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Nursing Home Privatization:

What is the Human Cost?

Steven H. Lopez

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EXECUTIVE SUMMARY

In response to increasing financial pressure and cuts in reimbursement, Pennsylvania county governments are considering privatizing county-owned nursing homes. The idea of saving money by turning county nursing homes over to private operators appeals to county leaders seeking to relieve budget pressures. But what happens to the quality of care when counties turn their nursing homes over to private firms?

This report investigates the effects of privatization or attempted privatization on the quality of care at several county and former county nursing homes in western Pennsylvania: Allegheny County's **John J. Kane Regional Centers**, where privatization was proposed but not implemented; **Comfort Home**, which remained public but whose operation was taken over by a for-profit management company; and **Chelsea Manor**, which was sold outright to a non-profit entity created by the county for the purpose of buying the facility. The report compares these homes with one another and with **Green Gables**, a private nursing home that is characterized by low wages, high employee turnover, and poor quality of care.¹

The study draws the following conclusions:

- **Although staffing levels declined whether or not privatization was ultimately carried out, the most significant staffing cuts occurred where privatization was taken furthest.** After the privatization of Chelsea Manor (the home sold to a newly created private non-profit organization), staffing levels appeared to be nearly identical to those at the low-quality private home—a home where understaffing led state investigators to suspend admissions temporarily in 1997.
- **Workers' wages and employee turnover, two factors affecting care continuity, were most negatively affected at the home where privatization proceeded furthest.** At the Kanes and Comfort home (where collective bargaining continued), workers' wages, benefits, and employee turnover remained stable. At Chelsea Manor, wages fell to levels almost identical to those at Green Gables (where staff turnover was rampant). Turnover at Chelsea Manor appeared to be increasing towards that at Green Gables.
- **At both homes where some form of privatization was implemented, workers complained about shortages of medical and patient care supplies.** Both of these homes seemed to have a more serious problem in this area than the Kanes, but at neither home was the problem as serious as at Green Gables.
- **The quality of care at all three of the county and former county homes deteriorated, regardless of whether privatization was actually carried out or only proposed.** Once again the worst declines in quality occurred where privatization was taken furthest. After privatization, Chelsea Manor began to develop a pattern of unexplained resident injuries, some of which were not properly investigated or reported. Chelsea Manor's problems were similar in nature, though not in extent, to quality problems at Green Gables, where several hundred such incidents occurred in a recent 18-month period.
- **Even the best homes in the study, the Kanes and Comfort Home, are now unable to meet all the physical, emotional, and social needs of their residents, even though they exceed federal and state standards for staffing ratios.** All of the nursing homes described in this report, in varying degrees of urgency, need more nurses' aides.
- **As do the Kanes, county nursing homes**

across Pennsylvania have much lower turnover among nurses' aides than is typical for private homes. Combined with the case studies, this strongly suggests that nursing home privatization may, in many cases, worsen the quality of care.

In an earlier Keystone Research Center report, Susan Eaton outlined a comprehensive set of policy recommendations designed to improve the quality of both private and public long-term care in Pennsylvania (Table 3 on page 34 lists Eaton's proposals).² The present report highlights four recommendations designed to accomplish a narrower goal: prevent nursing home privatization from undercutting the quality of care.

- **A current state requirement that counties pay for a portion of the operating costs of county nursing homes should be repealed.** This requirement effectively means that counties receive a lower state reimbursement than would private homes serving identical populations. The result is an artificial incentive to privatize. (Through ad-hoc compromises involving the use of federal funds, counties are currently relieved of the state-imposed obligation to contribute to county nursing homes. There is no guarantee, however, that this relief will remain in place.)
- **The Auditor General should conduct an audit of Health Department surveys from a sample including (1) county nursing homes, (2) all privatized or former county homes, and (3) private homes serving the same resident population as county homes.** The present report, based on case studies and worker interviews, reveals the underlying dynamics that can lead privatization to erode quality.

Nonetheless, we still need more comprehensive information about the effects of privatization on the quality of care. The recommended audit would give us that information and help Pennsylvania better understand how to provide the less affluent elderly with the high-quality care they deserve.

- **Pennsylvania should implement an annual nursing home report card.** A report card should gather together, in a format that is easy to read and understand, information about critical indicators of nursing home quality (such as turnover rates, staffing ratios, wages, and benefits). By making it easier to tell good homes from mediocre and poor ones, a report card would make the market—and consumer choice—more powerful forces for improving quality. A report card might also lead counties and the public to recognize the contribution that good county homes make to quality of life for Pennsylvania's elderly.
- **Pennsylvania should increase the minimum number of hours of front-line nurses' aide care that nursing home residents receive.** Pennsylvania nursing homes (including those reported on here) can currently meet state staffing requirements and still leave aides without enough time to attend even to residents' basic needs. As this report shows, privatization or the anticipation of it can exacerbate understaffing. Raising state staffing requirements would improve care quality throughout the Pennsylvania nursing home industry.

INTRODUCTION

With local governments under financial pressure, many of Pennsylvania's county nursing homes are currently facing the possibility of privatization. The effects of nursing home privatization on quality of care, however, have not yet been explored. Proponents of nursing home privatization have argued that privatizing Allegheny County's four county-owned nursing homes will lead to cost savings without jeopardizing quality.³ However, these writers do not make serious attempts to determine the possible impact of privatization on quality of care. After a single telephone conversation with the administrator of a privatized facility (Jefferson Manor), McDonough assures us that "the people of Jefferson County consider the privatization 'nothing but a positive experience.'"⁴

Haulk considers the matter settled on general principle:

Since there are hundreds of private nursing facilities providing quality care to patients and residents in Pennsylvania and regulations are enforced regardless of whether [the facilities are] privately or publicly managed, it is clear that quality of care should not be a deterrent in the decision to privatize. Obviously, those opposed to privatization will use the argument that quality of care will suffer if the Kanes are privatized because the private entity will care more about money and/or profit than about the patients entrusted to them [*sic*]. However, it is extremely unlikely that the state would allow incompetence or poor quality of care without taking action.⁵

Notwithstanding Haulk's confidence, more careful investigation into these issues is warranted. The experience of the Philadelphia Nursing Home, management of which was contracted out in February 1994 to a non-profit religious organization, Episcopal Long Term Care, undermines Haulk's and McDonough's assumption that market forces and state regulation will "naturally" prevent serious quality problems. The new management of the

Philadelphia Home doubled the number of residents from 200 to 400 after taking over in early 1994. By June 1995, state inspectors found deficiencies so serious that the state suspended admissions. According to the *Philadelphia Daily News*, state inspectors discovered numerous cases of unreported resident abuse by staff as well as "accounts of unattended bed sores, soiled clothing, expired medications, filthy floors, warming food freezers and inaccurate clinical records." The *Philadelphia Inquirer* described the situation inside the home as "total chaos." Admissions and re-admissions were banned for more than six months and, according to both news reports, the state came close to shutting the home.⁶

The example of the Philadelphia Home shows that the public cannot assume that privatization will have no impact on nursing home quality. But it cannot be determined from news reports whether quality at the Philadelphia Home was better before privatization, or whether privatization is likely to result in similar problems elsewhere. To explore the relationship between privatization and quality of care, this report compares the following nursing homes: Allegheny County's facilities, which were the focus of a failed privatization effort; a county home now managed by a private, for-profit company; and a former county home now owned and run by a non-profit entity. The report also compares these homes with a for-profit nursing home.

Green Gables, the private home chosen for this second comparison is appropriate for two reasons. First, it primarily serves, as do the others, poor residents whose nursing home expenses are reimbursed by Medicaid.⁷ Many high-quality private homes have higher proportions of "private pay" residents and residents whose care is reimbursed more generously by Medicare. Second, Green Gables represents a model of care combining low wages, high employee turnover, and poor quality that the public has an interest in avoiding; this report is concerned with whether privatization moves county homes toward this low-quality model. Thus, the report asks two related questions. (1) What were the

effects of privatization or privatization attempts on quality of care at the county homes? (2) Did privatization make the county homes more like the low-quality private nursing home and, if so, in what ways?

The four homes this report examines are all located in western Pennsylvania. They are not intended as a representative sample of nursing homes in the statistical sense; rather, they were carefully chosen for the purposes of the comparisons outlined above. Qualitative case studies, examining the interaction between privatization and nursing home quality in different contexts, can provide a more detailed and nuanced understanding than a conventional survey approach, while retaining more generalizability than a case study of a single nursing home.

1. Allegheny County's John J. Kane Regional Centers. In 1996 and early 1997, the Kanes were the target of a privatization plan that would have leased them to a private entity created by the county, known as Alleco. Alleco would have become the non-profit employer of all Kane workers. In March 1997, the county postponed implementation of the Alleco plan for one year in the wake of widespread protest by community and religious groups and labor unions. The Alleco process seems to have been shelved indefinitely. The county has directed Alleco to

return the balance of a \$500,000 grant it was awarded in 1996 to create a business plan for the takeover of the Kanes. But despite the failure of the privatization plan, political pressure to cut costs remains.

2. At Comfort Home, a private management company signed a two-year agreement to manage the home. Since the agreement took effect on October 2, 1996, Comfort Home has remained a public facility, and almost all of its workers retained their jobs. The collective bargaining agreement between Comfort Home workers and the county has not been affected. The facility's head administrator and its director of nursing, to whom the nursing home's workers ultimately report, are now employees of the private management firm. The new management company has complete control over all management decision-making, including staffing.

3. Chelsea Manor was sold in 1995 to a non-profit entity created by the county for the purpose of buying the home. The county first announced its intent to sell Chelsea Manor in late October of 1993. The union representing the workers at Chelsea Manor attempted to bargain with the county to prevent the sale of the facility, but would not agree to a county

offer that included a \$1.75 per hour cut in wages, a 50 percent reduction in the number of paid days off, and elimination of the workers' paid lunch periods. Without these concessions, the county would not agree to require the new owners to recognize the union. The private owners rehired only about half of the existing workforce and now operate without a union. In January 1995, the new owners unilaterally implemented wage and benefit cuts.

4. Green Gables is a nonunion, private nursing home operated by a for-profit chain.

RESEARCH METHODS

Rather than rely on nursing home administrators for information about the quality of care,⁸ this report relies on interviews with workers and, in the case of two of the homes, interviews with residents' family members. Workers and residents' families are more likely than administrators to have detailed knowledge about the quality of care. Workers are the caregivers and know more about how they deliver care than administrators do. Residents' families, when they visit the nursing home, observe the results of the caregivers' work in a more intensive way than administrators normally do. Attempts were made to contact administrators at all four Kane centers; however, only one official, the director of nursing at Kane Scott, returned telephone calls and consented to be interviewed. At homes other than the Kanes, workers agreed to be interviewed only on the condition that management not be contacted. In addition to the interviews, the report is based on analyses of recent Health Department surveys for each home, turnover data for all county homes, and other publicly accessible documents.

Two researchers, Steven Lopez and Mary Lewin, conducted a total of 24 interviews with workers from two of the four Kanes (Glen Hazel and McKeesport), Comfort Home, Chelsea Manor, and Green Gables. In addition to these worker interviews, five interviews were conducted with family members of residents from the Kanes and Comfort Home. At

each of the two Kane facilities, we interviewed six workers: nurses' aides from the day and evening shifts, two housekeepers (all housekeepers work day shift), and one day-shift licensed practical nurse (LPN). At Comfort Home, we interviewed five workers: four nurses' aides from varying shifts and units, and one registered nurse (RN). At the two nonunion facilities, we found it more difficult to recruit workers to participate in the study, and it was not possible to interview residents' family members. At Chelsea Manor, we contacted a total of nine workers by telephone but only three (two nurses' aides and one bath aide) agreed to participate in the study. The others expressed fear of reprisals from management. At Green Gables, we conducted interviews with four nurses' aides.

Interviews lasted from 30 to 90 minutes, with most lasting about an hour. Some of the interviews were conducted by phone. Others were conducted in person, either on-site during lunch breaks, at sites near the homes, or at workers' homes. The purpose of the interviews was not to gather quantitative data from a representative sample of workers but rather to get a qualitative sense of what working at each of these homes is like, gauge the kinds of conditions faced by workers at each nursing home, and understand how work processes and working conditions are related to the quality of care.

BACKGROUND: Residents' Needs and Nursing Home Division of Labor

In nursing homes today, changes in state reimbursement schemes and cost pressure on hospitals have increased the dependency of residents. Under Pennsylvania's new "case mix" reimbursement system, the state pays more money for residents whose health conditions are more serious, giving homes an incentive to house the most severely impaired residents. In addition, hospitals are discharging patients sooner, in some cases to nursing homes. As a former LPN who spent 20 years working in nursing homes said recently: "The residents are so much sicker today. When I started working in nursing homes in the early 1970s, most of the residents were ambulatory and continent. Nursing homes weren't dealing with the really sick patients back then." Today most residents at each of the homes in this study are neither ambulatory nor continent. Relatively few feed themselves. Many suffer from various forms of dementia or are unable to communicate verbally.

Workers from all of the homes told us that most of their residents have very little family involvement and receive few visitors. Some families, of course, visit their loved ones regularly and play an active part in decisionmaking about the kind of care that their relatives should receive. But more often than not, residents are essentially alone. Nursing homes must now attempt to meet all of the physical, emotional, and social needs of residents.

Nationally, nurses' aides comprise 85 percent of the nursing home industry's nursing staff.⁹ Similarly, nurses' aides deliver most of the hands-on care at all of the homes in this study. The aides help residents into and out of bed, dress them, bathe them, feed

them, and perform any toileting and personal care tasks that residents cannot do for themselves. Aides must reposition non-mobile residents every two hours and monitor food and fluid intake as well as residents' physical condition. They also communicate with family members. Aides' work is extremely demanding, both physically and emotionally. The job involves a great deal of heavy lifting, and back and neck injuries to nursing home workers are common.

Licensed practical nurses give residents medications and perform treatments for areas of skin breakdowns and contractures.¹⁰ Registered nurses oversee the work of nurses' aides and LPNs. At the facilities we studied, workers said that the majority of both LPNs' and RNs' time is taken up with paperwork. One nurses' aide commented, "I like the hands-on care. The nurses and LPNs don't have that hands-on care. They're too bogged down with paper work and meds and treatments."

Nursing homes do have specialized staff such as occupational and physical therapy technicians and activities aides. However, in all of the homes in this study, workers said that none of these auxiliary personnel are able to spend a great deal of time developing close relationships with individual residents. Only the nurses' aides have intimate, daily contact with specific residents. Because nurses' aides see that family members and other nursing home personnel are not meeting residents' emotional needs, aides at all of the homes we studied find themselves torn between their mandate to deal mainly with residents' physical needs and their desire to interact with residents as human beings in need of companionship.

STAFFING

At the Kanes, Comfort Home, and Chelsea Manor, recent privatization attempts or initiatives resulted in significant staffing cuts (see Table 1). Worker interviews indicate that evening and night shift staffing levels at the Kanes and Chelsea Manor are now identical to those at Green Gables—where understaffing was cited by state inspectors as a major reason for suspending admissions in 1997.¹¹ On the day shift (during which most resident care is performed), the Kanes, Comfort Home, and Chelsea

Manor also experienced reductions in staffing, but levels remain higher at the Kanes (one aide for every 10-12 residents) than at any of the other homes. At Chelsea Manor (the home that was completely privatized), however, day shift staffing levels are now essentially the same as at Green Gables: 15 residents per aide and up to 20 on weekends. In contrast, nursing home advocates generally agree that a desirable day-shift ratio of nurses’aides to non-Alzheimers residents would be 1 to 8 or better.¹²

TABLE 1— STAFFING
Ratio of Nurses’ Aides to Residents, Before and After Privatization or Privatization Attempt

	The Kanes: Failed privatization attempt		Comfort Home: Privatization of Management		Chelsea Manor: Fully Privatized		Green Gables
	Before	After	Before	After	Before	After	
Day Shift	1 to 10	1 to 10-12	1 to 9	1 to 11-14	1 to 10	1 to 15	1 to 15-20+
Evening Shift	1 to 12-15	1 to 15-20	1 to 9	1 to 11-13	1 to 10	1 to 15-20	1 to 15-20
Night Shift	1 to 20	1 to 30	1 to 15	1 to 20-30	1 to 20	1 to 30	1 to 30

The Kanes

Nurses' aides, LPNs, RNs

Workers interviewed on both day and evening shifts all reported decreases in staffing levels over the last several years. These decreases have come about through attrition. A slowdown in hiring began in early 1996, when new county commissioners took office with the stated objective of privatizing the Kane Regional Centers. A buyout of several thousand county employees in the summer of 1996 included many Kane workers. According to data from the Allegheny County Controller's office, the number of full-time employees at all four Kanes (excluding central administration) fell from 1,571 at the beginning of 1996 to 1,375 by July of 1997—a decline of 196 employees. The number of vacant full-time positions rose from 146 to 368. During the same time period, part-time workers were cut from 159 to 123.

During the effort to privatize the Kanes, the county and other privatization allies made much of recent declines in occupancy rates at the Kanes. Between 1994 and 1997, according to the Allegheny County Controller's Office, total occupancy of the Kanes declined from 94.5 percent to 88.1 percent. Occupancy at Glen Hazel, the Kane facility with the lowest occupancy rate, declined from 92.7 percent to 78.3 percent. Nonetheless, current total occupancy (88.1 percent) at the Kanes remains

about the same as it was in 1991 (89.2 percent). Also, staff declined 13 percent between 1996 and 1997, while occupancy rates dropped only 7.5 percent from 1994 to 1997.

Staff attrition has had a major impact on the ratio of nurses' aides to residents on all shifts and units we examined. On the day shift, the old standard was that each 60-resident unit would have six aides, for an average of 10 residents each. In addition, each unit would have two LPNs and one RN. A unit might be short occasionally because of absenteeism, but working with less than the full complement of six aides per unit was rare. Currently, however, day-shift nurses' aides at both facilities report frequently being short-staffed. One day-shift worker at McKeesport kept a log from January through July 1997. Her log shows her unit working with five aides (12 residents each) instead of the normal six for 92 out of 201 days.

Workers on the evening shift told us that before the recent staff cuts, there were always at least four aides, and quite often five aides, on units with 55 to 60 residents. Each aide was responsible for 12 to 15 residents during the evening shift, a fairly high workload even though evening shift contains only one meal service. Today, workers say that they always have at least 15 residents each on the evening shift and that two or three times a week they have 20. Evening-shift

staffing levels are now similar to those found at Green Gables and Chelsea Manor.

Notwithstanding workers' responses, the director of nursing at Kane Scott claimed that the current staff-to-resident ratio is still 1 to 10 and that short-staffing is not a problem.

Housekeepers

At the Kanes, unlike the other nursing homes, we were also able to interview housekeepers. Our interviews suggest that reduced staffing levels may also have affected the ability of the housekeeping staff to maintain previous standards of cleanliness. A family member of one resident, who told us that her initial decision to enroll her mother at Kane was influenced by the cleanliness of the facility, claimed:

Housekeeping doesn't seem to do the rooms as often as they used to. Rooms aren't cleaned every day. A few weeks ago, I noticed food under her bed... On the weekends the rooms are not too clean. They look worse [than before]. There are times on Thursdays, when I visit, that the room needs cleaning. I'm just talking about the floors. Food could sit for a few days. They don't dust too often now, and the bathroom doesn't look like it's cleaned every day.

Housekeepers admitted that

when they are short-staffed they have to skimp on things that they would normally clean thoroughly. One housekeeper at McKeesport described her job duties on a “normal day” (with full staff) as follows:

Every day you have one specific room targeted for “terminal cleaning” or sterilization, which can take quite a while to do right. Then the rest of a normal day is 30 rooms and 15 bathrooms.¹³

We wipe down furniture, dust, disinfect mirrors and sinks. We wipe down closets, and do “high” dusting—the light fixtures and above the doors—twice a day. Each room takes five to eight minutes to do, I guess. Then there’s the hallway railings to wipe, and trash cans to empty. Each of these gets done twice a day also. We clean the whirlpool room twice a day at least, which takes about 15 minutes to do a good job.

We asked the same housekeeper whether she typically has enough time to complete all of her tasks. “Only sometimes,” she said. Then, after a pause, she continued:

When you’re short, you have to cut down the wiping, forget the high dusting, empty trash less frequently. The dining room becomes a wreck; there’s stuff all over. The pantry is bombed. Trash piles up.

Comfort Home

At Comfort Home, day-shift staffing before the changeover to private management was six aides, two LPNs, and one RN for units housing 52 to 56 residents. The ratio of aides to residents was, therefore, roughly one to nine on the skilled care wing. There was one more LPN and one more RN on this wing than on others in the facility. The ratio of residents to aides was the same throughout. Workers say that under the old management, these staffing levels were met “almost always” or “90 to 95 percent of the time.” There were occasions when absenteeism brought the number of aides down to five (an aide-resident ratio of one to 11). On the other hand, workers say, there would sometimes be seven aides, a ratio of one aide for every eight residents.

The private management company allowed attrition to

reduce the number of day-shift aides per unit from six to five, giving a new daylight aide-resident ratio of roughly one to 11—slightly worse than the nominal current staffing at the Kanes on daylight shift. On weekends and holidays, or when absenteeism occurs, there are commonly as few as four day-shift aides, giving a ratio of one aide for every 13 or 14 residents.

Before the privatization of management, evening-shift staffing was the same as on day shift except that each unit had only one LPN instead of two. After privatization, the number of evening-shift aides per unit was reduced from six to five, for a new aide-resident ratio of one to 11. One worker told us that her unit currently works with four aides (one aide for every 13.5 residents) almost every day. “Several times a

month,” according to this worker, “we have only three aides for 54 patients,” an aide-resident ratio of one to 18. On the evening shift, therefore, current staffing levels appear to be slightly better, most of the time, at Comfort Home than at the Kanes. On the night shift, the old staffing level was four aides and one RN on each unit. This was reduced to three aides and an RN, and workers said that at present there are often only two night-shift aides per unit.

Despite management’s insistence that the new staffing levels were adequate, workers said that during Comfort Home’s annual Health Department inspection in September 1997, management went back to the old, higher staffing levels:

When the state was in, we had orientees and nursing students working without certification as regular aides and nurses. We

had six aides every day on all the units, too. It's amazing how we had so much staff coming out of the woodwork when the state was here.

As at the Kanés, staff cuts have been achieved through attrition. Workers said that the new management company has made little effort to fill vacant positions. Aides supplied by a temporary agency, working for reduced pay and no benefits, are being used to fill some of the gaps:

There are some [agency aides] who've been there 16 months and want to become full-time,

but [the administrator] won't award bids to them. We have open bids that we're not filling while these [agency aides] are getting passed over.

Finally, even as staffing has been cut, nurses' aides' duties have expanded. According to workers, the occupational therapy department once had sole responsibility for administering range-of-motion (ROM) exercises designed to prevent or ameliorate contractures. Under private management the aides now shoulder part of ROM responsibility. The aides do ROM in five-minute blocks per resident. One evening-

shift worker said:

Seven of my 14 patients need 15 minutes of ROM [each day]. You do the math—that adds up to a lot of extra work [one hour and 45 minutes], which is impossible to get done now that we have less staff. You only have seven and a half hours on your shift.

Hence, even though nominal staffing at Comfort Home is now only slightly worse than at the Kanés overall (and slightly better on the evening shift), the redefinition of aides' jobs to include performing passive motion exercises for a significant portion of the day is a de facto staff cut.

Chelsea Manor

Before privatization, Chelsea Manor had enough staff, according to workers interviewed. On the day shift, there were six nurses' aides, two dedicated "bath aides," three LPNs, and one RN for each unit of 60 beds. Each nurses' aide cared for 10 residents (equal to the pre-cutback ratio at the Kanés) and received help from bath aides. Evening shift staffing was the same as on the day shift, and the night shift had three nurses' aides, one RN, and one LPN.

After the home was privatized, workers said that staffing levels deteriorated. First, one nurses' aide and one LPN were eliminated from each unit on each shift. It is now common for units to have even

fewer workers:

They're supposed to have five nurse aides and two bath aides on days but they never work full staff. People on [workers'] comp are not replaced, and when they get call-offs [from workers saying they will not be coming in], they don't even call anyone to come in—you're just working short... We never have six nurse aides anymore. We work with five, four, or even three aides... Four aides is most common.

More often than not, day-shift nurses' aides have to contend with 15 residents each, and sometimes

as many as 20. This is more than on the day shift at either Comfort Home or the Kanés.

A worker from the afternoon shift saw a similar reduction in staffing. Instead of 10 residents, nurses' aides are now assigned as many as twice that number:

You never had full-staff there after [privatization]. It was a lot worse than before. I went in one afternoon and I was given more than 30 patients. It was next to impossible.... They tried getting help by pulling from another unit, to leave them with three aides instead of four—which isn't good either—but at least then our unit had three

aides instead of just two. So I ended up with about 20 patients.

When units are fully staffed, management often sends people home:

It's really terrible—like yesterday, they asked for volunteers to go home, and one person did.

[Q: Do they get paid?]
No, they don't get anything. And then we're short again. They do that whenever we have the full number of staff. Or they'll call people at home, especially some of the part-time workers, and ask them to stay home for the day.

We were not able to speak directly with a night-shift worker, but day-shift workers interviewed said that the night shift has experienced the same levels of staffing reductions as the other two shifts. Instead of three aides and one LPN per unit, after privatization the number of aides was reduced to two.

Green Gables

Staffing levels at nonunion, private Green Gables are similar to those at Chelsea Manor. Each unit of 60 residents is supposed to be staffed on the day shift with six nurses' aides, one "shower aide" (who works on weekdays only), one or two LPNs (two on the "skilled care" wing), and an RN. In practice, as at Chelsea Manor, most of the time there are only four nurses' aides instead of six (one nurses' aide for every 15 residents).

A worker from a skilled-care unit of 45 residents said, "Sometimes we do have four aides during the week [11 residents each], but the majority of time we have only three [15 residents each]."

On weekends, shortages are even more severe. "Nobody wants to come in on the weekends, so we're always really short then," one worker related. "Especially in summer." Another worker said, "On weekends they sometimes only schedule two nurse aides... This happens frequently." This worker elaborated:

A typical example on "A" wing [skilled care]: they had three aides scheduled last weekend, one called off... Then they tried to get the previous shift workers to stay for overtime. You don't mind [staying] once in a while... This weekend they [called] someone in who was off

but she didn't get there until the shift was half over.

On most weekdays, then, each nurses' aide at Green Gables takes care of about 15 residents — on both skilled and intermediate care wings—and on weekends that number can soar to above 20 on day shift. Staffing on the evening shift, about the same as on the day shift, is close to that found at all of the other homes: 15 residents for each aide, with more on the weekends. On the midnight shift, it is also similar: "They figure two nurse aides and an RN are capable of handling the whole [skilled] wing [with 45 residents]."

WAGES, STAFF TURNOVER, AND CONTINUITY OF CARE

This section explores wages, turnover, and “continuity of care” (the extent to which long-term relationships are possible between individual workers and the residents for whom they care) at each of the four

homes. We obtained starting wage and turnover data for the Kanes and Comfort Home. In the other homes, estimates rely on worker interviews (Table 2).

TABLE 2—NURSES AIDE WAGES AND TURNOVER Before and After Privatization or Privatization Attempt

	The Kanes: Failed privatization attempt		Comfort Home: Privatization of Management		Chelsea Manor: Fully Privatized		Green Gables
	Before	After	Before	After	Before	After	
Starting Hourly Wages	\$10	\$10	\$8.75	\$8.75	\$8.40	\$6.40	\$6.40
Annual Turnover	15%	15%	8%	15%	Low?*	50% in first year	50–60%

*Exact turnover figures for Chelsea Manor were not available, and we were unable to interview enough workers to make a reliable estimate. However, the workers we did interview claimed that employee turnover was very low before the facility was privatized.

The Kanes

Starting wages for nurses' aides and housekeepers at the Kanes are about \$10 per hour, with the top of the scale at about \$11 per hour.¹⁴ Kane workers enjoy a good benefit package, with employer-paid medical coverage, sick days, and paid vacations. Nurses' aides' wages at the Kanes are higher than at most private nursing homes in Pennsylvania, where starting wages for nurses' aides averaged about \$7.00 per hour in the mid-1990s.¹⁵ Workers we interviewed recognized this, but

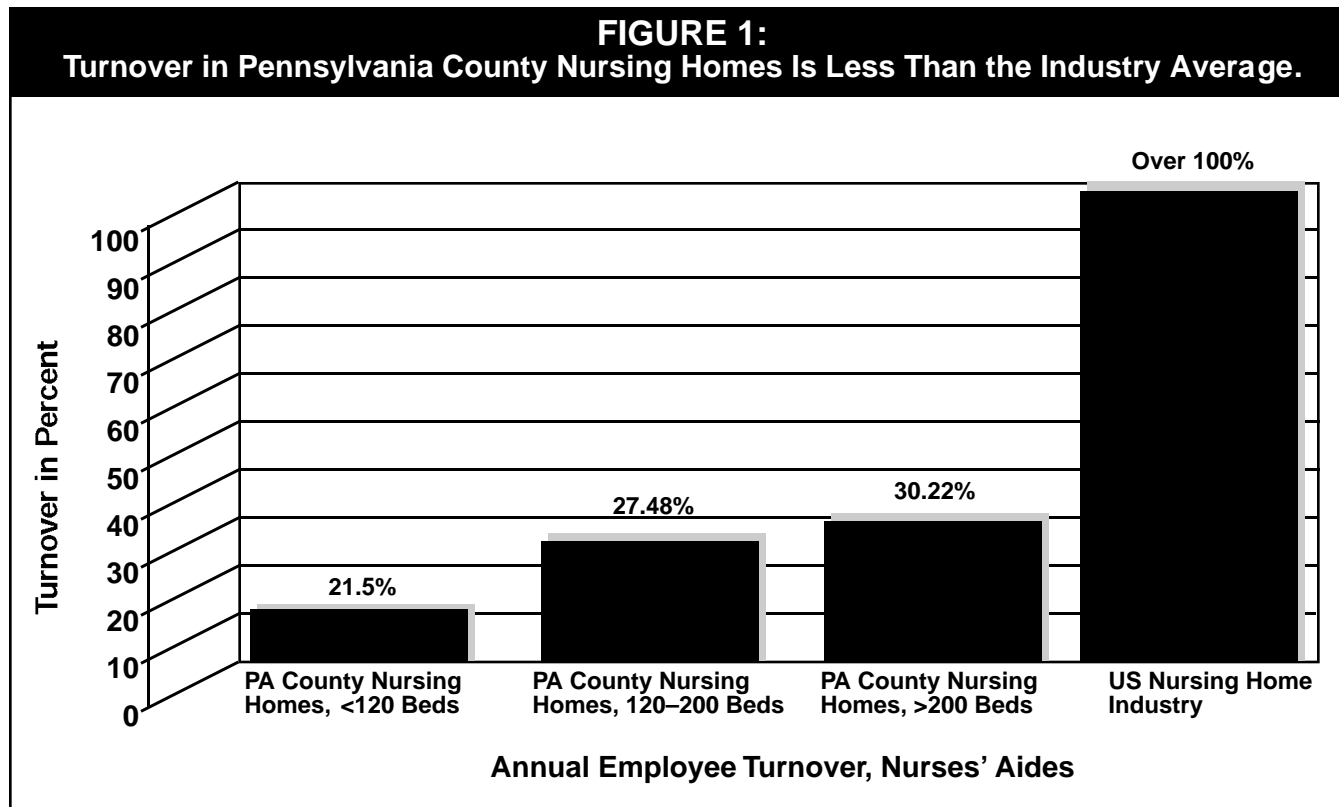
they emphasized that \$10 an hour is still a very modest wage. "I'm single, so I get along OK, but it makes me mad when I think of families with children trying to make it on this wage," said one worker. "I make about \$19,000 a year," said another. "That's not a heck of a lot of money."

Kane workers said that the relatively high wages they enjoy are a major reason for the facilities' fairly low rates of staff turnover. For 1995, turnover among nurses' aides across the four

Kanes averaged 15 percent. This compares favorably with turnover for other large county homes in Pennsylvania for the same year. Fifteen percent turnover is less than one sixth the average in the U.S. industry as a whole (Figure 1).

Kane workers believed that if any privatization plan led to wage reductions, turnover would rapidly become a problem. One worker said:

If they privatize the Kanes and wages are cut down to \$6 an



Sources: Pennsylvania Association of County-Affiliated Homes (PACAH) Annual Survey; Gooloo Wunderlich, et. al., ed., *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, DC: National Academy Press, 1996).

hour or whatever, I'm not going to stick around for that. This is hard work, both physically and emotionally. If I'm going to make that little money, I could be flipping burgers and it would be a lot fewer headaches.

Along with relatively low turnover rates, the Kanes' "case management" system fosters continuity of care. Individual nurses' aides work with the same residents over long periods. Workers and residents' family members praised the Kanes for allowing staff and residents to stay together and develop these long-term relationships. One worker explained the importance of this kind of staff consistency:

We have the same patients

every day. We get to know them as if they were family. We know their likes and their dislikes. We know their needs. And that's very important to them, because they don't like sudden changes.

A family member emphasized the central importance of the relationship between her mother and her day-shift aide:

It is extremely important for people like my mother to have a consistent relationship with their caretakers. The more people they have caring for them, the more confusing it is for them...Julie is an A-1 type of professional. She has had Julie since a month or two after she got there, for 75 percent of her care...Mom and

her roommate are very aware of when Julie is not there and miss her on her days off.

The same person, like several other family members interviewed, was less happy about the situation on the weekends, when part-time workers are sometimes used. "It seems like on the weekends, standards with the part-timers do go down a bit," she said. These family members' comments are consistent with the findings of a study by the National Citizens' Coalition for Nursing Home Reform. Focus groups with nursing home residents and family members revealed that the quality of residents' relationships with their primary caregiver is the issue residents and family members care about most.¹⁶

Comfort Home

The introduction of a new management corporation to run Comfort Home did not affect the collective bargaining agreement with the county. Starting wages for nurses' aides in 1997 were \$8.75 an hour, substantially lower than starting wages at the Kanes but much higher than starting wages at Chelsea Manor (after privatization) or Green Gables. The top end of the scale at Comfort Home is about \$11 an hour, nearly identical to the

Kanes.¹⁷ Like Kane workers, those at Comfort Home enjoy a package of benefits, including health care coverage.

Before the arrival of private management, staff turnover at Comfort Home was very low. Among full-time nurses' aides, turnover was a little under 8 percent in 1994 and just over 8 percent in 1995.¹⁸

Comfort Home workers suggested that the home's turnover

is rising, especially among new workers. One worker said:

In the past, almost all of the new aides in every class would stay. Turnover was very low here. In my class, 80 percent of us are still here after four years. But in the current class of 20, there are only eight left.

Other workers agreed, saying that while there has not yet been a

mass exodus of long-time employees, the most recent class of trainees has suffered a high attrition rate. Workers say that with staff cuts trainees are now entering a more difficult environment than in the past. Before the staff cuts, one worker explained:

The orientees were given very light responsibilities. Now, if we have an orientee on a shift, we're often so short that we're

just grateful for the help. They have to pull their weight.

Workers also have less time to spend helping the orientees.

They're just not prepared in their classes for the reality of what they have to deal with here. The classes are a joke. And when they get thrown into the fire because we're so short, they are finding it overwhelming

now...and so more of them are dropping out.

Seniority lists indicate that the turnover rate among full-time nurses' aides for the first 12 months of operation under private management was approximately 15 percent. This is much lower than turnover at Green Gables, but represents an increase of nearly 90 percent over each of the two preceding years.

Chelsea Manor

Before privatization, wages of nurses' aides at Chelsea Manor were similar to those at Comfort Home. The 1994 starting wage for Chelsea Manor aides was \$8.40 per hour (\$9.10 in 1997 dollars). When the home was sold, aides' wages were cut by \$2.00, to \$6.40 per hour. Since then, workers have received modest increases. One worker reported that she is now back up to \$7.90 per hour, although the starting wage is still less than \$7 per hour. On top of the wage reduction, workers lost their paid lunches and their benefit packages were slashed. The number of holidays was cut in half and the number of sick-days and personal days was also cut. One worker we interviewed said that she went from 20 vacation days per year to 10, and that she

lost 6 sick days and 3 personal days per year.

Workers said that staff turnover before privatization was low. "Very few aides left before," one said. "It was a good job." But as described earlier, when the new company took over in January 1995, less than half of the original workforce was retained. Workers' comments about the experience of new hires at Chelsea Manor were similar to those quoted earlier about Comfort Home:

They only called back half. The other half were new people who didn't know the patients; they were just thrown in and said here, you do it. There was no real training. We were expected to teach them as they went, but they didn't realize how hard it is when you're that

busy. Back when I was new, I was...an extra person. But when they did the changeover, they just threw the new ones in there. Lots of the ones they hired new were really new, [and had] never worked in a nursing home before.

Workers suggested that the changeover in staff had negative effects on the residents:

There were quite a few deaths in the first few months after they opened. Because it was traumatic, patients were depressed. They were used to all these aides and all of a sudden they've got all these different ones. They don't know if they can trust you or not.

In addition, the new workers were

not as competent as the old:

The ones they hired were less conscientious. Instead of giving a bath they'd just douse them with powder. I've seen that happen a lot. I'd go in after someone had supposedly given a bath and the towel and linen wasn't even wet.

Turnover at Chelsea has been held down by its location in a rural

area with high levels of joblessness. Nonetheless, one worker who recently left the home said:

After [privatization], they had them coming in, staying a week, and leaving. When I started the second time, during the first 5 months, they hired 10 more people, and only a couple of them stayed. I don't know if they were too young and didn't realize what they were getting

into or what. Eventually, I had enough, too, so I quit myself.

It seems likely that as the most experienced aides gradually separate from Chelsea Manor, more and more positions will come to be filled by short-tenure aides who turn over regularly. The overall workforce experience distribution will come to resemble that of a low-wage private home, such as Green Gables.

Green Gables

Starting wages at Green Gables, workers reported, are \$6.40 per hour. Workers said wages range from \$7.62 (after two years' service) to \$9.00 (after eight years' service). Turnover at Green Gables was at least 50 percent this year, according to workers. "I'd say between 30 and 40 percent of the workers have been here as long as one year," one worker estimated. Another said, "This year at least half have left. It varies from year to year." Therefore, more than half of the workforce is earning at or close to the starting wage of \$6.40.

Because wages are so low, the facility is having a hard time attracting new hires. "They have advertisements out," one worker said. "But they're not getting any applications. No one is beating down

the doors." Another worker added:

Why would anyone want to go to school [for certification] to work here at \$6.40 an hour? You can make that kind of money at McDonald's without the educational expense. And to be honest, as bad as fast food work might be, this is worse. The suffering you have to witness, the deaths—for \$6.40 an hour, it's really just nuts.

The fate of a recent experiment in case management illustrates the difficulty of attracting qualified staff at such low wages. In the summer of 1997, state inspectors, concerned about the high turnover and poor quality of care at Green Gables, forced the home to

implement a new case management plan that would guarantee a ratio of staff (including LPNs and RNs) to residents of no lower than one to seven. One worker described the problem:

We didn't have the staffing to do the case management. For the schedule they put up, we needed to hire 21 more people [out of a total staff of only 71], and nobody's applying. It's hard to be certified, and plus, they didn't pay the wages. They're not getting applications for that reason.

Instead of hiring the requisite number of new full-time workers, Green Gables used a variety of stopgap measures, including using

RNs as nurses' aides. In addition, aides were brought in from temporary agencies.

They used agency aides. Temps. They have to pay like \$15 an hour altogether to get them, but they did that all summer, so we'd have enough staffing for the case management.

The home finally passed a state inspection in the late summer of 1997. It immediately abandoned case management.

In Green Gables' high-turnover environment, there is no chance for the Kanés' kind of staffing consistency to operate. Experienced workers complained about the inexperience of other staff: "The staff is just too inexperienced because of all the turnover. The new people are not as capable of doing the work, and I have to pick up more." Another worker said, "[The turnover] is terrible because we have to show [the inexperienced workers]—orientate them. It slows us down. Then if they don't do things properly, we have to do their jobs." This is demoralizing to experienced workers:

When you're bringing somebody else new in you're going to have to spend time training them. It takes time away from the residents. When you're doing this you have in your mind that this person is more than likely going to

leave, too. It's hard to do a thorough job training someone when you know they will probably leave anyway, especially when you're pressed for time yourself. We usually place bets, like, in two weeks a person will leave.

The revolving-door nature of the place upsets the residents, according to workers interviewed.

Quite a few of our residents are very upset because a lot of people have been fired or left... We have very few people who have been there long. The residents keep asking for their old aides back.

Another worker made a similar comment:

If the residents—especially those who are "with it" mentally—if they get used to a particular aide, they get distraught if that person leaves. They either get scared, confused, and depressed, or else they become really loud and boisterous. One particular resident who this just happened to—she really got angry. She was yelling and screaming that she is sick and tired of having every day someone new. She started refusing basic care.

Other workers talked about additional problems that arise because of high turnover and the

lack of staff familiarity with individual residents:

You've got to know the needs and capacities of each resident. You get a new one in there, and the residents don't cooperate. It happens all the time. "No, I can't stand up, honey," [residents] will say. They try to get away with everything they can, even if they can do what they're being asked to do. There's no time for a new worker to read through the charting and the care plan to see what the resident can do. The aide just comes to us and asks, "What can this person do?"

Sometimes, workers continued, staff inexperience can be dangerous for residents:

The other day we had a meal tray come out from the kitchen for a diabetic. That patient is supposed to get Sweet'n'Low instead of sugar, but somebody made a mistake and put sugar on her tray. This aide was new and of course she didn't know, so she gave the sugar to the resident.

Occupational therapy and dietary staff, who also experience high turnover, can also make mistakes if they do not know the residents well:

The occupational therapy people come and go too, and

they only work with certain people, so they don't know all the patients that well. Sometimes [dietary staff] change the patients' food and the patients won't eat it or can't cope with certain kinds of foods or consistencies. They never ask the aides for their opinions.

Finally, a familiarity with

residents' desires is important for respecting residents' dignity:

We have female patients who don't like care being performed by a male. If I, being male, go in with a female resident who has that preference, it makes it difficult to do in a timely way because they won't cooperate. Or they may not say anything

because they're afraid of being picked out as a troublemaker or being ignored. Lots of times I think the inexperienced staff go against the wishes of the residents, and since the residents may not feel confident enough to speak up with a new person, it keeps happening.

Summary

Nurses' aides' wages, benefits, and turnover rates affect the continuity of care. Decent wages and benefits and low turnover rates are necessary but not sufficient conditions for care continuity. The Kanes' case management system, combined with decent wages and good benefits, produced the best continuity among the homes in this study. Comfort Home, which rotated staff, never achieved the

same continuity of staffing, even though its wages and benefits were good and its turnover low.

This section also shows that at Comfort Home and Chelsea Manor staff turnover increased with privatization, reducing continuity of care. At Comfort Home, turnover nearly doubled in the first year after a private company took over the management of the facility. At Chelsea Manor,

50 percent of the staff "turned over" all at once. Workers there believe that annual turnover is now higher than before and that the home has difficulty retaining new hires.

Green Gables, the nonunion private home, clearly illustrates the causal connections linking low wages with high employee turnover and poor continuity of care.

COST-CUTTING AND SUPPLIES

This section investigates the availability of supplies, including changes related to privatization. It also describes cost-cutting measures—undertaken

by private managers—that workers see as undermining their ability to care for residents.

The Kanes

Workers at the Kanes reported no serious problems with supplies of medical items, resident care items, linens, cleaning supplies, or laundry. One worker said that at several private homes where she had previously worked as an aide, residents were

individually charged for shampoo and other items necessary for personal grooming. She felt good about the fact that the Kanes provided these kinds of items at no charge.

Comfort Home

Workers objected to the ways in which the new administrator tried to cut costs. On the skilled-care wing, where nearly all of the residents are incontinent, the administrator decided to halt the use of “Attends” diapers on residents while they are in bed. Most residents now lie on cloth bed pads instead of being diapered. According to the administrator, workers said, this will save \$300,000 per year.

Workers said that the cloth pads do not keep urine away from the residents’ skin. One worker asked:

What’s better—to be wearing a very good quality plastic diaper with an absorbent lining that holds moisture away from your skin and that does not leak, or to be lying in your own filth on a mattress?

Workers also complained that the cloth pads do not protect the special “egg-crate” mattresses that some residents use. Since residents (or Medicaid reimbursements) pay for these, management calculations may not take into account the cost of replacing them when they get soiled—which now happens regularly.

In another cost-cutting move, the new administrator decided to eliminate the use of bedside Handi-Wipes. “The residents really liked them,” one worker maintained:

We used them to keep [residents] fresh and clean. [Managers] took those away from us, eliminated them, and now we’re supposed to use paper towels. It’s just not as nice for the residents.

Chelsea Manor

At Chelsea Manor, workers said that the new management of the home has attempted to save money by rationing supplies. As at Comfort Home, the supply of adult diapers has become an issue:

Before [privatization], most of the time we had enough of everything. We rarely had to skimp on supplies. There were a few times here and there, but most of the time it seemed like everything was pretty well

stocked. Now there are times when the Attends [diapers] are rationed two to a shift; we don't have them or aren't going to be getting them in for a certain amount of time. Maintenance only brings up so many.

[How do you deal with this?]

You have three rounds to do, so in this case you'd skip your second round and do your last round just before the shift ended.

That's a long time to go between changes. This is something that never happened before.

In addition to rationing supplies of diapers, workers maintain, nurses' aides no longer have discretionary use of other supplies:

Before, we could get anything except medicine and treatments. The new company started locking up gauze, tape—things we needed all the time.

Green Gables

Green Gables' problems with supplies seemed to be more serious than those at any of the other homes. "They run out of things all the time," one worker said:

The other night, they ran out of a certain type of feed for the G-tube [gastronomic feeding tube] people. So they had to make a quick fix...A lot of times we'll run out—dressing supplies, syringes, or needles—different things all the time.

Another worker complained:

We've gone without supplies because they didn't pay the bills and companies wouldn't

deliver. The diapers, Depends, they had to get a different company. They had the money, just didn't pay the bill.

A third worker focused on the quality of supplies and equipment used in the home:

The materials we require are either not available or they are of poor quality. There is not enough equipment to do vitals, or a lot of other times the equipment is faulty. You tell your charge nurse about it and basically it just goes on deaf ears. When somebody takes a turn for the worse and you have to rely on faulty equipment, how

can you get accurate information? Simple things like changing the battery in the blood pressure cuff.

As at Chelsea Manor and Comfort Home, Green Gables' workers described instances in which supplies were curtailed or downgraded to save money:

They skimp on linen...It wears out, you know, to where it's just frayed and torn, but they don't replace it...And we have been short on washcloths to where we had to use one end to wash them and the other end to dry them...They discontinue some supplies because they are

*supposedly not cost-effective...
The biggest thing is the gloves.
We need a good latex glove.
But they've gone to like a "deli
glove"—they're porous and thin.
You can transfer germs that way.*

Workers at Green Gables also complained about the physical safety of the building and grounds:

The ceiling fell in about a year

ago, the plasterboard tiles, and we have had a leaky roof for a whole year. They are just now putting a new roof on...The state didn't say anything about it because they said it wasn't a health hazard.

Another worker claimed that the home's airborne isolation ward (a special room for isolating infectious residents) was not functioning properly.

In our airborne isolation ward, there's no negative airflow and the doors are always open. When the state comes in it's a miracle how these people are cleared out of there. They're not on isolation because we can't do it properly. And if they're really bad, they find ways of sending them to hospital so they're not there.

Summary

Of the homes in this study, only the ones that are still managed directly by county government—the Kanes—have avoided cutting corners on supplies. The private management company at Comfort

Home, Chelsea Manor's new private owners, and the management of Green Gables have all cut costs by skimping on supplies and/or neglecting the maintenance of the physical plant.

Workers believed that in so doing, private managements at these three homes have compromised residents' dignity and/or health and well-being.

WORKERS' RIGHTS

Kanes and Comfort Home

At the unionized Kanes and Comfort Home, workers take for granted a range of rights that do not exist at Chelsea Manor and Green Gables. At the Kanes, we were able to interview workers during their lunch breaks. Workers were not afraid to meet and discuss their work. We were able to visit the facilities. After being interviewed, several workers showed us around their units so that we could observe the residents and staff interacting. At Comfort Home, workers requested to meet at a

neutral site near the home, but none of the workers was afraid to be interviewed.

In neither home do workers feel that they risk their jobs by speaking up about concerns that they have (although some feel that speaking up is futile). Workers at these two homes take for granted that their hours, shifts, and schedules will not be arbitrarily altered to punish them for speaking out; union contracts govern these matters.

Chelsea Manor

At Chelsea Manor, impending privatization divided the workers amongst themselves and weakened the union's ability to represent its members effectively during the period leading up to the sale of the home. When workers were told in the fall of 1994 that they would have to re-apply for their current positions and go through an interview process, the workers who served as the union's chapter president, vice president, and treasurer were placed in a bind. If they spoke out against the proposed concessions, their jobs were in danger. As a result, workers believed that these three officials negotiated with management to save their own jobs. Workers also said that the chapter president stopped energetically pursuing some grievances.

The new nonunion Chelsea Manor became a different sort of place to work when management placed gag rules on workers. One worker said:

You lost your freedom of speech. You were literally told not to discuss your work outside of the workplace. They might have worded it a bit differently but that is basically what we were told.

As a result, there seemed to be a climate of fear at the facility. Despite assurances of anonymity, it was extremely difficult to find workers willing to be interviewed. Five workers who declined to be interviewed expressed fear of being identified and targeted by management.

Inside the facility, workers are less likely to speak up when they see a problem. One said:

The way things are now, you just have to shut your mouth and do what you're told. If you think there's something not being done right, or something that's lacking, you just risk getting written up if you speak out. People are afraid to say anything...It's scary, it really is. This company is just out to save money, to cut expenses. Our jobs just aren't safe now.

A second worker agreed, saying, "[When you see a problem] there's nothing you can do but keep your mouth shut. People are afraid to speak up because they depend on that job. Don't rock the boat."

Green Gables

At Green Gables, workers expressed frustration with their inability to speak up about problems at work. One worker said:

You need somebody to go to when there's a problem, somebody who won't write you up for speaking your mind. Being a nonunion home, we're more or less told to shut up and do what we're told.

Another said:

They fired a nurse just for rolling her eyes. I love my job, but I hate it there because it's so bad...I'm just waiting for them to find a reason to fire me, and I'm doing my damndest not to give them a reason.

Workers also complained about being punished for things that were beyond their control or not their fault. One worker said:

I had to go to the lab for bloodwork and was going to be a little late to work...The head administrator said it was fine, but he didn't tell my DON [Director of Nursing]...I got written up even though I had gotten permission to be late.

Another worker claimed she was recently suspended for missing a mandatory "in-service" training while out of the state on a

scheduled vacation. "There was no warning. I didn't know they were having it but I still got suspended."

Workers resented what they saw as management's arbitrary and last-minute scheduling changes and demands. One worker noted:

[An aide] planned a trip for her anniversary. They were going to Florida. She had her plane tickets bought, hotel reservations, everything. She had four weeks' paid vacation coming and it was scheduled months in advance. At the last minute they said they had an urgent need for staff and that she couldn't take her vacation. She was going to lose the money she had spent on the trip, so she quit.

An evening-shift worker was told on a Wednesday that, as of the following Monday, he would be assigned to the night shift. He explained that his wife worked nights and that they only had one car. They had no one to care for their children. He asked for a little more time to make some alternate arrangements for child care and transportation. The administrator refused and told him that he was out of a job if he did not show up for work at midnight on Monday. This worker said, "they make up rules and the next day they're changed. You're never really given any reason for the changes."

Finally, workers were upset about what they saw as management's failure to take care to protect them from dangerous situations. Workers complained about not being informed of the infectious disease status of residents with whom they worked:

There are times where we'll be doing P.M. care on residents and then a week later we'll find out that they have a disease... Once we had a guy who had AIDS and we weren't told about it. He was combative and he would bite, and he would ejaculate and there would be semen we'd have to clean up. We all wear gloves and stuff like that but you want to take better precautions.

Another worker talked about how management seemed indifferent to the danger that combative residents posed to aides:

My supervisor told me to shower a lady, to take vitals on her. I told her that the lady was very combative but she made me do it anyway. I got beat up. I was down on the floor getting beaten up and they had to come running to help. I would have gotten written up for refusing. I've had my clothes torn off, glasses knocked off.

PRIORITIES OF MANAGEMENT: Quality Care Versus Costs and Profits

Kane workers interviewed said that, for supervisors and managers at their facilities, the quality of care was the highest priority. “Whenever there is a problem,” one said, “they are on it right away.” Another said, “I feel that the administrator does care about this place. She’ll be the first to chip in and help.” A third worker said, “They care. If you’re not doing a good job, they’ll tell you.” Kane workers understood that staff reductions resulted from political pressures emanating from within county government.

At Comfort Home, workers had a much different view of the new private managers. The workers felt that the mandate of private managers was to reduce costs first and worry about the quality of care second. As one worker put it:

Management makes the rules but they don’t know or care how or whether they can be carried out. They expect us to do more work with fewer people but they have no idea whether it’s possible. It’s just the almighty dollar now. In my opinion, the patients are nothing to them but dollar signs.

Another worker complained, “Our old administrator had a heart. With this one it’s just the bottom line that counts.”

At Chelsea Manor, workers expressed similar views about the priorities of the new company. One worker commented:

They say they care [about quality], but I don’t feel that way. The cutbacks in staff don’t show that they care about us doing a good job... They send volunteers home or call people and tell them to stay home. They only care about saving money.

Another worker said:

Management doesn’t come back to see patients, except for a few that have money, the private pays. There’s favoritism there. They tell us to go

out of our way for those who have money, even if it means we have to skimp on the Medicaid patients. That’s just not right.

Likewise, at Green Gables, workers said things such as, “If they really cared about the kind of job we do, they’d reward us with staff instead of a pizza party.” Workers complained that the bottom line seemed to be the first priority for Green Gables. They talked bitterly about the indifference of their superiors to problems that they identify. One nurses’ aide said:

We’re with the residents more than anyone else in the facility. Yet I feel that we don’t get taken seriously if we report a change in a resident’s condition. It falls on deaf ears. For example, we might notice that a patient seems to have had a stroke, and we’ll go to a nurse and say, “I think this patient may have had a stroke.” And they’ll say, “how do you know?”—because we haven’t gone to school or whatever. About two-thirds of the nurses won’t respond at all. They don’t want an aide to be telling them their job.

Another worker maintained that supervisors at Green Gables commonly make decisions that place residents at risk of injury.

Recently we had a patient whose special wheelchair—it has belts to keep him in place because he doesn’t have any legs—was missing. At first that patient had to stay in bed all day. Then the next day they put him into a non-belted wheelchair and he fell out of it. The supervisor told the aide to put him in a regular wheelchair even though it was pretty obvious that wouldn’t be safe.

A third worker told us about a recent situation in which a resident with an unusual-looking rash received no treatment for three weeks:

We reported it three weeks ago, and they said, nah, it was just diaper rash. And they didn't do anything at all. We kept reporting it every couple of days, but nothing happened.

This worker then came down with scabies, which she believes she got from the resident. When she

brought the DON a doctor's note containing her diagnosis, the DON told her that she didn't really have scabies and that if she did, one of her kids had probably brought it home from school. "That's possible," the worker said, "except that all my kids have graduated from college and none of them live at home."

In this for-profit, chain-run home, workers viewed the administrator's primary responsibility to his corporate superiors as showing a good bottom line. One worker said, "They don't care what kind of job we do, so long as they're not in trouble with the state."

QUALITY OF CARE

The Kaness

The Kaness' case management system is still basically intact, but it has been compromised by the staff cutbacks outlined earlier. For example, in September 1997, workers were regularly being bused from one Regional Center to another to help cover staff shortages on the evening shift. This nibbling away at the case management system tends to undermine a feature of the Kaness—long-term relationships with caring staff—that workers, residents, and residents' family members all appreciate.

Workers felt that staff cutbacks lowered the quality of care. Most workers complained that their ability to socialize with residents has been curtailed. As a day worker at McKeesport said, "It seems like we had more time in the past to talk to the patients, when we had 10 [residents] all the time. Now since we have 12 so often, we're more rushed." An evening-shift worker at McKeesport agreed:

If we had more time, we could read to them. These are the things that we used to do before we got so short-staffed... They say there are volunteers who can do that kind of thing. But there aren't enough, and on [the] 3 to 11 [shift] there aren't any volunteers. They come on daylight shift only.

Another evening-shift worker at Glen Hazel said:

There used to be enough time and enough staff that you could give someone an extra shower, or if someone was upset you could ease their problems, or walk someone who needed assistance. You don't have that kind of time now.

Workers emphasized that these sorts of activities were not frivolous, but precisely the kind of interpersonal human contact critical to the well-being of the residents. "We are these people's family," one worker said, echoing a common theme, "and this is their home. Do you understand what that means? We're all these

people have got, a lot of them." Or as another worker put it, "You know these people don't have anybody else. They need loving." A third agreed, saying:

We used to have time to sit with them, read to them, or just talk. Have a cup of tea, or whatever... That's really important for them. That's all the interaction they may have in the course of a day. If we're too busy to talk to them, then who will?

A fourth worker said:

Some of the residents wonder why we can't spend as much time with them as we used to. They ask us, "What did I do to make you not love me anymore?" They think it's something they did wrong. It's heartbreaking. All you can do is tell them it's not their fault and go on to the next patient. They deserve better.

A day-shift worker at McKeesport said "If you spend more than 20 minutes with a single resident in the course of a shift, you're really in trouble in terms of being behind. That's just not enough time."

While residents and the facilities at the Kaness looked fairly clean, we saw many residents sitting for lengthy periods in wheelchairs without any sort of stimulation or interaction. When we visited a lunchroom, there were seven or eight residents sitting in wheelchairs staring into space while a single aide helped one resident eat. There were not enough workers to engage the residents individually for any length of time.

Even in terms of physical care, some areas have been getting short shrift since staff cuts were made. For example, residents are supposed to have restorative care programs aimed at increasing their independence. One worker described this program in detail, but none of the other workers interviewed mentioned restorative activities when describing their job duties or their "typical day." Restorative care seems to

take a back seat to the more immediate tasks of waking, dressing, feeding, and changing residents. In particular, aides' jobs are not oriented towards keeping people continent or trying to restore continence. Aides are simply too busy to respond quickly to requests to be taken to the bathroom, so as a result residents end up becoming or remaining incontinent.

In addition to these problems, some workers said that, since staffing has been reduced, it has not always been possible to turn residents as frequently as they are supposed to be turned, or to loosen restraints every two hours as required by law. State inspection reports for the Kanes do not reveal any significant problem with bedsores. But Kane workers say that they are able to stay ahead of that problem only because their familiarity with each resident enables them to act at the first sign of any change in skin condition.

Reports of state Health Department surveys from 1995 and 1996 focused on isolated mistakes by staff, on problems with equipment, and, more seriously, on the lack of activities for residents. In a few cases, the Health Department criticized care plans for residents' bedsores as not being specific enough. In other cases, residents did not receive the proper amounts of nutritional supplements.

In 1997, a more serious problem occurred at Kane

McKeesport. The Department of Health conducted an investigation in response to complaints by a family member who alleged that a seriously ill resident had not received appropriate medical care. In June 1997, investigators found one resident to be dehydrated, and the facility was cited for (1) "failure to meet professional standards of care," (2) "failure to acquire the appropriate information to make necessary adjustments in the dosage of a medication," and (3) "failure to provide residents with sufficient fluid intake to maintain proper hydration and health."

In a return visit in August 1997, the Health Department found that two residents were dehydrated, and again cited the facility for several instances of "failure to provide residents with sufficient fluid intake to maintain proper hydration and health." The facility's notes under the heading of "Provider's Plan for Correction" include the comment that one of the two residents in question died in August. The report contains no detailed information on the cause of death.

Another result of staffing cuts at the Kanes has been a decline in some workers' morale and commitment. While most of the workers interviewed seemed to identify strongly with their residents and to continue to enjoy doing extra things for them whenever possible, some workers expressed a sense of hopelessness. One day-shift McKeesport worker, said:

Look, I like taking care of residents. We are their only family. In the past, if I was out shopping and saw something a resident would like, I would pick it up for them. Our payback was in hugs. But now we're so stressed, we have to run, we don't have time to do extra stuff. I just can't do it anymore.

Another worker said:

I used to go out of my way more in the past, though. I would paint fingernails, bring in jewelry and berets, etc. Now there's really only one resident that I go out of my way to do these kinds of extra things for. I stopped doing this stuff because I don't care as much anymore. We don't have a contract since last year,¹⁹ we're short of staff, and the residents are sicker, harder to cope with, more time-consuming than they used to be.

Being asked to do more with less, with little regard to the needs of the residents, may lead some workers to disengage emotionally from residents. It can be painful for workers to recognize that they are not doing, and cannot do, as much for the residents as they would like to be able to do or as they did in the past. Some workers may respond by skipping their breaks and lunch periods in an attempt to provide everything residents need. Others may deal with the internal conflict by becoming alienated from residents.

Comfort Home

Comfort Home workers said that, as a result of the staffing reductions instituted by private management, the aides can no longer complete their normal duties properly within the time they have available. On the day shift, for example, a worker maintained that “we have residents in bed after lunch every day now, that we haven’t been able to do A.M. care on.”²⁰ Another worker said that on her unit, “we have people still in bed until 3:30 sometimes.” Before the staffing cuts, residents rarely remained in bed beyond noon. “This would happen occasionally in the past,” one worker admitted, “but now it’s constant.” Another said, “On my unit, when we had six aides, they’d all be up by 12 o’clock. That’s not true now.”

Workers said that management is not interested in hearing that there is not enough time to do everything they have been assigned:

Working short is not an excuse we’re allowed to use as to why something didn’t get done. We’re not allowed to chart that something didn’t get done. They say, “find the time.” They’re basically encouraging us to lie. You get doctors’ orders, you know, these things are supposed to get done, and you absolutely have to chart them exactly as they were ordered, even if you really didn’t have time to do it all.

They’re encouraging us to commit Medicaid fraud.

Workers also claimed that they are sometimes instructed to alter their charts to avoid giving the impression that there was not enough time to do something:

The other day, I only had time for 5 minutes of a 15-minute range-of-motion on a patient. I charted it that way, but I was told to reword it as “resident could only tolerate 5 minutes.” That resident could have tolerated an hour. I just didn’t have time to do it.

And workers agreed that the staff cuts, combined with the additional range-of-motion duties, have impaired the aides’ ability to perform the most basic of functions consistently. One worker said, “Nobody gets changed every two hours anymore.”

Like workers at the Kanes, workers from Comfort Home lamented the impact staff cuts have had on their ability to socialize with residents and to do little “extras” that improve the residents’ quality of life:

Before [the management was privatized], we did a great job here. We used to do a little extra, too—patients’ nails or hair, for example. We had time to sit with a dying patient if we needed to. Now, they want you to talk to them, but we don’t

have time. Where we’re at now is that we’re barely getting their basic physical needs met.

Another worker agreed, emphasizing that now there is no time to sit with a dying resident. “These days,” the worker said, “you see people die alone because you don’t have enough time to spend with them.”

State inspection reports do not show a clearly worsening pattern of deficiencies. They do show that the new private management company did not do a good job of implementing plans of correction for several problems identified shortly before the changeover to private management. In September 1996, less than two weeks before the changeover, a state inspection report criticized the home for failing to document medical necessity in two cases of restraint use to keep a resident from falling out of a wheelchair, and for failing to include in the residents’ care plans an effort to decrease the use of the restraints. The September 1997 inspection report again refers to several cases in which restraints were used without documentation of medical necessity. The September 1996 state inspection report also criticized the home for failing to report to the Department of Health the results of investigations into 14 cases involving allegations of abuse, neglect, or injuries of unknown origin. Although the report found that the home

conducted appropriate investigations in these cases, state inspectors cited the home for failing to report the results of these investigations to the state. In response, the facility (still under public management) made the following three promises.

(1) “The Department of Health will be notified of alleged violations” in this area “within 5 working days.”

(2) “The Director of Nursing and Director of Social

Services...will review and investigate all alleged [such] violations.”

(3) “[F]acility staff will be inserviced [trained on-site] on reporting any instances of suspected abuse, neglect, or injuries of unknown origin.”

Despite these promises by the home’s outgoing public administration, the following year’s inspection (after nearly one year under private management) found:

no evidence of a system in place to report, investigate, and prevent mistreatment, neglect, or abuse of the residents. Upon interview, the director of nursing confirmed that there were no written policies or procedures to be followed to investigate allegations of mistreatment, neglect, abuse, and misappropriation of resident property.

Chelsea Manor

As at the Kanes and Comfort Home, Chelsea Manor workers complained about being overworked and rushed since the staff cuts were implemented:

The biggest problem since the changeover, when we have all full beds, is that you’re just rushing, working too fast. I’d work an hour or 90 minutes of overtime every day almost. And when you’re rushing that fast you have a big fear of making mistakes. There’s just too much to get done in a seven-and-a-half-hour workday. I would just be running all the time. And most times, I wouldn’t even take my lunch.

Like workers at the other two

homes, workers at Chelsea Manor lamented the loss of time that could be spent socializing with residents:

If they wanted you to put a roller in their hair or just sit there with them for a little while, you could do it. And even if you were busy you could explain that to them and go back later and they were happy. After [privatization], you couldn’t do that at all... The only talking you did was when you actually were doing something on the resident. They might want to tell you a little story or something and you have to cut them off.

Chelsea Manor workers spoke about

a rise in resident injuries and falls:

We have falls, injuries that shouldn’t really happen. The aides do try to do their best, but they’re running from hallway to hallway when they’re understaffed. If there’s an emergency or something down at the end of one hall, you can’t hear the call lights from the other hall too well, and when you’re short-staffed, sometimes an emergency can pull all your staff down one way like that.

Workers also spoke of a rise in family complaints:

Oh, it’s a lot more than before...Just last night there

was a situation down one hall that took everybody's attention and another resident was waiting for 45 minutes to get changed—she was wet—and her family was there the whole time.

Another aide talked about the kinds of shortcuts she is forced to take with resident care when her unit is down to three aides:

If they don't eat, you eventually take it away. You just do not have any time to sit and encourage them to eat. If you did you'd be there till 2 p.m. trying to get lunch done, and your A.M. care still unfinished. But they really need that encouragement. That's why so many of them go downhill.

Workers said that the burden of caring for up to 20 residents each

on the day shift was causing stress among the staff. One worker said:

One of the worst effects of all the shortages of staff are the short tempers... You are trying to do your best but it's impossible... There was some stress before but nothing compared to what I see now.

Recent state inspection reports on Chelsea Manor document worsening problems. A 1996 inspection report noted the occurrence of several injuries. One resident fell in the facility and broke his hip, necessitating a transfer to a nearby hospital. Another had a broken finger, “etiology unknown,” which sent the resident to the emergency room. A third resident suffered a fractured right femur and was admitted to the hospital as a result.

According to the report, none of these injuries was properly reported to the Department of Health.

Unexplained injuries also occurred in 1997. In May of that year, state inspectors conducted a “special investigation” in response to complaints of abuse and neglect at the facility. The investigators found that the facility had failed to notify the proper agencies about a “suspicious/unusual injury”—several large bruises on a resident’s upper thigh and left groin area—which sent the resident to the hospital. The facility administration had investigated “inconsistent information that was provided by facility staff in relation to the injury sustained.” Finally, the state’s investigation found that the administration had failed “thoroughly [to] investigate an injury of unknown origin in a timely manner.”

Green Gables

The quality of care at Green Gables is worse than at any of the other homes studied. In 1997, Pennsylvania Department of Health inspectors suspended admissions for several months because of the severity and number of deficiencies found on initial and repeat inspections of the home. These 1997 violations are detailed in inspection reports totaling 72 pages—by far the

lengthiest of any inspection reports that we examined for any of the last three years. And the seriousness of some of the violations goes beyond anything reported at any of the other facilities.

One of the violations, for example, concerned the fact that ants were found in a “cognitively impaired and totally dependent” resident’s bed and in her diaper.

Insect bite marks were observed on the resident and, although a doctor was notified, nothing was done about the problem for several more days, when the resident was finally transferred to another room. Although the doctor ordered some medication to treat the inflammation caused by the bites, the medication was not administered. Furthermore, the resident was found to have an

unexplained bruise on her hand, a fractured bone in her finger, and several skin tears. These injuries, although reported to the RN on duty, were never assessed or investigated further. No effort was made to determine the cause of the injuries, and no plan of care was developed to prevent additional injuries to the resident.

This was not an isolated incident. The report found that the home failed to ensure proper standards of nursing care for at least 23 residents. In case after case detailed in the report, residents suffered unexplained injuries such as severe bruises and skin tears, which consistently went uninvestigated and, in many cases, untreated. In a review of incident and accident reports from the beginning of 1996 through the spring of 1997, the report found that 235 incidents of “injuries of unknown origin” had occurred (in a facility with only 104 residents), and that nearly all of them had gone uninvestigated. Furthermore, in a number of cases in which residents alleged that they had been abused by staff, no investigations were conducted to determine the veracity of the charges. Other problems included the home’s failure to deal properly with pressure sores in a number of cases; required assessments were not done, no plans of care were developed, and no treatments were given. Nursing staff assigned to care for the residents were not informed of the problems and family members

were not notified. Finally, in 11 cases, residents’ personal property (such as clocks, radios, etc.) was missing, and the home did not investigate these situations.

Workers mentioned several of these incidents in their answers to questions about the quality of care at Green Gables, including the incident involving ants in a resident’s bed. Nurses’ aides agreed that the home offered very poor quality care. One worker said:

[People] are led to believe that the quality of care is really top-notch here, when in reality it’s not. Even if it is Medicare or Medicaid paying for the home, these people have a right to better.

Workers said that they cannot always meet even residents’ physical needs. As one day-shift worker related:

On Saturday I had 14 people, which was a good day for a weekend. And that’s just too many to make sure that everybody stays dry. At lunch time I still had five people to do A.M. care on. These people never even had morning care done, and it was afternoon. That happens constantly. And they weren’t getting the quality care that they need. They don’t get motions on their arms and their legs. They’re not always turned every two hours. When

you’re that busy you just give them a lick and a prayer and dress them. You just wash the main parts of the body: their armpits, faces, hands, and groins.

Workers at Green Gables do not have time to socialize much with the residents. The following comment was typical:

The only socializing we do is when we’re doing A.M. care. You tell them about the weather, we have some who are real alert, they ask me about the grandkids, etc. Other than that we don’t have time.

Despite this, even at Green Gables, workers talked about the importance of having time to interact more with residents, and their frustration with the lack of opportunities residents have for social interaction:

It’s disappointing. The residents don’t all have someone to come see them. Not everyone even has a TV. I’d hate to be in a room and just stare at the four walls. We do have activities, but we don’t have time to take them over there; it’s half the length of the building. Activities will come to get them sometimes, but not in the mornings. So if we don’t take them they don’t get there.

Another worker spoke at

length about residents' need for more social interaction:

Most of the residents there are there for 24 hours [a day]. Families can't be there constantly. Most of the residents are lonely, withdrawn, and you just can't spend the time with them. A lot of these people, they're not

eating. Depressed, they're staying in their room, not talking to anyone, they're just totally cut off from reality. They basically give up. They figure that this is the last place they go before they die...

When they're there for the long-term...the first two weeks [are] critical. If you don't get

the resident to socialize, get into a living-type situation like at home—if you don't get to that resident within the first two weeks you lose them. An aide needs to spend an hour with them when they first come in, basically just talking to them.

CONCLUSION

Privatization

The debate over nursing home privatization needs to be informed by a thorough understanding of the human costs of privatization to residents and workers. On each of the major indicators of quality of care—staffing, turnover, supplies, workers’ rights, and management priorities—privatization or attempted privatization lowered quality. It tended to move the other homes closer to the low-quality, high-turnover model of care observed at Green Gables.

- At the Kanes, attrition and reduction in staffing in the face of threatened privatization have eroded quality.
- At Comfort Home, where privatization was limited to management, staff cuts have also

affected workers’ abilities to perform their jobs properly, and management seems less responsive to deficiency reports.

- At Chelsea Manor, the fully privatized home, the quality of care appears to have declined the most. The quality of care at Chelsea Manor may still be better than at Green Gables, but it is clearly moving in Green Gables’ direction.

For local governments faced with fiscal problems, privatization’s promise of reduced costs may sound tempting. But governments, and the citizens who elect them, should realize that any cost savings may come at the price of the well-being of our society’s most dependent and vulnerable adults.

The need for a new model of nursing care

The standard model of nursing home organization, and the official expectations about the kinds of staffing levels required for quality care, are badly in need of rethinking. Current state regulations mandate that staffing levels provide for a minimum of 2.3 hours of nursing care per resident per 24-hour period. For a unit of 60 residents, where there are three eight-hour shifts, this typically means an average of at least 5.75 nursing staff members (with nurses’ aides, LPNs, and RNs all counted equally) on each shift. At best, this permits perhaps five day-shift nurses’ aides, or one staff member for every 12 residents. At the Kanes and Comfort Home, the homes in this study with the best current staffing, staffing levels are typically above this minimum. If all three shifts in a 24-hour period are fully staffed, the Kanes provide at least 2.7 hours of nursing care per resident.²¹ Even when each shift on a particular

day is short, the Kanes still provide 2.3 hours of nursing care per resident (the legal minimum).

Although the Kanes and Comfort Home are meeting the official staffing requirements for nursing care, this report makes it clear that residents’ needs, conceived holistically, are still not all being met. Residents are simply not getting enough social interaction. Other studies of “high-quality” nursing homes have reached similar conclusions.²² And even when legal staffing requirements are met, our interviews suggest that there are not enough nurses and nurses’ aides to make restorative (or what Eaton calls “regenerative”) care a high priority.²³

One way for nursing homes to solve these problems is to hire additional specialized activities staff, schedule more activities, and spend more time trying to get residents to participate in activities. This, of course, is welcome, especially for those residents

who are most capable of taking advantage of and enjoying organized activities. But by itself this may not be the best solution.

The best solution to residents' need for more human contact and for restorative care may be to reconceptualize the jobs of nurses' aides.

Instead of seeing the job as a series of physical operations that have to be performed on as many residents as time permits, each aide should be given a smaller number of residents and encouraged to devote much more time to restorative care and socializing with residents. Such a reconceptualization

also would work against the kind of alienation from and dehumanization of residents that can, in the worst cases, lead to abuse and neglect. Increased levels of socializing between aides and residents are crucial ingredients of a better quality of life for workers and residents alike.

Policy Recommendations

In *Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs*, released in 1997 by

the Keystone Research Center, Susan C. Eaton proposed a comprehensive set of reforms to

encourage high-quality long-term care and discourage low-quality practices (Table 4).²⁴

TABLE 3: Promoting Quality Care and Quality Jobs in Long-term Care—Policy Recommendations	
1. Form a Pennsylvania Quality Care Council (PQCC)	<ul style="list-style-type: none"> A. Modify Act 185 to establish a quality care council with stronger representation from resident advocates, families, and workers who deliver care. B. Develop a "Charter of Customer and Worker Rights and Responsibilities" C. Develop a long-term industry strategic plan
2. Promote Research and Information Dissemination to Promote High Quality and Regenerative Care	<ul style="list-style-type: none"> A. Support research and dissemination of best-practice models of care <ul style="list-style-type: none"> • <i>research and pilot programs on innovative approaches</i> • <i>a Business-Quality Partnership Grant for dissemination</i> • <i>meetings to discuss "best" and "standard" practice</i> B. Conduct survey research on the human resource and quality connection C. Develop an annual quality report card on providers
3. Reform the Survey Process to Discourage Low-Quality and Promote High-Quality Care	<ul style="list-style-type: none"> A. Increase fines for serious deficiencies to discourage low-quality models of care B. Use Health Department surveys to promote learning about high-quality practice
4. Change Reimbursement to Reward Quality	<ul style="list-style-type: none"> A. Maintain a higher case-mix reimbursement after residents improve B. Increase reimbursement for homes with low turnover C. PQCC should conduct a general review of case-mix
5. Paraprofessionalize Nurses' Aides in Long-Term Care	<ul style="list-style-type: none"> A. Pay nurses' aides a living wage and health benefits B. Improve training and credentialing; emphasize peer mentoring C. Create career ladders that cut across all health care organizations in an area D. Promote paraprofessional association <ul style="list-style-type: none"> • <i>strengthen protections for union formation in individual homes</i> • <i>promote occupation-wide nurse aide associations</i>

Policymakers should rely on Eaton's analysis and recommendations to guide them as they address concern about nursing home care in Pennsylvania.

In the immediate future, to reduce the danger that privatization poses to care quality:

1. Pennsylvania Public Law 31, Number 21, Section 412, should be repealed. This legislation, passed in June 1967, specifies that counties must contribute 10 percent of the non-federal government contribution to county nursing homes. Since the federal contribution is about half the total, this 10 percent figure is about 5 percent of the total reimbursement of a county home. Prior to the introduction of case-mix reimbursement, county homes were in a separate reimbursement category from private homes and were reimbursed more generously. Therefore, the required contribution from the county did not represent a special penalty on county homes. With case-mix, county homes are now in the same reimbursement category as private homes but still are required to pay the 5 percent. **This means that state reimbursement is now lower for county homes than for private homes, which creates**

an artificial incentive to privatize county homes.

Counties have so far been able to negotiate away this 5 percent penalty. However, in the future, this 5 percent penalty on county homes could once again become operative. Pennsylvania needs to remove this potential statutory penalty against county homes.

- 2. More research into the relationship between privatization and quality of nursing home care is needed. The Auditor General should conduct an audit of Health Department surveys from a large sample of (1) county nursing homes, (2) partly or fully privatized (former) county homes, and (3) private homes serving the same resident population as county homes.** This audit could provide the citizens of Pennsylvania with comprehensive information about the effects of privatization on the quality of care.
- 3. Pennsylvania should implement an annual nursing home report card.** A report card should gather together, in a format that is easy to read and understand, information about critical indicators of nursing home quality (such as turnover

rates, staffing ratios, wages, and benefits). By making it easier to tell good homes from mediocre and poor ones, a report card would make the market—and consumer choice—more powerful forces for improving quality. A report card might also lead counties and the public to recognize the contribution that good county homes make to quality of life for Pennsylvania's elderly. Report card legislation could be based on House Bill 1802, introduced by Representative Anthony DeLuca (D-Allegheny), and the original version of Senate Bill 1216, introduced by Senator Edwin Holl (R-Montgomery). The House bill, and the original version of the Senate bill, would create a World Wide Web site as well as a toll-free telephone hotline, through which consumers could obtain "report card" information about any nursing home in Pennsylvania. The listings would include basic information such as the facility's name, address, phone number, bed capacity, owner and managing company, and payment sources accepted. In addition, the listings would include (1) information indicating whether the facility had been subject, within the last five years, to any Department of

Health penalties (such as a provisional license or a ban on admissions) in connection with the licensing or certification process; (2) nursing hours per patient per day, for both permanent and temporary (agency) staff, in comparison to state requirements; (3) average tenure of nursing staff and nurses' aides; (4) information about staff qualifications; (5) a list of available therapy services; (6) information about whether a resident council exists and meets regularly; and (7) additional information, such as whether the facility has a registered dietitian,

a written emergency evacuation plan, isolation rooms for patients with contagious diseases, written policies on "do not resuscitate" orders, and a variety of other characteristics.

4. Pennsylvania should increase the minimum number of hours of front-line nurses' aide care that nursing home residents receive. While nursing home residents are typically less independent today than in the past, state staffing regulations have not adequately recognized this. Nursing homes (including those reported on here) can meet

state requirements and still leave aides without enough time to attend to basic needs, never mind maintain the social relationships that are critical to residents' quality of life. Privatization or the anticipation of it can exacerbate this problem. Higher staffing requirements would reduce the danger that privatization will be used to cut staffing levels below acceptable levels. Higher staffing requirements would also improve care quality throughout the nursing home industry.

REFERENCES

1. Except for the John J. Kane Regional Centers, the names of the homes analyzed in this report are pseudonyms. Workers interviewed wished to avoid negative publicity for their home or feared for their jobs.
2. Susan C. Eaton, *Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs*. (Harrisburg: Keystone Research Center, 1997.)
3. See, for example, James M. McDonough, *John J. Kane Regional Centers: Privatization Options* (Pittsburgh: Allegheny Institute for Public Policy, 1996); Jake Haulk, *The Case for Privatizing the Kane Regional Centers* (Pittsburgh: Allegheny Institute for Public Policy, 1997).
4. McDonough, *John J. Kane Regional Centers*, p. 19.
5. Haulk, *Case for Privatizing*, p. 10.
6. "Nursing Home Painted As Hellhole," *Philadelphia Daily News*, June 22, 1994, p. 1; "State: Philadelphia Nursing Home Patients At Risk," *Philadelphia Inquirer*, June 22, 1994, p. B-1.
7. In 1995, 96 percent of the Kanes' 503,616 patient days were reimbursed by Medicaid. The corresponding percentages for the other nursing homes in this report were: Comfort Home 93 percent, Chelsea Manor 79 percent, Green Gables 73 percent. Pennsylvania Department of Health, State Center for Health Statistics and Research, *Data From the Long Term Care Facilities Questionnaire*, 1996. The industry average is 67 percent, according to Eaton, *Pennsylvania's Nursing Homes*.
8. McDonough, *John J. Kane Regional Centers*, relies on administrators for information about the quality of care.
9. Gooloo Wunderlich et al., ed., *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, DC: National Academy Press, 1996), p. 161.
10. Contractures are cases of muscle constriction and reduced range of motion in extremities, generally resulting from inactivity.
11. At Green Gables, the state inspector estimated a ratio of residents to nurses' aides of 15 to one based on an examination of worker schedules over a six-month period. This is consistent with worker claims.
12. Susan Eaton, personal communication, March 19, 1998.
13. Interviews by Stephen Herzenberg at two business class hotel chains indicate that housekeepers there clean about 16-18 rooms per day.
14. These figures are from Allegheny County payroll printouts, 1997.
15. Eaton, *Pennsylvania's Nursing Homes*, p. 10.
16. National Citizens' Coalition for Nursing Home Reform, *Consumer Perspectives on Quality Care* (Washington, DC: National Citizens' Coalition for Nursing Home Reform, 1985).

17. The wage scale for Comfort Home is from the Collective Bargaining Agreement between the Service Employees International Union and Comfort Home, 1993.
18. These estimates were produced using data from the Pennsylvania Department of Health Statistics (various years) and seniority lists provided by the union.
19. After this interview, new contracts were signed at Kanes in the late Fall of 1997.
20. A.M. care refers to the duties performed by day-shift workers from the time they arrive (usually 7 a.m.) until lunch. These duties include waking residents, getting them out of bed, cleaning and dressing them, feeding them breakfast (taking time to encourage residents to eat and helping those who cannot feed themselves), and doing range-of-motion exercises. While all of this is going on, residents must be turned and repositioned every two hours; incontinent residents must also be changed whenever they are wet.
21. The number of direct care staff (aides, LPNs, and RNs) on each shift was added together. Then the shift totals were added up to give the number of “direct care” workers per 24-hour period. This figure was multiplied by eight (because each worker’s shift is eight hours) to yield the direct care staff hours per 24-hour period. Finally, the number of residents on a unit (60 if the unit is full) was divided by the direct care staff hours per 24-hour period. Kane day shift when fully staffed is six aides, two LPNs, and one RN (nine workers in total). Kane day shift when short-staffed is five aides, two LPNs, and one RN (eight workers in total). Kane evening shift when fully staffed is four aides, two LPNs, and one RN (seven workers in total). Kane evening shift when short-staffed is three aides, two LPNs, and one RN (six workers in total). Kane night shift when fully staffed is three aides and one RN (four workers in total). Kane night shift when short-staffed is two aides and one RN (three workers in total).
22. See, for example, Eaton, *Pennsylvania’s Nursing Homes*. Eaton found that residents at a home with staffing levels well above the legal minimum spent an average of only 7 percent of their waking hours interacting with staff, other residents, or visitors.
23. Eaton, *Pennsylvania’s Nursing Homes*.
24. Eaton, *Pennsylvania’s Nursing Homes*, p. 43.

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