spread knowledge of high-quality practices. At the moment, the survey process may not perform either function particularly well.

**A. Increase Penalties for Serious Deficiencies to Discourage Low-Quality Models**. Surveys today may not discourage low-quality models of care because of incomplete reporting and weak sanctions. For example, questions exist about the extent to which Pennsylvania surveyors catch or cite violations of staffing standards, a defining characteristic of low-quality care models. In addition, Pennsylvania does not enforce new federal nursing home regulations as aggressively as some other states. Texas, for example, has fined one home $210,000 for life-threatening conditions. Texas sued another home after the state found "weight loss to the point that residents look like people coming out of concentration camps." While one industry executive suggested that Texas has greater need of tough sanctions, a meaningful economic deterrent for persistent, serious deficiencies would still help Pennsylvania eliminate low-quality models of care. To reduce industry opposition, Pennsylvania might contribute the fines to a pool that can be awarded to model homes that deliver high-quality care or to efforts to replicate such models.

**B. Use Surveys to Promote Learning About High-Quality Practice.** While inadequate fines make surveys a weak tool for eliminating substandard care, federal law also prohibits surveyors from acting as "consultants" as opposed to "cops." Stakeholders are divided on the advisability of this. Many resident advocates fear that integrating responsibility for identifying deficiencies with a role in helping homes improve — even if a way around federal constraints could be found – might tighten social ties between administrators and surveyors, further cutting willingness to report deficiencies. On the other hand, most administrators – even those at good homes — see surveys as diverting attention from what most influences quality of life. This perception contributes to industry interest in establishing self-certification of the kind that exists in the hospital industry.[43]

The disagreement within the industry, including among parties with a commitment to high quality care, makes this an issue on which to the Quality Care Council might seek a creative consensus solution consistent with federal law. Are there possible benefits from training surveyors in high-quality and regenerative practices and then modifying the survey to take better advantage of surveyors knowledge of practice in a large number of homes.[44] Should "quality of life" indicators be given more weight in surveys? Could reports include recommendations for improvement on which homes would be evaluated on subsequent surveys? Would it be possible to design a survey process that reserves the most severe sanctions for homes that cover up deficiencies and that show no improvement, thus encouraging more open communication on a first visit and a focus on "problem-solving"? Modifications along these lines might better utilize the knowledge accumulated by experienced surveyors. If their direct experience is complemented by training (and periodic refresher courses) on industry "best practice," it might contribute more to the movement towards high quality and regenerative approaches.

***Recommendation 4. Modify Reimbursement Formulas to Promote Higher Quality Care***

The weakness of economic incentives to improve the quality of care contribute to the prevalence and persistence of low-quality care. Three approaches to addressing this problem follow.

**A. Maintain Higher Case Mix Reimbursement After Residents Improve**. Pennsylvania's new "case mix" system reimburses care providers based on the nature of their residents' infirmities; reimbursement thus falls if resident status improves.[45] Homes do need more money for residents that require more labor-intensive care, and case mix does help ensure that nursing homes take in these more incapacitated (and remunerative) patients. Case mix, however, can create perverse incentives. According to one aide, her Pennsylvania home maintained a gastric tube and catheter beyond the time a resident needed it to maintain higher reimbursement. To ameliorate this problem, the state should permit homes to maintain a higher reimbursement rate for a limited period after a resident improves. This suggestion was proposed by advocates, and rejected by the Department of Welfare, in its initial formulation of the Pennsylvania Case Mix Index.

**B. Increase Reimbursement for Homes with Low Turnover**. At present, the Pennsylvania reimbursement system also contains no incentives for human resource practices consistent with high quality models. To address this, reimbursement could be made more generous for homes with lower turnover. Along the same lines, homes could be reimbursed for investing more in training, or paying higher wage and benefit levels (see 5A).

**C. The PQCC Should Conduct a General Review of Case Mix**. The state should also request the new Quality Care Council to conduct a general review of the case mix standards. This review should pay special attention to perverse incentives and promoting positive staff practices, and should develop a proposal for reform.

***Recommendation 5: Paraprofessionalize Nurse Aide Work***

Much long term care is seen as "unskilled" work that almost anyone can do. That is why economists would say it pays so little. As with many so-called unskilled jobs, however, many "skilled" people would find themselves hard pressed to do a good job in a nurse aide role. Turning 12 to 14 patients safely and gently every two hours; treating bedsores; cleaning and changing people; feeding them when they don't want to eat; developing a relationship with them; dealing with every psychological state from acute depression to dementia to mania, and with patients who can be verbally or physically abusive; cheering people up, helping them regain or maintain whatever level of dignity and functioning (bladder, bowel, walking, feeding, talking) they can; reporting to nurses who may not have time to hear what you have to say: these are difficult tasks to do well and patiently, day in and day out.[46]

Since the quality of care is ultimately only as good as the level of commitment, experience, training, staffing and tenure of the front-line caregivers, Pennsylvania should adopt the following proposals.

**A. Pay Long-term Care Workers a Living Wage Plus Health Benefits.** In a wave of campaigns in major U.S. cities recently, including Baltimore and Philadelphia, ordinances have been sought that require city contractors or firms receiving government subsidies to pay their workers a living wage. In line with these recent campaigns, Pennsylvania should require nursing homes and other providers receiving Medicaid dollars to pay their workers a living wage and health benefits. Given the importance of experience and low turnover in long-term care, a living wage would pay off significantly in better quality.

Of course, a real "living wage" – one high enough to generate what polling data and research on the cost of basic necessities suggest to be a minimum income – would require paying a full-time, full-year worker about $12.00 per hour (for a brief discussion and references, see Keystone's The State of Working Pennsylvania (Herzenberg with Nearman:35)). As a starting point in long-term care, we define a "living wage" by a more meager standard: high enough to permit a family of four with a full-time worker to earn above poverty-level wages. We define this as 110% of the 1996 federal poverty guideline for a family of four (with future adjustment for inflation), which would be $17,160, or $8.58 an hour for workers who work 2000 hours a year.[47] Providers should also be required to contribute at least a dollar an hour toward family health care per worker and, failing that, to raise wages to $9.58. Regulations must ensure that front-line, or direct care, staffing is not reduced when wages increase.

Government need not pay the full cost of wage and benefit increase because of reductions in recruitment and training costs when turnover falls. Additional savings to providers may result over time from reduced medication costs, fewer injuries, lower workers' compensation premiums, fewer pressure sores, incorporation of more responsibility into aide positions and streamlining management and ancillary staff. Reimbursing homes for the increase in their

**The Pennsylvania Home Care Industry On The Importance Of Adequate Pay And Benefits For Home Care Workers**

A recent policy statement of the Pennsylvania Association of Home-Health Agencies (PAHHA) emphasizes the importance of adequate compensation to low turnover and high quality in long-term care:

…PAHHA believes that the availability of adequately trained personnel is actually the fulcrum on which the success of the entire [effort to reform long-term care and move from an institutional/medical focus to a home and community-based care focus] depends. The workers who will be the most crucial to the implementation of a home and community-based care focus will be home care aides. Home care aides are paraprofessional workers who provide frontline care…

The largest current challenge in the employment of home care aides is Retention…The work of home care aides is a complex, difficult, and strenuous job that often involves both high physical and high emotional demand…

There is a demonstrated correlation between compensation and retention…An adequate salary and competitive benefits – most importantly, health care benefits – are the cornerstone of employing and retaining a cadre of committed, caring, competent care givers…

…The Older Women's League, in its '1996 Mother's Day Report," puts a human face on the issue for both caregivers and for consumers. Some excerpts: "Paid caregivers - including home health aides… - provide the bulk of day-to-day care in consumers' homes…High quality care offers consumers the assistance they need to maintain and improve their level of function – physically, mentally, and socially. Poor care can cause consumers to lose critical abilities, such as walking or bladder control…Poor wages and benefits make it difficult for paid caregivers to care for themselves properly, which limits their ability to care for others…High turnover undermines the continuity of care so important in assuring high quality."

The primary and ultimate focus of all long-term care policy must be on the well-being of the consumer of care. There are few things more crucial to quality care for long-term care consumers than their ability to rely on continuity from their home care aides – it is the consumer who is ultimately either well-served or disadvantaged by agencies' ability to retain their home care aides. The nature of the work of home care aides is such that it frequently forges strong bonds between the consumer and the aide, and a constant turnover in the aide who is assisting the consumer with some of their personal needs is disquieting and disruptive for the elderly or disabled person.

---

The Pennsylvania Council on Long-term Care is in a unique position to insist that public policy issues with retention of home care aides be given prominence in Pennsylvania's discussion of long-term care for the 21st century, and the Pennsylvania Association of Home Health Agencies encourages the Council to ensure that those issues are addressed.

compensation minus savings because of lower turnover would cost the state approximately $56 million dollars annually, between two and three percent of the total spent on long-term care in Pennsylvania (PIGCLTC 1996, p. 3), and about 5 percent of what the state itself spends (this estimate takes account of increased taxes that result from paying workers more; for details, contact the Keystone Research Center).

A living wage and benefit requirement might would make some low-quality nursing homes less profitable. It would create a level playing field for high-quality nursing homes and long-term care providers that already meet the requirements of the living wage. We see both of these effects as positive, and means for accelerating industry movement in a high quality direction.

**B. Improve Training and Credentialing to Increase Skills.** At present, in Pennsylvania, nurse aides are required to receive 75 hours of training, the Federal minimum, to be 'deemed competent.' Several other states, including Vermont, now require licensing of nursing aides who work in nursing homes.[48] While licensing can increase accountability, certification can be a double-edged sword, sometimes closing off opportunities for advancement by adding educational requirements that have little to do with competence on the job. If adequate provision is made for the existing workforce to obtain new credentials while on the job, higher levels of training could support a move towards higher quality care. Drawing on the experience of other states, the Council on Quality Care should develop a proposal for long-term care licensing and a curriculum that combines classroom and on-the-job and peer training to obtain a license.[49] A curriculum committee should include some aides as well as researchers and practitioners familiar with regenerative care models. The curriculum should include specialized geriatrics training; only about 8% of nursing directors have such training, and even fewer RNs, LPNs and aides do (Wunderlich et al 1996; Maas et al 1996).

**C. Strengthen Career Ladders**. As a complement to licensing, the state should encourage the development of career ladders that give aides access to higher-paid jobs in clerical and administrative work, nursing, social work, or physical therapy. This would assist those who desire to move out of nursing homes as well as reducing turnover in homes because they would be seen as less dead-end jobs. In Philadelphia a multi-employer group and District 1199C, AFSCME, have created a joint labor-management training fund which provides opportunities for employees to advance either within their own employer or other employers in the area. In its anticipated reform of workforce development in Pennsylvania, the state government should designate funds to create and strengthen career ladders that span large numbers of health care providers in geographical areas rather than just the jobs in an individual home.

**D. Promote Paraprofessional Association of Aides**. The best protection against abuse and vehicle for promoting high quality across the full spectrum of long-term care settings will be through the paraprofessionalization of nurse aide work. The state should therefore promote the creation of paraprofessional associations of aides. A paraprofessional association should be linked to the occupation rather than the individual homes. If the issue of wages has been partly removed from bargaining, through the establishment of occupational living wage minimum, that would allow the more professional dimension of care provider identity to flourish.

Formation of paraprofessional associations could be done in a variety of ways. **Strengthening protections for forming unions in individual homes** could be a stepping stone to an association that cuts across represented homes. The state should require that nursing home report cards include information on labor-management disputes that potential residents or their families might consider relevant to their judgments about care quality and continuity.[50] In addition, legislation should mandate that the state of Pennsylvania stop doing business with repeat labor law violators. Such a law could include an exemption for past violations. It would send a clear signal that, henceforth, the state believes long-term care employers should abide by national labor law both for its own sake and because it will help discourage low-quality models of care in which profits are derived at the expense of residents and workers.

**Protect employees rights to speak out about conditions**. The people who work in nursing facilities know the most about the real quality of care. But like doctors at some HMOs — indeed, much more so, because of the relative lack of economic power possessed by aides — aides may be intimidated or explicitly prohibited from informing families or other outsiders about patient care. At Beverly Enterprises, according to representatives of the Service Employees International Union, managers dictate that nursing home workers may not talk about the quality of patient care with anyone not employed by the home. Employees at nursing homes, from aides to administrators, should be extended the same kinds of protections to speak out on behalf of those they serve as doctors have been seeking within HMOs[51]

**E. State Labor-Law Innovation to Promote Paraprofessional Association Statewide**. Pennsylvania could also take advantage of a provision of the NLRA that permits the National Labor Relations Board (NLRB) to cede jurisdiction in particular areas to states. Morand (1995) has proposed using this provision to give states scope to pursue labor law innovation in industries in which the labor market is essentially local, such as long-term care. Once granted jurisdiction, Pennsylvania could pursue a variety of options to foster occupational forms of representation as opposed to the industrial, single worksite model. Options proposed include sector-wide certification (or an election to determine if a majority support such certification) once a given number of affected workers request it . Less far-reaching proposals include facilitating amalgamation of existing single worksite units and making it harder for unions or employers to drop out of multi-employer bargaining (Wial 1993). The state could also use jurisdiction over labor law for long-term care to make first contract disputes in nursing homes subject to arbitration. That way, workers would not have to interrupt their relationship with residents to gain collective representation.[52]

### *Summing Up*

Given pressures to reduce government spending, the dependence of long-term care on public programs, and the dramatic increases projected in the number of elderly, particularly the "oldest old," we could easily be headed for an unmitigated disaster within the long-term care industry.[53] The most likely scenario is a future shaped by budget cutting in the context of today's usually limited conception of how to provide care (with the fig leaf of consumer choice serving to assuage guilt about what is really happening outside the public, and the regulatory,

eye). At the bottom end of the market, inside nursing homes and out, staffing levels and the quality of care will deteriorate below today's poor levels. Higher income families will dig deeper into their own pockets to give their relatives adequate care. More economically pressed families will expose their kin and friends to neglect with the emergence of the end-of-life equivalent of the latch-key kid. More frail elderly will die unnecessarily. One can paint this scenario either in darker terms or as a form of "muddling through" that looks roughly like today. But it seems unlikely that we will do much better than this without an explicit, self-conscious, and organized effort.

A negative scenario is not inevitable. The long-term care industry today is a surprisingly dynamic one. New ideas are circulating about the importance of reconceiving care in terms of supporting resident independence and life quality. Many nursing homes throughout the industry are beginning to struggle with how to implement a philosophy different from the traditional custodial/medical approach. We have the opportunity to use our capacity for social negotiation, and our collective imagination, to develop a shared vision of a regenerative future. By pursuing that vision pragmatically, and continuously challenging ourselves to think of ways to improve quality — of care, of jobs, of life — in affordable ways, Pennsylvania has a chance to set an example for the nation.

# 7. Endnotes

[1] Family and friends provide an estimated 80% of long-term care in private homes.

[2] The Intra-Governmental Council on Long Term Care has recommended developing a single definition for assisted living and a subcommittee is now undertaking that task (See its September 1996 Interim Report). On the Council and how it should be changed, see the policy section of this report.

[3] Medicaid pays for 63.8% of all nursing home revenues in Pennsylvania. Medicare funds pay for the remainder of the 72.5%. Counties contribute an additional one to two percent of the cost of Pennsylvania nursing homes.

[4] Payments to nursing homes consumed more than 32% of Medicaid funds or $36 billion in 1993.

[5] The 1995 average wage reported for nursing aides 'deemed competent' by the state is $7.57, but some aides in the first three months of work have not yet passed the Pennsylvania nurse-aide test and earn less than this average. The 1994 starting nurse aide wage in county homes, which pay higher than most facilities, was $7.07. Some homes visited for this report paid $5.40 - $5.60 an hour to entry-level aides.

[6] Unionized and county home workers are an exception, as are many employees of religious non-profit and county nursing homes; in unionized and county nursing facilities, employers usually pay between 70% and 100% of the single premium, and some contribute to family health care.

[7] Few nursing facilities offer pensions; in Hunter's 1994 study of Massachusetts homes, only 4 of 24 homes offered pension plans, and some of these were contributory. Although 100% of homes in this study stated they offered health insurance, many workers are unable to afford the premium payments or co-payments.

[8] The federal share of Medicaid costs varies from 46.5% to 73% of state set eligibility standards, procedures, and most other guidelines for administration. In Pennsylvania, Medicaid is administered through a program known as Medical Assistance (MA).

[9] William Bordner of Pennsylvania's Department of Health reports that the first financial sanction, issued by the federal government in July 1995 was only beginning to go to

litigation in December 1996. No Pennsylvania home has paid sanctions for violations as of this writing.

[10] See the December 1996 issue of Contemporary Long Term Care for a current listing.

[11] Pennsylvania encourages this by providing separate reimbursement for drugs, therapies, and other services rather than a "bundled" price as New York does. Residents can use their own pharmacy if they choose, but this does not often happen.

[12] Government and not-for-profit Pennsylvania facilities averaged slightly higher at 93.5% and for-profits are at 91.5% occupancy (PANPHA 1996a: 19).

[13] In December 1996, Pennsylvania's Certificate of Need (CON) legislation expired, but the effects cannot be ascertained yet in terms of bed growth and increased costs. The PA Health Law Project research showed that when Pennsylvania put a moratorium on depreciation and interest reimbursement by Medicaid in the early 1980s, it did so without regard to bed need in each region. Philadelphia already had a bed shortage of several thousand nursing home beds. The moratorium particularly restricted access to homes for African-American and Hispanic individuals in the Philadelphia area. A lawsuit resulted.

[14] I thank Kathy Cubit of CARIE for raising this point; she notes that it is hard to document but that ombuds agencies get calls from residents who are afraid to speak up and do not want anyone to know that they complained.

[15] Moreover, the so-called Massachusetts miracle in the mid-1980s drove wages up in nursing homes. When Hunter conducted his survey in the early 1990s, the miracle had ended but cost-based reimbursement allowed employers to continue paying good wages and investing in good practices (while wages in less regulated low-wage service industries probably fell more quickly).

[16] William Bordner, Director of the Division of Nursing Care Facilities for the State of Pennsylvania, noted that new survey definitions and methods led the number of out of compliance facilities to jump dramatically. (Personal communication, 12/19/96) Some advocates believe the new numbers more accurately reflect quality.

[17] Official surveys, moreover, understate some deficiencies. Only 2% of homes were cited for abuse of patients, but in one study 40% of staff voluntarily admitted to inflicting psychological abuse within the last year and 10% admitted to committing one or more incidents of physical abuse (Pillemer 1989).

[18] "High performance" work organizations encourage higher levels of employee involvement and give front-line employees more responsibility for quality and decision-making (Kochan and Osterman 1994.) The tendency of for-profit nursing home chains to lag non-profits in workplace innovation contrasts with Osterman's finding that branch offices were more likely than freestanding companies to have high performance work systems (see Appelbaum and Batt 1994; Osterman 1993.) In this particular industry, chains may

maximize economies of scale on purchases, advertising, information technology, and reimbursement. Doing this raises profits while implementing innovative work systems may not.

[19] The ADLs include eating, getting in or out of bed, getting in or out of chairs, walking around inside, going outside, dressing, bathing, using toilet, and controlling their bowel movements or urine.

[20] For a theoretical analysis of the kinds of "relational" practices typical of skilled nurse aides, see Joyce Fletcher 1994 and Jean Baker Miller 1976.

[21] See State Medicaid cost reports (in Pennsylvania, Schedule H). Available from the Office of Medical Assistance, Department of Public Welfare. I calculated this hours shortage by multiplying the number of total patient days by 2.3 hours to get the required minimum staffing, and comparing the result to the reported nursing hours for which the facility had paid. The difference was more than 14,900 hours.

[22] Research shows that a higher number of registered nurses is associated with higher quality care, but the causal connection between the two is not clear (Harrington et al 1996). Some facilities with more RNs may also have higher staffing and wages, with the latter driving improvements in quality of care. In other cases, nurses with specialized geriatric training are on staff and can offer guidance.

[23] Pennsylvania requires training "to be deemed competent" and the test must include a "hands on" component.

[24] This strong scientific evidence is the basis for OBRA's requirement of "individualized care" for all residents. Many industry observers interviewed felt that most residents were not getting such care, and that many providers did not truly understand the requirement.

[25] This issue is similar to problems nurses have expressed in getting the "invisible" caring part of their work done. Roy Jacques notes: "While these activities are critical to the operation of any complex organization, especially health care delivery systems, they have not been core criteria for reward and advancement in organizational personnel systems." (1993: 3) Jacques found that nurses in hospitals convey such informal information 87 times per day, or once every 6 minutes.

[26] Many other unions represent smaller numbers of nursing home workers, including the Union of Needletrades Industrial and Textile Employees (UNITE), the United Food and Commercial Workers (UFCW), and the United Steel Workers of America (USWA).

[27] Beverly placed near the middle of the industry in the Consumer Reports ranking (see Table 6). This probably reflects the distinct markets served by different parts of the chain: as in the private sector as a whole, some Beverly homes disproportionately serve higher-paying private pay patients. In addition, Beverly over the past several years is reported to have instituted a mock survey process that teaches its homes how to avoid Health Department deficiencies.

[28] The particular facilities recommended as high-quality models by Pennsylvania resident advocates and ombuspeople did not include any for-profit facilities. For an example of a for-profit regenerative home near San Francisco, California , see Eaton 1995.

[29] In a planning conference for resident care, representatives of all groups involved in the person's care should be present, including the physician (personal communication, Jean Volpetti, Jan. 22, 1997). However, interviews for this report with nursing staff, union officials, and family representatives suggest that this is rarely the case.

[30] Field visits were made to two high-quality Jewish nursing homes in Pennsylvania, one union and one non-union, the latter of which is profiled in the text. For a profile of the unionized high-quality home in San Francisco, see Eaton 1995.

[31] For a Massachusetts example of a high quality home, see the MIT Ph.D. dissertation of University of Pennsylvania's Wharton school Professor Larry W. Hunter (1994).

[32] The practice of separate billing for medication provides a disincentive to cutting down on use of drugs.

[33] Pressure sores raise care costs an estimated $2-$12 billion annually (the wide range reflecting different estimates of the prevalence of such sores). This figure and the earlier one in the paragraph come from U.S. Senate, Subcommittee on Aging, 1991.

[34] Resident advocates complain that nursing home managers over-medicate to keep their residents quiet and sedated. Over-medicating patients is not more cost-effective in the long run, even if it were ethical, as patients require more care, are more incontinent, are more likely to fall, break a bone, and require expensive acute care, and are more likely to become ill. Kathy Cubit of CARIE (The Coalition of Advocates for the Rights of the Infirm Elderly) in Philadelphia says that this has been less of a problem in Pennsylvania since the passage of OBRA, with its discouragement of physical and chemical restraints (Personal communication, 1/14/97). Liz Capezuti of the Institute of Aging notes that Pennsylvania and California used to have the highest restraint use in the country, but that excellent work on reducing restraints has occurred in some of Pennsylvania's research and training institutes (personal communication, 1/6/97). One home visited had benefited from training by an Institute of Aging staff member on reducing restraints.

[35] This proposal is designed to emulate the success of the national Campaign for Quality Care in building a consensus behind federal nursing home reform regulation in the 1980s. The Campaign was a multi-year effort spearheaded by advocates of better patient care, specifically the National Citizens' Coalition for Nursing Home Reform. The Campaign brought together representatives of providers, professionals, para-professionals, unions, senior citizens' organizations, and government to craft a consensus on a regulatory approach to improving resident care following the 1986 Institute of Medicine Report which documented the need for reform (personal correspondence, Sarah Greene Burger, 1994).

[36] Members of the council not identified in the text include two representatives of the aging, two representatives of the insurance industry, four legislators, a county commissioner, housing authority managers from rural and urban communities, and a representative of area agency on aging.

[37] At the inception of the Healthcare Cost Containment Council, the possibility of giving the HCCC jurisdiction over long-term was considered. The HCCC has earned a good reputation for its data gathering and reporting on quality in hospitals. In addition, incorporating the staff of the PQCC into the HCCC might help ensure that the new council would be stakeholder led.

[38] A new residents' association recently formed in Pennsylvania called the Association of Residents of Retirement Communities. Such associations can be a positive force in promoting accountability and should be represented on the Quality Care Council. See Gibson 1996.

[39] The Pennsylvania Intra-Governmental Council on Long Term Care recommended in its September 1996 interim report an outreach effort to "determine what values ought to be used in developing a long-term care system in Pennsylvania."

[40] This charter could draw from the so-called Nursing Home Code of Conduct, which itself is based on Section 201.29 of the Pennsylvania Code. That section of the Code says, "The patient shall be treated with consideration, respect, and full recognition of (his/her) dignity and individuality. The patient shall be free from interference, coercion, discrimination, or reprisal."

[41] One nursing director in a high quality facility told me that she had a difficult time learning from other nursing directors because they are not encouraged at their infrequent meetings to talk about the nitty-gritty of organizing care, supervising aides, dealing with dementia, workers' schedules, etc.

[42] Providers will want to ensure that the report card controls effectively for differences (e.g., in case mix) that influence publicly reported outcomes. New regulations that require submission of computerized MDS (Minimum Data Sets) on a range of variables should facilitate the production of report cards without increasing the administrative burden on providers.

[43] The power, authority, and professional and legal obligations of the employees with control over care quality in hospitals and long-term care – doctors and nurse aides — could hardly be more different. Despite self-certification, moreover, hospitals remains a good idea in the age of managed care, moreover, is likely to be hotly debated in the future.

[44] This recommendation is in accordance with PANPHA's recommendation on developing new survey standards for assisted living— helping surveyors become purveyors of best practice rather than only serving as 'cops' focused on the most minute details of building code (cite).

[45] A massive research literature exists on the Case Mix Index systems used in various states, their benefits and problems, and suggestions for improvement. While we are not able to review the literature in detail in this report, the actual Index system is very important to shaping how access is granted to needy persons and how care is delivered. The Quality Care Council should work to make sure that Pennsylvania's system does not create perverse incentives that work against the promotion of better quality of life. One major issue of concern to providers is the "snapshot" nature of the case mix reimbursement process, in which the case mix on a particular day determines reimbursement—not an average over time, for instance.

[46] One VP of health services, formerly a director of nursing, told how she had gone to one of the units one day — she does this once a year to stay in touch with direct patient care— to feed a resident. She said they gave her a "challenging" resident. Just as she was getting ready to feed her, the individual said "Oh, I'm so sorry, honey, I just had a bowel movement." So she had to stop, clean her, change clothes, change bed, and then eventually get back to feeding her— but by then, if she were a nurse aide, her other 10 patients would have been calling. The aides listening to her story noted with some satisfaction that she took forever getting this little chore done and didn't know exactly how to do it. This is a registered nurse who is considered a bit of a heroine because she does this level of interaction even once a year, a good person that the people can talk to. Yet aides have this type of event happen on a daily and even hourly basis.

[47]Many nursing home workers are scheduled for fewer than 2,000 hours a year, and this issue would also need to be addressed in calculating a living wage, and working with employers on designing work schedules which were better for employees but met their need. Figures from Federal Register, Vol. 61, No. 43, 1996.

[48] Two states have recently required that nurse aides come under the jurisdiction of their Boards of Nursing Practice in order to be legally licensed/registered to do their work. This way, they can be held legally responsible for their actions, according to an RN who heads the board of Nurse Practice in Vermont and their license to practice can be withheld by the state if they are guilty of any non-vocational practices.

[49] The recommendations of PANPHA's Regulatory Review Project (1996) concerning expanding training and certification for nurse aides in the state, particularly with respect to deregulating RN functions, are generally consistent with this proposal, provided that they be considered in the context of career ladders and uniting responsibility in one agency for the Nurse Aide Program, which is now split between the Department of Public Welfare, Department of Health, Department of Education, and the Department of Aging. One exception is the PANPHA proposal that nurse aides pay for and obtain their own training, which seems unrealistic at best and punitive at worst given the existing problems with these programs, unless paraprofessionalization and significant wage increases become a reality. (see pp. 31, 41-42 of the 1996 PANPHA report.)

[50] This proposal is a variation on House Bill 2978 which would have required that public records from the National Labor Relations Board and the Occupational Safety and Health Administration be posted publicly in facilities along with Health Care Financing Administration records.

[51] A recent Supreme Court decision held LPNs/LVNs in a specific case were effectively managerial employees and therefore were not entitled to protection for concerted activity on behalf of patients (Weiler, personal communication.)

[52] See the US Commission on the Future of Worker-Management Relations recommendations, dated September 1995, one of which includes first contract arbitration as an option if agreements cannot be reached by the parties.

[53] One source estimates that “block granting” (or allocating all functions and funds to the states) Medicaid programs would lead to cuts in spending of more than 30% by 2002 (Chernick and Reschovsky 1996). While the immediate danger of ‘block grants’ to states for Medicaid seems to have lessened in the near term, longer term funding pressures on such programs, Medicare, and Social Security continue unresolved.

# 8. Bibliography

Aaronson, William E., Jacqueline S. Zinn, and Michael D. Rosko. "Do For-Profit and Not-for-Profit Nursing Homes Behave Differently?" The Gerontoloqist. Volume 34, no. 6,775-786.

Appelbaum, Eileen and Rosemary Batt. The New American Workplace: Transforminq Work Systems in the United States. Ithaca, New York: Cornell ILR Press, 1994.

Bordner, William. Telephone interview, December 19, 1996.

Boyd, Charlene. "Residents First: A Long Term Care Facility Introduces a Social Model that Puts Residents in Control." Health Proqress. September, 1994.

Brown, Ronald H. and Jeffrey E. Garten. U.S. Industrial Outlook 1994. Washington DC: U.S. Department of Commerce, 1994.

Byrd, Jerry W. 1995. "Employees Gain Stake in Their Firm," Philadelphia Inquirer, August 18, 1995.

Clark, Peggy, and Steven L. Dawson. 1995 "Jobs and the Urban Poor: Privately Initiated Sectoral Strategies." Aspen Institute: Washington, DC. November 1995.

CARIE, Coalition of Advocates for the Rights of the Infirm Elderly. "Ensuring Quality Care for Pennsylvania's Nursing Home Residents." CARIE: 1315 Walnut Street, Suite 1000, Philadelphia, PA. 19107.3/6/96.

CARIE, Coalition of Advocates for the Rights of the Infirm Elderly. "Policy Issues for Older Pennsylvanians: An Aging Agenda." The Legislative Committee, CARIE: 1315 Walnut Street, Suite 1000, Philadelphia, PA. 19107. August, 1995.

Chernick, Howard and Andrew Reschovsky. "State Responses to Block Grants: Will the Social Safety Net Survive?" June 13, 1996.

Cutler, David. "Why Doesn't the Market Fully Insure Lonq Term Care?". National Bureau of Economic Research, 1993a. Working Paper 4301.

Cutler, David and Louise M. Sheiner. “Policy Options for Lonq Term Care”. National Bureau of Economic Research, 1993b. Working Paper 4302.

Diamond, Timothy. Makinq Gray Gold: Narratives of Nursinq Home Care. Chicago: University of Chicago Press, 1992.

Dick, Andrew, Alan M. Garber, and Thomas MaCurdy. “Forecastinq Nursing Home Utilization of Elderly Americans”. National Bureau of Economic Research, Inc., 1992. Working Paper No. 4107.

Eaton, Susan C. Beyond ‘Unloving Care:’ Work Organization in Nursinq Homes. Office of Technology Assessment, U.S. Congress, 1995. Unpublished draft report M3-0491.

Eaton, Susan C. Beyond ‘Unlovinq Care:’ Promotinq Innovation in Elder Care Throuqh Public Policy. Radcliffe Public Policy Institute, 1996. Changing Work in American Series.

Engle, V. F. “Mental Status and Functional Health Four Days Following Relocation to a Nursing Home.” Research in Nursinq and Health 8 (1985): 355-361.

Fein, Rashi. Medical Care, Medical Costs: The Search for a Health Insurance Policy.

Second edition. Cambridge Ma: Harvard University Press. 1989.

Foundation, Mt. St. Vincent. “The Mount’s Vision”. Sisters of Providence Health Foundation, n.d. brochure.

Freeman, Richard and James Medoff. What Do Unions Do? NY: Basic Books,

1984. Friedan, Betty. The Fountain of Aqe. NY: Simon and Schuster, 1993.

Friedlaender, Lenore. Telephone interview. December 21, 1996.

Friends Services for the Aging. n.d. “Guide to Quaker Services for the Aging: Pennsylvania and New Jersey.” Available from FSA, 6834 Anderson St., Philadelphia, PA. 19119.

Gibson, Elizabeth. “Nursing Home Residents Network.” The Patriot-News, April 11, 1996, B-4.

Harrington, Charlene A. “Nursing Facility Quality, Staffing, and Economic Issues.” In Nursinq Staff in Hospitals and Nursinq Homes: Is It Adequate, ed. Gooloo S. Wunderlich Frank A. Sloan, and Carolyne K. Davis. 453-502. Washington DC: National Academy Press, 1996.

Health Care Financing Administration (HCFA), Office of Research and Demonstrations. "Number of Residents in Nursinq Facilities by Type of Resident, October, 1994;" and "Number of Providers and Proportion of Medicare, Medicare/Medicaid, and Medicaid

Only Beds (Certified) to Total Beds, December 1994." HCFA, Office of Research and Demonstrations Support, 1996. Via facsimile from Roger Keene.

Health Care Financing Administration (HCFA), Health Standards and Quality Bureau (HSQB), Survey and Certification Division. State Implementation Report 1, for 7/1/95 to 12/4/96. U.S. Department of Health and Human Services, dated December 30, 1996. Via facsimile from David Bell, Survey and Certification Division, January 7, 1997.

Healthcare Financial Management Association, HFMA. "Long Term Care for the Elderly in the 1990s: Structure and F nancing". Healthcare Financial Management Association, 1989. Report of the Long-Term Care Roundtable.

Herzenberg, Stephen with Lesley Nearman, The State of Working Pennsylvania. Harrisburg, Pennsylvania: Keystone Research Center, September 1996.

Hochschild, Arlie Russell. The Managed Heart: Commercialization of Human Feeling. Berkeley, California: University of California Press, 1983.

Hunter, Larry W. Bu ding Affiliative Employment Relationships: The Case of the Massachusetts Nursing Home Industry. Ph.D. dissertation, Massachusetts Institute of Technology, 1994.

Illinois Citizens for Better Care. Report on Illinois's Regulatory Process. 1994.

Institute of Medicine, Committee on Nursing Home Regulation. mproving the Quality of Care in Nursing Homes. Washington, DC: National Academy Press, 1986.

Jacques, Roy. ""Nursing as a Basic Service to Society: The Caring Phenomenon"." Nursinq Administration Quarterly 17:2 (Winter 1993): 1-10.

Johnson, Jean, C. McKeen Cowles, and Samuel J. Simmens. "Quality of Care and Nursing Staff in Nursing Homes." In Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?, ed. Gooloo S. Wunderlich Frank A. Sloan, and Carolyne K. Davis. Washington DC: National Academy Press, 1996.

Kane, Robert L. "Long-Term Care in the United States: Problems and Promise." In Economic Security and Intergenerational Justice, ed. Timothy M. Smeeding Theodore R. Marmor Vernon L. Greene. 287-302. Washington DC: Urban Institute Press, 1994.

Kochan, Thomas A. and Paul Osterman. The Mutual Gains Enterprise: For-qin.q a Winninq Partnership Among Labor, Mana.qement, and Government. Boston: Harvard Business School Press, 1994.

Koetting, Michael. Nursing Home Organization and Efficiency. Lexington, MA: Lexington Books, 1980.

Koop, C. Everett. Financial World, January 9, 1990. 1990.

Langer, Ellen J. Mindfulness. New York: Addison-Wesley, 1989.

Lieberman, S. "The effects of roles on the attitudes of role occupants." In Basic Studies in Social Psychology, ed. H. Proshansky and B. Seldenberg. 485-494. NY: Holt, 1965.

Lieberman, Trudy. 1995a. "Can Your Loved One Avoid a Nursing Home? The Promises and Pitfalls of Assisted Living." Consumer Reports (October 1995): 656-662.

Lieberman, Trudy. 1995b."Choosing the Right Nursing Home, Part Three." Consumer Reports (September 1995).

Lieberman, Trudy. 1995c. "Choosing the Right NursingHome, Part Two." Consumer Reports (August 1995).

Lieberman, Trudy. 1995d. "Nursing Homes: When a Loved One Needs Care." Consumer Reports (August 1995): 516-527.

Lieberman, Trudy. 1995e. "Who Pays for Nursing Homes?" Consumer Reports (September 1995): 591-597.

Maas, Meridean, Kathleen Buckwalter, and Janet Specht. "Nursing Staff and Quality of Care in Nursing Homes." In Nursinq Staff in Hospitals and Nursinq Homes: Is It Adequate?, ed. Gooloo S. Wunderlich Frank A. Sloan, and Carolyne K. Davis. Washington DC: National Academy Press, 1996.

MacAdam, Margaret. "Paraprofessionals: Enhancing Their Ability to Deliver Quality Services." Natural Aging Resource Center, Brandeis University. November, 1990.

Macdonald, Cameron and Carmen Sirianni. Workin.q in the Service Society. Philadelphia: Temple University Press, 1996.

Maraldo, Pamela J. "Quality in Long-Term Care." In Mechanisms of Quality in Long-Term Care, ed. National League for Nursing. 1-12. New York: National League for Nursing Press, 1991.

Mendelson, Mary Adelaide. Tender Lovin.q Greed. NY: Alfred Knopf, 1974.

Miller, Jean Baker. Toward A New Psycholo,qy of Women. Boston: Beacon Press, 1976.

Morand, David A. "Questioning the Preemption Doctrine: Opportunities for State-level Law Initiatives," 5(1), 1995.

Mt. St. Vincent, Sisters of Providence. "An Alternative to Nursinq Homes: Impactin,q Resident Functional and Health Decline". Sisters of Providence, 1994.

Mt. St. Vincent, Sisters of Providence. Research Project Summary. Providence Mt. St. Vincent, nd. mimeo.

National Citizens' Coalition for Nursing Home Reform (NCCNHR). 1985. "Consumer Perspectives on Quality Care." Washington, DC: NCCNHR.

National League for Nursing Press. Mechanisms for Quality in Lon.q-Term Care: Service and Clinical Outcomes. Pub. No. 41-2382 ed., New York, New York: National League for Nursing Press, 1991.

O'Brien, Jack, Borje O. Saxberg, and Howard L. Smith. "For-Profit or Not-for-Profit Nursing Homes: Does it Matter?" The Gerontoloqist 23(4) (1983): 341-348.

Osterman, Paul. How Common is Workplace Transformation and How Can We Explain Who Adopts It? Results from a National Survey. Allied Social Science Association Meetings in Anaheim, California, 1993.

OTA, Office of Technology Assessment. Special Care Units for People with Alzheimer's and Other Dementia. U.S. Congress, 1994.

Pear, Robert. New York Times, December 17, 1996. "U.S. Seeks to Limit Inspections' Scope at Nursing Homes." A-1 and B-8.

Pennsylvania Association of Non-Profit Homes for the Aged (PANPHA). 1996a. Long-Term Care Statistics and Information: Demographics on the Aging Population Long-Term Care Nursinq Facilities Personal Care Homes Housing. Compiled by PANPHA. Harrisburg, PA: PANPHA.

Pennsylvania Association of Non-Profit Homes for the Aged (PANPHA). 1996a. Regulatory Review Project. Harrisburg, PA: PANPHA.

Pennsylvania, Commonwealth of. 1994. Department of Health. State Center for Health Statistics and Research. Division of Health Statistics and Research. Data from the 1994 Lon.q Term Care Facilities Questionnaire. Harrisburg, PA.

Pennsylvania, Commonwealth of. Pennsylvania Bulletin. Vol. 25, No. 41m Part III. "Department of Public Welfare Nursing Facility Services; Case-Mix Reimbursement System." October 14, 1995. Harrisburg, PA: Fry Communications.

Pennsylvania Intra-Governmental Council on Long-Term Care (PICLTC). "Interim Recommendations: Long-term Care for the Twenty-First Century: A Time for Change." Harrisburg, PA: September 9, 1996.

Pennsylvania Intra-Governmental Council on Long-Term Care (PICLTC). "Long-term Care and Services Discussion Guide." No date.

Personick, Martin E. "Nursing Home Aides Experience Increase in Serious Injuries." Monthly Labor Review (February 1990): 30-36.

Karl Pillemer and Beth Hudson, "A Model Abuse Prevention Program for Nursing Assistants." The Gerontologist. Vol. 33(1) (1993): 128-131.

Pillemer, Karl and David W. Moore. "Abuse of Patients in Nursing Homes: Findings from a Survey of Staff." The Gerontologist 29 (3) (1989): 314-320.

Sacks, Karen. Caring by the Hour. Chicago: University of Illinois Press, 1988.

SEIU, Service Employees International Union. Caring Till It Hurts: How Nursinq Homes are Becoming the Most Dangerous Industry in America. 1995a. Report.

SEIU, Service Employees International Union. Fallinq Short: The Staffing Crisis in Beverly Enterprises' Texas Nursing Homes and the Need for a Minimum Standard. Service Employees International Union, 1995b.

SEIU, Service Employees International Union, Locals 585, 668, and District 1199P. "Dignity: Family Newsletter for Families of Pennsylvania Beverly Nursing Home Residents." SEIU, 1500 N. 2nd St., Harrisburg, PA. 17102. 1996.

Senge, Peter. The Fifth Discipline: The Art and Practice of the Learning Organization. NY: Doubleday. 1990.

Tellis-Nayak, V. "Quality of Care and the Burden of Two Cultures: When the World of the Nurse's Aide Enters the World of the Nursing Home." The Gerontoloqist 29 (3) (June 1989): 307-314.

Thomas, William. The Eden Alternative. University of Missouri Press, 1992.

Torregrossa, Ann. Telephone interview, December 20, 1996.

Twentieth Century Fund, Task Force on Worker Retraining. Draft Report. Twentieth Century Fund, 1995.

U. S. Census Bureau, U.S. Department of Commerce. “The Aging of the U.S. Population.” accessed by Internet 1/29/96: gopher://gopher.census.gov:70/00/ Bureau/PR/Subject/Pop/cb95-90.txt>pop, “Aging of the U.S. Population, 5/4/95”, 1995.

U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook. Vol. Bulletin 2400. Washington DC: U.S. Government Printing Office, 1992.

U.S. Department of Labor, Bureau of Labor Statistics. Employment and Earninqs. January 1993 ed., Vol. 40 (1). Washington DC: U.S. Government Printing Office, 1993.

U.S. Departments of Labor and Commerce. Commission on the Future of Worker-Management Relations. Report and Recommendations. Washington, DC: Government Printing Office, September 1995.

U.S. Senate, Committee on Labor and Human Resources, Subcommittee on Aging. Nursinq Home Resident Riqhts. U.S. Senate, 1991. Staff Report.

U.S. Senate, Special Committee on Aging, Subcommittee on Long Term Care. Nursinq Home Care in the United States: Failure in Public Policy. An Introductory Report. U.S. Senate, 1974. Senate Report 93-1420, cited in Hunter, 1994.

U.S. Senate, Special Committee on Aging. “Nursing Home Care: The Unfinished Agenda.” 48. Washington DC: U.S. Government Printing Office, 1986.

U.S. Senate, Special Committee on Aging. A.qin.q America: Trends and Projections. U.S. Senate Special Committee on Aging (Washington DC: U.S. Department of Health and Human Services), 1988.

U. S. Senate, Staff Report by the Subcommittee on Aging, Senate Committee on Labor and Human Resources, 6/13/91, “Nursing Home Resident Rights.”

Viadeck, Bruce. Unloving Care: The Nursing Home Tragedy. New York: Basic Books, Twentieth Century Fund, 1980.

Weber, Max. The Theory of Social and Economic Organization. Translated by A. M. Henderson and Talcott Parsons. Oxford: Oxford University Press, 1947.

Weiler, Paul. Personal communication, January 23, 1997.

Wial, Howard. “The Emerging Organizational Structure of Unionism in Low-Wage Services.” Rutgers Law Review. 45 (3): Spring 1993.671-738.

Wunderlich, Gooloo S., Frank A. Sloan, and Carolyne K. Davis, ed. Nursing Staff in

Hospitals and Nursing Homes: Is It Adequate. Institute of Medicine, National Academy of Sciences. Washington DC: National Academy Press, 1996. (Also known as the “Institute of Medicine, 1996” report.)

Zinn, Jacqueline S., Diane Brannon and Vincent Mor. “Organizing for Nursing Home Quality.” Quality Management in Health Care, 3(4) (1995): 37-46.