

**A Review of the
Virginia Gold Quality Improvement Program
Interim Report**



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Executive Summary

Over the last few decades, public attention has periodically focused on issues related to nursing facility quality of care. This attention stems partly from the fact that resident quality of care is largely dependent on the availability of qualified certified nursing assistants (CNAs) and other direct care staff. CNAs are the backbone of the formal long-term care delivery system and provide the majority of paid care to nursing facility residents. These workers primarily help residents with activities of daily living (e.g., bathing, dressing, toileting and eating). While CNAs perform an important role in resident care, nursing facilities typically encounter considerable difficulties with recruiting and retaining these workers. In fact, annual CNA turnover often exceeds 100 percent in nursing facilities. As a result, considerable research has been done to identify factors associated with CNA turnover. Examples of these factors include low pay, difficult working conditions, and lack of employment benefits. The end result of high CNA turnover is increased costs for nursing facilities, high levels of stress for remaining staff, and compromised continuity of care for residents and poor quality of care.

In an effort to improve nursing facility staffing and quality of care, the Virginia General Assembly directed the Department of Medical Assistance Services (DMAS) to establish a nursing facility quality improvement program. The intent of the directive was to improve the health, safety, and welfare of residents in nursing facilities in Virginia. To comply with this directive, DMAS formed an interdisciplinary advisory committee that studied issues related to nursing home quality of care. Based on its review, the committee recommended that the state implement a pilot program focused on the recruitment and retention of nursing staff in selected facilities. The program, which is known as the Virginia Gold Quality Improvement Program, officially became operational on September 1, 2009. The overall goal of the program is to improve the quality of care provided to nursing facility residents in Virginia through the retention of qualified CNAs. To implement the pilot, five nursing facilities from across the state were selected through a competitive process. Each facility received grant funding to develop a quality improvement project that included activities such as peer mentoring, new staff orientation, recognition and rewards, and in-service training. The quality improvement projects were intended to retain CNAs by developing supportive work environments in the nursing facilities. As part of the program, the facilities agreed to report on their success in meeting the goals established in their proposals and to participate in an evaluation.

This report contains the results of a preliminary evaluation performed on the Virginia Gold Program during its first year using a series of focus groups with CNAs and residents at the pilot facilities. The focus group findings suggest that the program is progressing toward its intended goal. Prior to Virginia Gold, the ability of CNAs and other staff to care for residents was hampered due to poor communication and lack of teamwork. However, after the program started, three processes developed that improved working conditions for CNAs at the nursing facilities: peer mentoring and the dissemination of consistent information, enhanced communication and teamwork, and worker empowerment. The development of these processes is important because they are characteristics of supportive work environments. The program also improved the quality of CNA jobs through in-service training and recognition and benefits. Overall, these five processes appear to have influenced CNA retention and quality of care in the pilot facilities. As a result, the financing of quality improvement projects in nursing facilities may represent a good investment for Virginia. However, two caveats exist to this observation.

First, clinical quality of care measures (e.g., rates of restraint use, psychotropic drug use, and catheterization) were not examined so the extent to which care improved (if at all) was not empirically verified. Second, overall CNA retention remained stable during the program's first year. This finding may result from the fact that developing a comprehensive program that encompasses many of the issues related to CNA retention is a long-term process that requires considerable time and effort.

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Introduction

In an effort to better the lives of nursing facility residents, the 2007 Virginia General Assembly directed the Department of Medical Assistance Services (DMAS) to develop a nursing facility quality improvement program using civil money penalty (CMP) funds.¹ To comply with this directive, the agency formed an advisory committee composed of various stakeholder organizations (e.g., state agencies, universities, and long-term care associations) to develop criteria for a Virginia quality improvement program. Based on a review of similar activities in other states, the committee concluded that the quality of care provided in nursing homes depended largely on the recruitment and retention of well-trained and motivated direct care staff, such as certified nursing assistants (DMAS, 2007).² As a result, the committee recommended that DMAS develop a two-year pilot quality improvement (or culture change) program known as the Virginia Gold Quality Improvement Program (Quality Improvement Advisory Committee, Virginia Gold proposal, October 27, 2008).³

To implement the Virginia Gold Program, DMAS solicited applications from licensed, Medicare/Medicaid-certified nursing facilities in good standing with the Commonwealth through a request for applications (RFA) in April 2009 (DMAS, 2009). Twenty-eight nursing homes (out of approximately 278 facilities in Virginia) responded by submitting applications indicating how they would use grant funds to improve CNA retention based on the guidelines presented in the RFA. After reviewing the applications, five nursing homes were selected to participate in the program:

- Autumn Care (Portsmouth),
- Birmingham Green (Manassas),
- Dogwood Village (Orange County),
- Francis Marion Manor (Marion), and
- Trinity Mission (Charlottesville).

The Virginia Gold Program became operational on September 1, 2009. The overall goal of the program is to improve and expand the quality of care provided to nursing facility residents in Virginia through the retention of qualified CNAs (Hickey, 2009). Each facility was awarded grant funding of up to \$50,000 to implement a quality improvement project. Examples of “culture change” activities planned by the facilities included enhancing new staff orientation, recognition and rewards, peer mentoring, and in-service training. To facilitate the implementation process, the nursing facilities received technical assistance from the Virginia

¹ Civil money penalty (CMP) funds are collected from nursing facilities that are noncompliant with federal quality of care standards based on the results of annual licensure and certification surveys. Federal regulations give states the authority to use CMP funds to improve conditions for residents in nursing facilities that fail to meet federal and state quality of care standards.

² The terms “direct care staff” and “certified nursing assistants” (CNAs) are used interchangeably in this report. Direct care staff typically perform tasks that do not require professional nursing skills (Stone & Dawson, 2008).

³ Culture change represents a fundamental shift in nursing facility structure and management. Using this approach, nursing facilities are viewed as person-centered homes (rather than as health care institutions) that offer residents long-term care services. Culture change requires facilities to reorient their organizational and delivery structures by incorporating values, such as imbuing residents with decision-making authority and believing that staff who are treated well will provide good care to residents (Koren, 2010; Lehning & Austin, 2010).

Health Quality Center, which is a federally designated quality improvement organization.⁴ As part of the program, the facilities had to agree to report on their success in meeting the goals established in their proposals and to participate in a review by an independent evaluator (DMAS, internal memorandum, August 14, 2009).

This report contains the results of an evaluation performed by DMAS policy and research division staff to assess the overall performance of the Virginia Gold Program across all five facilities during its first year of operation, which was from September 1, 2009 to August 31, 2010. Due to the nature of the evaluation, only qualitative data from CNAs and residents at each facility were collected. Quantitative data, such as clinical quality of care, job satisfaction, and staff turnover measures, were excluded from the evaluation due to time and resource constraints. Information on the specific quality improvement projects developed by the nursing facilities and their success in meeting the goals established in the proposals is presented in a separate report available online at: http://dmasva.dmas.virginia.gov/Content_pgs/ltc-vagold.aspx.

The sections that follow provide information on nursing facility quality of care and staffing issues, the conceptual framework that guided the evaluation, the methodology used to evaluate the program, the focus group interview findings and a discussion of their relevance to nursing facility quality of care and staffing in Virginia, and the limitations of the evaluation. The report concludes with a summary of important points to consider about the Virginia Gold Program.

An Overview of Nursing Facility Quality of Care and Direct Care Staffing Issues

In the United States, nursing facilities are an important source of long-term care for persons who are elderly and younger adults with disabilities. In 2007, 1.4 million individuals lived in approximately 16,000 nursing facilities nationwide. The typical nursing facility resident was 85 years old, female, and widowed. Most residents had multiple chronic conditions, with six in 10 having multiple mental and/or cognitive diagnoses (Wiener, Freiman, & Brown, 2007). Due to the nature of their conditions, nursing facility residents often require assistance with activities of daily living (e.g., bathing, dressing, toileting, and eating). With the aging of the baby boomer generation and the increasing longevity of adults with disabilities, the number of nursing facility residents is expected to surpass three million by 2020 (Burgio, Fisher, Fairchild, Scilley, & Hardin, 2004; Stone & Dawson, 2008).

Since the 1950s, public attention has periodically focused on nursing facility quality of care.⁵ A series of investigations conducted in the 1970s and early 1980s indicated that many residents were neglected or even abused. In response, the federal government enacted the Nursing Home Reform Act (NHRA) through the Omnibus Budget Reconciliation Act of 1987, to reform the regulation of nursing facilities (Walshe, 2001). While the scope of the NHRA was broad, the legislation contained several components relating directly to staffing because evidence indicated that quality of care depended largely on the availability of qualified staff (Burgio,

⁴ For example, the Virginia Health Quality Center assisted pilot facilities with developing quality improvement plans and culture change activities, and CNA career development techniques (DMAS, 2010).

⁵ Quality of care encompasses various activities that nursing facility residents receive including medical treatments and physical care routines (Koren, 2010).

Fischer, Fairchild, Scilley, & Hardin, 2004; Zhang & Grabowski, 2004; Castle, 2008). Research conducted since the final NHRA regulations became effective in 1995 suggests that the staffing requirements generated some quality improvements (Zhang & Grabowski, 2004). Despite this observation, nursing facility quality and staffing still continue to be important public policy concerns, largely due to the fact that annual turnover among staff is exceptionally high (Weiner, Freiman, & Brown, 2007; Mukamel, Spector, Limcango, Wang, Feng, & Mor, 2009; Temple, Dobbs, & Andel, 2010). Annual turnover among RNs and licensed nurses typically range between 55 and 75 percent, while turnover for CNAs often exceeds 100 percent (Mukamel et al, 2009).⁶

High CNA turnover is especially problematic because these workers are responsible for most of the care provided to nursing facility residents (Riggs & Rantz, 2001). CNA turnover is expensive because it costs nursing facilities approximately \$2,500 to replace each CNA who resigns (Bishop, Weinberg, Leutz, Dossa, Pfefferle, & Zinzavage, 2008). It is also costly for the remaining staff because they have to increase their workloads until replacements are hired. While these costs are important, the most serious costs associated with high turnover are borne by residents in the form of poor health outcomes. Residents are typically frail and highly dependent on CNAs for their physical, mental, and social needs. This dependency predisposes them to adverse outcomes because turnover disrupts continuity of care and contributes to psychological distress (Castle & Engberg, 2005; Temple, Dobbs, & Andel, 2010).

Prior research suggests that the CNA workforce is particularly vulnerable because it is composed primarily of low-income, single-parent women, who typically work multiple jobs to support their families. This vulnerability is further compounded by the racial and ethnic diversity of the workforce that contributes to working conditions where the potential for miscommunication and conflict among CNAs, other nursing facility staff, and residents is heightened (Stone & Dawson, 2008; Dill, Morgan, & Konrad, 2010). Due to their role as frontline caregivers, considerable research has been done to identify factors associated with CNA turnover. This research revealed that associated factors include lack of training and promotion opportunities, low pay, emotionally and physically demanding work, job stress, poor supervision, understaffing, lack of respect, and lack of health insurance and other benefits (Kemper, Brannon, Barry, Stott, & Heier, 2008; Howes, 2008). A number of policy initiatives have been implemented to reduce CNA turnover; however, evidence on the effectiveness of many of these interventions is lacking because they were not rigorously evaluated (General Accounting Office, 2001; Tsoukalas, Rudder, Mollot, Shineman, Lee, & Harrington, 2006; Mukamel et al, 2009; Dill et al., 2010; Lehning & Austin, 2010). The fact that staff retention and quality of care continue to be public policy concerns suggest that they are complex phenomena not easily addressed by policy interventions (Mukamel et al, 2009). Nevertheless, a pressing need exists to develop interventions that address these issues and to rigorously evaluate their effectiveness. Because the demand for CNAs is projected to increase along with an aging population, failure to identify solutions to these issues could have dire consequences for the nation as growing numbers of Americans turn to nursing facilities for their long-term care needs.

⁶ Annual CNA turnover can exceed 100 percent if CNAs and their replacements work less than one year in the nursing facilities. For example, some CNAs may only work for a few weeks/months before resigning and their replacements may only work for a short time before they also resign.

The evaluation presented in this report sought to examine the effectiveness of the Virginia Gold Quality Improvement Program using a qualitative design that allowed for an in-depth understanding of the program's processes from the perspectives of its main beneficiaries – the CNAs and nursing facility residents (Patton, 2002). The evaluation is intended to provide DMAS management, the participating nursing facilities, and other stakeholders with evidence-based information on the program's effectiveness during its first year.

Conceptual Framework for the Virginia Gold Quality Improvement Program

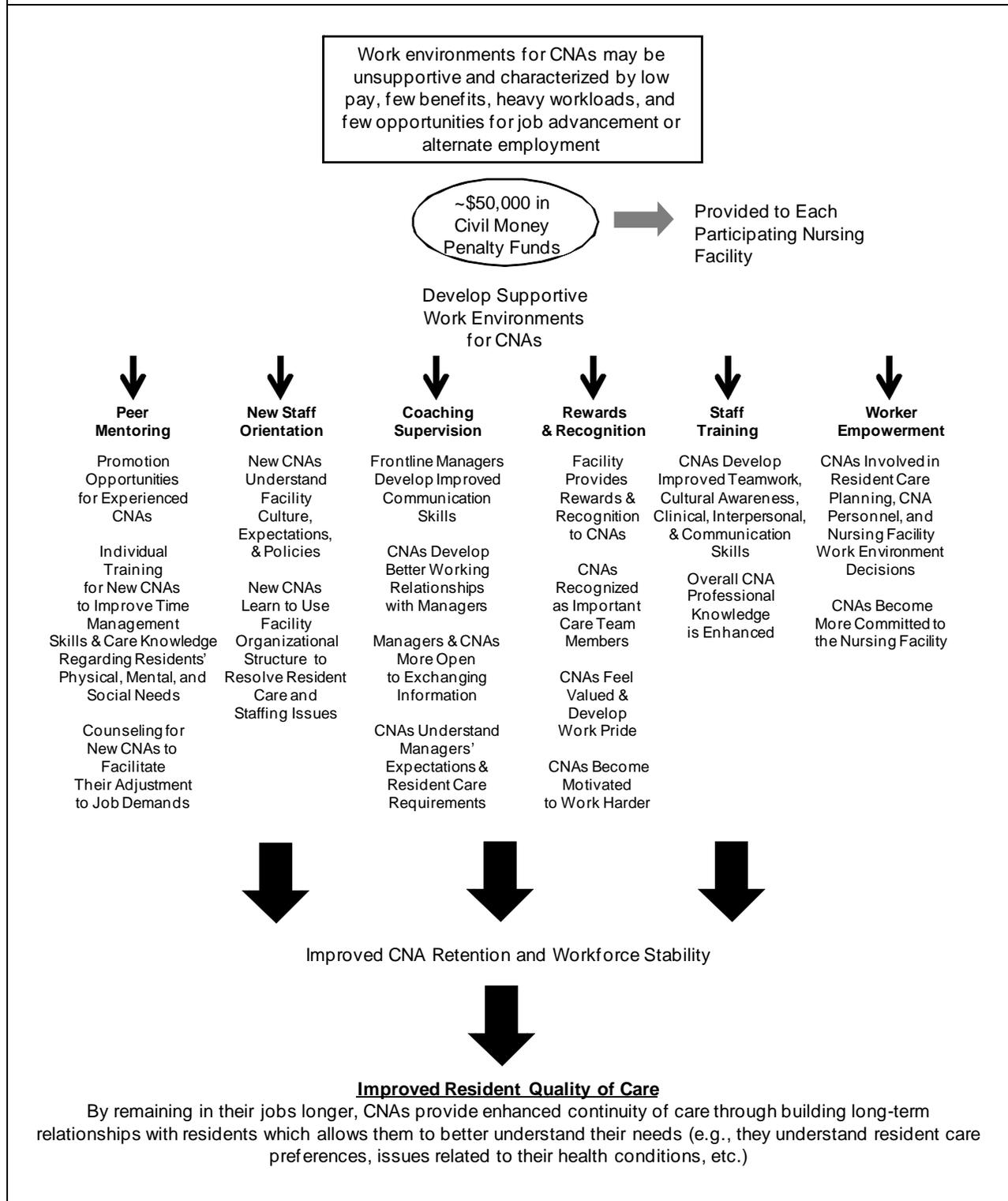
Social programs are often implemented to improve life for specific groups of people by changing one or more outcomes (Bodgan & Biklen, 2007). Program theory provides the conceptual framework that an intervention follows to produce change. Understanding this framework is important because it identifies the mechanisms and assumptions that a program operates under to achieve its intended outcomes (Weiss, 1998). Virginia Gold is based on a theory that: 1) CNAs employed in nursing facilities with unsupportive work environments (e.g., work environments where CNAs are not treated with respect by their supervisors, their work is not valued because it is unskilled, resident-level information is not readily shared with CNAs, and CNAs do not receive proper support to perform their jobs) may not consistently provide good care to residents, and 2) quality of care can be improved by providing nursing facilities with financial support to develop supportive work environments through quality improvement projects. The program's theory is supported by research indicating that resident health outcomes can be affected by nursing facility work environments (Rantz, Hicks, Grando, Petroski, Madsen, Mehr, Conn, Zwiygart-Staffacher, Scott, Flesner, Bostick, Porter, & Mass, 2004; Bishop et al., 2008; Stone & Dawson, 2008; Tempkin-Greener et al., 2010).

Virginia Gold's theory is based on six culture change mechanisms that are believed to lead to the development of supportive work environments: peer mentoring, new staff orientation, coaching supervision, rewards and recognition, staff training, and worker empowerment (Barry, Brannon, & Mor, 2005; Kemper, Heir, Barry, Brannon, Angelelli, Vasey, & Anerson-Knott, 2008; Bishop et al., 2008; Koren, 2010). Each mechanism is supported by certain assumptions that outline how it will improve quality of care. For example, the peer mentoring mechanism is based on three assumptions:

- 1) experienced CNAs will be retained through promotion opportunities as peer mentors,
- 2) peer mentors will provide individualized training to new CNAs to improve their time management skills and ability to care for the physical, mental, and social needs of residents, and
- 3) peer mentors will help retain new CNAs through training and ad hoc counseling to facilitate their adjustment to working in a stressful, demanding career field.

The program's model and assumptions related to the remaining five change mechanisms are presented in Figure 1.

Figure 1
Conceptual Framework for the Virginia Gold Quality Improvement Program



Virginia Gold's program theory provided DMAS staff with a structure for conceptualizing, planning, and implementing the evaluation presented in this report. Using the theory as a guide, two overall study questions were developed for the evaluation: 1) What changed for CNAs and residents as a result of their facilities' participation in the Virginia Gold Program? and 2) Has the Virginia Gold Program made a difference in the lives of CNAs and residents, and if so, how? The first question sought to identify important changes that occurred in the work environments and quality of care at the facilities during the first year of the Virginia Gold Program, while the second question sought to determine if the program produced meaningful experiences for staff and residents. Addressing these questions allowed DMAS staff to examine the program over time from the perspectives of the CNAs and nursing facility residents.

Evaluation Methodology

The Virginia Gold Program was evaluated using a qualitative design based on ten focus group interviews. This design was selected because it is appropriate for addressing descriptive evaluation questions that focus on the "hows" and "whys" of the program (Fitzpatrick, Sanders, & Worthen, 2004). Focus groups are moderator-led interviews conducted with small groups of individuals to examine their views on particular topics (Patton, 2002). The focus groups for this study were conducted by two DMAS staff during April and May 2010. One staff member with program evaluation experience served as the focus group moderator, while the other staff member with nursing facility experience took notes. Two focus groups were conducted at each facility (one group consisted of CNAs, while the other consisted of residents) in locations selected for maximum privacy, such as conference rooms and administrative offices. The CNAs and residents received no incentive for participation and all signed consent/confidentiality agreements. The focus groups were audio recorded and lasted approximately 45 minutes. Prior to data collection, DMAS management reviewed the evaluation design and determined that it was appropriate to meet agency requirements regarding the program's effectiveness.

Because DMAS staff did not have direct access to the CNAs and nursing facility residents, the facility administrators were asked to select individuals for the focus groups who were familiar with the Virginia Gold program. The number of CNAs per focus group ranged from four to nine (N = 32), while the number of residents per focus group ranged between five and six (N = 27). Most participants were female (78% of the CNAs and 59% of the residents were female). The average work experience of the CNAs at their respective facilities ranged between 3.8 and 24.4 years, while the average length of stay of the residents ranged between 1.0 and 5.2 years. Eight CNAs (25%) worked as peer mentors and were directly involved with implementing the Virginia Gold Program at their facilities. Based on the composition of the participant pool, DMAS staff concluded that the focus groups were sufficient to meet the objectives of the evaluation. Some observers may question the generalizability of the evaluation based on the participant sample; however, the credibility of data collected in qualitative evaluations is more important than the representativeness of the study sample.

While DMAS staff had prior knowledge of the facilities' quality improvement activities, they did not ask focus group participants specific questions about these activities. Instead, staff asked general questions to elicit participants' thoughts regarding events and activities that they

deemed important. Conducting the focus groups in such a way contributed to the depth, openness, and detail of the interview data (Patton, 2002). The CNAs were asked five questions during the interviews: What do you know about Virginia Gold? What were your impressions of the work environment at this facility before Virginia Gold was implemented? What are your impressions of the facility's current work environment? What staff retention event that happened during the past year has made the biggest impression on you and why? How do you think your facility's participation in Virginia Gold has influenced staff retention? The residents were also asked five questions: What do you know about Virginia Gold? What was the care like that you received from staff last summer? Does anything seem different about your care now? In what way has your life changed because of the care you receive from staff at this facility? Overall, how do you think Virginia Gold has influenced the care that staff provide to residents? For both groups, the first question served as an "ice breaker" to get participants talking about Virginia Gold, while the remaining questions were used to collect evaluative information about the program. After each interview, DMAS staff compared field notes and discussed group processes and findings.

Each focus group recording was transcribed verbatim and then analyzed through a process that involved identifying and arranging important segments of interview text into meaningful themes that captured the essence of the participants' experiences during the program's first year. For example, all text statements were identified that pertained to the question about nursing facility work environments prior to the Virginia Gold Program. These segments were then grouped into themes that characterized particular patterns present in the data. For instance, the theme "Poor Communication and Lack of Teamwork" (i.e., lack of communication among CNAs and other nursing facility staff that resulted in staff not working together) was developed from statements that described how participants experienced the nursing facility work environments prior to Virginia Gold. Because Virginia Gold primarily sought to develop supportive work environments for CNAs, themes that emerged from the CNA focus groups were used to evaluate the program, while findings from the resident focus groups were used to support CNA themes where appropriate.

To ensure credibility of the focus group findings, five strategies were employed: 1) the use of mechanically recorded data, 2) participant member checking (e.g., DMAS staff summarized themes that emerged during the interviews and asked participants to verify their accuracy), 3) multiple researchers (e.g., two DMAS staff established consensus by independently reviewing transcript codes and themes), 4) a peer reviewer (e.g., a disinterested peer who challenged the accuracy of the interview themes), and 5) a draft evaluation report was provided to staff at the nursing facilities and the Virginia Health Care Association (McMillan and Schumacher, 2010).

Focus Group Interview Findings

Focus group interview findings are provided in this section. Based on an analysis of the interview transcripts, eight major themes emerged as key factors related to the nursing facility work environments before and after Virginia Gold implementation (Exhibit 1). These themes are: Poor Communication and Lack of Teamwork, Peer Mentoring and Consistency, Enhanced Communication and Improved Teamwork, Empowerment, In-Service Training, Recognition and

Benefits, Staff Retention, and Improved Resident Care. The themes, which are grouped around the interview topics, provide qualitative evidence on the program's performance from the perspectives of the participants. Additional information on the themes is provided in the subsections below.

Exhibit 1
Focus Group Interview Themes

I. Nursing Facility Work Environments Before Virginia Gold

- A. Poor Communication and Lack of Teamwork: Lack of communication existed among CNAs, other staff, and residents prior to Virginia Gold which resulted in staff not working together to accomplish common objectives, such as providing quality care to residents.

II. Nursing Facility Work Environments After Virginia Gold

- A. Peer Mentoring and Consistency: Peer mentoring to create a supportive work environment for new CNAs through the dissemination of consistent information about assignments, duties, and responsibilities
- B. Enhanced Communication and Improved Teamwork: More effective communication exists among CNAs, other staff, and residents allowing them to work as a team to accomplish common objectives.
- C. Empowerment: CNAs are involved in planning and decision making activities related to the facility's work environment and resident care.

III. Meaningful Experiences During Virginia Gold

- A. In-Service Training: Education provided to CNAs to increase their professional knowledge and skills and interpersonal abilities.
- B. Recognition and Benefits: CNAs recognized for their work through monetary and/or non-monetary benefits, rewards, and recognition.

IV. Virginia Gold's Perceived Influence on the Nursing Facility Work Environment

- A. Staff Retention: Supportive environment exists that promotes CNA retention.
- B. Improved Resident Care: Residents receive care that is appropriate and timely.

Nursing Facility Work Environments Before Virginia Gold. Focus group participants were asked to describe the nursing facility work environments prior to Virginia Gold. One theme emerged around this topic: Poor Communication and Lack of Teamwork. Across all facilities, participants indicated that poor communication and lack of teamwork existed among CNAs, nursing facility staff, and residents prior to the program. One CNA mentioned that poor communication, “[was] always a big issue,” while another said, “lack of communication among everybody...played a very important part [in the environment].” Poor communication affected the ability of staff to work together. One CNA said, “If we had a new CNA come in, and she didn’t know anybody, you would just walk. You wouldn’t introduce yourself, you wouldn’t say, well do you need any help?” Another CNA said, “The communication [was] not there between the CNAs and nurses. If you [told]...a nurse... that [a resident] needed something, [sometimes] they just blew it off, and that’s not good communication...and a lot of nurses were bossy, and some CNAs didn’t take that very well.”

Additional comments described how staff did not work together to accomplish common objectives or share pertinent information about residents before Virginia Gold. For example, one CNA said, “We were here as individuals. We did our jobs, got our paychecks, and went home.” Another said, “There used to be [an attitude] like, the resident in room 23 needs something, but the CNA has [rooms] 16 to 21, so she was like, well that’s not my resident.” The lack of teamwork contributed to CNA turnover and low job satisfaction. According to one CNA, “We used to lose a lot of CNAs. The new ones sometimes would leave by the next week or by the next pay period, simply because they wouldn’t get any help from staff.” Additional comments from one CNA that illustrate this theme include:

A year ago, it was very hectic. I would wake up in the morning and think, oh my God, I’ve got to get to work, because you know when you came [here], you’d be faced with 14, 15 patients just assigned to you, and it felt really overwhelming, and then you saw new people coming in...[and] they’re going to feel so overwhelmed because we’re so [under staffed] that they would quit in two months...[and] you could see that the residents’ morale was affected because they didn’t get the care they deserved...It hurt to see [residents] get mad at us. It would upset them a lot. They would get frustrated at us.

Comments from residents supported this theme. One resident said that before Virginia Gold, CNAs were not happy with their jobs, and were not willing to help residents who were not directly under their care. Another said that in the past, CNAs did not respond very quickly when residents called for assistance nor did they talk to residents to find out what was wrong with them when responding to their calls. In fact, one resident stated that, “CNAs would come in [to the facility], work two or three weeks, and they’re gone. You know, and it [was] like they [didn’t] care the way you needed something done. They just wanted out of the room.”

Nursing Facility Work Environments After Virginia Gold. Three themes emerged around the discussion of the nursing facility work environments after Virginia Gold implementation: Peer Mentoring and Consistency, Enhanced Communication and Improved Teamwork, and Empowerment. The themes reflect beneficial changes that participants reported occurring at the facilities during the program’s first year. For instance, participants reported that

peer mentoring was beneficial because it placed experienced CNAs in positions to help new CNAs adjust to their jobs through individualized training and consistent information about duties and responsibilities. Peer mentoring is part of the orientation process that new staff members undergo after they are hired by the nursing facilities. Before Virginia Gold, mentoring (if it was even provided) was usually an ad hoc process performed by any available CNA. This contributed to low morale among new CNAs because they did not always receive appropriate training or consistent information about their positions. As one participant stated, “many CNAs didn’t want to fool with [training] a new hire because they’d say, well, that person slows me down...and that made it look bad on the new person because they felt that, if [staff] don’t want to work with me then why do I want to work here at all.” Another said, “I started when [new CNAs] were still floating around to different staff, and you were really concerned with the next day, who am I going to get stuck with? Are they going to show me the ropes right or are they going to show me their bad habits?”

After Virginia Gold started, the nursing facilities moved to correct these issues by using funds to hire experienced CNAs as peer mentors to facilitate training and the exchange of information during the orientation process. The new peer mentoring process provided senior CNAs with career advancement opportunities, pay increases, and new responsibilities in staff training and patient care. The CNA participants reported that the new peer mentoring process was effective. One CNA said, “Now that we have this mentorship, it has brought everybody together, and we’ve learned to know each other, we’ve learned to help each other.” Another said that, “The peer mentors teach new CNAs how to care for the residents, they teach [them] how to use the facility policies on the mechanical lifts and doing all the paperwork [needed to perform their jobs] before they are by themselves.” Comments from one peer mentor succinctly summarized this theme:

I try to get [new CNAs] comfortable. Most of the time anyone who comes in, they have the skills, obviously if you pass the state board, the skills are there. We just want to acclimate them to our facility, the way we like to have things done...The first day they’re with us, we’re showing them exactly what we’re doing. And then the second day they’re with us, we nurture them along...and we tell them, whatever is on that [resident care] assignment sheet is what you are expected to do. And then the third day, we just let them go on about their business, but we are still with them. [After that] we check on them once a week, and then every month until we are sure they’re okay.

Enhanced Communication and Improved Teamwork arose as a theme from participant comments about how these areas improved after program implementation. The CNAs attributed these improvements to the fact that Virginia Gold funds were used to provide staff with in-service training on communication and teamwork skills, and new staff with enhanced peer mentoring services. One CNA said, “Virginia Gold has improved everybody’s awareness [about] communication [which] has improved the overall work environment.” Another said, “I’ve been here so long I knew the [problem]; lack of communication. So now we got more communication skills. We have more interest in how to communicate, how to get along and how to deal with people’s tempers, attitudes, and feelings.” One CNA provided a good description of how his nursing facility improved communication:

We have a system that we recently started where at shift change, we have a walk around so staff know exactly what's going on with each resident. The group that's leaving [the facility] gets with the group that's coming in and [they] walk the hallways [and] check on residents, and discuss how they [were] that day...[they discuss] anything out of the ordinary that occurred with the residents...Also, we [are] keeping the residents informed on what we're doing. We want them to be part of their care, [so we] keep them informed about what we're doing.

Regarding teamwork improvements, one CNA said that before Virginia Gold, CNAs did not help each other care for residents; however, this changed after the program started because of the emphasis placed on developing communication and teamwork skills. Other CNAs indicated that the training instilled staff camaraderie. For example, one CNA said, "...the coworkers...[have become] a big family. We can have dinner together, we can party together...We actually interact outside this building." According to the CNAs, the end result of the emphasis on communication and teamwork was that staff members were staying longer. Decreasing CNA turnover is important because it improves quality by allowing staff to spend more time learning the residents' needs and preferences (Wiener, Squillace, Anderson, & Khatutsky, 2009). As one CNA mentioned, "We've got [more staff] and everybody is happy. The patients are happy and everybody is a team." Another said that after Virginia Gold, "I just feel like we're all family...everybody is a team...and I think that makes you want to come to work...If the CNAs are happy and all of us get along and you're recognized for your work, it makes you want to produce more and that makes you want to go above and beyond."

Comments from residents supported this theme. For example, one resident reported that he had noticed a "big difference" in the CNAs since Virginia Gold started because they were more willing to help residents, while another reported that the CNAs seemed happier with their jobs, were eager to work, and were more focused on meeting resident care needs. According to this resident, "They'll listen to your complaints [now]." Another said CNAs seemed to be "kinder" and were helping each other. This resident stated that:

There's teamwork. Like I used to have one person try to put me to bed in the Hoyer Lift. Now I've got at least two, and I don't have to request it no more. It's just automatically two, sometimes three helping each other. And you used to not ever see that. All you would see was one [CNA] fussing about how the other ones wouldn't help them. And you don't see that no more...It's the same staff...so that shows something is working.

Finally, the Empowerment theme came from CNA comments about how they began to receive more decision-making power after Virginia Gold. Research indicates that many CNAs lack empowerment because they feel undervalued by their employers and stigmatized by society due to low wages, difficult working conditions, and lack of job advancement opportunities (Dill et al., 2010; Lehning & Austin, 2010). As one CNA remarked, "Before Virginia Gold, you were just a CNA, you didn't have any input or anything. You didn't care as much." Empowerment is important because empowered staff members are more confident in their abilities, have control over their work, and feel that they have an impact on organizational outcomes (Kostiwa &

Meeks, 2009). After Virginia Gold, the CNAs became more involved in activities as part of their facilities' quality improvement efforts. Additional comments regarding this theme include, "We [were] asked for our advice on different things that can improve our work environment," "Now we go to care plan meetings," and "CNAs sit in on interviews and ask questions...we'll ask things we know would happen [to see] how [applicants] would handle the situation...[to find out if] they're going to be a good person to work here."

Meaningful Experiences During Virginia Gold. The themes In-Service Training and Recognition and Benefits developed through discussions about meaningful experiences during Virginia Gold's first year. The nursing facilities used Virginia Gold funding in part to provide staff with in-service training to increase their professional knowledge and interpersonal abilities. Training was provided on various topics including resident care, communication, teamwork, personality and self awareness, and cultural competence and sensitivity. Comments from CNAs indicated that the trainings were especially meaningful because they learned new skills and about how their behaviors influence relations with peers and residents. One CNA said that the training on diseases, such as dementia, was "very, very useful [because] it helped us know more about how residents act and how we should act toward them. We also learned how to keep residents safe [when acting aggressively] and how to keep staff safe." Another CNA described the training as, "Awesome. We had a good time and a good instructor. She did a good job of making you feel more aware of your body language and how you may come across [to other people]." Finally, one CNA said, "The training was fine...It was like a day of fun, because we were learning how to be team players." According to this individual, the training helped staff learn how to resolve conflicts by, "...pulling [staff] to the side...and that's the most important thing we learned, how to get along instead of trying to stab each other in the back."

Due to substantial ethnic and racial diversity among CNAs, the cultural competency training conducted at one nursing facility is especially noteworthy because 32 languages are spoken by staff and residents at this facility. Having individuals from such diverse backgrounds in close proximity raises the potential for conflict due to miscommunication. However, training can ameliorate this by helping staff understand cultural differences. As one CNA stated:

We are a very diverse company. We have people from all over. When I talk to someone, I like to look them in the eye and I like them to look me back in the eye, but in other countries, they...find that as rude. Well, when I first came here, I'm like, why are they constantly looking at the floor, why aren't they looking at me? I thought they were rude. But then we had the diversity training and it helped me understand that we are from different places. They were not being rude and I think that's helped a lot.

CNAs typically receive little recognition or employment benefits for the work they perform (Kemper et al., 2008; Dill et al., 2010). The nursing facilities using Virginia Gold funds developed monetary and/or non-monetary benefits, rewards, and recognition incentives for CNAs as part of their quality improvement programs. Examples of incentives included lunches, employee of the month awards, and performance bonuses. Because CNAs work under difficult conditions, the lack of appropriate incentives can lead to low job satisfaction and poor quality of care. One CNA reported, "If you're recognized for your work, it makes you want to produce

more and the happier we are, the happier the residents are.” The CNAs indicated that they appreciated the incentives offered to them as part of Virginia Gold. As one CNA said, “When I get recognized, I’m feeling good because somebody appreciates me.”

While recognition is important, one nursing facility used Virginia Gold funding to provide CNAs with health insurance benefits (in addition to the health insurance that the facility already provided to staff) through a local community health center. Health insurance is particularly important to CNAs, because many lack this benefit (Stone & Dawson, 2008). As a result, using Virginia Gold funds to provide this benefit is important because employment-based benefits can be an effective strategy for retaining CNAs (Temple et al., 2010). Comments from one CNA illustrate why health insurance is a particularly meaningful benefit:

You can offer us a lot of stuff, but it’s the whole realm that’s important. Like me, \$25 to see a doctor is much better than what I was paying when I first got here, \$80 just to walk in [the clinic], and that’s not including blood tests or x-rays. That’s just to sit down and see a doctor. If he wants to draw blood because of the problems I have, that’s more money. I could spend \$200 going to see a doctor and getting blood drawn. So that’s a big chunk of my paycheck gone. So with [the health insurance benefit], it doesn’t matter whether x-rays or blood work or whatever [is needed], you pay \$25 and they take care of you. That makes it really nice.

Virginia Gold’s Perceived Influence on the Nursing Facility Work Environment. Two themes emerged from the discussion about Virginia Gold’s perceived influence on nursing facility work environments: Staff Retention and Improved Resident Care. These themes suggest that the program is progressing toward its overall goal, which is to improve the quality of care provided to nursing facility residents in Virginia through the retention of qualified CNAs. During the focus groups, CNAs indicated that they believed Virginia Gold’s emphasis on developing supportive work environments improved staff retention. As one CNA stated, “...having the extra training and the mentors...makes people feel...not as uneasy about working here, it makes them feel like they can do it. [The facility] also rewards people for doing well, so people want to stay.” Similar comments included, “I think this year has been the best year as far as keeping CNAs,” “We still have some positions open, but...we are retaining [staff] with the Virginia Gold grant,” and “...with the grant money, the facility is able to show people more appreciation...it’s the little things that say thank you...[that] keeps people here longer.” Finally, one CNA at the facility that provided health insurance reported, “The turnover rate is not that great. I guess [staff] understands that this is about the best thing going with the insurance.” These comments suggest that Virginia Gold improved (or at least stabilized) CNA retention which is important because a stable workforce can improve nursing facility quality of care (Eaton, 2000).

Finally, comments from several CNAs suggested that quality of care improved after Virginia Gold started due to its emphasis on work environments. As one CNA reported, participating in Virginia Gold, “...actually makes it better for the residents because if the [CNAs] are happy, then we just pass it on to them.” The CNAs indicated that they began to feel more responsibility for residents after Virginia Gold: “...it’s like now everybody knows that all

the residents in the building is each of our residents, instead of before, it was like that's not my resident" and "...when you walk through [the front doors], all of the residents belong to you. You know, they are all [our] responsibilities." Comments from two CNAs are particularly revealing because after Virginia Gold started, they began visiting residents on their off days: "Some of us when we're off, we come [here] to be with the residents...we sit with the residents, we have games, we have fun" and "A lot of the residents ask me to bring [my children]...so on my day off, I'll bring them here and the residents like it."

Many residents indicated that they received good care from the nursing facility staff before and after Virginia Gold. However, some reported that the quality of care improved after the program started. For example, one resident said the CNAs seemed to be spending more time getting to know residents so they could provide better care, while another said residents could now simply notify peer mentors if the CNAs provided substandard care instead of having to contact multiple staff as they did prior to the program. Another said CNAs were, "...willing to talk to you now. Instead of just flying in your room and flying back out. They even call you by your first name, which is important." Other residents indicated that CNAs appeared better prepared to respond to emergencies, were more responsive to resident care needs, and were more focused on comforting residents in pain.

Relevance of Evaluation Findings to Nursing Facility Staffing and Quality of Care in Virginia

The aim of this study was to evaluate the Virginia Gold Quality Improvement Program across all five nursing facilities during its first year from the perspective of the CNAs and residents who experienced it. The evaluation was performed to provide DMAS management and other stakeholders with evidence-based information on the program's effectiveness. The subsections that follow provide information on the findings related to the study questions and the policy implications of the evaluation.

Study Question Findings. According to some observers, the CNA workforce is currently inadequate to meet the health care needs of many older adults and people with disabilities. This primarily results from the fact that the recruitment and retention of CNAs is becoming increasingly difficult due to factors such as heavy workloads, low pay, and limited benefits (Lehning & Austin, 2010). CNA recruitment and retention are further complicated because many nursing facilities lack supportive work environments. The end result is high CNA turnover and poor quality of care (Eaton, 2000). Virginia Gold was implemented to address these issues by providing nursing facilities with funding to develop supportive work environments. Because the program seeks to create change through various environmental enhancements, the first study question asked, "What changed for CNAs and residents as a result of their facilities' participation in the Virginia Gold Program?" This question was developed to determine if staff and residents viewed the program as producing tangible changes in the facility work environments. The evaluation findings suggest that the program produced some important changes. Prior to Virginia Gold, the study participants indicated that the work environments were characterized by poor communication and lack of teamwork among CNAs and other workers which interfered with their ability to care for residents. However, they reported that three processes developed after Virginia Gold that improved the work environments: peer

mentoring and the dissemination of consistent information, enhanced communication and improved teamwork, and worker empowerment. These processes are important because they offer CNAs career advancement opportunities, improve the quality of their jobs, give them credibility within their organizations, and improve nursing facility quality of care (Koren, 2010). Overall, these processes suggest that the program is performing as intended because they are characteristics of supportive work environments (Hayunga, 2007; McDonald & Kahn, 2007).

The second study question asked, “Has Virginia Gold made a difference in the lives of CNAs and residents, and if so, how?” The rationale for this question was to determine if the program produced meaningful experiences for the study participants. Information collected from the participants suggests that the program produced meaningful experiences in two areas: in-service training and recognition and benefits. Training is important because it improves the clinical skills of CNAs. Recognition is important because it demonstrates that nursing facility management views CNAs as valuable staff members, and employment benefits are important because they offer an effective means of retaining CNAs (Kostiwa & Meeks, 2009; Temple et al., 2010). Overall, information obtained from the participants suggests that Virginia Gold’s emphasis on supportive work environments, training, and recognition and benefits influenced their perceptions of CNA retention and quality of care. However, two caveats exist to this observation. First, DMAS staff did not examine clinical quality of care measures to verify whether care actually improved, and second, a separate analysis performed by DMAS staff revealed that only two nursing facilities experienced improved CNA retention rates during the program’s first year, while retention rates for the other three facilities remained about the same (DMAS, 2010). Although there was not a substantial improvement in CNA retention across all facilities during the first year, this result could be due to the fact that developing a comprehensive CNA retention program that addresses many of the factors associated with this issue is a long-term process that involves considerable time and effort.

Finally, the focus group findings supported the program’s conceptual model (Figure 1). For example, themes emerged from the focus groups that corresponded to four of the program’s six change mechanisms: peer mentoring, rewards and recognition, staff training, and worker empowerment. Themes related to the orientation and coaching supervision (or supervisory training) mechanisms did not emerge from the focus group discussions. This observation does not imply that the nursing facilities failed to implement initiatives related to these mechanisms. Rather, it simply indicates that they were not discussed during the interviews. Two reasons exist that may account for this: 1) the participants may have viewed the new peer mentoring process as a more important development than the new staff orientations, and 2) coaching supervision training was not discussed because management staff were excluded from the focus groups. Because the nursing facilities provided new staff orientation and supervisory-level training as part of Virginia Gold, the focus groups may have produced findings related to these topics if different individuals participated.

Policy Implications of the Virginia Gold Evaluation. According to some observers, appropriate investments are “key” to addressing issues that affect the direct care workforce. These issues occur at both the policy and practice levels and are often complex, cross-cutting, and systemic. While nursing facilities are usually able to address practice-level issues, they are not always able to influence policy-level issues (Stone, 2007). For example, state and federal

reimbursement policies that impact provider compensation, benefits, certification, and training requirements are usually beyond the control of most nursing facilities. In order for workforce investments to be successful, they must include both policy- and practice-level components (Stone, 2007). The objective of Virginia Gold is to improve the quality of care provided to nursing facility residents in Virginia through the retention of qualified CNAs. The program seeks to accomplish this using both policy- and practice-level components. The state legislature directed DMAS to implement the program using civil money penalty (CMP) funds that were derived from nursing facility fines, while the agency required the pilot facilities to prepare plans detailing how these funds would be used to develop supportive work environments specific to the unique needs of their staff and residents. The nursing facilities were required to include certain cultural change mechanisms in their improvement programs and to submit financial and quarterly progress reports to DMAS for review. In addition, the nursing facilities were required to participate in an evaluation to assess the program's effectiveness. Information collected for this evaluation suggests that including both policy- and practice-level components may have allowed the Virginia Gold Quality Improvement Program to influence staff retention and quality of care at the pilot facilities through relatively simple changes in the work environments.

Finally, improving nursing facility work environments and quality of care is a long-term process that progresses through several stages of change. These changes often occur quickly in some areas, such as improving staff communication and teamwork, and slower in other areas, such as creating home like atmospheres in nursing facilities and implementing resident-directed care (Koren, 2010). While awareness of quality improvement initiatives is growing among providers, and other stakeholders, the development of "deep" culture change in nursing facilities is relatively rare. Quality improvement projects that generate meaningful changes require dedicated leadership over many years, a stable workforce, buy-in from nursing facility management, and funds for environmental improvements. These characteristics represent substantial investments in time and effort that the nursing facility industry is ill-prepared to address for various reasons including lack of adequate funding for quality improvement projects (Koren, 2010).

In 2007, the Virginia General Assembly established the foundation for financing quality improvement projects when it directed DMAS to establish a quality improvement program to improve the health, safety, and welfare of nursing facility residents. DMAS has historically used CMP funds for emergency purposes, such as paying to relocate residents from nursing facilities closed for substandard conditions; however, using these funds to pay for quality improvement projects may represent a cost-effective strategy that benefits CNAs and residents across the state. For example, Virginia Gold was originally planned to be financed using \$250,000 in CMP funds per year. However, it only cost the nursing facilities \$136,469 to implement the program during its first year (DMAS, 2010). While the evaluation suggests that Virginia Gold may be a good investment, certain policy issues must be addressed before CMP funds are used to pay for quality improvements projects in nursing facilities statewide. For instance, one issue concerns the sustainability of the quality improvement projects. CMP funds are not an unlimited funding source; therefore, quality improvement projects must be sustainable after state funding expires. If DMAS continues funding nursing facility quality improvement projects, then certain financial incentives (i.e., pay for performance) may be needed to assist facilities with continuing these projects. Another issue involves obtaining federal approval to use CMP funds to finance quality

improvement projects. While some states have used CMP funds in the past to finance these projects (Tsoukalas et al, 2006); recent guidance from the U.S. Department of Health and Human Services (HHS) indicates that they cannot be used to pay for activities that the nursing facilities are responsible for under state/federal regulations and laws (Centers for Medicare and Medicaid Services, memorandum, March 11, 2011). Finally, another issue concerns whether DMAS should even be involved with funding quality improvement projects in nursing facilities because other more appropriate private or nonprofit funding sources may exist as well as other nursing facility initiatives that provide funding for training staff on topics such as identifying and reporting abuse and neglect or reducing pressure ulcers. Because this evaluation is preliminary, these and other issues may be addressed in the final evaluation that will be completed after the pilot ends in August 2011.

Study Limitations

While this evaluation was performed using a qualitative design that incorporated rigorous procedures to ensure the credibility of the study findings, four limitations still exist that should be considered when interpreting the results. First, the study does not represent a definitive evaluation of the Virginia Gold Quality Improvement Program because it is only based on the perceptions of a small number of CNAs and residents from each facility. As such, the study provides insights into activities that occurred at the nursing facilities during the program's first year using information obtained from these participants. Their views do not necessarily represent the views of other CNAs and residents at the facilities. Second, the information collected from the participants may be biased because they were selected by nursing facility management staff. While the evaluators informed management staff that the study was not focused on determining the performance of the individual facilities, some managers may still have selected individuals who they believed would portray the program positively. Third, the study did not account for differences between the nursing facilities or control for quality improvement initiatives that may have been implemented prior to Virginia Gold. While DMAS staff informed the participants that they were only interested in discussing Virginia Gold-related events, it is possible that some participants described events that were not related to the program. If this occurred, then additional bias may be present. Fourth, the evaluation may be subject to facilitator bias if the lead evaluator's comments influenced the participants' responses.

Summary

The Virginia Gold evaluation was conducted to provide DMAS management and other stakeholders with information on the effectiveness of the Virginia Gold Quality Improvement Program during its first year. The program began on September 1, 2009 and is scheduled to culminate on August 31, 2011. The evaluation suggests that the program is progressing toward achieving its intended goal of improving nursing facility quality of care in Virginia through the retention of qualified CNAs. The evaluation found that prior to Virginia Gold, the ability of CNAs and other staff to care for residents in the pilot facilities was hampered due to poor communication and lack of teamwork. However, three processes developed after the program started that improved the nursing facility work environments: peer mentoring and the dissemination of consistent information, enhanced communication and teamwork, and worker empowerment. These processes are important because they are characteristics of supportive

work environments. The evaluation also found that the program improved job quality for CNAs through in-service training and recognition and benefits. While overall CNA retention did not improve across all pilot facilities during the first year, qualitative data collected for this study suggests that these five processes influenced CNA retention and quality of care in the facilities. Nonetheless, decisions regarding Virginia Gold's future should be deferred until the final evaluation is completed and certain policy issues are addressed regarding the future funding of long-term nursing facility quality improvement projects.

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