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The Political-Economy of Nursing Home Care

by

Tovah E. Bates

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Sociology

In the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

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Dedicated to my children

Mordechai Yisrael
Miriam Chana
Feige Nechama

who sacrificed their mommy time
so this work could be completed.

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reality embedded in society. She taught me to think sociologically, applying theory to observation.

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THE POLITICAL-ECONOMY OF NURSING HOME CARE

Tovah E. Bates

ABSTRACT

The nursing home is a critical link in the continuum of long-term care services for elderly persons. Despite improvements in nursing home regulatory standards resulting from the 1987 Omnibus Budget Reconciliation Act, research continues to show deficiencies in quality of care. This dissertation examines the political, economic, and social context of nursing home care to better understand the influential structures behind these deficiencies. This project is a secondary analysis of data collected in a larger qualitative, ethnographic study examining the treatment of acute illness in nursing homes. Data for two of the three facilities from the original study are examined in this dissertation. One is a 1,200 bed, government-owned facility and the second a 135 bed, proprietary facility owned by a corporate chain. Thirty of each patient, family, physician, and nursing staff interviews (n=120) from the original study were analyzed for distinctions in the quality of care provided at both sites. Thirty acute illness episodes and 450 pages of observational field notes were also analyzed. Interviews with high ranking officials from aging and nursing home organizations contributed a current perspective to the issues explored in the secondary analysis. Ethnographic analytic methods were used for data analysis. All data were coded for concepts and clustered into thematic categories. Structural differences between sites were found, including: (1) nursing staff wages, turnover, and leadership; (2) physician organization, reimbursement, and responsiveness; (3) institutional ownership, services, and philosophy of care; and (4) social constructions of health, medicine, and aging. Using a political-economy framework, this dissertation argues that the high wages, low turnover, and strong leadership of the nursing staff, in combination with on-site physician staff and auxiliary services, enables the government facility to provide higher quality care than the proprietary facility with its low wages, poor supervision, and physician absence. Findings are interpreted within the intersection between political-economy and organizational theory, exploring the role of resource dependence and medicalization. The significance of this study is that it not only further describes and analyzes deficiencies in quality care in the nursing home, but also provides a theoretical framework for understanding these deficiencies.

Carm J Estes
Jeanie Kayser-Jones

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CHAPTER I: Introduction

Historical Background: The Evolution of Nursing Homes as an "Industry"

Prior to the Great Depression, frail, poor, and chronically ill elderly were housed primarily in almshouses or poorfarms, locally supported by counties or municipalities (Vladeck, 1980). Based on principles of the Elizabethan poor laws, the American public welfare system provided locally supported, "indoor relief" (i.e., institutions, workhouses) for the indigent (Vladeck, 1980; Stevens & Stevens, 1974). Typically, these public facilities were small, understaffed, and inadequate for providing proper care to the elderly (Vladeck, 1980). Elderly residents were mixed with "the retarded, insane, and immoral," thus not receiving the specialized attention they needed (Vladeck, 1980, p. 34). The privileged rich were primarily cared for in their own homes by private physicians (Marmor, Schlesinger, & Smithey, 1987).

The enactment of the Social Security Act of 1935 was a "landmark to this date in American social-welfare legislation" (Stevens & Stevens, 1974, p. 7). With this legislation was the inception of the nursing home industry. It transformed the provision of long-term care for the elderly. First, in response to the dreadful conditions of public almshouses and poorfarms serving the poor and elderly, Congress ruled that federal old-age assistance would be withheld from any individual residing in a public institution. Thus, the demand for proprietary nursing homes grew, and the private sector responded (Stevens & Stevens, 1974). Second, elderly age 65 years or older

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now received income protection, a guaranteed monthly income, with which they could contribute to the cost of living in a for-profit, privately owned nursing home (Kayser-Jones, 1990a).

In 1946, Congress enacted the Hospital Survey and Construction Act, known commonly as Hill-Burton (Starr, 1982). The measure provided public funds to support the construction of community hospitals. Other medical services remained unfunded, and the hospital emerged as the centerpiece of the health care system (Vladeck, 1980). In 1954, Hill-Burton was amended to provide grants to support public and nonprofit nursing home construction. Although little money was actually funded, this amendment contributed to the growth of nursing homes. First, it modestly increased the supply of nursing home beds. Second, it brought nursing homes "into the prevailing hospital-based system of health care (Vladeck, 1980, p. 43). Third, it set the first government standards for nursing homes: for their construction, facility design, and staffing.

With Hill-Burton subsidizing the construction of only public and nonprofit nursing homes, the American Nursing Home Association (ANHA) pressured for similar support for proprietary nursing homes (Vladeck, 1980). In 1956, the ANHA succeeded by securing loans from the Small Business Administration for the construction of proprietary nursing homes. In 1959, the ANHA obtained federal loan insurance under housing programs of the Federal Housing Administration (FHA). The FHA, subsequently, guaranteed nearly a billion dollars in mortgage loans to the

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proprietary nursing home industry. These two loan programs further stimulated the nursing home market, leading to "the real boom in nursing home construction" in the late 1950's and early 1960's (Vladeck, 1980, p. 107).

The dramatic growth of the nursing home industry continued, reaching a peak with the passage of Medicare and Medicaid in 1965 (Stevens & Stevens, 1974; Starr, 1982). These programs encouraged the growth of nursing home beds (Mezey, 1992), as evidenced, in part, by a 36 percent increase of nursing home bed capacity between 1973-74 and 1985 (Strahan, 1987). Specifically, Medicare and Medicaid stimulated the growth of the proprietary nursing home industry (Starr, 1982). Medicare and Medicaid established regulations requiring nursing homes to maintain a certain level of quality of care, for example by setting staffing requirements for nursing personnel. These federal guidelines "forced an appraisal of the whole industry, so that standards for participation could be established" (Stevens & Stevens, 1974, p. 140). Those facilities that could not meet federal guidelines were ineligible for federal matching funds and were pushed out of the nursing home industry. Public financing "made health care more lucrative for providers... (and) made it exceedingly attractive to investors and set in motion the formation of large-scale corporate enterprises," (p. 428) including the purchase of nursing homes by corporate chains (Starr, 1982). During the immediate post-Medicare period, with a booming United States' stock market, over fifty nursing home chains issued stock in the market (Vladeck, 1980). The nursing home industry of today was now well established.

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Statement of Problem: Quality of Care in the Nursing Home is Inadequate

Long term care for the elderly is provided through a continuum of services. The nursing home is a critical link within this continuum, providing a 24-hour institutional skilled care option, often for those with severe impairment and limited or no alternatives for care. Over 40 percent of the elderly 65 years of age or older (Murtaugh, Kemper, & Spillman, 1990), and a greater number of those over 85 (Mezey, 1992), will spend some time in a nursing home. While serving a large portion of the elderly population, nursing homes have been documented to have poorer quality of care than any other segment of the health care industry (Harrington, 1991). Despite large support by public funds and consumer and government regulatory attempts, nursing home studies continue to reveal deficiencies in quality of care (Harrington, Thollaug, & Summers, 1995).

Goffman (1961) defines a "total institution" as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). Although his work focused on mental hospitals, Goffman (1961) refers to homes for the aged in one category of total institutions-- "those established to care for persons felt to be both incapable and harmless" (p. 4). According to Goffman (1961), a total institution strips residents of their identity, autonomy, and adult self-determination. In essence, total institutions are entities of social control.

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Although there is some debate about the extent to which nursing homes are total institutions in the way Goffman conceived them (see Shield, 1988), there is little disagreement that the quality of care in nursing homes is in a tenuous state. The Institute of Medicine (IOM) study (1986) on the quality of care in nursing homes found that "quality of care and quality of life in many nursing homes are not satisfactory" (p. 21). Harrington et al. (1995) summarize data collected by state surveyors on nursing home inspections in 1991-1993. Their analysis reveals that nursing homes still suffer deficiencies in quality. For all facilities surveyed in 1993, 30 percent were found to have unsanitary food, 25 percent with inadequate care plans, 20 percent with inadequate sanitary environment, and 19 percent with failure to maintain dignity of residents. Other quality deficiencies found in 15 percent or more of the surveyed nursing homes in 1993 were hazards in the environment, improper use of restraints, lack of comprehensive resident assessments, and inadequate infection control (Harrington et al., 1995).

Ethnographies of nursing homes have exposed the poor quality of daily life in the nursing home. These studies describe conditions in which nursing home residents find themselves dehumanized, depersonalized, infantilized, isolated, and neglected, as they are subjected to inadequate facilities, overcrowding, understaffing, unpalatable food, lack of privacy, abuse from staff, and poor medical care (e.g., Townsend, 1962; Henry, 1963; Mendleson, 1974; Gubrium, 1975; Kayser-Jones, 1990a).

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In Living and Dying at Murray Manor, Gubrium (1975) describes the experience of living and working in a nursing home, by examining the social worlds of the residents and staff. Gubrium (1975) describes the pressure on the administrators to keep a "well-running system" (p. 81) and the nurses' challenge to complete their "bed and body work" (p. 124) within a time frame that is too short.

Kayser-Jones (1990a) compares care provided in an American nursing home to that provided in a nursing home in Scotland, finding that the elderly in the Scottish nursing home received higher quality care. Factors identified as barriers to quality care in the American facility she studied included: the lack of professional leadership and involvement in the care of the elderly; the lack of accountability for care by health professionals but rather "to the proprietor of the institution, who hopes to make a profit and who is in turn accountable to the State Department of Health to avoid being closed for violations of regulations" (p. 121); and that Medicare and Medicaid contribute to the view of elderly residents as paupers and undeserving of care.

In Shield's (1988) study of the Franklin Nursing Home (FNH), she describes what one would consider a "good" home with friendly and caring staff. Even so, Shield (1988) found that residents at FNH suffered from infantilization, passivity, loss of personal identity, loss of choice, and lack of community. Similar to Kayser-Jones (1990a), Shield (1988) found that a lack of reciprocity in staff-resident relationships, as residents are placed in passive, receiving roles, contributes to an "uneasy life" in the nursing home.

Recent ethnographies by Savishinsky (1991), Diamond (1992), and Foner (1994a) have focused on nursing home life from the perspective of nursing home staff. These studies focus on the constraints, difficulties, and dilemmas confronting nursing home staff which in turn contribute to a diminished level of quality care in these institutions. Diamond (1992) describes how the drive for profit in the nursing home industry has created an underpaid and overworked labor pool of nursing assistants, who are primarily poor women of color. Diamond (1992) shows that nursing assistants do not receive adequate training, are not acknowledged for the work they do, and earn a wage that produces poverty. Diamond (1992) argues that "state policies are thus in collusion with corporations in the creation of caregiving as a commodity. The state acts to guarantee profits-- not for each home, for some lose money, but for the sector as a whole" (p. 202). He states that the state inspects nursing homes on the basis of what is charted, while ignoring the "invisible" work of the CNA's and the actual quality of life of the residents. Medicare and Medicaid do not provide adequate coverage and force many nursing home residents into poverty as they "spend down" their resources to qualify for Medicaid. Thus, while "...validating and encouraging the process of pauperization for staff and residents...in inspection, the state implicitly certifies poverty wages and spend down" (p. 202). Diamond (1992), while focusing on the nursing assistants, brings to the forefront many socioeconomic and political factors affecting the experience of residents and staff in the nursing home and the provision of quality care.

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Acute Illness in the Nursing Home

Acute illness is one cause of increasing morbidity and mortality of nursing home residents (Beck-Sauge, Banerjee, & Jarvis, 1993; Sims, Hauser, Adewale, Maislin, Skeie, Lavizzo-Mourey, & Rubin, 1993). Acute illnesses that are most prevalent in the nursing home population are infections, such as respiratory tract (pneumonia, bronchitis), urinary tract, and skin/soft tissue (infected pressure ulcers, cellulitis) (Beck-Sauge et. al, 1993; Colling, McCreedy, & Owen, 1994; Yoshikawa & Norman, 1996). It is estimated that 1.5 million infections occur each year in nursing homes, with prevalence rates ranging from 5.4 to 32.7 infections per 100 residents per month (Yoshikawa & Norman, 1996). For example, pressure ulcers occur commonly in nursing home residents, with a prevalence rate of approximately 25 percent, with infection as a frequent complication, in 10-65 percent of these cases (Yoshikawa & Norman, 1996). Less common infections include gastroenteritis (infection in gastrointestinal tract) and conjunctivitis (eye infections). These infectious diseases have a higher prevalence rate in the elderly institutionalized population than in the community dwelling population (Colling et. al, 1994; Beck-Sague et. al, 1993). Rates are higher in the nursing home population due, in part, to the higher proportion of elderly who are incontinent, bedbound, or who have indwelling catheters (Beck-Sague et. al, 1993).

There are many consequences to acute illness in the nursing home, including increased rates of hospitalization and mortality among residents

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(Beck-Sague et. al, 1993). For example, the mortality rate for nursing home-acquired pneumonia may reach 40 percent (Yoshikawa & Norman, 1996). Recognizing and treating pneumonia and other infections in the nursing home is complicated by the particular presentation of these illnesses in elderly people and by confounding factors within the nursing home, such as understaffing, lack of 24 hour access to chest x-rays or laboratory results, and lack of patient advanced directives (Fried, Gillick, & Lipsitz, 1995; Hecht, Siple, Deitz, & Williams, 1995). One result of this is that many residents are hospitalized with acute illnesses that may have been successfully treated in the nursing home (Hecht et. al, 1995; Kayser-Jones et. al, 1989).

Purpose of Study: Examining Quality in a Structural Context

The nursing home is not an isolated institution. It is a health care industry, set in a political, social, and economic context. This context is comprised of structural factors, such as: nursing home labor; financing and reimbursement; regulation; ownership; medicalization, and social constructions of aging that affect the provision of care in the nursing home. In order to study the experience of residents and staff in nursing homes, its relationship with the structural setting-- the facility, the industry, the government, and society-- must be considered. The purpose of this study is to examine several issues of quality of care in an effort to understand the complexity of the social-political-economic context in which the nursing home exists. Although this will not be an exhaustive list of quality of care

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issues or the structural factors impinging on them, it is a starting place for examining the linkages between the external, structural environment of the nursing home and the daily care experience of residents and staff in the nursing home.

Significance of the Study

An Increasing Demand for Nursing Homes

While only 5 percent of elderly persons reside in nursing homes at any point in time (Kane & Kane, 1987), over 40 percent of individuals 65 years of age or older will spend some time in a nursing home (Murtaugh et al., 1990). In 1991, the National Health Provider Inventory identified 15,511 nursing homes in the United States, with 1,615,686 beds, and 1,478,217 residents (Sirrocco, 1994). In 1993, almost \$70 billion was spent on nursing home care, nearly 8 percent of the total national health expenditures (HCFA, 1994).

Many factors have contributed to the increased demand for nursing home services, such as the aging of the population, the incidence of chronic illness, and Medicare's adoption of the prospective payment system (PPS). Taeuber and Allen (1993) summarize some dramatic statistics from the U. S. Bureau of the Census, 1990. Between 1900 and 1990, the proportion of elderly grew from 1 in 25 to 1 in 8 being elderly. In 1990, 31.1 million were age 65 or older. Of these, 3 million were over the age of 85. Estimated projections for the 21st century are even more dramatic. By 2030, 65.6 million persons will be 65 or older, with 8.1 million 85 or older. By 2050, the projected number of

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elderly over 65 is 68.5 million, with 15.3 million over 85. The increasing number of elderly 85 years and older is a significant factor in the growing demand for nursing home services, considering that 22 percent of persons 85 and older reside in nursing homes (Hing, 1987).

As the population ages, the incidence of chronic illness increases. Jahnigen and Binstock (1991) explain that "the age specific prevalence of many acute and long-term chronic diseases and other disabling conditions rises exponentially among populations in their late seventies and in their eighties." In 1984, 81 percent of men 85 years and older, and 90 percent of women in that age group, had at least 1 chronic condition (Guralnik, La Croix, Everett, & Kovar, 1989). Thus, with the increasing size of the oldest population, those 85 and older, it is suggested that "more Americans will seek long-term care as they move from independent living, to assisted living at home, to institutional care" (Taeuber & Allen, 1993, p. 35).

In addition to population demographics, the introduction of Medicare's prospective payment system (PPS) in 1983 contributed to the increased demand for nursing home care. Under the PPS, Medicare reimbursement to hospitals is based on diagnosis-related groups (DRG's) which limit the number of hospital days permitted to treat each diagnosis, in order to contain costs to hospitals. The PPS created a financial incentive for acute care hospitals to reduce patients' lengths of stay, the implication being that many elderly are discharged sicker and in need of post-hospital care (Harrington, Estes, de la Torre, & Swan, 1993). Research has shown that the

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PPS has increased the demand for skilled nursing care after hospital discharge, as evidenced by a 23 percent increase in Medicare nursing home admissions after the implementation of PPS (Harrington et al., 1993). Guterman and associates (1988) found that the PPS resulted in shorter lengths of stay in hospitals, while increasing the number of referrals and admissions to nursing homes. Along with the aging population and the increased prevalence of chronic illness, the PPS has contributed to the growing demand for nursing home services.

Although the overall demand for nursing home care has been increasing, the growth in demand may have been reduced by several factors. DuNah Jr., Harrington, Bedney, & Carrillo (1994) point to state policies that "may have had a constraining effect on demand," such as Medicaid eligibility policies and preadmission screening programs (PAS). Additionally, the expanding home care market and other community alternatives to institutional care may reduce the demand for nursing home services (DuNah Jr. et al., 1994). Others argue that future medical advances may reduce the number of severely disabled elderly requiring skilled nursing care or delay the onset of chronic illness, thus further reducing the demand for nursing home care (Jahnigen & Binstock, 1991; Taeuber & Allen, 1993). Despite these factors, it is likely that the demand for nursing home care will continue to increase, considering the ascending life expectancy, the growing proportion of those over 85, and restrictions in nursing home bed supply.

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A Constrained Supply of Nursing Home Beds

While the demand for nursing home services increases, the growth in supply of nursing home beds is not adequate to meet the needs of the aging population. Between 1978 to 1993, the number of nursing home facilities increased 19 percent, from 14,264 to 16,959, and the total number of beds increased 33 percent from 1.3 million to 1.74 million (DuNah Jr. et al., 1994). Despite the steady bed growth rate from 1978-1993, "it did not keep pace with the increase in the population aged 85 and over in the 16 year period (DuNah Jr. et al., 1994, p. 11). Beginning in the 1980's, the bed growth rate slowed. Harrington (1991) explains:

The slowing of growth is the result of complex market factors, including the high costs of capital construction, problems with the labor market, recent lowering of profit rates over previous high levels, and in some states, limits on construction by state regulations (p. 194).

Although the federal requirements for health planning and certificate of need programs, which required approval for new nursing home beds or services, were removed in 1986, many states retained their programs. In addition, several states added moratoriums on building new facilities or increasing services. In 1992, 41 states used a certificate of need program and/or moratorium to control nursing home bed and facility growth (Harrington, 1993). The slowed growth rate along with an overall increase in occupancy rates in nursing facilities has constrained the supply of nursing home beds, restricting access to long-term care services (DuNah Jr. et al., 1994).

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Rising Nursing Home Expenditures

The percentage of national health expenditures spent on nursing home expenditures has increased, from 6.3 percent in 1970 (GAO, 1988) to 8 percent in 1993 (HCFA, 1994). In 1995, 73 percent of the national long-term care expenditures was spent on nursing home care (Levit et al., 1996). The federal and state governments were the largest funders of the \$77.9 billion spent on nursing home care in 1995, with Medicaid paying 46.5 percent and Medicare paying 9.4 percent of the total bill (Levit et al., 1996). While Medicaid funds the majority of nursing home care, public spending from Medicare funds constituted the largest increase in public spending. In 1995, the Medicare share of nursing home expenditures was 9.4 percent, increasing from 3.3 percent in 1990 (Levit et al., 1996). According to data collected by the Health Care Financing Administration, the average charge per day for nursing home care was \$127.00 in 1995, with a 1-year stay at that rate costing more than \$46,000 (Levit et al., 1996).

Medicare covers nursing home expenses only "in situations where skilled nursing care is required for a relatively brief period of time as part of a program of recovery from acute illness, or in connection with hospice care for the terminally ill" (Ball, 1989, p. 27). A Medicare visit, with a maximum length of 100 days, must follow an acute illness in which the patient was hospitalized. Medicaid, the primary source of public funding for nursing home care, requires individuals to meet an income requirement and establish

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that they lack other financial resources or assets to assist in paying for care, before qualifying for benefits. Ball (1989) explains:

[A]s the only public program that provides financial support in most long-term care situations, Medicaid has become, by default, the safety net for increasing numbers of elderly and disabled poor, including large numbers of middle-class Americans devastated by the extraordinary burden of paying for nursing home care (p. 29).

Many elderly must now "spend down" their assets to qualify for long-term care coverage, leaving chronically ill elders and often, their spouses impoverished (Estes, 1979; Kayser-Jones, 1990a; Diamond, 1992).

Medicaid's share of nursing home expenditures has been increasing, growing 326 percent between 1975 and 1985 (GAO, 1988). At an even faster rate, out-of-pocket payments for nursing home services have been increasing, 420 percent between 1975 and 1985 (GAO, 1988). In 1993, consumers paid \$23 billion, or 33 percent of the total nursing home expenditures, out-of-pocket (HCFA, 1994), with private insurance assisting with only 2.4 percent of the bill. By 1995, 36.7 percent of nursing home costs was paid by consumers out-of-pocket, with private insurance covering a minimal 3.2 percent (Levit et al., 1996). Thus, Medicare and private insurance play a limited, but growing, role in financing nursing home care. Individuals ineligible for Medicare nursing home benefits must pay for care themselves, as they spend down their resources to qualify for Medicaid benefits (Harrington, 1991). With the tremendous disbursement of both public and private (out-of-pocket) money

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spent on nursing home care, the quality of care in these institutions would presumably be superior; however, this is far from the case. This is primarily because, although economics has an important affect on the nursing home, quality care is not solely an issue of economics and the market place.

Thus, the study reported here is significant considering the rising demand for and constrained supply of nursing home services, the growing proportion of Medicare and Medicaid funds to pay for these services, the increasing cost for care that elderly patients must pay for themselves, and, in spite of increased regulations, the continuing poor quality of these services. Few studies have examined the nursing home within the larger structural context that is contributing to poor quality. The literature review below will discuss each of these points in detail, further demonstrating the significance of this study.

Finally, the significance of this study is that it not only further describes and analyzes deficiencies in quality care in the nursing home, but it provides a theoretical framework for understanding these deficiencies. The hope is that this knowledge will contribute to the improvement of nursing home care. Thus, this study has significance for health care providers, elderly people, their families, and society.

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CHAPTER II: Literature Review and Conceptual Framework

Structural Factors in the Nursing Home's Political-Economic Context

The following is a literature review of several political, social, and economic factors related to quality of care in the nursing home.

Nursing Home Labor

The relationship between nursing home labor issues, such as staffing, training, wages, and turnover, and quality of care has been given considerable attention in the literature. Although all nursing staff have an effect on the experience of nursing home residents and the care they receive, this section focuses mostly on nursing assistants (nurse's aides, NA's, CNA's) for several reasons. First, nurses' aides spend the most time with residents, providing the most direct care. In nursing homes, 70 to 90 percent of nursing and personal care is provided by nurses' aides (Institute of Medicine, 1986; Strahan, 1987). Second, the characteristics of the nurses' aides themselves reveal an interesting situation where one vulnerable population is caregiving for another.

Over 90 percent of nursing home aides are women (Crown, 1994). Based on information from the 1987-1989 Current Population Surveys (CPS), 25 percent of nursing home aides never completed high school (Crown, 1994). Nursing home aides have a lower level of educational attainment than do hospital aides (Crown, 1994). Although the majority of nursing home aides are white, there is a "much heavier concentration of minority workers" in this occupation "than in the rest of the work force" (Crown, 1994, p. 30).

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According to the CPS, 19 percent of nursing home workers had family incomes of under \$10,000 (Crown, 1994). The median income of the nursing home worker at \$9,000 is substantially lower than hospital aides' median income of \$12,000, with less than half of nursing home aides receiving health insurance coverage through their employer (Crown, 1994). Further, only 36 percent of nursing home aides have an employer that offers a pension plan, in contrast to 68 percent of hospital aides (Crown, 1994). Brannon and Smyer (1994) refer to nursing home aides as "the underclass of the health services delivery system" (p. 34).

The fact that nursing home aides are a vulnerable population themselves, affects the care of the elderly residents. On one level, this is because nursing aides are less educated and under-trained. On another level though, this is because, as a vulnerable group, they are more likely to be victimized by their corporate employers. Low wages and low levels of staffing, poor supervision, and an increased complexity of care alter the working conditions of the nurse aides, thus constraining the care they are able to provide.

Nursing home aides have assumed the increased responsibility to "deliver postacute and subacute care to a more physically ill population of elders" (Close, Estes, Linkins, & Binney, 1994, p. 24.) As the result of the Medicare prospective payment system (PPS) and diagnosis-related groups (DRGs), much of the care for the elderly has been transferred from the acute

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care hospital setting to nursing homes (Close et al., 1994; Harrington et al., 1993; Shaughnessy & Kramer, 1990).

Harrington (1991) explains that as the acuity level of nursing home residents increases so does the complexity of the care provided, as exemplified by the use of medical technology in nursing homes, once isolated to the hospital (Harrington, 1991). Harrington (1991) summarizes: "Thus, changes in the characteristics of residents are placing greater demands on nursing home providers-- demands that are frequently beyond the capacity of the current financing and delivery system" (p. 155).

Inadequate Staffing

While the complexity of patient care has increased, concerns about the adequate staffing of nursing personnel in the nursing home continue. In 1985, there were 5.1 FTE (full time equivalent) registered nurses (RNs) per 100 patients in nursing homes, in contrast to the hospital ratio of 1 RN per 4.5 patients (Strahan, 1988). In the same year, for every 100 nursing home residents, there were 7.4 FTE licensed practical nurses (LPNs) and 30.8 FTE nursing assistants (Strahan, 1988). Harrington (1987) notes that nursing assistant ratios have dropped as low 1 to 15 patients during the day, 1 to 25 in the evening, and 1 to 40 or 50 at night.

In 1994, in response to concerns about adequate staffing in nursing homes, Congress directed the Secretary of the Department of Health and Human Services to ask the Institute of Medicine (IOM) to conduct a study examining whether or not the need exists to increase the number of nurses in

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nursing homes (Wunderlich, Sloan, & Davis, 1996). With the intention of promoting quality patient care in nursing homes, the relationship between staffing levels and patient outcomes were explored. While the IOM study (Wunderlich et al., 1996) found that staffing levels have increased since 1985, the change was only slight and staffing levels are still problematic.

Low levels of staffing means less staff time for patients. In one study, RNs in hospitals spent an average 45 minutes with patients per day; whereas, in the nursing home, RNs spent only 12 minutes per day with each patient (Jones, Bonito, Gower, & Williams, 1987). In 1993, RNs, LPNs, and NAs spent .4, .7, and 2.1 hours respectively with their patients per day (Harrington et al., 1995). With the low staffing levels described above, the time to provide direct care is strained. Nursing home ethnographies have portrayed the time pressure nursing aides experience to complete their job duties, let alone to spend any extra time, meeting the psycho-social needs of patients (Gubrium, 1975; Diamond, 1992; Foner, 1994).

Poor Wages

Despite the increased complexity of care and the increased demands due to inadequate staffing, wages offered in nursing homes are low compared to the hospital setting. Hospitals pay an estimated 20 to 40 percent more than do nursing homes for comparable nursing positions (Harrington, 1987). Nursing assistants who conduct the majority of direct patient care, generally earn only minimum wages and have few benefits (Harrington, 1991). In 1993, the average hourly wages for RNs, LPNs, and NAs were \$15.79, \$11.51, and

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\$6.06, respectively (AHCA, 1995). Additionally, many nursing facilities do not provide their nursing staff with health care benefits (Wunderlich et al., 1996).

One consequence of low wages is that it is more difficult to attract highly educated or specialty nurses. In 1992, the Health Care Financing Administration instituted a requirement that nurse aides in Medicare and Medicaid certified facilities must receive certification based on specific training and/or competency examinations (Pokalo, 1992). Those already working in facilities for a minimum of 24 months are exempt from this requirement. Thus, some of the problems with undertrained nurse's aides will continue. However, even with their additional training, nursing wages remain low.

Turnover

The combination of limited career advancement opportunities (Close et al., 1994), low wages, low levels of staffing, and a challenging work environment have contributed to the high turnover rate of nursing personnel in nursing homes, estimated at 50 to 100 percent per year (Harrington, 1987). While the IOM (Wunderlich et al., 1996) found that facilities could reduce their rate of staff turnover by offering free on-site childcare, health insurance, and other benefits, data from the American Health Care Association (AHCA, 1995) illustrate the severity of the turnover rates. For example, in January 1994, the average turnover rate in nursing facilities for RNs was 56.3. The rate for LPNs and NAs were 52.5 and 100.4 (AHCA, 1995). Wunderlich et al. (1996), summarizing recent studies on

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turnover (e.g., see McDonald, 1994; Robertson, Herth, & Cummings, 1994), conclude that turnover rates have increased in recent years and have negative consequences for continuity of care, supervision of staff, residents' adjusting to frequent change, facility costs due to hiring and training, and overall quality of care.

"Invisible" Work

Furthermore, much of the work actually done by nurse's aides is not accounted for in the official job description of "nurse's assistant." Diamond (1992) describes how much of the work of the nursing assistant becomes "invisible," because it does not fit into the categories of nursing work routinely charted. Henderson (1994) argues the importance of investigating the work of nurse's aides:

In nursing homes, it is the paraprofessional staff who have the most direct contact with residents and whose behind-the-scenes work is most underappreciated. As a result, quality-of-care issues will forever be muted if a detailed insider view of the work of certified nurse's aides (CNAs) is lacking (p. 20).

Henderson (1994) writes of the "unofficial CNA work," work that is "hidden" and "departs from the official job description" (p. 20). He suggests that the "bed and body work" (i.e., feeding, washing, turning, dressing) described by Gubrium (1975) only provides a partial picture of the actual work load of the CNA.

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An example of work "rarely recognized or rewarded" is the attention aides pay to the specific wants and needs of individual residents, such as placing a glass of juice on the left side of the tray so it will be more visible to a stroke-impaired person (Henderson, 1994, p. 21). Additionally, CNA's identify subtle changes in patient conditions that RN's may not notice, simply because of their intimate knowledge and frequent hands-on contact with residents. With this knowledge, CNA's often make decisions about certain aspects of patient care, such as treating constipation, or reporting a condition to the charge nurse. "Yet," Diamond (1988) summarizes, "this caring work is invisible in the language of business and medicine, and is written out of the charts. On the chart it is physical life that is monitored and recorded" (p. 1291).

Constraints, Dilemmas, and Difficulties in Providing Quality Care

Several studies have explored the effect of structural constraints on the provision of care by nursing home aides. Diamond (1988, 1990) describes the economic challenges of working for a wage that creates poverty. He illustrates how the use of Third World female workers in low pay assistant positions, has drawn caregiving into the world economy. With low educational levels, poor economic position and gender and racial disadvantages, nursing assistants are vulnerable to the structural constraints in the nursing home. The medical-centric emphasis and business organization within the nursing home are foundations for many of the structural factors impinging on the provision of care by nursing assistants. Diamond's (1988, 1992) analysis

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examines nursing aides and residents "within the context of these social conditions as political participants in the ongoing production of everyday life, though at the present time caught in a set of relationships over which they have little or no control" (1988, p. 1294). He explores the "macropolitical forces in the micropolitical moments of their everyday execution" (p. 1287).

Foner (1994a) studied the lives of nursing assistants in a nonprofit, higher quality nursing home, she named Crescent. At Crescent, nursing aides were better off than in the average facility, receiving above average wages, pensions, insurance coverage for themselves and their dependents, as well as an active administration with many policies securing quality care already in place. Even so, aides at Crescent were confronted by "caregiving dilemmas," situations in which structural forces work against the provision of compassionate and supportive care. These structural forces include the bureaucratic nature of the nursing home organization, with an emphasis on rules and regulations that are not always in either the aides' or the residents' best interest. Time constraints, abusive residents, labor intensive work, the suppression of emotional labor, opposition with supervisory nurses and administration, and family pressures are several of the structural inhibitors Foner (1994a) identifies at Crescent Nursing home.

Foner (1994a) describes how nursing aides are also challenged as victims of racial tension in the nursing home. Nursing aides experience racial slurs, stereotypes, and resistance as some residents do not want to be cared for by nurses of another culture, race, or country (Diamond, 1992; Foner,

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1994a) Foner (1994a) acknowledges that nursing aides are often the perpetrators of racial tension and conflict, as well. This tension between residents and staff may be better understood when the racial composition of nursing home residents is examined. Minorities are a significant minority of the nursing home resident population. In 1985, 93.1 percent of nursing home residents were white, 6.2 percent were black, and less than one percent from other races (Hing, 1987). This disproportionate distribution is the result of several factors. Hing (1987) summarizes data showing that elderly people of color are more likely to remain in the community, even when they are considered at-risk and appropriate for residential long term care. Second, there is evidence that unfair access procedures have contributed to the lack of minority presence in nursing homes. Buchanan, Madel, and Persons (1991) explain that nursing homes prefer private pay patients because they can charge them a higher rate than would be paid by a Medicaid patient. Buchanan et al. (1991) report that private nursing home daily rates are 20 percent more than Medicaid daily rates. Therefore, nursing homes tend to choose private pay patients over poor elderly on Medicaid, often people of color. Thus, from the point of access, racial tension may be present in the nursing home-resident relationship. As described, this has an impact the experience of both staff and residents in the nursing home. Foner (1994b) concludes that nursing home aides', in contrast to the popular stereotypes, are "neither saints nor monsters" (p. 247), but rather "'in the middle,' subject to

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contradictory pressures and demands from a variety of groups in the nursing home" (Foner, 1994a, p. 2).

Bowers and Becker (1992) examined the work of nursing home aides through participant observation and in-depth interviews with 30 nurse's aides. Similar to the above findings discussed, they found that nursing aide's work is organized based on the challenge of providing individualized, affective care in a formal, institutional setting. Bowers and Becker (1992) argue that poor quality of care in the nursing home, illustrated by nurse's aides cutting corners and breaking the rules, is more a result of economic pressures to keep their jobs than other factors, such as lack of training and education. "Getting the job done well enough to stay out of trouble"-- being efficient without visibly violating facility and state policy-- was the focal issue for the nursing aides in their study (p. 365), rather than the quality of care being provided. This study is another example of how the structural constraints based in the political-economic and social context of the nursing home affect the care nursing aides provide to residents.

Not only are nursing home aides confronted by challenges in the workplace, they return home to precarious life situations (Diamond 1992; Tellis-Nayak & Tellis-Nayak, 1989). In an examination of nurse's aides' lives and their life in the nursing home, Tellis-Nayak and Tellis-Nayak (1989) found that "nursing home quality is tied closely both to the social background of the staff and the institutional culture of nursing homes" (p. 308). They describe:

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Despite their diversity, nurse's aides share a common denominator: their socioeconomic class. They are mostly women and belong to the lowest rung of the health care labor market: they are the least educated, the least skilled, and the least paid, often barely above the minimum wage, and they endure a low occupational status. They share the lower class lifestyle, perched precariously, as most of them are, just above the poverty line, straddling that uneasy fence that separates the two lowest classes, the working class and the lower class (pp. 308-309).

Thus, when the world of the nursing home aide collides with the world of the nursing home, which is institutional and unsupportive, the result is poor quality of care.

In her study of Martindale, a small private nursing home, Vesperi (1983) found that the poor and strained working conditions of the nursing home aides, creates an additional challenge to the aides to provide quality care to nursing home residents. Vesperi (1983) suggests that nurse's aides blame their frustration on the residents, even when there may be a larger context to consider, such as the institutional environment and structure. She explains: "Unable to achieve an overview of their own exploitation within an employer-employee relationship, staff members trace their disappointment to the residents themselves," blaming their feelings of frustration and powerlessness on the residents or specific resident characteristics (p. 236).

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Tellis-Nayak and Tellis-Nayak (1989) share this argument, as their findings reveal that nurse's aides individualize their problems and make residents "the target of their discontentment and resentment" (p. 312). They conclude:

And that completes the vicious cycle. Two parties, both powerless, little respected, and hardly recognized by society are made to face each other in a difficult setting not of their own making. They are bound in an intimate association, but enjoy little intimacy. Neither party controls the institutional environment in which they exist, neither can break the negative cycle, and so the problem feeds on itself (p. 312).

It is as if two powerless groups have turned the battle between themselves, when really what must be considered is the larger context that is disempowering them both. Vesperi's (1983) and the Tellis-Nayak's (1989) work illustrates how one oppressed group can displace their discontentment onto another vulnerable and oppressed group.

It is important to qualify the above description of nurse's aides as powerless pawns of the structural environment of the nursing home. Nursing staff do have control or take control over pieces of their experience. What is suggested here is that the structural constraints limit the amount and range of free choice possible. Nurses' aides chose where to cut corners in care. In a time constrained environment, they decide what will and will not get done, or which residents will receive more care (Gubrium, 1975; Bowers and Becker, 1992). In a supportive and respectful work environment, with

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enough staff to meet residents' needs, nursing aides will still have control, but the choices may be different. Perhaps then, nursing aides will not have to choose between feeding and toileting or between one resident and another. Their power, control, choice can be put to greater use-- such as providing quality care.

A second point of qualification must be made on the above description of nurse's aides. Although both nursing home aides and residents are vulnerable populations, it would be neglectful to ignore the power differential in the nurse aide-resident relationship. Kayser-Jones (1990a) explains that because nursing home residents are dependent on staff for services, they are, to a certain degree, at the will of the staff. Thus, staff can provide services to residents quickly and respectfully, "or they can use the situation to exercise power over the aged" (p. 113). Kayser-Jones (1990a) observed many instances of staff members abusing their power over the residents in the American nursing home she studied. Staff mistreat residents by violating their privacy and dignity, by ignoring calls for help, and by making fun, bullying or even physically striking them (Gubrium, 1975; Kayser-Jones, 1990a; Foner, 1994a). Abusive staff members may blame the system for their own poor care. However, although structural factors such as low wages and under-staffing, create stressful work environments for nurse aides, this does not give them license to mistreat residents. It is critical that structural improvements are made to create a more supportive environment for staff and residents. In combination with more education and supervision,

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the number of instances of power abuse may be reduced. Perhaps if the socioeconomic context and the negative conceptualizations of old age and the elderly (to be discussed in the next section) did not create such an oppositional relationship between aides and residents, they could join together to place their discontentment where it belongs-- with those who own, govern, and reproduce the inequitable environment of the nursing home.

Nursing Home Residents: Constructions of Aging and the Aged

How old age is regarded by members of the society is socially constructed by what is attributed or imputed to aging. These attributions, in turn, determine how old age is processed and treated by society. Thus the conceptualization of old age and of the aged as inherently sick or healthy is socially created in the sense that it is not determined solely by objective facts (Estes et al., 1984, p. 4).

In our society, aging is often equated with "traditional notions of illness (that is, a pathological or abnormal condition)" or disease (Estes, et al., 1984, p. 4). The focus is on "physical debility and physiological decline" (p. 5). Drawing from Arluke and Peterson (1981), Estes et al. (1984) describe how the construction of the elderly as "ill" has created a societal expectation that all elderly should take on the role of a sick person. Thus, elderly are expected to withdraw from society, reduce their social and occupational responsibilities, and become dependent on others.

From this perspective, institutionalization could be viewed as a necessary, if not inevitable part of old age. Further, one could question

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whether those already institutionalized are expected to be, and then treated as, more sick and dependent than they may actually be. Services within the nursing home that perpetuate dependence or limit independence are not challenged because they are aligned with the social construction of who the elderly are and what the aging process involves. For example, Kayser-Jones (1990a) witnessed "innumerable incidents of staff treating residents like children" (p. 39). Infantilization may be a consequence of the socially constructed view of aging as a return to a state of infancy, of the elderly as dependent and child-like.

Vesperi (1983) concludes that the poor quality of care provided by nurse's aides is directly linked to the "institutional conceptualizations of old age, within which elderly people command no potential for future development" (p. 228). Vesperi (1983) argues that "Policy is directly informed by the definition of what an old person is, wants and needs as constructed within the framework of an institutional setting" (pp. 231-232). Thus conceptions of withdrawal as "normal adjustment" in old age (p. 233), of the "limited potential" of the elderly (p. 228), of patient protests (refusing to eat, incontinence) being problematic or deviant, and "of the old person as childlike, dependent, and intellectually deficient or 'senile'" (p. 235), shape the quantity and quality of care provided in nursing homes.

It is not only the view of the elderly found within the nursing home, it is the societal view of the elderly that permeates into the nursing home. Butler (1975) identifies several myths about the elderly held by society,

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including the aged as unproductive, as inflexible, as disengaged, and as senile. He suggests that these myths are in part due to ignorance, but are also the result of a "deep and profound prejudice against the elderly" (p. 11). Butler (1975) labels this prejudice "ageism":

Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills.... Ageism allows the younger generations to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings (p. 12).

Further, Butler (1975) suggests that ageism permits society to ignore the unfortunate plight of many elderly. He describes that "at times ageism becomes an expedient method by which society promotes viewpoints about the aged in order to relieve itself of responsibility toward them" (p. 12).

In summary, social constructions of aging and the aged are embedded in our social structure. They contribute to the prevalence of poor quality of care in nursing homes. Whether it is affecting the interpersonal relationship between residents and nurses' aides, or affecting the attention quality of care issues receive on the policy and regulatory level, ageism and these constructions of reality shape the experience of staff and residents in nursing homes.

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Medicalization

The degree to which the nursing home is a medicalized institution and the question of whether this is, in itself, problematic is an additional factor to be reviewed for its relationship with quality of care. The nursing home is a setting in which medical care is supposed to be provided in a home-like environment. Tellis-Nayak (1988) asserts the degree of medical dominance "has turned the term 'nursing home' into a misnomer," explaining: "...the medical bias has taken such deep roots in our culture, that it has invaded the nursing home, and it even dominates its process of care" (p. 149). Nursing homes modeled off of hospitals do not necessarily meet the residents' long term care needs as residents, not only as patients. Tellis-Nayak (1988) argues: "A medical culture...usually permeates the nursing home life; its care often takes cues from the acute care model even at the expense of long-term care principles" (p. 157).

Irving Zola (1972/1990) argues that medicine has become an institution of social control by, "'medicalizing'" much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence" (p. 398). Zola (1972/1990) delineates four processes which illustrate how medicalization has occurred. These dimensions of medicalization are applicable to the nursing home. First, Zola (1972/1990) suggests that medicine has expanded its territory into all aspects of life that it has deemed relevant to medicine-- such as, diet, sleep patterns, work life. In the nursing home, all aspects of the residents' lives are deemed relevant and

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brought into the domain of medicine-- eating, sleeping, and toileting, for example. Residents' daily schedules become structured by medical regimens and routines.

Second, medicine has retained "absolute control" over medical technology, including drugs and surgery (p. 401). The nursing home physicians decide, or must approve, when and what medications and treatments are appropriate. One might argue that the physical absence of the physician has lessened the degree of medicalization in the nursing home. The lack of involvement by physicians in nursing homes has been explained by physicians' ageist attitudes toward the elderly, by inadequate geriatric training in medical school, by the rising influence of corporate power, and by the low reimbursement rates, late payments, and burdensome paperwork associated with providing care in nursing homes (Butler, 1975; Harrington, 1984; Mitchell & Hewes, 1986; Kayser-Jones, 1990a). Physicians generally conduct monthly visits to residents which may or may not involve direct examination (Kayser-Jones, 1995). Despite the physicians' physical absence from the nursing home, they maintain the role as gate-keeper of admission, diagnosis, treatments, and prescriptions (Tellis-Nayak, 1988). Although nursing staff participate in recommending certain treatments and sometimes controlling if and when medications or treatments are administered, the physician holds the ultimate power of prescription.

Furthermore, even though nurses have significantly more direct contact with residents than physicians, the care they provide is still based on

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and set within a medical model, where psycho-social care is de-emphasized and medical care is emphasized, where medicinal cures may be substituted for what may have been resolved outside the medical domain. Whereas the emphasis in long-term care might better be placed on rehabilitative and psycho-social care, in the nursing home, these "have become adjuncts to medical services" (Tellis-Nayak, 1988, p. 149).

Third, Zola (1972/1990) contends that medicine has secured and retained exclusive access to what were once considered "taboo" areas-- for example, aging, a once considered natural process now medicalized as a problem requiring medical intervention (p. 403). The nursing home is a site where the process of aging is medicalized as a problem.

Fourth and final, Zola (1972/1990) suggests that increasingly, what the medical establishment approves is legitimate and recommended for the "good practice of life". In other words, if it is the medical trend it is right for life. In the nursing home, medical knowledge and recommendations guide the type of care residents receive. Knowledge drawn from the social/psychological sciences, or lay or experiential knowledge from the nurses' assistants is not held in high regard.

Like Zola, Estes and Binney (1991) argue that the aging process has been socially constructed as a medical problem. They assert that policies and behaviors affecting the elderly emerge out of this conceptualization of aging as a medical problem. One example Estes and Binney (1991) offer is the increased medical management, such as institutionalization, of the elderly's

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problems, with a de-emphasis on social and environmental factors. Practice and policy resulting from this perspective tends to individualize the elderly's problems, by focusing on diseases and disabilities. The de-emphasis of psycho-social care in the nursing home, as Tellis-Nayak (1988) discusses and many ethnographies illustrate (e.g., Diamond, 1992; Gubrium, 1975; Foner, 1994; Kayser-Jones, 1990a), is one of the consequences of medicalization.

Another consequence of medicalization is referred to in lay literature as the "cascade of interventions" (Davis-Floyd, 1990, p. 181, in footnote). As medical technology and interventions are introduced, they often create the need to use additional technologies (Wertz & Wertz, 1989). This is similar to the occurrence of iatrogenic illness, illness caused by medical treatment. Tellis-Nayak (1988) asserts that one consequence of the nursing home being a medical institution inadequately supervised by physicians is that problems arise such as misdiagnosis, nondiagnosis, and over or incorrect medication use. Iatrogenic illness can be the result of a specific medical intervention, such as a reaction to medication or an infection from a feeding tube, or it may be a more subtle negative consequence of the medical model. For example, Lyman (1993) offers an example of a man in an Alzheimer's day-care facility who wears a medical bracelet that reads, "THIS MAN IS UNABLE TO SPEAK" (p. 104). This man, however, engaged Lyman in several conversations during the course of her research. Although the staff are aware that he communicates verbally, the man cannot escape his medical label. Lyman (1993) concludes, "At times like these, the medical model is not only

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inappropriate but iatrogenic. Medical labels blind the staff to the realities of cognitive impairment and to the remaining potential of the person" (p. 104).

In addition to iatrogenic illness or treatment, Lyman (1993) asserts that increased dependency and infantilization are consequences of medicalization. Both the process of aging and of disease progression (especially in dementia) are often conceptualized as a return to childhood or infancy. Lyman (1993) argues that framing child-like behavior as an expected medical condition of the elderly, allows the staff in institutional settings to justify infantilizing treatment. Infantilizing the elderly, in turn increases their dependency. Supporting this, Hofland (1988) found that residents' attempts at independence are either ignored or punished in long-term care facilities. Thus, Lyman (1993) concludes that medicalization may in fact "inhibit quality of care" (p. 32).

While the over-medicalization of the nursing home, described above, may influence resident care, one might argue that the concurrent under-medicalization of care is compromising quality, perhaps more significantly. For example, medical care that is necessary and appropriate is often inaccessible, unavailable, or inadequately provided. This is due, in part, to federal regulations that reimburse physicians for only one visit a month per resident, resulting in the remainder of care negotiated over the telephone, in what Kayser-Jones (1995) labels "the practice of medicine by telephone" (p. 241). Vladeck (1980) states that while the organization of the nursing home is based upon the medical model, it is essentially a medical model

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without a physician. Furthermore, registered nurses (RNs), who have the highest level of training of nursing home nurses, have the least opportunity for direct patient care (Strahan, 1988). Even as the most highly trained nurses, RNs in nursing homes have less education than hospital nurses. Only 56 percent of all RNs in nursing homes graduated from diploma programs, and less than 3 percent have a master's degree (Strahan, 1988). Thus, few nursing homes benefit from the specialized knowledge and training of gerontological nurse practitioners. The nursing home is, therefore, in somewhat of a paradoxical situation, subject to both over- and under-medicalization. Medicalization is an important structural factor in investigating quality of care in the nursing home.

Regulation

An additional structural factor in the quality of care of nursing homes is regulation (Harrington, 1991). The first nursing home regulations were established in 1965, as part of the Social Security Act. In order to receive funding from the government programs, Medicare and Medicaid, facilities were required to meet the federal certification requirements (Harrington, 1996). Despite these regulations, poor quality continued in nursing homes across the nation (Townsend, 1962; Mendleson, 1974; Gubrium, 1975).

In the 1980's, a decade of deregulation, support of private industry, and cost-containment (Estes & Binney, 1993), the Reagan administration proposed to curtail regulation of the nursing home industry. This sparked significant controversy, with consumer groups and professionals strongly opposing the

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proposal (Kayser-Jones, 1990a), and with public awareness of nursing home horrors from two decades of nursing home exposés (e.g., Townsend, 1962; Henry, 1963; Mendleson, 1974; Gubrium, 1975). In response, Congress authorized the Institute of Medicine (IOM) to study the debate over nursing home regulation. The IOM Committee on Nursing Home Regulation concluded that quality of care is a significant problem in nursing homes and that regulatory efforts must be strengthened (IOM, 1986). The Institute of Medicine (1986) recommended profound changes in the regulatory system to attain effectiveness. They argued: "more effective government regulation can substantially improve quality in nursing homes. A stronger federal role is essential" (p. 21). They recommended changes in these areas among others: staff and management training and certification, the development of quality measures to rate nursing homes, and the inclusion of aspects of quality of life (not just quality of medical care) subjected to regulation.

In response to the IOM committee's recommendations, as well as efforts by consumer groups and professional organizations, Congress passed the first federal legislation for nursing home reform since 1965 (Harrington, 1996). The Omnibus Budget Reconciliation Act (OBRA) Nursing Home Reform legislation was enacted in 1987 and implemented in 1990 by the Health Care Financing Administration (HCFA) (Harrington, 1996).

Harrington (1991) discusses several of OBRA's requirements, such as: comprehensive assessments of residents upon admission which define their functional, cognitive, and affective level, with periodic updates afterward;

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the use of quality indicators based on health outcomes, such as incontinence or mobility; the reduced use of restraints; and prohibiting the unnecessary use of medication. New enforcement regulations were issued by HCFA in 1994 that increase the scope of penalties that may be imposed on nursing homes not complying with federal requirements (Harrington, 1996). The implementation of new regulatory efforts may be jeopardized by a revived Congressional interest in deregulation, similar to that of the 1980's (Harrington, 1996).

Although regulation improves the quality of care, it often receives resistance from the nursing home industry. Harrington (1991) points out that special interest groups battle with opposing interests, often ending in a stalemate. The nursing home industry wants minimal government regulation, while obtaining high government reimbursement rates. Industry wants reimbursement rate increases, but would oppose any regulation that would require them to guarantee increases in employee wages. The government is skeptical of the nursing home industry and tries to contain costs of reimbursement rates. Harrington (1991) explains:

Because substantial amounts of public funds to nursing homes traditionally have been used to finance excessive administrative costs, high profit rates, and the expansion of chain operations, there is a legitimate distrust of the industry and an unwillingness on the part of the government to spend more money (p. 161).

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Thus, government strives for regulation and enforcement, with the minimum reimbursement rates to ensure quality of care; while, the industry resists attempts any financial monitoring systems that would make them more accountable for their spending.

In addition, Harrington (1991) warns that regulatory efforts are not enough to improve the quality of care in nursing homes. She writes:

We argue that regulatory efforts, while essential, are not sufficient to improve the overall quality of nursing home care. Rather, efforts to develop structural reforms will be seen as necessary to make nursing home care safe, to ensure high quality of care, to preserve the basic rights of residents, and to promote an acceptable quality of life for residents (p. 153-154).

Thus, nursing home reform must be comprehensive and not rely solely on regulation to dictate and enforce standards of care.

Furthermore, quality care is not always as simple as strengthening or increasing regulation, for there are those who illustrate how inappropriate regulation or an over-emphasis on regulation can be detrimental to the provision of quality of care. Through charting regulations, both the lives of the residents and of the nursing assistants "become objectified..." (Diamond, 1988, p. 1294). Diamond (1992, 1988) examines how charting regulations, although intended to protect the residents, also function as a distraction from the provision of direct care and staff time with the residents. Foner (1994) illustrates how nurses' aides experience certain bureaucratic rules and

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regulations as oppressive and restricting aspects of caregiving. She also shows how regulations protecting residents from physical abuse in the nursing home can backfire, hurting innocent staff members. The point here is not that regulation should be discarded, but that careful investigation of the effects of regulation on both staff and residents is critical to improving the quality of care in nursing homes. Thus, after three decades (1965-1995) of consumer action and government regulatory efforts, quality care is still lacking in nursing homes.

Profits and Revenues: Ownership and Quality of Care

The relationship of facility ownership to quality of patient care has been the focus of many studies and a relationship debated in the literature. This section includes background information on ownership in the nursing home industry and a review of the debate on this relationship.

In 1991, 71 percent of nursing homes were proprietary, 24 percent were nonprofit, and 5 percent were government owned facilities (Sirrocco, 1994). With the exception of the drug industry, Harrington (1991) points out that "the nursing home industry has more proprietary ownership and chain ownership than any other segment of the health system" (p. 156). There has been a significant concentration of ownership by several large nursing home chains (Hawes & Phillips, 1986). Hawes and Phillips (1986) summarize several factors that have contributed to this corporate concentration of ownership, including "stricter licensing and certification" that put smaller nursing homes out of business, a more complex public reimbursement

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system that "favors more sophisticated operators," increased demand for long-term care, the profitability of expansion, state restrictions on bed supply that encouraged "acquisitions rather than new construction" for expanding nursing homes (pp. 502-503).

Nursing homes have been referred to as a major component in a growing "medical-industrial complex" (Estes, Harrington, & Davis, 1992). Relman (1980) defines the new medical-industrial complex (MIC) as "a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit-- services heretofore provided by nonprofit institutions or individual practitioners" (p. 963). Features of the MIC include the consolidation of industries into larger organizations; horizontal integration-- the development of multiorganizational systems across the same level of care; and vertical integration-- the linkage of organizations providing different types and levels of services (Estes, Harrington, & Davis, 1992).

Relman (1980) argues that the growth of this large and profitable industry is concerning because the health care market does not function according to the laws of economics under which other markets function. For example, health care is not a commodity in the way other marketable items are (Relman, 1980). Many people consider health care to be a basic right. Further, patients cannot be compared to consumers in other markets because when they are sick, they pay for care, without necessarily looking for the best deal. Additionally, patients are not choosing to consume health care; rather,

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it is generally ordered by the physician with little say from the patient.

Relman (1980) contends that these characteristics distinct to the medical market combine:

...to produce an anomalous situation when private business enters the scene. A private corporation in the health-care business uses technology often developed at public expense, and it sells services that most Americans regard as their basic right--services that are heavily subsidized by public funds, largely allocated through the decisions of physicians rather than consumers, and almost entirely paid for through third-party insurance (p. 968).

This, Relman (1980) argues, creates many opportunities for abuse, distortion and commercial exploitation. Estes et al. (1984) assert, "The competition model as a prescription for the nation's health care woes is aimed at restricting access to health care, and it is doubtful that it will ensure quality of care" (p. 70).

As a major component of the MIC, the nursing home industry features the characteristics described by Estes et al. (1992). The industry has seen significant growth and consolidation in proprietary ownership. There is both vertical and horizontal integration within the industry, with nursing homes under joint ownership with other nursing homes, as well as hospitals and other health care organizations.

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Although concerns have been expressed about the effect of profit and the growing MIC on the health care system, the effect of ownership on quality of care in nursing homes has been "disputed" (Harrington, 1991, p. 157). A substantial research effort has been made to determine the relationship between nursing home ownership and quality of care and quality of life in those institutions (Kane & Kane, 1987; Wunderlich et al., 1996). Harrington (1991) notes that nursing home ownership has been identified as one factor in quality of care. In one review of the research on quality and ownership, a "mixed picture in terms of the relationship" was found (Wunderlich et al., 1996, p. 162). In the above review, while some researchers found that non-profits were more likely to be associated with a higher level of quality care (Davis, 1991), others found no relationship between quality of care and ownership (Cohen & Dubay, 1990). Hawes and Phillips (1986) argue that despite limitations and inadequacies in many of studies of quality of care and ownership, "the evidence for the superiority of nonprofit owners seems conclusive" (p. 530). From the studies they summarized, Hawes and Phillips (1986) conclude that "on the average, nonprofit nursing homes provide better quality of care and quality of life to residents than do the for-profits" (p. 530). Estes et al. (1984) mention the problem of medical iatrogenesis, where illness is the result of medical treatment or intervention, describing it as, "largely a symptom of a system that allocates profits through institutional solutions fostering dependency, passivity, and acquiescence" (p. 89).

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In their literature review of quality of care studies, Hawes and Phillips (1986) found that most studies revealed "significant differences between for-profit and nonprofit facilities in the amount of resources allocated to direct patient care (p. 513). In the studies summarized, proprietary nursing homes, on average, were found to spend less money on food service, medical care, nursing staff wages, and housekeeping. Nursing personnel in nonprofit nursing homes earn higher wages than their counterparts in proprietary facilities (Holtmann & Idson, 1991). Many nurses' aides earn minimum wage and lack benefits (Harrington, 1987; Harrington, 1990; Butler, 1992). Harrington (1987) describes the consequences of inadequate wages and benefits, including inadequate staffing levels, high turnover rate, lower educational levels of staff, poor quality of care, and higher cost. In addition to paying lower wages, proprietary facilities have lower staffing levels. In 1985, for every 100 nursing home residents, proprietary facilities had rates of 4.3 RN's, 7.1 LPN's and 29.6 nurses' aides (Strahan, 1987). This is in contrast to the higher rates per 100 beds in voluntary nonprofit facilities-- 6.7 RN's, 7.7 LPN's, and 32.8 nurses' aides. The rate for government facilities was even higher, with 7.4 RN's, 8.6 LPN's, and 35.7 nurses' aides per 100 nursing home residents (Strahan, 1987).

It is not surprising that with lower wages and lower staffing levels, proprietary nursing homes have higher nursing personnel turnover rates than nonprofit homes (Munroe, 1990). Although high turnover is detrimental to quality of care, "nursing homes, like other health facilities,

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have some economic incentives to encourage high turnover rates to keep wages low" (Harrington, 1991, p. 158).

Although proprietary facilities pay lower wages and have lower staffing levels, nonprofits are confronted by similar economic constraints that keep staff wages and staffing levels low. Harrington (1990) explains:

Nonprofit nursing home corporations are also increasingly responding to the competitive economic environment by placing great emphasis on the enhancement of net revenues. The distinctions between profit and nonprofit corporate ownership are increasingly blurred as both types of corporations become part of multi-organizational systems and compete for clients and resources (p. 383).

Thus, "The desire to enhance profits and net revenues encourages nursing homes to reduce expenditures for needed nursing personnel, particularly by keeping wages and benefits artificially low" (Harrington, 1990, p. 383). Thus, some challenge the significance of the effect of a specific ownership status on quality of care in nursing homes.

Referring primarily to hospitals, Marmor, Schlesinger, and Smithey (1987) note:

The contemporary growth of investor-owned health care facilities, for example, has been viewed by proponents as the elixir for all that ails the American health care system. Opponents see it as indicative of the virtual abandonment of a set of cherished social institutions and values" (p. 234).

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Marmor et al. (1987) argue that it is unlikely that problems in the health care system are a result of the shift in form of ownership from nonprofit to proprietary. Rather, they suggest that quality, access, and cost of care were problems preceding the ownership debate and remaining through it. They argue further that focusing on issues of ownership only deflects attention from curing problems in access and cost that are "fundamental, long-standing features of American medicine" (p. 234). Perhaps Marmor et al. (1987) are correct in de-emphasizing the form of ownership, but they do not acknowledge that quality, access, and cost of care problems result, in part, from the drive for profit. In the case of non-profit nursing homes the drive is not for profit, but for revenue, and financial growth and cost containment are still motives (Harrington, 1990).

Gray (1991) summarizes studies and literature reviews on the performance of for-profit and nonprofit health care organizations. He concludes that it "is not carved in stone" that nonprofits and for-profits behave differently due to their form of ownership; rather, their performance depends on a number of circumstances (p. 110). For example, nonprofit nursing homes "appear more likely to spend money on enhanced quality than on expansion" (p. 110). Even so, it is not conclusive that "the average quality of care differed in for-profit and non-profit facilities" (p. 108). In summary, Gray (1991) states: "Though unsatisfactory to people who want a simple, unambiguous conclusion, the evidence examined in this chapter

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suggests that both for-profit and nonprofit forms of ownership may serve legitimate purposes in health care" (p. 110).

DiMaggio and Powell (1983) contend that "once a field becomes well established, there is an inexorable push toward homogenization" (p. 148). DiMaggio and Powell (1983) refer to this process of organization homogenization as "isomorphism" (p. 149). They explain that although, in their origin, organizations within a field may vary significantly, over time, organizations begin to resemble one another. This occurs because organizations in the same field may confront similar conditions in their environment, such as competition, certification/accreditation requirements, and imitation.

Estes and Binney (1993) argue this has been just the case with nonprofit health care organizations. With the 1980's emphasis on deregulation, budget cuts, market ideology, and mixed organizational types (combining nonprofit and for-profit entities within one organization), nonprofit health care organizations are under growing pressure "to place efficiency and market goals above mission and service goals" (p. 41). Thus, Estes and Binney (1993) suggest that the boundary between nonprofits and for-profits is increasingly blurred, stating: "Nonprofit service agencies are being disciplined to act like for-profits..." (p. 32). They argue:

With the addition of new and mixed organizational models (e.g., health corporations) that combine nonprofit entities and proprietary subsidiaries, nonprofits have been pressed (if not coerced) to create and

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seek out their own forms of profit making-- a phenomenon heretofore considered antithetical to the mission or raison d'être of the nonprofit sector (p. 25).

Further, the restructuring of the nonprofit sector has serious consequences on individual non-profit organizations, including lower staff salaries and benefits, de-skilling, high staff turnover and burnout, and "a trend toward careerism and professionalism in which organizational survival and efficiency goals override service goals" (Estes & Binney, 1993, p. 41).

From this perspective, it can be argued that nonprofit nursing homes have a growing resemblance to for-profits. Thus, form of ownership may be less of a significant factor in quality, being that nonprofit and proprietary nursing homes are now more similar in structure and confronting similar market pressures. The influencing factor may be less ownership form than the market pressures themselves under which both nonprofits and for-profits exist. Although the current data discussed above finds an overall higher quality in nonprofit nursing homes, as the nonprofit sector continues to restructure in this direction, it seems likely that high quality care in nonprofit nursing homes may be jeopardized.

At this time, researchers have not answered key questions in how to define or measure quality in nursing homes and the effect of ownership on it. The debate continues. The differences between nonprofit and proprietary facilities discussed above, including the amount of resources allocated directly to patient care, staffing levels and wages, and staff turnover rates, have been

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identified as preconditions to or factors of quality care. It is evident though, that regardless of ownership status, the drive to enhance profits or net revenues contributes to the compromised quality of care in nursing homes and has consequences for both nursing home labor and residents.

Conceptual Framework: Political-Economy

To understand aging and the lived experience of the aged, they must be considered within a larger political, economic, and social context. Works on the political economy of aging (e.g., Estes, Gerard, Zones, & Swan, 1984; Estes, 1991) have employed Walton's (1979) definition of political economy:

...the study of the interrelationships between the polity, economy, and society, or more specifically, the reciprocal influences among government... the economy, social classes, strata, and status groups.

The central problem of the political economy perspective is the manner in which the economy and polity interact in a relationship of reciprocal causation affecting the distribution of social goods (p. 9).

Political economy provides a "structural view of aging" (Estes, 1991, p. 21), where "the dependency of the elderly is understood as a social product of the market and the social relations it produces" (p. 21).

The idea that definitions of aging and the aged are socially constructed is another component of the political economy of aging perspective (Estes, 1979). According to Berger and Luckmann (1966), knowledge is socially created and then presented as objective reality, regardless of its actual validity.

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Thus, social constructions are definitions of reality that have become accepted as factual in society. Estes (1979) illustrates how the social construction of reality has implications for the structure of society, particularly in the case of the elderly population. Estes (1979) argues that old age has been defined as a problem in American society, and this has led to social policies that support services that segregate the elderly from society while creating a structural or forced dependency of the elderly on society. An analysis of issues of aging and the aged must consider the social meanings and definitions (e.g., of aging, medicine, nursing homes) and how they may be affecting social institutions and policies.

Thus, Estes et al. (1984) suggest that a political economy of aging analysis encourages the examination of these issues affecting the elderly:

1. the social determinants of health and illness;
2. the social creation of dependency and the management of that dependency status through public policy and health services;
3. medical care as an ideology and as an industry in the control and management of the aging;
4. the consequences of public policies for the elderly as a group and as individuals;
5. the role and functions of the state vis-à-vis aging and health; and
6. the social construction of reality about old age and health that both undergirds and reinforces the institutional arrangements and public policies concerning health and aging in the society (pp. 2-3).

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The lived experience of the aged must be considered in relation to the broader societal, political, and economic processes occurring within capitalist society.

A political economy perspective offers a useful framework for analyzing social policies and organizations. Organizations are subject to constraints and controls by both their external and internal political economy (Zald, 1970). The external polity and economy influence the structure of the organization by controlling resources, determining regulations, and enforcing sanctions. The degree of influence depends on the organization's relation to the state and to other external organizations that hold this control. Zald (1970) contends that in addition to the external political economy, organizations are affected by an internal political economy, as he explains:

The [external] political economic environment directly impinges on, and interacts with, the internal political economy. It imposes constraints and presents opportunities to an organization. Goals and procedural choices tie an organization into a web of users, suppliers, distributors, and to a set of influences, relationships, alliances, and hostile antagonists (p. 236).

Zald (1970) identifies the internal polity as "an organization's internal power system" (p. 237). This system is the manner in which power is distributed, utilized, and limited within an organization. The power may be used to control resources or to maintain a set of goals and values.

The amount and distribution of power outside of and within the organization is associated with the degree to which the organization is

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dependent on other entities for its resources. In this resource dependence perspective, the relationship between the organization and its external and internal political economy is examined for the degree to which a particular social actor controls access and use of the resources on which others depend (Pfeffer, 1981). The resources involved need not only be monetary, but may include physical resources, information, or social legitimacy (Pfeffer & Salancik, 1978). Relations of resource dependency may be established among social actors internal or external to the organization (Zald, 1970).

This study will examine a primary organization in the care of the elderly-- the nursing home. The experience of nursing home residents, as the experience of elderly in general, cannot be fully understood without examining the sociopolitical and economic factors that are influencing that experience. Weiner and Kayser-Jones (1990) found that both macrosociological conditions, such as medical technology advances that prolong life without curing disease or a market economy that supports investor-owned nursing home corporations over national health insurance, and organizational conditions, such as poor quality of nursing care or limited medical supplies, "impinge with great force on the illness trajectories of nursing home patients in the United States" (p. 100). Using decision-making surrounding and the experience of having an acute illness in a nursing home as an example, Weiner and Kayser-Jones (1990) illustrate how these factors influence patient care in nursing homes. The structural factors discussed by Bates (1995) compose the political economy of nursing homes. Identifying and

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understanding the complexity of the relationship between these structural factors and the nursing home is critical for improving nursing home quality. The political economy perspective can inform our understanding of quality of care in the nursing home.

Definition of Terms

In a review of quality of care studies, Kane and Kane (1987) find that "quality in long-term care has been inadequately defined (i.e., too much emphasis on structure, credentials, and written policies and too little on the quality of life of residents)" (p. 85). In addition to quality being an elusive and subjective concept, it is difficult to measure. What constitutes an acceptable level of quality in an outcome and which outcomes to emphasize in quality of care studies are debatable issues (Kane & Kane, 1987). Further, once factors in quality are identified, assessing them accurately has been problematic. Kane and Kane (1987) state that quality assessment surveys of nursing homes "have been unreliable and their validity is in question both because facilities are forewarned and because the residents themselves are not the usual source of data" (p. 85). Kane and Kane (1987) cite research that has successfully identified problematic areas in quality of care in nursing homes, including: the misuse of chemical and physical restraints, inadequate diagnosis and treatment of acute illnesses, inadequate nursing care (e.g., bedsores), poor food quality, and insufficient rehabilitation and social programs. Thus, quality of care studies have identified problematic areas of

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care needing improvement, but have not yet defined what is an appropriate level of quality, or how this can be assessed and enforced.

Is quality care difficult to define? As researchers struggle to identify and define individual, outcome measurements of quality, do we lose sight of a more basic understanding of quality care, one that focuses on the rights of the elderly as human beings? When American nursing homes are compared to European nursing homes that emphasize individualized care, most free of chemical and physical restraints and feeding-tubes, quality care becomes clearly envisioned (Kayser-Jones, 1990a; Williams, 1989). For example, Williams (1989) discusses the highly personal and individualized quality care she observed on visits to nursing homes in Sweden and Denmark, pointing out that "By contrast, in our country [U. S.], responses to individual needs tend to be seen as interruptions of the schedule of tasks to be accomplished by staff on any given shift" (p. 8). In addition to Williams (1989), studies comparing American nursing homes to European facilities that provide a homelike environment of nursing care, document that quality care for disabled and chronically ill elderly is possible (Kayser-Jones, 1990a; 1991). Kayser-Jones (1990a) concludes her study by arguing that, "Quality care for the institutionalized aged is neither difficult to define nor costly to provide. In comparison with acute care, which often involves expensive diagnostic medical and surgical procedures, long-term care is not costly" (p. 132). She proceeds to define quality care:

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Primarily, long-term care institutions should provide professionally competent and emotionally supportive staff, good food, meaningful activities, and some of the amenities of life. The aged need just what everyone else needs when ill: attention to their medical problems and physical needs and, especially, emotional support, because many are suffering from multiple physical and social losses. They need care, kindness, compassion, and understanding; and they need to be treated with dignity and respect. Meeting the needs of most of the chronically ill aged does not take a great deal of expensive and sophisticated equipment or diagnostic treatments and tests. To provide quality care, we must surround the elderly with an environment as normal and "homelike" as possible (permitting them to have some control over their lives) and we must demonstrate by our care that we value them as human beings

(p. 132).

For the purpose of this study, Kayser-Jones' (1990a) definition of quality care will be employed. More study is needed to fully illuminate the degree of poor quality in the nursing home; however, the purpose of this paper is not to list and describe each aspect of quality. Rather, this study will examine the relationship between structural factors and quality care, in general. For the purpose of this study, "structural factors" will refer to social, political, and economic conditions, both outside and within the nursing home, that shape and influence the care provided. A political economy perspective can help in

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understanding the context in which this low level of care occurs and inform
our understanding of daily life and experiences in the nursing home.

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CHAPTER III: Methodology

Research Design

Original Study

This project is a secondary analysis of a qualitative study. The original data were collected in a larger ethnographic study examining the treatment of acute illness in nursing homes— the social, cultural, and environmental factors involved in who receives treatment and what care is provided to residents with acute illness (Kayser-Jones, The Treatment of Acute Illness in Nursing Homes, Grant No. AG 05073). The study (1985-1990) was conducted in three West Coast nursing homes, including two proprietary and one nonprofit facility. It included in-depth interviews with residents, nursing assistants, registered and licensed nurses, physicians, as well as some administrative and ancillary staff (dietitians, activities staff, etc.). One hundred interviews were conducted in each of the following categories: resident, family, nurse, and physician. Additionally, event analysis was used to follow 215 residents prospectively through acute illness episodes (AIE). Field notes based on participant observation recorded many dimensions of day to day life in the nursing home and the provision of care to residents.

Current Study

This study asks original questions of the data; however, the data set is appropriate for the current study because of the wealth of data collected on quality of care issues, the provision of care, and the nursing home environment. The benefit of ethnographic research is the detailed

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description obtained through ethnographic methodology (in-depth interviews, event analysis, extensive participant observation).

In addition to the secondary data, original data were collected from the nursing home sites. At Facility A, the Medical Director, Assistant Medical Director, and the Director of Nursing were interviewed by telephone. The facility Administrator was not available for interview. At Facility B, attempts were made to interview the Administrator, the Director of Nursing, and the Medical Director; however, access was denied. The interviews lasted between 30 and 45 minutes and addressed two issues. First, they focused on changes that have occurred in the facility since the original time of data collection, thus addressing the relevancy and current validity of the data. Second, the interviews examined the administration's perspective on the structural factors influencing care in their facility. In place of interviews at Facility B, data obtained on the current environment or changes at Facility B were drawn from articles published on a more recent research study investigating the social, cultural, environmental, and clinical context of eating and nutrition in the nursing home (Kayser-Jones, 1993-1997).

Another source of original data were interviews with five high-ranking officials of national and state level aging and long-term care organizations (see section on Sample for specific organizations). The primary purpose for interviewing the organization officials was to inform the study by addressing whether or not the trends found in this study coincide with what may or may not be seen, more generally, in other nursing homes across the

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United States. Questions addressed quality of care, the relationship between structural factors and quality care, how the industry has changed in the last decade. The interviews were also used as an opportunity for consulting experts in the field on the emerging findings. The interview guide was generated from concepts and themes that emerged from the data during analysis.

Research Questions

The following research questions guided the course of data analysis to provide an in-depth examination of the social, political, and economic context of nursing home care. Following each question is a brief description of anticipated findings, based on previous research on nursing homes, summarized by Bates (1995), and on initial readings of some data from the larger study used here.

What are the political, economic, and social factors within the nursing home's political-economy that influence patient care?

1. To what degree do financing and reimbursement policies influence the provision of care to residents?

The structure of financing and reimbursement, of nursing home services, creates structural constraints on the provision of quality care to residents. Reimbursement issues, such as Medicaid and Medicare reimbursement for medical procedures, equipment, or physician visits, is one example of where this impact is expected to be seen.

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It is anticipated that social constructions defining aging and the aged in the larger society penetrate the nursing home and influence the care elderly

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residents receive. Social constructions of aging as a decline into poor health and debility, and the aged as dependent, infantile, and disengaged are often grounded in ageism and ignorance. These constructions shape the care provided, whether affecting the interpersonal relationship between residents and health care professionals, or affecting the attention quality of care issues receive on the policy or regulatory level.

6. To what extent is medicalization an influential process in the nursing home?

While most studies of medicalization critique the over-medicalization of the phenomena studied, it is expected that under-medicalization is more salient in the nursing home. Inadequate medical knowledge, resources, technology, and the absence of physicians and gerontological nurse specialists are all components of under-medicalization seen in the nursing home. It is also expected that in addition to inadequate medical care, residents receive insufficient psycho-social caregiving. The under-emphasis on psycho-social caregiving, that might be attributed to medicalization, may in fact be a consequence of economics-- not enough staff to care for residents-- thus psycho-social caregiving is disregarded.

Description of Setting

Secondary data were collected in two West Coast nursing homes. Descriptions of the sites have been provided elsewhere (see Kayser-Jones, 1989, 1990b, 1991, 1995; Weiner & Kayser-Jones, 1990); however, it is important

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to describe here features of the two facilities relevant to the current study.

Facility A is a government-owned, facility of 1,200 beds, operated by the city and county. Facility B is a proprietary facility with 135 beds, owned and operated by a corporate health care chain.

Both facilities provide skilled nursing care; however, they vary greatly in the services they provide and in their organization. There are three wards in Facility B, one of which is a Medicare floor. Basic nursing care is provided on two of the floors, while a higher level of nursing staff on the Medicare floor, permits the provision of an increased skill level of care, such as the use of intravenous therapy for medications, hydration, and feeding. Occupational and physical therapy, as rehabilitative services, are also available on the Medicare floor. Facility B also has social work and activities departments that provide a range of services to the nursing home patients. In addition to these basic services, Facility A provides more extensive services. For example, they are licensed to provide surgical and acute care. This license requires that they provide other auxiliary services, such as radiology, laboratory, and pharmacy. As a "Distinct Part" facility, where skilled nursing is located within (a distinct part of) a licensed acute care provider, Facility A receives a higher per diem Medicaid reimbursement than Facility B which is a "Freestanding" skilled nursing facility. Although the rates fluctuate, an example from between 1995-1996 illustrates the dramatic differential in reimbursement. During that time, Facility B received approximately \$93.00 per day, per Medicaid patient, while

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Facility A received \$211.00. These figures were provided by the business office at Facility B and the Assistant Medical Director at Facility A.

Table 1. Facility Characteristics

Characteristic	Facility A	Facility B
Level of Care	Skilled nursing	Skilled nursing
Number of beds	1,200	135
Tax Status	Non-profit	For-profit
Ownership	City/ County government	Corporate chain
Licenses	Medicare certified- all beds Acute care license Surgical care license	Medicare certified- 45 beds
Percent of patient population receiving Medicaid	95 percent	Under 10 percent
Percent of patient population receiving Medicare	Under 5 percent	35 percent
Percent of private pay patients	Under 5 percent	60 percent

There are also differences in the structure of physician services at the two facilities. Facility A has twenty to thirty staff physicians that are assigned to specific patient wards. Many physicians have worked at Facility A for years,

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establishing long-term relationships with the nursing staff. In contrast, at Facility B, physicians are not nursing home staff, but rather private or associated with an insurance plan, and have followed their patients into the nursing home. Patients without a previous physician (or one their insurance will cover now in the nursing home) are assigned to a physician, often the Medical director of the facility.

The settings' descriptions may appear quite different; however, they are comparable in their institutional purpose- the provision of long-term and skilled nursing care to elderly patients. Facility A is atypical in regard to its large size, auxiliary services, and medical staff; yet, it is just these characteristics that make it of interest to study. With this in mind, the contrast of the two sites is important to illustrate the different institutional environments in which care can be provided. The implications of these differences will be discussed later.

Sample

Secondary Data Sample

Due to the nature of secondary data analysis, the sample for this study was already selected. However, this original study resulted in a voluminous amount of data, and it was only possible to analyze a portion of it for the current study. For analysis, a purposive sample of 15 interviews was selected from each nursing home, in each of the following categories: patients, patient family members, physicians, and nursing staff (RNs, LVNs, CNAs) (total 120

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interviews). Additionally, 15 acute illness cases were selected from each site for analysis. Finally, 200-225 pages of field notes, spanning approximately six months of time, were selected from each facility to provide observational data to augment what was reported in the interviews. A purposive sample of data was utilized for two reasons. First, having a purposive sample guaranteed that the interview respondents included varied in age, race, religion, and gender. Second, a much larger pool of interviews and AIE's were read before the final selection was made, and this allowed for selecting those data that were most informative and relevant to the current study and research questions.

Drawing data from a variety of sources, as described above, will assure triangulation of data. For this study, other methods of triangulation of data include: having two sites, collecting the original data by a research team (versus an individual researcher), interviewing informants on the state and national level who connected the findings to a larger context. Triangulation was used to increase the study's credibility. Erlandson, Harris, Skipper, and Allen (1993) describe: "Triangulation may establish that the information gathered is generally supported or disconfirmed; more important, however, it enhances meaning through multiple sources and provides for thick description of relevant information..." (p. 115).

All data from the original study were collected with complete human subjects protection assurance. The following are some of the methods used to secure human subjects protection: permission granted by nursing home

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Original Data Sample

At Facility B, access to the staff was denied by the facility. Upon initial contact with the administrator at this facility, she expressed concern that the interviews would consume too much of her time and her staff's time. She asked for a fax of the interview questions and said she would call me after she decided whether or not her facility would participate. She was faxed the materials, along with a project summary and consent form. After waiting two working days, telephone contact was attempted again. The secretary explained that the administrator was out of the facility, and a message was left with the secretary. No one returned the call. Three days later, another call was placed to the facility, and the secretary stated that the administrator was on the other line, but after the secretary asked for my name, she said, "Oh, she's in a meeting right now." A second message was left. Three days later, a third and final message was left at the facility, requesting that even if the

The image shows a vertical strip of a document, possibly a book cover or endpaper. It features a repeating pattern of a stylized 'U' and 'B' logo, which is the emblem of the University of Birmingham. The logo is printed in a dark color on a lighter background. The strip is oriented vertically, and the pattern repeats down its length.

administrator had decided that she could not participate, it would be helpful to know that, and perhaps the secretary could call or fax a response. She assured me that someone would contact me. One week after this final call, a call was received from the administrator of Facility B. After apologizing for the delay in returning the call, she explained that she could not participate in the study because she was resigning from the facility. She said that she would be leaving in two weeks, and the facility had not yet hired a new administrator. She did not offer any explanation of her resignation, and it did not seem appropriate to ask her. I did ask, however, if her staff members would perhaps still be available for interview and explained that I could arrange the appointments myself by calling them directly. She said that even that was not acceptable because it was going to be a very busy transition time. Therefore, current data were not obtained from Facility B staff.

Officials from the following organizations were interviewed: National Citizen's Coalition for Nursing Home Care Reform, California Advocates for Nursing Home Reform, Wisconsin Health Care Association, National Council on Aging, and the National Senior Citizen's Law Center. Their selection was based on their knowledge, experience, and accessibility. Those interviewed were asked if they desired confidentiality and anonymity. This piece of the study was approved by the Committee on Human Research, University of California- San Francisco. Approval was also attained from the individual facilities. Protection of all subjects in the study was assured.

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Nursing home administrators, medical, and nursing staff from Facility A were interviewed once by telephone. Those subjects recruited from the aging and long-term care organizations were also interviewed once by telephone. As discussed above, the interview guides were developed during the course of data analysis, and the questions asked reflected emerging findings in the data and an attempt to contextualize the findings into the current time. Notes were taken and written up immediately following the interviews. Informants were asked for their permission to contact them an additional time for follow-up questions or issues that may have arisen.

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Data Analysis

Data were analyzed with ethnographic analytic methods associated with qualitative investigation, as described by Hammersley & Atkinson (1983). The primary goal of the data analysis was to generate theory out of a systematic analysis of data on the topic area. First all interviews and field notes were read several times and then coded for meaningful concepts. The concepts were labeled and compared and contrasted across interviews and observational data, in order to identify recurrent patterns and themes. Concepts were clustered into larger theoretical categories, and dimensions of these categories were analyzed based on variations in the data. As theoretical categories were identified, data were assigned to and organized in terms of these categories.

To assist with data organization and theory development, two methods of data management and analysis were applied. First, an index of concepts and theoretical categories was created, similar to the analytic index Hammersley and Atkinson (1983) discuss. In the index, segments of data were assigned to categories and presented in outline form. This facilitated data retrieval, organization, and analysis. Second, throughout the data analysis, memorandums were written, recording emerging categories and themes. Hammersley and Atkinson (1983) explain that writing analytic memos prevents "aimless drifting through the collection of data" and encourages "reflexive monitoring of the research process"

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(p. 165). Accumulated memoranda then constitute a preliminary analysis.

In this analysis, categories were generated that described the relationship between structural-- socio-political-economic-- factors and quality care in the two nursing homes, including the impact of this relationship on residents, staff, and families. The interrelationship of factors in the political economy of nursing homes was analyzed by focusing on structural factors such as: financing and reimbursement, regulation, ownership, labor issues, social constructions of aging, and medicalization. In the tradition of qualitative analysis, the informants' perspectives were central to the analysis, and data were analyzed by identifying the emerging concepts and categories, not forcing the data into pre-determined classifications.

It is important to clarify that throughout the reported findings and analysis, except for where specifically designated as 1996-97 interview data, all data are from the secondary analysis of data obtained in the original study. Unless otherwise stated, staff members and patients referred to are those of the facilities at the time of the original data collection.

Another explanatory note is that throughout the findings, analysis, and discussion, persons residing in the nursing home are referred to as "patients." While it has become more acceptable to refer to persons in a nursing home as "residents" or "clients" (Henderson, 1994), this study maintains that those included in the study, living in the nursing home, were in fact patients. They were living in an environment developed from an acute care model, a medical model. Additionally, many of the original subjects were being

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treated for an acute illness, and thus were in a state of "patienthood".

Support for this in the literature is found in Henderson (1994) who argues similarly "that these terms ["resident" and "client"] tend to mask the fact that people in nursing homes are treated like patients, so I prefer to use the word 'patient'."

Limitations of Study

It is important to acknowledge the limitations of this research. First, there are limitations resulting from the study being a secondary analysis. In this methodology, the data exists before the study has begun. Here, the data set was chosen for its depth of detail on nursing home care, qualitative methodology, availability, and convenience. Additionally, as a research assistant on another project, I worked for several years in one of the facilities, providing first-hand knowledge of one of the nursing home sites. While there are great benefits to utilizing secondary data, as the study proceeded, the limitations became more apparent.

The main difficulty encountered in secondary analysis is that the only data to work with is that which is available. Therefore, through the analytic process, interesting questions arise that may not be answered by these data. In this study, this may also be a function of the small sample size. Having included the entire data set from the original study, may have enabled more questions to be explored in-depth.

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Another limitation in secondary analysis pertains to the age of the original data. In this study, the original data were 10 years old. In the past decade, the nursing home and larger health care system has experienced many changes. For example, at the time of data collection, the 1987 Omnibus Budget Reconciliation Act which included the Nursing Home Reform Act had just passed. Additionally, shifts in the industry have occurred due to the rising prevalence of managed care. Conclusions from the study must be assessed for their relevancy to the current time.

Other limitations of this study result from being a dissertation. As a student project, with limited resources, the sample size of the study is small. Including only two nursing homes, while there is much to learn from them, it is a disadvantage that limits the explanatory power and generalizability of the findings. While one facility selected was representative of the majority of facilities in the industry, the other is unique in many of its features. A larger study, including more sites, would allow for a broader and more generalizable comparison. Thus, the focus here was on what could be learned by comparing two different facilities.

Another limitation of this study is the inability to establish strong relationships. This is, in part, a result of doing a secondary analysis in which the original data did not offer enough information on particular issues. It was at these points, had this been an original study, more questions would have been asked of the informants. Findings and conclusions related to physician visits and reimbursement are a good illustration here. As will be

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shown, physicians complained about the low reimbursement they received for visiting nursing home patients. An analysis of AIE cases, as well as patient and family complaints in interviews revealed that physicians visited the nursing home infrequently and for short visits. While there was likely a relationship between these two findings, it was one only of suggestion, as causality was not evidenced in these data. No physician specifically stated that it was due to low reimbursement that he spent fewer minutes with his patients on visits. It was clear, however, that low reimbursement did not function as an incentive to encourage physicians to visit their patients. Again, while an association can be discussed, the conclusions that can be made are limited.

The argument will be made here, that even with the changes in nursing home regulation and managed care, the quality of nursing home care today demands improvement. To compensate for some of the limitations discussed above, interviews were completed in 1996-97 with some of the facility staff and with officials of aging and long-term care organizations. Finally, the limitations are accepted as a part of the study and conclusions made here will be qualified within these limitations. The concluding chapter will discuss how to build beyond these limitations through future research.

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CHAPTER IV: Findings

This study investigated the provision of care in two nursing homes prior to implementation of OBRA 1987 Nursing Home Reform Act. Data were selected from a larger study investigating the treatment of acute illness in the nursing home (Kayser-Jones, J. S., 1985-1990). These findings are the result of a secondary analysis of these data, and unless otherwise specified, refer to the time period of the original data collection, 1985-1987. From the original study, interviews from each nursing home, 30 in each of the following categories: patients, patient family members, physicians, and nurses, were analyzed for distinctions in the quality of care provided at each site. Additionally, 15 acute illness episodes (AIE's) were selected from each site for analysis. These AIE's provided descriptive medical chart and observation notes on patient care for patients followed for an acute illness while in the nursing home. Interviews with the patient and family members were often included in these cases. Finally, 200-225 pages of field notes, spanning approximately six months of time, were selected from each facility to provide observational data to augment what was reported in the interviews.

Five dimensions of quality care were identified in the data: nursing care, medical care, psycho-social care, social constructions and care, and policy and care. With the exception of social constructions and care, differences across facilities were found for each dimension of quality care. What is reported here does not reflect all aspects or indicators that might be examined

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in an analysis of quality of care; however, these were categories for which consistent information was provided in the AIE reports, interviews, and fieldnotes.

Preceding the presentation of the major findings in each dimension is an overview of the thirty acute illness episodes (AIE's) analyzed. Examining AIE cases was fruitful in the investigation of care provision, for it provided a nursing home situation in which nursing care, medical care, and psycho-social care were immediately and visibly provided to the patient. When this care was lacking, this too was immediately apparent. Thus, many quality of care issues emerged through the analysis of the AIE's.

Overview of AIE's

Patients in both facilities were treated for a range of acute illnesses. At Facility A, in nearly 50 percent of the patients with AIE's examined, pneumonia was the acute diagnosis. Other diagnoses in the Facility A AIE's included urinary tract infections, complications of chronic illness (e.g., diabetes), and gastro-intestinal (GI) bleeds or abscesses. The most prevalent acute diagnosis for AIE's at Facility B was dehydration, with 40 percent of the patients with AIE's observed for this condition. Other diagnoses in the Facility B AIE's included urinary tract infections, pneumonia or chest pain, and GI bleeds or obstructions.

Treatment requirements varied according to the nature of the illness and the patient. As this is not a clinical study, the AIE's were not evaluated

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on the appropriateness of specific treatment courses. Rather, the findings reported whether or not concerns were identified regarding the medical treatment, nursing care, and outcome of the AIE. Statements of concern made by the project research assistant or principal investigator, the project physician, the patients and/or their families, nurses, and physicians during the time when the patient was observed and followed for an acute illness were counted as concerns. These were then categorized according to the subject of concern: nursing care, medical treatment, or outcome of the acute illness. When medical treatment or nursing care were identified as absent or delayed, they were labelled as such only when there were no indications that it was either the patient's or family's wishes that treatment be withheld. When patient/family wishes opposing treatment were found, the physicians and nurses were viewed as upholding the patient's right to refuse treatment, and therefore may not have been accountable for negligence. However, it was important to consider confounding factors, such as poor communication between physicians, nurses, and patients that may have affected the patients' decisions regarding treatment. These complexities are presented where relevant.

Concerns About Nursing Care

Concerns raised about the nursing care of patients included the treatment of patients by the nursing staff and the issue of staffing. In 15 (100%) patient cases at Facility A, there was no mention of any concern regarding nurse treatment of patients or nurse staffing. In contrast, at Facility



B, in 9 out of 15 cases (60%) concerns about nursing care were mentioned, including the following: understaffing, inappropriate use of physical restraint, patients waiting for help, patient left in bed with no chart order for bed rest, and dehydration.

Table 2. Number of Concerns Raised Regarding Nursing Care In Acute Illness Episodes (AIE's)

AIE Cases (N=15 per facility)	Number of AIE Cases with Concerns Raised	Number of AIE Cases with No Concerns Raised
	n (%)	n (%)
FACILITY A	0	15 (100)
FACILITY B	9 (60)	6 (40)

Concerns About Medical Treatment

Concerns or questions about the medical treatment patients received during their AIE were raised by nurses, patients or their families, or the researcher following the AIE. Additionally, each AIE report was reviewed by the original project's staff physician. If in his review of the case, concerns were raised they were counted here. Medical care referred primarily to the physician's treatment of the patient, for example, delays in or the absence of medical examination or treatment orders. In three instances, physicians raised concerns regarding nursing care that directly impinged on the patients'

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medical care received (e.g., nurses inadequately following medical orders). Thus, these instances were counted as a separate category of concerns about medical treatment.

At Facility A, in 5 of the 15 (33%) AIE's, concerns were raised about the medical treatment provided during the acute illness. In three of these cases, questions were raised whether treatment had begun too late, with two of these patients dying. In the other two cases, patients were treated symptomatically, meaning that the medical treatment relieved them of their current symptoms (e.g., a fever) from the acute illness, but the underlying condition (e.g., a lung infection) was not thoroughly assessed or treated.

Table 3. Number of Concerns Raised Regarding Medical Treatment in Acute Illness Episodes (AIE's) (N = 15 cases per facility)

Type of Concern	Number of AIE Cases with Concerns Raised at Facility A	Number of AIE Cases with Concerns Raised at Facility B
	n (%)	n (%)
Concern that Rx was absent or delayed	3 (20)	6 (40)
Concern that only symptoms were treated	2 (13.3)	2 (13.3)
Concerns raised about nurses' medical Rx	0	3 (20)
No concerns raised	10 (66.7)	4 (26.7)

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In contrast, at Facility B, concerns about medical treatment were raised in 11 of the 15 (73%) AIE's. In six of these cases there were concerns that treatment was delayed or absent. In two cases, patients were treated symptomatically only, and in three cases concerns about the provision of medical treatment by nurses were mentioned.

Concerns About the Outcome of Illness

The focus of the data presented, because this is not a clinical analysis, is on the general outcome- whether or not the conditions were resolved, if the patient died, and whether any questions or concerns were raised about the outcome by nurses, physicians, families, or the researcher. At Facility A, the acute illnesses of 9 of the 15 (60%) patients followed were resolved, 3 patients died either suddenly (e.g., cardiac arrest) or as expected after treatment was attempted (e.g., terminal leukemia), and 3 patients died with some question or concern regarding their death (e.g., if treatment had begun sooner, perhaps the patient would have survived the illness). At Facility B, the acute illnesses of 7 of the 15 (46.7%) patients were resolved, 1 patient survived with the illness not resolved, 6 patients died with some question or concern regarding their death, and 1 patient's outcome was unknown after a transfer to another facility.

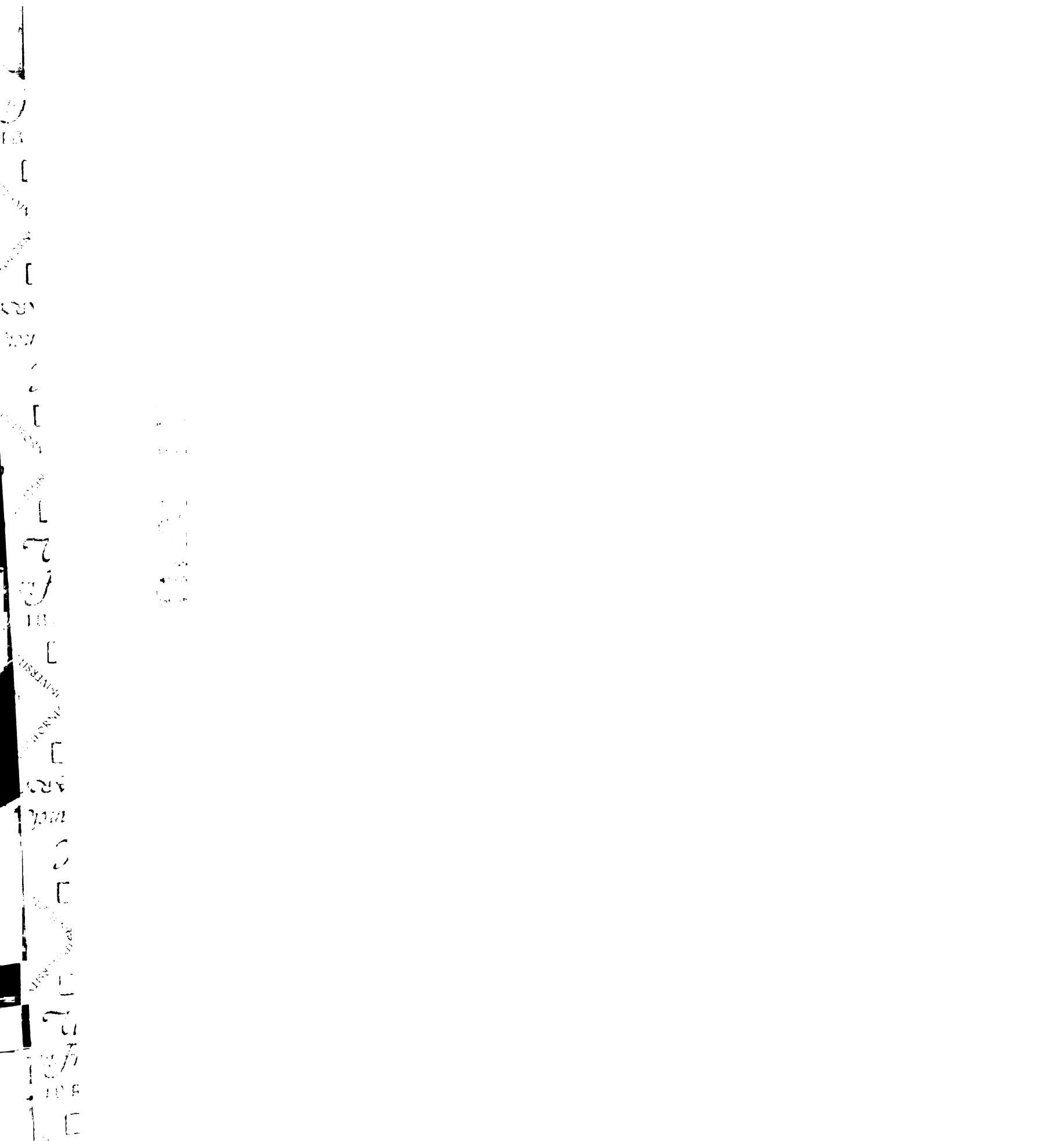


Table 4. Outcomes of Acute Illness Episodes (AIE's) (N = 15 cases per facility)

Outcome	Number of AIE Cases at Facility A	Number of AIE Cases at Facility B
	n (%)	n (%)
Acute condition resolved	9 (60)	7 (46.7)
Acute condition not resolved, but patient survived	0	1 (6.7)
Patient died as expected in illness course	3 (20)	0
Patient died and concerns raised about death	3 (20)	6 (40)
Outcome unknown	0	1 (6.7)

Case Examples

Four AIE's are presented here as case examples, two from each facility. These cases were selected from the 30 AIE's in both facilities for the range of quality of care issues found in each case. They were also selected because, based on the general findings, they are representative of the other AIE's in their facility, with regard to the care and treatment they received from the nurses and physicians. The cases are presented here without elaboration and

will be referred to as case examples throughout the findings. The names of the patients have been changed to protect confidentiality.

Facility A Case #1: Mrs. Kane

At 6 a.m. on December 8, the night shift RN noted that, Mrs. Kane, a 91 year old woman was congested, with a stuffy nose, a cough, and an elevated temperature. At 8 a.m., the head nurse on the day shift posted Mrs. Kane's name on the board so the ward physician could examine her on his morning rounds. After examining Mrs. Kane at 8 a.m., the physician suspected either pneumonia or bronchitis and ordered a chest x-ray (CXR), which was done on-site at 10 a.m. A blood draw (CBC), urinalysis (UA), Acetaminophen, and a cough expectorant were also ordered. The results of the CXR, CBC and UA were available that day, and Mrs. Kane was diagnosed with pneumonia and a urinary tract infection (UTI).

The ward physician contacted the physician on the acute care ward to evaluate whether transferring Mrs. Kane to the acute unit (at Facility A) was appropriate. As a result of this consult, she was transferred the same day to the acute unit, for intravenous antibiotic treatment. Mrs. Kane returned to her regular ward on December 17, with the pneumonia and the UTI resolved.

Facility A Case #2: Mrs. Bandos

Mrs. Bandos, a 67 year old woman at Facility A, with severe Alzheimer's disease, developed a fever on April 26. The nurse's aide noted this status change and informed the head nurse who notified the ward physician. The physician arrived to visit Mrs. Bandos about five minutes

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later. The physician suspected pneumonia or a urinary tract infection and ordered a sputum and urine culture. Acetaminophen, an antibiotic, and oxygen were started immediately. A chest x-ray, ordered for the following day, indicated pneumonia. In the following days, the fever diminished, the antibiotics were continued, and the pneumonia was resolved.

Facility B Case #3: Mrs. Pelman

A 90 year old woman residing in Facility B, Mrs. Pelman, vomited a small amount of emesis on March 26, in the evening. Later that night (now the 27th), she vomited an increasing amount. During the day on the 27th, the nurses notified Mrs. Pelman's physician by telephone; however, the doctor did not respond-- he was out of town. Once again, the next night, March 28th, she vomited an increasing amount. That morning, Mrs. Pelman again vomited, this time a thick brown emesis with a fecal odor. While the patient vomited, the DON stood at the foot of the bed, with her clipboard; she did not approach or speak to the patient. The nurse's aide, also present when the vomiting occurred, tried to roll the head of Mrs. Pelman's bed up with a crank at the bed's foot, but the crank was malfunctioning and did not work.

On the afternoon of the 28th, two and a half days after the initial call into his office, the physician visited Mrs. Pelman. He ordered that she be transferred to an acute hospital and that a "stat" abdominal x-ray be taken. She was transferred later that afternoon, and the x-ray at the hospital revealed a mechanical small bowel obstruction. Mrs. Pelman's condition was resolved at the hospital with appropriate medications, a naso-gastric tube, and

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intravenous hydration. She then returned to Facility B. Upon readmission, the doctor stressed in the medical chart that constipation must be avoided in this patient, ordering, "call STAT if lack of B.M. [bowel movement] over period of 48 hours."

A few weeks later, Mrs. Pelman was observed sitting in the hallway in her wheelchair. She was very upset because she had to go to the bathroom, but she knew it was the nurses' dinner hour and no matter what, she would not be taken to the bathroom for probably an hour. She distressingly told the research assistant:

If I could only walk, I could get myself to the bathroom. I am so restricted because there aren't enough people here to help me. I have to go to the bathroom, so badly, and I know that no one is going to help me.

The RA informed the charge nurse who responded, "We are too busy. My aides are at the other end of the corridor, and also, it is the dinner hour. There is no way that anybody can help this patient. She will just have to wait."

Facility B Case #4: Reverend Jenkins

An 83 year old man, Reverend Jenkins, with a six year history of prostate cancer, now metastasized, was a patient at Facility B. Reverend Jenkins was admitted to the hospital following a fall, the result of weakness and pain from the cancer. He remained in the hospital for over a month, where he was treated for pain, anemia, and dehydration secondary to the

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cancer. There, the Reverend received IV hydration and pain medication. The hospital pressured the physician to discharge his patient, but the physician had difficulty finding a bed in any nursing home for Reverend Jenkins. He needed a bed on a Medicare certified ward, where IV's were permitted. Facility B had one bed open on the first floor, which was not a Medicare ward. The nursing home refused the patient due to his IV. The physician tried to admit the patient, but when the regulation could not be side-stepped, he ordered that the IV hydration be discontinued, and Reverend Jenkins was admitted to the facility.

When asked why the fluids were discontinued, and the physician responded, "He [the Reverend] wasn't any better with them than without them." The facility's social worker asked the physician if he were discontinuing the IV because of the bed situation, to which the physician yelled, "Well, he [the Reverend] is going to die anyway in a couple of days!" Both the charge nurse and the social worker confirmed that the reason the physician discontinued the IV was to permit his admission into Facility B.

Upon admission to Facility B, a nurse timidly approached Reverend Jenkin's physician saying, "Doctor, there is a policy here in the nursing home that we have to weigh all patients." The doctor asked, "Do you have a bed scale?" and she answered, "No." He said, "Well, the patient cannot stand. I'll write an order, 'Do not weigh.'" The nurse looked relieved and responded, "We'll be covered then."

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After admission, Reverend Jenkin's continued to show signs of dehydration. He was very thin, with his skin pulled tightly, the shape of his bones visible, and his mouth extremely dry. His wife explained that she could no longer understand his words because his mouth was dry, and he was confused. Finally, the Reverend's daily urine output while at the nursing home was only between 100 cc and 200 cc.

The admission orders had included that the patient's lips and mouth be moistened with swabs or sponges throughout the day, and the physician told the Assistant Director of Nursing directly that a moist gauze sponge could be kept over the patient's mouth. Despite these orders, the Reverend did not have a gauze sponge, and while there were unopened moistened swabs on his bed table, the nurses were not observed using them.

The physician visited Reverend Jenkins two days following his admission, but did not examine the patient. Later, in the progress notes from that visit the physician stated, "Does not have any decubitus ulcers." The basis of this note was questioned, however, because the patient's skin was very fragile, and the physician had not examined the patient.

The Reverend died his fourth day in the nursing home.

Nursing Care

The data revealed a significant contrast between the nursing staff's work environment at Facility A and at Facility B. This section reports findings on the work environment in the nursing home that were

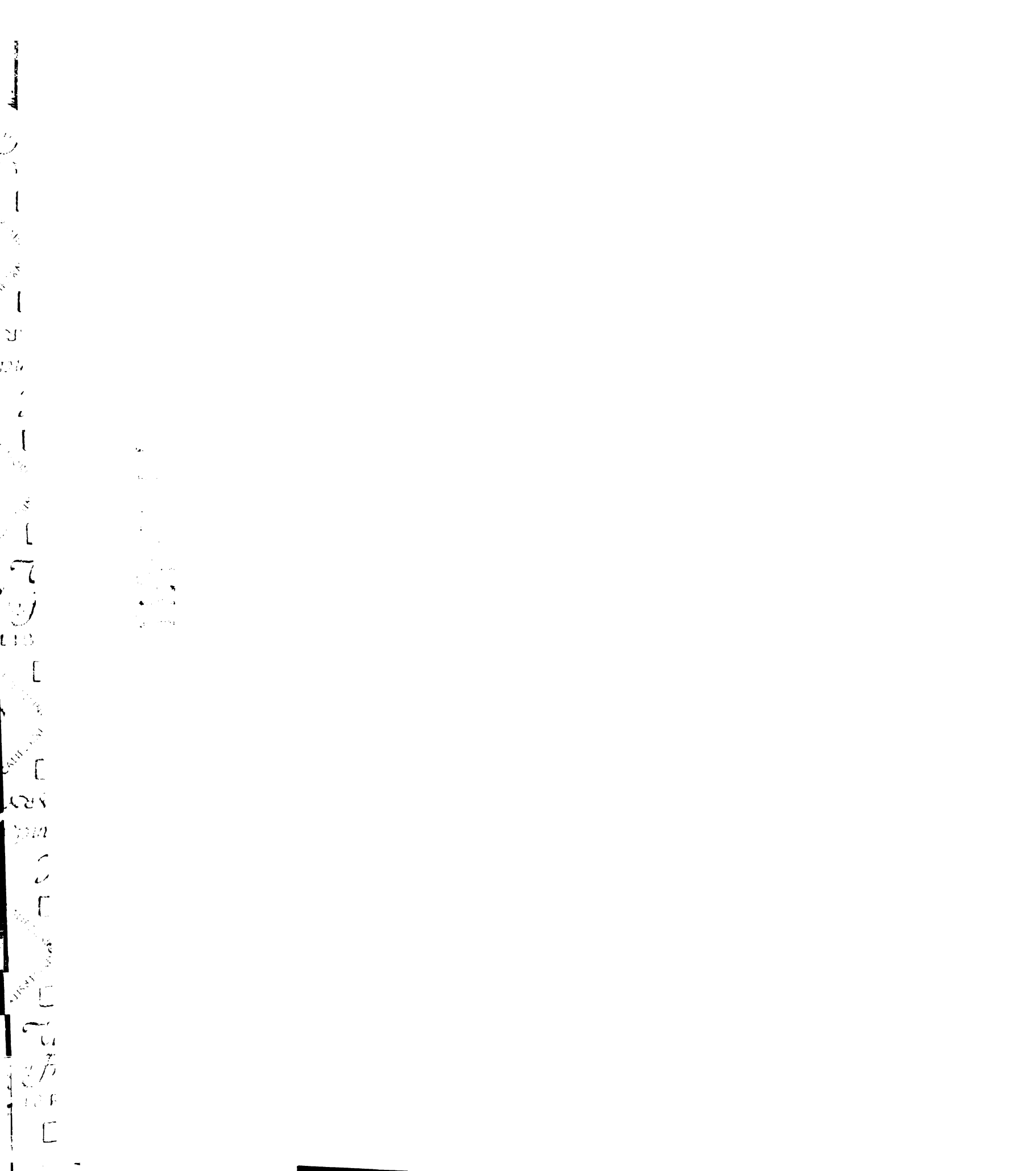
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prominent in the data, including permanence of the staff, the nurses' relationship with physicians, leadership, and staffing. Additionally, findings are reported on the high cost of nursing home care to patients and their families.

Permanence and Turnover

The data revealed that turnover among the nursing staff and administration was more prevalent and problematic in Facility B than in Facility A. At the time of their interviews RNs, LVNs, and NAs reported how long they had worked in their facility. With the lengthy employment of the DON included (32 years), the mean length of employment for all nurses at Facility A was 8.9 years, while nurses at Facility B were employed for a mean of only 3.6 years. When the DON is excluded, the mean for all nurses at Facility A remains noticeably higher at 7.6 years. While the average length of employment was similar for nursing assistants (A=7.7 years; B= 7.3 years), there was a greater disparity between the two facilities for RN (including nursing administrators) length of employment. The mean length of employment for RNs at Facility A was 10 years; at Facility B the mean was 2.5 years.

Where the mean length of employment was less, there was a greater turnover of staff. In fact, from 1985-1987 the Assistant Director of Nursing position at Facility B changed individuals four times. One RN at Facility B explained that the nursing staff had been "traumatized by turnover in the facility of DON's and administrators." In 1986, Facility B lost its



Administrator, DON, ADON (twice), Director of Medical Records, and Director of Social Work Services. This was in contrast to Facility A where the same DON had been there for 32 years (at time of interview). In fact, the same nurse is still the DON at Facility A currently, having worked there for 42 years.

Table 5. Nursing Staff Length of Employment

Nursing Staff	Facility A Years of Employment (mean)	Facility B Years of Employment (mean)
All nurses interviewed	8.9*	3.9
Registered Nurses	10	2.5
Nursing Assistants	7.7	7.3

*With DON excluded, mean = 7.6 years

In their interviews and in field notes from site visits, nurses at Facility A cited job satisfaction, good wages, quality care, job security, strong nursing leadership, and feeling like a family to the patients as incentives for staying in their facility. In their interviews, 12 out of the 15 (80%) nurses at Facility A expressed satisfaction with their job and the care in their nursing home. The other three nurses (20%) did not mention whether they were satisfied or not with their position. When one of the RNs was hired at Facility A, her intention was only to work one year, but she liked it and decided to stay. At

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the time of her interview she had now been there almost eight years.

Another RN said she came to work at Facility A after seeing several other convalescent homes. She felt pride in her facility, as she stated: "We provide good nursing care here. We give good nursing care." During a group interview with five NAs, they all expressed satisfaction and pride in their patient care. They said that families of patients often thought the NAs provided good care to their relatives in Facility A. Several of the aides had worked at different nursing homes prior, and they thought the care at Facility A was better. The NAs also said that they felt lucky to be at Facility A because of the DON: "She's very good. She's very good to us." Another RN at Facility A for 2 1/2 years decided to stay at Facility A permanently, saying: "There's good job security here. I want to buy a house, and I'm a woman alone so you have to think about job security." Aspects of desirable job security the nurses mentioned were good wages and job advancement. One RN explained why Facility A was ideal for her, saying that while geriatrics is usually a poor paying field, Facility A pays well, so she can be both well paid and work in the field of her choice. These nurses believed they were well-paid and that Facility A provided good nursing care.

In 1986-87, average nursing salaries were higher at Facility A than at Facility B (OSHPD, 1986-87a; OSHPD, 1986-87b). The average RN salary at Facility A in 1986-87 was 61 percent higher than the salary earned at Facility B. LVNs earned, on average, 32 percent more, and NAs 104 percent more than their Facility B counterparts.

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Table 6. Average Hourly Earnings for Nursing Staff, 1986-87

Nursing Position	FACILITY A	FACILITY B	% Difference
RN	\$19.97	12.37	61
LVN	11.58	8.74	32
NA	11.26	5.51	104

Source: OSHPD, 1986-87

Facility A nurses described their job history, demonstrating the opportunity for advancement. During the eleven years that one RN worked at Facility A, she moved from a float nurse on different wards, to a staff nurse, and then a head nurse. Two other RNs reported advancing from nursing assistants, to staff nurses, to head nurses, during their tenure at Facility A.

While job advancement may have occurred at Facility B, when interviewed the nurses did not emphasize this or link it with their job satisfaction or security. Only two of the 15 (13.3%) nurses interviewed expressed satisfaction with positions and the care at Facility B. The remaining 13 (86.7%) nurses expressed frustration and dissatisfaction with the care environment in which they worked. One RN had worked at Facility B for six years prior to Facility A where she had now been for 12 months. She said that she changed facilities largely due to the pay increase she received. She explained that as an LVN at Facility B, she earned \$9.15 an hour, but as an

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RN at Facility A earned \$16.35 an hour plus a raise each year. She spoke of another NA from Facility B who also relocated to Facility A after Facility B denied him his request for a \$.25 per hour raise.

**Table 7. Nursing Staff Job Satisfaction, Self Report in Interviews
(N = 15 per facility)**

Level of Satisfaction	Facility A Number of Nurses	Facility B Number of Nurses
	n (%)	n (%)
Satisfied with job and work environment	12 (80)	2 (13.3)
Dissatisfied or frustrated	0	13 (86.7)
Did not mention in interviews	3 (20)	0

Many consequences of the high turnover rate of nursing administration at Facility B were found. First, the nursing staff at Facility B did not know their patients as well as the nurses at Facility A. For example, nurses at Facility A spoke about their patients more often and in more detail in their interviews than did the nurses at Facility B. Nurses at Facility B had more difficulty recalling the details of their patients, as in the case of one RN after three months working as ADON. For many patients, the ADON was unsure of their prognosis or the pathophysiology (manifestation of the diseases) of their conditions. For others, the ADON lacked basic information.

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For example, she referred to a patient who was refusing many fluids, but did not know if that patient was on "I & O" (a record of fluid intake and output). The "I & O" record was consulted regularly to assess a patient's condition when his or her fluid intake was low. Further, the ADON reported she had not discussed these cases with the physician. Thus, in this case, the ADON lacked pertinent information required to supervise care and participate in treatment decisions.

Another case demonstrated the DON's lack of knowledge of and investment in the patients. A female patient who, according to her chart, had been very lonely and depressed wanted to have her sister, who resided at another nursing home, transferred to Facility B. She was successful, and the two sisters had finally been placed together in one room at Facility B. At the nurses' station, the DON remarked in response to the patient's new situation: "Two sisters in the same room- oh yuck- just like husband and wife-- you have probably had it with each other-- she needs someone else to pick on." In addition to having spoken in a disrespectful tone toward the patients, this was also an example of not knowing the patients' needs well.

In contrast, many nurses at Facility A reported the importance of knowing their patients well, caring for them continuously for an extended period of time. Nurses reported that this provided them with a depth of knowledge about their patients and enhanced their ability to discern subtle changes in patients' conditions. One RN stated that when nurses know their patients well, they can make better decisions regarding treatment. A nursing

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assistant at Facility A described how knowing the patient provides insight into their condition: "I can tell by their expression who slept well the night before and who didn't." She looks at the color of skin, if flushed or grayish. She knows by "experience," explaining: "If they don't look like they looked yesterday" then she notes the change.

Another nursing assistant at Facility A described how she noticed something was wrong with her patient: "Sometimes it's just their expression.... Something in their eyes." One RN at Facility A explained that when the nurse knows the patient well and sees him or her everyday, she can detect "subtle cues" to the patient's condition, such as: color, respiratory patterns, patient attitude, confusion, posture. She stressed that it was especially important for nurses to be aware of these "cues" with patients who cannot speak for themselves. Adding to this point, another RN at Facility A explained that some patients who were severely impaired and dependent would only eat or take pills from certain nurses, usually the nurse they knew best. To accommodate this need, she said that Facility A tried to have each patient cared for by a particular staff member for one full month so they would get to know that nurse very well.

Nurse Relationships with Physicians

Nurses at Facility A reported more satisfaction with their relationships with physicians than nurses at Facility B. While some Facility B RNs and LVNs stated that physicians depended on nurses' judgments in decisions of

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transferring and treating patients, more prominent in the data was the conflict between nurses and physicians.

Much of the conflict at Facility B occurred over the telephone. Several RNs stated that doctors did not like to be called for treatment or transfer questions, "Because they are being disturbed," as one RN explained, "I work evenings, so I am disturbing their evening. For example, they'll say, 'My G-d, why are you calling me about that?'" RNs discussed knowing they had to call the physicians whether or not they made the physicians upset and often were yelled at. When one RN called about a patient's congestion, the physician became angry, yelling, "Why call me-- the patient is always sick!" One LVN described calling a physician to report a patient concern when it happened to be the lunch hour. When the physician telephoned back, he scolded the nurse, saying, "When I'm out to lunch, I'm out to lunch. It's just as easy for you to call at 1 p.m."

In contrast, the nurses at Facility A reported they had better relationships with the physicians. Several RNs at Facility A stated that they had good communication with the facility physicians and were able to discuss issues of patient treatment with them. One RN who had been head nurse for six years, while the same physician had been assigned to her ward for 4 years, described their relationship: "Dr. B. never overlooks anything I report. Anything I report he takes as important.... I have been very blessed to have such a doctor to work with." The RN said she feels good that she was trusted by the doctor who respected her assessment of her patients. Dr. A. had been

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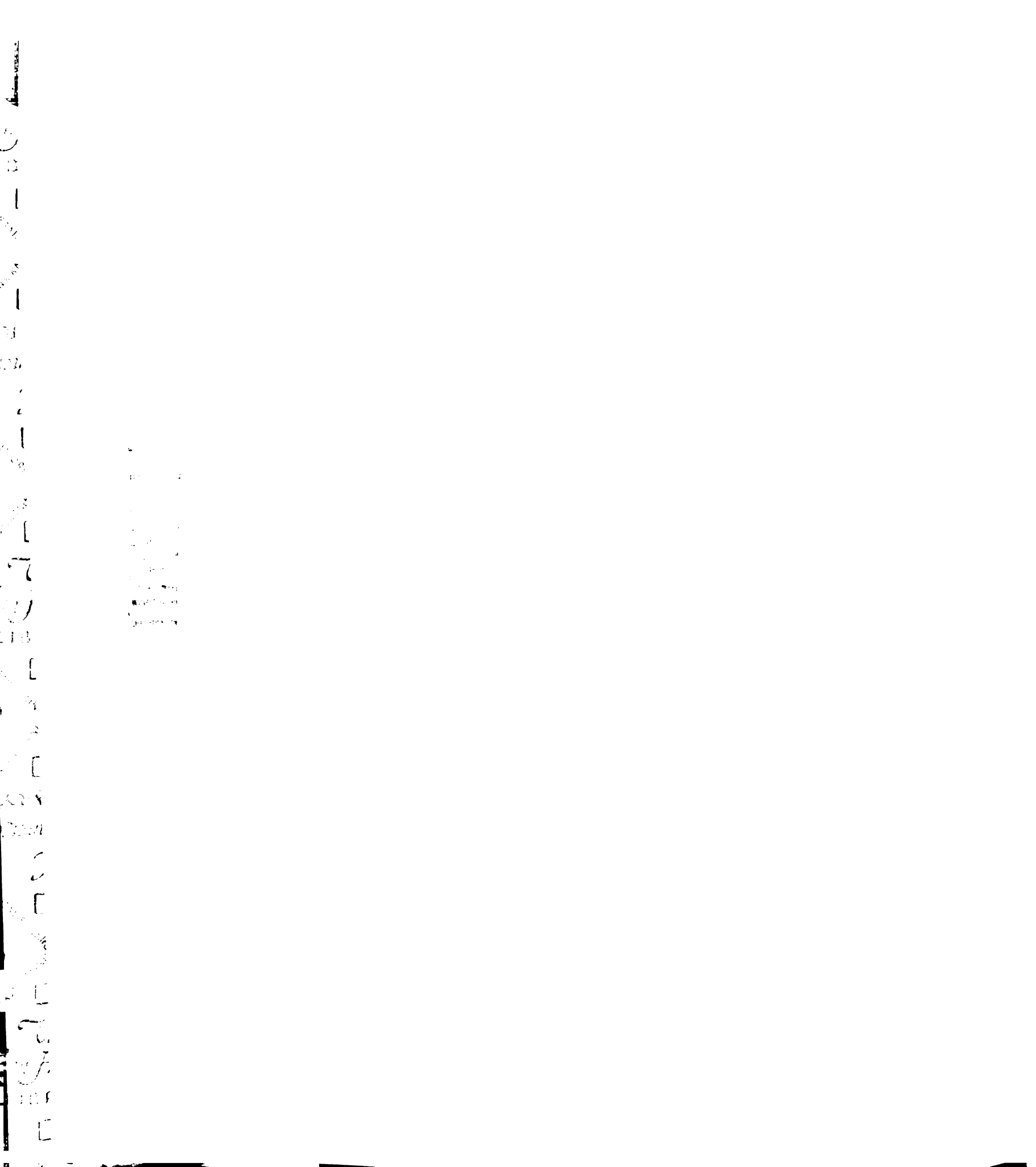
the ward doctor for six years at time of this RN's interview, when she said that the ward doctor was always available and came to examine a patient when the RN requested: "We have a really good relationship." Another RN stated: "We [RNs] really work well with the doctor. We can make suggestions because we know the patients better and the doctor really depends on nursing information." Another head RN explained: "The doctors I work with respect my opinion and they let me know why they don't think a treatment is needed." These statements demonstrate the positive physician-nurse relationships found at Facility A.

Nursing Leadership

Nursing leadership is another aspect of nursing care in which differences in the provision of quality care was found between facilities. The dimensions of nursing leadership reported here are nursing staff supervision and philosophy of care.

Supervision

Supervision, as described here, included overseeing or directing the work of the nursing staff. It also included being a role model in the way care was provided and the attitude about patients and the facility. At Facility B, the RNs complained that they could not provide leadership in a supervisory role because they were understaffed and overwhelmed with paperwork. One RN explained that the licensed nurses are "loaded" with work-- for example, the charge nurses spent almost all day passing medications, leaving no time for supervision and direct patient care. This RN believed that this had



contributed to the problem of a high number of decubitus ulcers in the facility.

The Assistant DON at Facility B was responsible for the entire facility, with almost 150 beds. She supervised one RN on the second floor and an LVN on each the 1st and 3rd floor. She was the only RN responsible for seeing all the patients. She explained that if there were a change in a patient's condition, and she did not see that patient, the status change may not get reported to the physician. Even so, there were days when she could not see every patient.

Reverend Jenkin's Case #4 exemplified a situation where nursing supervision and leadership were inadequate. In this case, the physician discontinued IV hydration in order to have his patient admitted to Facility B. He ordered that the Reverend's mouth be kept moist by swabs or gauze. This was an attempt to provide modest comfort to the Reverend in his suffering with end-stage cancer and dehydration. These orders, however, were not followed through by the nurses, even though the ADON had been told directly.

While currently, a debate exists on the value of IV hydration in the final stage of terminal illness (see Zerwekh, 1997), at the time of data collection, the withholding of hydration was concerning to the researcher. While the social worker was concerned about this, no nurse administrator took the leadership role to question the doctor's orders. Even if the physician had not ordered hydration upon admission, once the Reverend was admitted,

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the facility became accountable for providing adequate care. If the Reverend needed hydration and did not receive it, the facility led by the nursing administration was accountable for providing the necessary staffing and care to meet the patient's needs. These were examples of insufficient nursing leadership and supervision at Facility B.

Another aspect of supervision at Facility B were the perceptions of the CNA's who expressed dissatisfaction with the lack of supervision they received from licensed staff and nurse administrators. One CNA described: "I hate the assembly line showers. This is something that can only be changed if there was the leadership. A nurse out there everyday explaining to them [the CNAs] and helping them to understand that this is not the way to shower patients." Another CNA added that the nurses do not inform the CNAs about their patients' conditions, stating, "Like they give you gloves but don't tell you why." She said the CNAs must ask or attend "report" (the transferring of patient information between nurses of two shifts) so the CNA can be informed. Several CNAs expressed that it was difficult to turn to the nursing administration for consistent leadership and supervision when the staff kept turning over their positions. While the CNAs desired more supervision, one ADON at Facility B explained that due to the low wages the CNAs earned, their motivation was low. She explained that from her perspective, it was difficult to supervise and provide leadership to those who had little motivation.

Supervision, as described above, involved monitoring and directing the work of the nursing staff, but it also included modeling the way care was to be provided and the view of the patients and the facility that should be held by the nursing staff. At Facility B, some of the nursing administrators modeled negative behavior and attitudes toward their patients and the facility. For example, from January to April in 1986, Facility B had one DON. This DON made statements that were extremely negative about the facility, the residents, and the staff. Further, he did not supervise the nurses- or provide leadership to them, as described by other nurses. He did not set a positive, professional example as a role model.

In one case, a patient returned from the hospital and said she was "glad to be home" [meaning the nursing home]. The DON, in response, commented to a CNA-- that he hoped he would never end up in a nursing home, saying: "How could anyone be glad to be back here?" An example of the DON modeling inappropriate care to the patients was when a patient asked the DON if he could return to his room, the DON answered: "No, you cannot go to your room until after lunch-- they are spraying [for roaches] the rooms-- now don't pester me all day."

Nursing supervision and leadership were found to be stronger at Facility A than at Facility B. The head nurses at Facility A were knowledgeable of their patients and involved with their care enabling them to provide meaningful supervision. For example, one head nurse described a case where she entered her ward and noticed that a mentally impaired patient

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appeared lethargic. She asked the staff nurse about this patient, who responded, "Oh, she's just tired." The head nurse proceeded to take the patient's vital signs herself, not convinced the patient was "just tired." The patient did, in fact, have pneumonia. Had this head nurse simply said "okay" in response to the "tired" explanation, how much longer might the patient's pneumonia have gone undiagnosed? Another head nurse at Facility A explained that she follows up on her patients' lab reports in order to "screen or double-check the system of the ward doctor." In this way she could better supervise her nurses as well as question the physician's treatment or lack of treatment of her patients. These examples demonstrate the active nursing supervision seen at Facility A.

Additionally, data from interviews with the nurses and observations revealed that the nurses at Facility A perceived their relationships with the nursing leadership positively. For example, the group of nursing assistants interviewed worked on a heavy care ward and had very demanding positions. The Head Nurse referred to these nurses in her interview, saying: "They give very, very good care." These NAs gave a birthday party for their head nurse. Another head nurse stated that her nurses knew what she wants and expects, and they would tell her when a patient's status had changed, saying: "We are like family [to the patients], and the staff know what I expect." These statements were typical of statements made by Facility A nurses regarding their relationships with other nurses.

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Many nurses commented on the particular power of the DON at Facility A, saying that the DON has more power than physicians. One RN described the DON, saying: "She does the work of 10 women and it's going to be a real slap in the face when she leaves" [meaning, hard to replace her]. For example, the DON strongly advocated a pro-life approach to treatment, firmly discouraging the status of "no-code" (patients who would not receive CPR upon cardiac arrest). This approach to treatment was adhered to by most of the facility's nurses, as many nurses emphasized. Two RNs reported that nurses could override a physician's no-code orders, and that if the head nurse did not agree, then she did not put a "no code" on the patient's chart. Another RN said that the decision of whether or not to insert a naso-gastric feeding tube into a patient was a "nursing decision." These are additional illustrations of the strength of the nurses' voice and their supervisory role over patients and staff at Facility A.

As a strong leader of Facility A, the DON continuously advocated for patients and staff. For example, when a governmental freeze on hiring occurred, the DON wrote a letter to the Mayor of the city explaining what happens when there is not enough nursing staff. She described that when there were not enough staff, there was a "delay in care." She explained:

When there is shortage, it takes much longer to feed the patients. It will take an hour to an hour and a half to get all the patients fed. There is a delay in changing patients when they are incontinent. This can lead to decubitus ulcers. There is not enough time to do bowel and

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bladder training, so then you have more incontinence, and again this can lead to decubitus ulcers.

The Mayor had not yet responded to the DON's letter at the time of her interview.

Philosophy of Care

The philosophy of care as discussed here is the guiding principles underlying the provision of care, including how care tasks and treatment are prioritized and the perception of the patient as viewed by the facility or its administrators.

At Facility A, the Director of Nursing, who as mentioned above, had been the same nurse for 32 years, infused the institution with her philosophy of care. This philosophy made patient care a priority. In her interview, the DON emphasized the importance of the nurses knowing their patients well, observing them on a day-to-day basis, and noticing subtle changes. The DON also stressed that it was very important for nurses to be involved with evaluation and treatment decisions, not just the physician. She also instructed head nurses to educate the nurse assistants about patient conditions so that they would be aligned with and would follow through with decisions regarding evaluation and treatment of illness. Through this direct supervision, the DON also encouraged and strengthened nursing leadership, by reinforcing the importance and skills of leadership to head nurses, who in turn are leaders to the nursing assistants.

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For example, in her interview, the DON explained that the facility's philosophy was to prevent decubitus ulcers (bedsores). This was achieved by offering patients bed pans and commodes to reduce incontinence. Further, according to the DON, patients were checked regularly for incontinence at night and turned every two hours when in bed. Patients were also out of bed everyday. The DON said that usually, the only patients with decubitus ulcers were those who transferred in with them from other facilities. She reported that of 1100 patients, many of whom are heavy care, they had only three patients with a reddened area.

In addition to the DON's description of Facility A's philosophy of care, the physicians and nursing staff referred similarly to Facility A's philosophy of care. While not asked directly, nearly half of the nurses interviewed at Facility A referred to the strong leadership of the DON. All fifteen nurses interviewed expressed philosophies in line with that of the DON: prolife, patient-centered care, aggressive treatment, viewing the patient as family. A few nurses expressed concern that their views may not be consistent with the DON's views and concern that the DON would discover this.

Within this philosophy of patient care as priority, the nurses at Facility A, according to their interview data and direct observation, considered themselves to be like family to the patients. The DON explained that "at this facility, the nurse is the extended family." This view was supported and adhered to throughout the nursing ranks in the facility. In a group interview with five nursing assistants, they reported that they viewed themselves as the

patients' family. In discussing their relationship with the patients, several nurses reported that "we are like family"; "we're very close to the patient"; "If we lose one patient, [we're] very sad." Several RNs described themselves as "advocate" for the patient. One head RN expanded on this, saying: "If you notice that a patient is confused, for example, part of nursing care is to make decisions for them when they can no longer make decisions for themselves."

In over half of the physician interviews included in this study, physicians mentioned the strong pro-life philosophy of Facility A. They reported that this often affected their decision of whether or to what extent to treat a patient. Two physicians mentioned that when they do not treat patients' illnesses aggressively, they do so quietly; they "don't let the front office know." Twenty-five percent of the physicians referred specifically to the strong leadership of the Director of Nursing and to the DON as the main proponent of the institutional philosophy.

In contrast to Facility A, Facility B did not have a philosophy of care espoused by nursing leadership. The philosophy of care at Facility B was that the priorities of the institution were of greater importance than the nursing and patient care priorities. A CNA at Facility B explained:

Love is the answer to giving good care in these nursing homes-- love and caring. The problem here is that the management does not have a philosophy of love and care-- it is making money that matters to them. What a happy place this would be if we could all come to work and just

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be content to love the patients as much as we could- and to have the management value that in their nurses!

Another CNA explained that the nursing home is basically interested in making money by keeping the staffing critically low. She said the current nursing supervisors were insensitive to patients and did not promote the essential aspect of love of the patient with the nurses they supervised.

For example, several respondents commented on Facility B's unspoken policy of waiting to fill a position until a crisis occurred. They explained that the purpose of this was to push off the expense of a new hire to the facility for as long as possible. When the Director of Medical Records resigned, for instance, he explained to a research assistant that his position would not be refilled until the state of patient records was in such disarray that it required immediate attention and hiring a new director could no longer be postponed. The following month, when the new Medical Director was hired, the social worker reported that this was in fact what had happened.

One RN, who was the Assistant Director of Nursing (ADON) at Facility B for six months described the difficulty with setting a philosophy of care or making change at her facility. She had entered her position optimistic and energized to make change, only to realize that the barriers to making change within the facility could not be overcome. For example, she explained that although many of the staff are excellent, they are paid very poorly, saying: "You just can't expect them to do very much for what they are paid. The motivation just is not there." At the time of her interview, she confided:

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Between the two of us, I am looking for something else. I don't think I can stay here much longer because I am a person who likes to get things done and to do things. I just cannot do what I want to do under these circumstances.

She specified understaffing, low pay, and the lack of leadership as barriers to quality of care in the facility. Here, the philosophy of the institution was the philosophy of cost containment rather than the philosophy of caring. This environment was found to be less supportive of nursing leadership.

There were nurses at Facility B who were found to be patient advocates and competent supervisors. One RN explained how she was careful to examine patients with acute conditions or changes in status, including double checking vital signs or temperature readings. Although some individual nurses held their own philosophy of caregiving, the institution's philosophy of care, one promoted by the nursing home administrators, affected the overall ability of nursing administrators and other department heads to provide quality care.

Staffing

A large disparity was found between the usual staffing levels in each nursing home. The DON at Facility B reported that the on the day-shift, the lightest care floor had 43 patients and 4 nurse's aides, a ratio of about 1:10. The second and third floors having 44 and 46 patients, respectively, both had five to six aides. Therefore, the nurse's aides generally had eight to ten patients in their care. In contrast, a head nurse at Facility A reported a lower

[illegible]

patient to staff ratio on her ward. The ratio on her moderate-heavy care ward was approximately 4:1, with six nursing aides, two staff nurses, and one charge nurse for about 30-35 patients.

Data from the facilities' disclosure reports to the State of California Office of Statewide Health Planning and Development (OSHPD, 1986-1987a; OSHPD, 1986-1987b) disclosed a similar discrepancy between the staffing at Facility A and Facility B. During the fiscal year, 1986-87, patients at Facility A received 27 percent more nursing care time than patients at Facility B. RNs provided over 3 1/2 times the amount of care hours to patients at Facility A than at Facility B, and NAs provided 17 percent more time to Facility A patients. LVNs were the only category of nursing staff that provided more care hours at Facility B, providing almost 3 times as many hours. With all nursing care combined, patients at Facility A still received substantially more care hours than patients at Facility B.

In 1995-96, the number of nurse hours per patient was greater than in 1986-87. However, while the overall staffing level in each facility was higher, the difference in the amount of nursing hours between the two facilities increased. In 1995-96, patients at Facility A received more than 4 times as much RN time each day than patients at Facility B. With all nursing hours combined, Facility A patients received 34 percent more nursing time than Facility B patients, an increase of 7 percent since 1986-87.

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Table 8. Number of Minutes of Nursing Care per Patient per Day, 1986-1987

Nursing Position	Number of Nursing Care Minutes per Patient	Number of Nursing Care Minutes per Patient
	Facility A	Facility B
Supervisors	10.8	10.2
RNs	55.2	15
LVNs	6.6	19.2
NAs	132	112.8
Combined Nursing	200	157

Source: OSHPD, 1986-87

Table 9. Number of Minutes of Nursing Care per Patient per Day, 1995-1996

Nursing Position	Number of Nursing Care Minutes per Patient	Number of Nursing Care Minutes per Patient	National Average 1995*
	Facility A	Facility B	
Supervisors	n/a	n/a	n/a
RNs	74.2	18.4	30
LVNs	n/a	n/a	42
NAs	n/a	n/a	126
Combined Nursing	264	197.7	194.4

Source: Data provided by Charlene Harrington

*Source: Health Care Financing Review data cited in Harrington, Carrillo, & Mullan (1997)

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With the low staffing level at Facility B, nurses expressed difficulty in having time to attend to all the patients' needs. Patients, patients' families, nurses, and auxiliary staff commented on the high ratio of patients to staff at Facility B and the difficulty in providing quality care when short-staffed.

One RN summarized her concern about understaffing:

They are just going to have to make a decision about hiring more staff here.... For example, patients who should be suctioned every hour are maybe getting suctioned once a shift.... If patients get pneumonia they need to be suctioned often. They are probably not going to get suctioned. Even if we gave them IV antibiotics, they might not recover because they would not be getting the right nursing care.... Even if they are treated medically, they do not have the resources to give the nursing care. For example, the coughing and deep breathing. The chest PT. Turning. These things just aren't done here and they really work; but they are not going to be done here. So even though we give antibiotics, the patient might not recover. (A portion of this statement was previously quoted in Wiener and Kayser-Jones (1990), as an example of the consequences of understaffing).

This concern was not only expressed by nurses, but family members as well. Some family members mentioned that the staff did not have enough time to walk with their relatives. Others described their relatives waiting and waiting for necessary care. For example, one patient's daughter described seeing

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patients pleading with staff members to take them to the bathroom. She observed one woman who had a bowel movement in her wheelchair. The patient asked for help two or three times, but no one came to help her. The patient was very embarrassed, angry, and upset. The daughter explained that the CNA knew about the patient needing to be cleaned and changed but waited a half an hour to do so. The daughter concluded, "It's so degrading."

A similar situation was observed in Mrs. Pelman's Case #3 when she had to go to the bathroom during the nurses' dinner hour. The RA asked for assistance from the charge nurse who explained, in frustration, that with the dinner hour, "There is no way that anybody can help this patient. She will just have to wait."

The data revealed that because family members at Facility B knew the nursing staff situation, they were more likely to practice protective or defensive visiting. This was identified as visiting and being involved not only out of the love for one's relative, but out of the fear or concern for what might happen to the patient should the family member not be around. One son explained that he visited his mother in Facility B every day because he had to make sure that pneumonia and bed sores were prevented, saying: "I make sure the bed is dry... and to see if they've given her a bath." He asked every other day if his mother has had a fever or anything else he should know about. The son concluded that he has seen "many patients have no family members that visit, and that leads to neglect." Another daughter said that she also visited daily because she knew that patients got better care when

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there was a family member visiting often. With staffing levels low, turnover high, and poor supervision, relatives felt the need to practice protective and defensive visiting.

In contrast to these examples at Facility B, understaffing was not found to be a problem at Facility A. A wife at Facility A was pleased that there was a nurse available to walk her husband daily, after being told that her husband had rehabilitative potential if only he were walked often. Another daughter described that if she stated a concern to the nurses, they followed-up soon after. For example, once her mother was eating lunch, had a bowel movement, and stopped eating. The daughter informed the nurse who, after changing another patient, came and changed her mother. Her mother resumed her lunch, eating and drinking her entire meal. This is in contrast to Facility B patients (described before) who pleaded for help and still had to wait to be changed.

Recently however, in the mid-1990's, understaffing has become more problematic for Facility A. Until 1996, the situation of the nursing staff remained relatively consistent with the situation a decade ago. Nurse-patient ratios were the same, turnover still low, and supervision and leadership strong. The same DON of 42 years continues to set a high standard of care for her residents. The DON's strong leadership is still critical to the quality of care provided at Facility A. She has organized the nursing staff in a hierarchy of leadership, with head nurses supervising nursing assistants, and nurse

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supervisors supervising head nurses. However, recently, in response to fiscal concerns, the organization of nursing care at Facility A has changed.

In 1996, due to an immediate fiscal "crisis" resulting from a lack of supplemental city funding, the nurse supervisor position was eliminated and one half of all head nurses (RNs) were laid off. In addition, the facility laid off seven CNAs, several LVNs, and several from the activities department. The remaining head nurses assumed responsibility for those who were let go, meaning that each head nurse now supervises two wards with a total of 70 patients, instead of one ward with 35 patients. The DON reported that this staffing change has directly resulted in a "lack of close supervision by head nurses." Although there are still staff nurses on the wards, the DON said they are so busy with distributing medications that they have "no time to supervise CNAs." She described:

...I have seen the standard of care not kept up. Okay, here is a good example, I was making my rounds at 4:25 pm and patients were doubled, tripled, even quadrupled (patients lying on 2-4 absorbent pads at a time) with the incontinence linen. Then I saw a CNA just pull out the top pad and leave the patient. This is completely unacceptable. Also, the CNAs are more impatient. We've had some minor abuse cases, with hitting and slapping. No patient got beat up, but no one has a right to touch any patient.

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The DON stated that "with supervision, this would not have happened. The head nurses were on the wards circulating, guiding, educating, talking with patients. Even the best CNA you have needs some supervision."

The Assistant Medical Director reported a second consequence of the staffing cut which is the reduction of head nurses available to serve on supervisory and leadership committees. Thus, while communication remains strong between nurses and physicians, the Assistant Medical Director reported that the relationship has been affected by the RNs' diminished time for interdisciplinary participation on this level.

High Cost of Care to Patients and Their Families

Patients' families in both nursing homes expressed concerns about the high cost of nursing home care. While family members were not asked specifically about their opinion on cost of care, 20 percent of the family members at Facility A and 50 percent of those at Facility B volunteered their concerns in their interviews. Although families reported a range of actual costs, what was significant was that they perceived the cost as too high for the quality of care provided. Some families were concerned about having to spend down their financial resources, paying for this high cost care, until they were eligible for Medicaid. The husband of a patient at Facility B, reported that, in 1986, he paid \$2,300 a month for his wife's care, stating his concern: "I won't have anything left.... I have to spend down to \$1,500 before she [his wife] will be eligible for Medi-Cal [Medicaid]." One female patient received a Social Security benefit of \$594 a month, and her husband \$800. This, her

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daughter explained, was hardly enough to pay the \$2,000 a month for her mother's care at Facility B. In their interviews, some family members reported that the high cost of care had negative consequences on the patient and their family, such as how the strain on their financial resources compounds the already emotionally stressful situation of having a family member in the nursing home.

As reported, a greater number of families at Facility B expressed concern during their interviews about the high cost of nursing home care than families at Facility A. Several reasons for this were evident in the data. First, many of the patients interviewed at Facility A were already on Medicaid, and their families stated that cost of care was not a concern because Medicaid paid their relatives' bills. Another reason family members were more distressed about the high cost at Facility B was that they were more dissatisfied with their relative's care than families of patients at Facility A. Due to their dissatisfaction, some family members questioned whether the quality of care at Facility B was worth the high cost they were paying. For example, after finding her aunt disheveled and malodorous, one niece complained to the nurses at Facility B, exclaiming, "For \$6,000 a room [\$2,000 per bed, 3-bed room], what do you do? Can't you give some kind of care?!" The wife of another patient at Facility B complained, "Our lifetime assets have been calculated. We're paying \$2,000 to \$4,000 a month for this horrible care in the nursing home." This concern of the quality of care being worthy of the high cost was only mentioned by families at Facility B.

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Medical Care

Cost of Medical Treatment

One way cost was found to influence patient care was by acting as an incentive or disincentive to treat patients. One illustration of this was how patients were treated when they developed an acute illness in the nursing home. When patients at Facility A developed an acute condition that required them to be transferred from their skilled nursing ward, their first transfer was to the acute care ward within the facility. As a licensed acute care ward, the reimbursement received for patients on the ward was higher than that received on the regular wards. Thus, a Facility A physician pointed out that because of the higher reimbursement rate on the acute ward, "It's financially remunerative for the patient to be treated, up here [in the acute care ward]. [Facility A] prefers... everybody with pneumonia no matter what-period- up here." With the on-site acute care ward, then, the incentive was to transfer and treat.

In contrast, Facility B did not have its own acute care ward; therefore, patients requiring increased skill and care for an acute condition were transferred directly to a separate, freestanding hospital. When a patient at Facility B required transfer, it meant the facility lost the reimbursement money that came with having that patient fill a nursing home bed. An empty bed meant a loss of money. The Director of Nursing at Facility B explained that the administration wanted to keep the beds filled at all costs, regardless of the nursing staff situation or patient needs. She revealed that

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they had patients with pneumonia whom she thought should be sent to the acute facility, and the administration did not want them sent out of the facility. The DON was upset by this because she knew that these patients would not receive appropriate care in the nursing home, but the cost incentive for the administration was to keep the beds full and the reimbursements flowing in.

Barriers to Care in the Nursing Home

Physicians at both facilities reported that there were barriers to providing care to elderly patients in the nursing home. Barriers reported by physicians in their interviews included: limited control over treatment decisions, inadequate training, cost of care, difficulties with the nursing staff, reimbursement, lack of medical resources, policies not in the patient's best interest, and inconvenience of traveling to the nursing home. Physicians at Facility B reported more of these barriers to care than physicians at Facility A.

Table 10. Barriers to Nursing Home Care Experienced by Physicians

FACILITY A	FACILITY B
Limited control - treatment decisions	Limited control - treatment decisions
Inadequate training	Inadequate training
Cost of care	Cost of care
	Difficulties with the nursing staff
	Reimbursement
	Lack of medical resources
	Policies not in patients' best interest
	Inconvenience of travel to NH

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Limited Control over Treatment Decisions

Five physicians, 33 percent of those included from Facility A, stated that they experienced limited control over treatment decisions, resulting from the strong nursing staff and pro-life philosophy of care. As reported above in the section on nursing care, the strong nursing leadership pressured physicians to adhere to a pro-life, pro-treatment orientation to patient care. Physicians at Facility A described that they were under constant review from the nursing staff, specifically the DON. They described discussing patient care with head nurses, but having supervisor nurses override their orders, such as when a supervisor changed one doctor's orders from not transferring to transferring his patient to the hospital. Another physician explained:

If somebody is more or less left to be untreated or symptomatic treatment for some sort of infection, the evening nurse, evening supervisor, will maybe call the evening doctor, and if necessary they will call two, three, or four, or six doctors until they can get somebody who will go ahead and treat the patients.

Another commented, "They [nurses] tube feed everyone and it has been taken out of the physician's hands." When one physician ordered IV hydration but no tube feeding for his patient with tremendous arthritic pain, he described hiding this from the nursing supervisor, saying:

She [patient] doesn't want an NG tube and her daughter doesn't want an NG tube. We don't make a big deal out of this with the supervisors.

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We don't let the front office know. I work things out with the head nurse. As far as I'm concerned we don't need supervisors around here.

Some of this impotence physicians attributed to the lack of a treatment protocol for patients. A recurrent theme was the physicians struggling with the question of how much treatment, for which kind of condition, for which kind of patient. They mentioned the lack of a standardized set of criteria that would guide their treatment decisions. However, they also acknowledged the complexity of each patient case, the importance of individualized decisions, and the possibility that a standardized protocol may not be possible or beneficial. Thus, with the lack of treatment protocol, in the face of strong nursing care philosophy and leadership, physicians reported their decisions regarding patient treatment were constrained.

Physician Training and the Nursing Home

One-fifth of the physicians from Facility A and one-third of those from Facility B reported that medical training does not adequately prepare physicians to meet the specific needs of a geriatric, long-term chronic care population. Physicians spoke of the discrepancy between their medical education which trained them to heal and cure illness and the nursing home in which comfort care was the priority. On the physician's role as curer, one physician explained: "Their [physician's] instinct, every instinct in their body tells them that 'I can separate this patient from his disease.'" Another commented, "Doctors always feel that they have to be doing something [treating], that's the whole 'playing G-d' syndrome." The antithesis to curing

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is dying, and a few physicians expressed being ill prepared to deal with death and dying, so common in the nursing home, as one physician explained:

You know, in the medical tradition, we deny the existence of death.

We are taught to revive. We are taught that it is up to us to make judgments. I never heard a lecture or heard of a lecture on death in medical school.

Physicians found their training did not prepare them for the work required of physicians in the nursing home, the care of frail and chronically ill elderly patients.

Furthermore, several physicians acknowledged that they did not have the necessary geriatric training to benefit their patients. One physician, who had practiced at Facility A for 26 years focused on this issue in his interview:

... in my feeling, most of these patients are overtreated, overmedicated, overpharmacied, very badly overpharmacied by well meaning doctors.

... As soon as the nurse reports to you a blood pressure that she thinks is abnormal-- 170/90-- The nurse gives you what in her mind is an abnormal number. She immediately expects you to do some sort of response. I think doctors are trained that any abnormality, and nurses too, needs to be corrected. These things don't need to be corrected....

Don't always be jumping in there and be willing to do stuff. I think if you go down on my ward, you'll see that I've probably, on 3 wards of 20 patients each, or about 100 patients, that I've probably removed 300-400 orders in the last 2 months that I've been down there..... I think as you

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

2. Once the problem is identified, the next step is to develop a plan of action. This plan should outline the steps that need to be taken to address the problem and the resources that will be required.

3. The third step is to implement the plan. This involves putting the plan into action and monitoring progress. It is important to stay flexible and adjust the plan as needed.

4. The final step is to evaluate the results. This involves assessing the effectiveness of the plan and identifying any areas for improvement. This step is crucial for ensuring that the problem has been successfully addressed.

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get older, you develop more respect for pharmacology and the geriatric patient. [And you use...] much less. Probably Dr. X and I, who have been here about the longest, use less medications than anybody here. It takes the doctors a long time. Doctors don't understand this at all because every fiber of their training -[teaches them differently-- to aggressively treat]. Unfortunately medical students are exposed to too much of that [examples of overly aggressive prescribing which leads to side effects or gains not helpful to the geriatric patient]. And they don't learn from doctors who have been out there; maybe the doctors who can't remember how many hemoglobins there are out in the world right now, and I can't remember the 20 or 30 steps toward blood clot, when there were only 2 steps when I memorized it... but as you forget all that garbage, you learn how to be a doctor, and learn how to recognize it and how to deal with people.

This lengthy excerpt highlights how some physicians perceived their medical training as inadequate preparation for the geriatric care setting.

Cost of Care and Physicians

Many physicians expressed concern about the high cost of treating nursing home patients. In their interviews, physicians were asked whether cost of care influences how they treat patients. Fifty-three percent of the Facility A physicians and 66 percent of Facility B physicians responded that cost influences their treatment of patients, as one Facility B physician explained, "It [cost] certainly makes a difference. I try to not let it compromise

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the quality of care. I don't think it should, but it's a hard decision as to how far one should go [in treating elderly nursing home patients]." Another physician at Facility B said that he would like to say that cost is not a factor in treatment, however, "Somehow I think it has sort of crept into my practice without my realizing it. It has a way of affecting your decisions although you'd like to say it doesn't."

Difficulties with the Nursing Staff

Difficulties with the nursing staff was the most reported barrier by Facility B physicians. While no Facility A physicians reported this as a barrier, 100 percent of the Facility B physicians cited some aspect of this problem, such as: poor communication, nursing staff incompetence, low staffing, high turnover, poor monitoring of patients by nurses and other physicians.

In their interviews, physicians expressed concern that the nursing staff at Facility B was not competent enough to care for their patients. One physician compared the acute hospital to the nursing home, saying:

First, we [hospital] have higher quality of staff. They are smarter. They speak English better. They have more quality assurance programs in acute hospitals. The patient - staff ratio is better. Nursing homes are what your mother could do for you. When I have a patient who needs only like what a mother could do, then they go to the nursing home.

Similarly, another physician commented on the inadequate staffing and training of nursing home nurses in contrast to those in acute care:

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The nurses in acute care are better trained. They're more used to acute care medicine. The acute care hospitals are better staffed, therefore patients get much closer attention, the nurses are more up to date, they know more. When I give them an order I know they will follow through. In the nursing home there are a lot of foreign graduates and they're shorter staffed.

Reimbursement for Physician Care

Medicare and Medicaid reimbursed physicians for one visit per patient per month. Making additional visits required seeking approval through a complex administrative process or giving charity care. As contracted, fee-for-service physicians, those at Facility B were reimbursed directly. In contrast, at Facility A, the payment was absorbed by the facility, as staff physicians were compensated only through the salary paid by the facility.

Fifty percent of the physicians interviewed at Facility B reported that they had difficulty with the amount of reimbursement and/or the number of visits for which they could be reimbursed. In contrast, the physicians on staff at Facility A did not report reimbursement as an influential factor in patient care. The Facility B physicians stated that the reimbursement for patient visits was too low for the inconvenience of traveling to the nursing home. For example, one Facility B physician explained why he does not like taking care of elderly patients, saying, "You spend two to three [times] as much time with them as you do with other patients, and you're paid half.... taking care of them is hard and less remunerative."

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An attempt was made to find the 1986-88 reimbursement rates for physician visits to nursing home patients. However, an analyst of the State of California Department of Health Services Rate Development Branch (E. J. Fishman, personal communication, July 14, 1997) explained that it was not possible to track the comparable codes back that far. She recommended examining current reimbursement rates because, "nursing home rates for Medi-Cal haven't really changed." In 1997, the Medi-Cal reimbursement rates for physician visits to established patients in the nursing home range from \$7.36 to \$27.60, depending on the number of patient conditions examined and the complexity of medical decision-making required. For comparison, physicians are reimbursed between \$7.36 and \$46.00 for Medi-Cal office visits. While simple cases provide the same reimbursement, increasingly complex cases in the nursing home reap lower reimbursement than comparable cases in the office setting.

Lack of Medical Resources

The medical resources referred to here included laboratory (e.g., blood, urine, sputum cultures), radiology (e.g., chest x-rays), specialty physician consult (e.g., pulmonary, surgical), and acute services (e.g., acute ward- at Facility A only). As previously introduced in the setting description, Facility A provides these services in-house by facility staff; where as, at Facility B, many services were contracted from outside providers. For example, blood samples were drawn from patients while in the nursing home, and samples were then sent for analysis to an external lab. Almost 50 percent of Facility B

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physicians mentioned difficulties with the absence or delay in evaluative or specialty medical services in their facility. In contrast, 13 percent of Facility A physicians mentioned this difficulty at their own facility. Several other Facility A physicians mentioned this as a problem in nursing homes, in general, as this physician asserted:

Nursing homes don't have a laboratory, they don't have a radiology department, they don't have a nuclear medicine department, most don't have a social services department. All of the various services that are provided in the acute care hospital-- most of the services are not found in the nursing home. That's why you hear about that; why doctors don't like to go. It's because they don't have any facilities there. If you want to do anything it's a pain. If you want to do anything, you have to do it yourself. There are no technicians. If you need an EKG, you do it yourself. If you need to collect a specimen, you collect a specimen yourself.

The data from the AIE's showed that Facility A patients received more medical services during the course of their AIE's than Facility B patients. Three times as many patients were transferred to an acute hospital for treatment from Facility B than from Facility A. Patients at Facility A were more likely to receive evaluative x-rays or laboratory tests than those at Facility B. For example, a patient at Facility B who had previously fractured her hip, fell again. Her daughter expressed concern that a week had passed since the fall and the physician had not yet visited her mother and no x-rays

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were ordered. The daughter also explained that despite her mother's hip condition, no orthopedic specialist visited. Whenever her mother needed the orthopedic services, she had to hire an ambulance service to transport her to the hospital. In patient cases at Facility A, x-rays were conducted regularly in acute illness evaluations, such as screening for pneumonia, and specialists were available on site.

Table 11. Number of Patients who Received Auxiliary Medical Services during their Acute Illness Episode (AIE's) (N = 15 per facility)

Medical service received by patient	Number of AIE Cases Receiving Service at Facility A	Number of AIE Cases Receiving Service at Facility B
	n (%)	n (%)*
Received in-house services by facility staff	10 (66.7)	0
Received services by contracted providers	0	6 (40) (3 patients transferred to the hospital)
Services ordered but patient died	1 (6.7)	0
Services not ordered	2 (13.3)	6 (40)
Patient transferred to hospital for treatment	2 (13.3)	6 (40)

* Numbers in this column do not equal the total due to three patients who received services and were subsequently transferred to the acute hospital.

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Facility A, having a surgical ward for example, provided physician specialists to their patients. In several cases, patients at Facility A were visited by, or their physicians consulted physician specialists, such as in Mrs. Kane's AIE Case #1 where an acute care physician was consulted by the patient's ward physician. Mrs. Kane was then transferred for a short period to the acute care ward for IV antibiotics. Thus, she was able to stay on-site through the course of her illness. These specialized services that would be routine in an acute setting and were available at Facility A, were not available at Facility B.

In addition to the specialized medical services, the data revealed cases in which more basic medical resources at Facility B, such as patient beds, geri-chairs, and wheelchairs were either unavailable or not working properly to meet the patients' needs. For example, a patient at Facility B described a morning when he had been put in a wheelchair in the dayroom. He was very uncomfortable because his body kept sliding down from the chair. The patient said he really needed a geri-chair which stabilized him a lot better, but they were all being used. In Mrs. Pelman's case at Facility B, the nurse aide could not elevate the head of a patient's bed due to a malfunction of the equipment. This was dangerous because at the time, the patient lying in bed was vomiting, and there was concern that she would aspirate, risking pneumonia.

Policies not in Patients' Best Interest

One-fifth of Facility B physicians interviewed reported that regulations and policies were not always in the best interest of their patient. This issue

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was not addressed by Facility A physicians. For example, one physician wanted a Facility B patient with a poor skin condition to be able to self apply a prescriptive cream; however, the nursing home did not permit bedside medications. This physician, while understanding the patients' safety this policy protects, wanted to increase his patient's autonomy and comfort. He questioned the benefit of a policy without room for individual variation. Two physicians discussed the difficulties that arise from having a limited number of Medicare beds (only one floor at Facility B) because it restricted the number of beds where IV therapy could be conducted . One physician explained:

[When] I want to put an IV in a patient-- The patient has to be transferred to another floor. But we can't transfer them to another floor because there are no beds available. So we have to transfer to acute care. You know, it's just the regulations are so screwed up that it's an impossible situation.

This was also evidenced in several AIE cases where patients were transferred to another floor for IV therapy. When no bed was available, however, either the patient went to acute care or the IV was discontinued as in Reverend Jenkin's AIE.

Inconvenience of Travel to Nursing Home

In their interviews, 25 percent of Facility B physicians mentioned the inconvenience of traveling to the nursing home. This barrier was not mentioned by Facility A physicians. Facility B physicians interviewed

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represented at least five different hospitals (those who reported affiliation) and many small private practices. One-third reported that they visited three or more nursing homes to see their patients. The others did not provide this information. One physician traveled to four different cities for his nursing home patient visits. This physician stated that he was trying to "cut back" on the number of nursing home patients he has because of the travel time involved.

Physicians' Presence in the Nursing Home

The AIE's from both facilities were examined for the frequency of physician visits to their patients, as recorded in physician reports, nursing notes, and researcher observations. Physicians at Facility A visited their patients more frequently than those at Facility B. In over one-third of the patient cases at Facility A, physicians visited daily or frequently. The remainder of Facility A physicians visited their patients when concerns were listed by the nurses during their morning rounds. At Facility B, all physicians, for which information on visit frequency was available, visited their patients once a month for their monthly exam. These visits ranged in time from 1.5 minutes to 20 minutes. In two cases, nurses reported that, during their monthly visits, rather than meet with the patient, the physicians often checked the patient's chart or asked the nurses for the patient's condition.

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Table 12. Frequency of Physician Visits to Patients with Acute Illness Episodes (AIE's) (N = 15 cases per facility)

Frequency of MD Visits	Number of AIE Cases Facility A	Number of AIE Case Facility B
	n (%)	n (%)
Physician visit patients daily or frequently	6 (40)	0
Physician visits during morning rounds if a concern is listed on the ward board	8 (53.3)	0 (daily rounds not conducted at Facility B)
Physician visits once a month only for required visit	0	13 (86.7)
No time reported	1 (6.7)	2 (13.3)

Patients (or their families, if the patient could not reply) who were followed with acute illnesses (AIE's) were asked about the nature of their relationship with their physician (length of relationship, time spent with patient). In interviews, patients and families were asked if they discuss issues of treatment with their physicians. Many patients at Facility B complained of having little or no contact with their physicians, as one woman described, "[I] have never talked much to [my] doctor. I don't even remember ever talking to my doctor here [at Facility B]. I looked down at my name band and was surprised to see Dr. XXX-- I've never seen him." One patient's daughter

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explained that the physician had not visited her mother for two months and finally came only after she had called and called. Another daughter stated that the doctor visits her mother the obligatory once a month "only to see if she's dead or alive."

Some patients and families reported that when their physicians came for their monthly patient visit, they often stayed only a few minutes and did not always examine the patient. In their interviews, more Facility B patients and families complained of short visits with their physicians than the Facility A patients and families. One doctor, for example, visited his patient and informed her he was going on vacation. The woman recalled, "I wished him a happy vacation, but wondered why he didn't take a look at me-- like examine my arm or look at the sore on my tailbone as long as he was there." In another case, a daughter described her mother's physician, saying, "He's one of these busy doctors, and he's not the sort of person who would say, 'Now, let's sit down for fifteen minutes and talk about these things [the care and treatment of her mother].' He's always on the way out." A nurse commented on the Medical Director at Facility B, saying, "You have to rope and lasso him into the nursing home, if you want him to see any patient or talk with any patient...."

Data from the AIE's were analyzed for the length of time between the initial nursing report of a patient's acute illness symptoms to the physician and the physician's response to the report. If an on-call physician responded, it was counted the same as the primary physician, since medical treatment

and supervision had begun regardless. In the 15 AIE's followed at Facility A, the physician responded immediately to the page or call placed to his office. In only a few cases the physician proceeded to instruct the nurses by telephone; more often, the physician came quickly to visit the patient. While in eight cases (53.3%) at Facility B, physicians responded immediately by telephone, in seven cases (46.7%) there was a delay in the physician's response, ranging from one hour to two weeks.

Table 13. Physician's Response to Acute Illness Symptoms: Time between Report and Telephone Response

Length of Time	Number of AIE Cases Facility A (N = 15)	Number of AIE Cases Facility B (N = 15)
	n (%)	n (%)
Immediately	15 (100)	8 (53.3)
Within 1 - 5 hours	0	2 (13.3)
Within 1 - 2 days	0	3 (20)
After 2 weeks	0	1 (6.7)
No call placed to MD	0	1 (6.7)

Differences between facilities was also found in the length of time between the initial nursing call placed to the physician and the physician's visit to the patient. In 9 AIE cases at Facility A (60%) the physician visited within 30 minutes, in 3 cases (20%) within 1-2 hours, and in 3 cases (20%)

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within 12 hours. In contrast to cases at Facility A, there were longer delays in time between the nursing call and physician visit in the AIE's at Facility B. No physicians visited their patient in less than one hour from receiving their call. One physician visited within 1-2 hours, two within 12 hours, and three within 1-2 days. The remainder visited after four days or not at all.

Table 14. Physician's Response to Acute Illness Symptoms: Time between Report and Physician Visit

| Length of Time | Number of AIE Cases
Facility A
(N = 15) | Number of AIE Cases
Facility B
(N = 15) |
|---|---|---|
| | n (%) | n (%) |
| Within 30 minutes | 9 (60) | 0 |
| Within 1-2 hours | 3 (20) | 1 (6.7) |
| Within 3- 12 hours | 3 (20) | 2 (13.3) |
| Within 1-2 days | 0 | 3 (20) |
| In 4.5 days | 0 | 1 (6.7) |
| In 2.5 weeks | 0 | 1 (6.7) |
| Never visited | 0 | 6 (40) |
| N/A- Patient transferred
to hospital immediately | 0 | 1 (6.7) |

In the case examples presented earlier in the findings, Mrs. Kane and Mrs. Bandos (Case #1, Case #2), patients at Facility A, were seen by their in-house, staff physicians immediately, and the necessary lab, x-ray, and acute

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care services were accessible quickly and in-house. Both patients' conditions resolved after an apparently smooth course of evaluation and treatment. In contrast, the patients at Facility B experienced delays in visits from their physicians and delays in treatment. For example, the physician in Case #3 visited Mrs. Pelman two and a half days after the nurse reported symptoms of a bowel obstruction.

With the delay of the physician in Mrs. Pelman's case, she was not informed about the nature of her illness until a researcher intervened. In this case, Mrs. Pelman initially refused a transfer to the hospital, saying that she was afraid of hospitals and not afraid to die because she would be with her husband who had passed some years before. When the researcher asked the patient if she knew what a bowel obstruction was, the patient replied, "No." She did not know the nature of the condition, nor of the degree of pain that would come from leaving the condition untreated. When the researcher explained this to the patient, the patient agreed to be transferred. In this example, there was a lack of communication between the patient and the physician and nurses.

When physicians did not visit the nursing home often, the data revealed that they were ignorant of significant patient care concerns. One physician had patients in four nursing homes including Facility B. During this physician's interview, the researcher stated, "There's quite a lot of staff turnover [at 'B']," and listed several names of the staff who had left since the project started (including the Director of Nursing). This physician did not

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recognize the names. He also demonstrated his ignorance about the potential negative consequence of staff turnover on patients with this comment:

The staff turnover I don't think really affects the patients.... Most of what they are doing in nursing homes is just a simple skill that can be learned and it really does not matter who does that. I don't think that at the patient level it matters at all.

In the 1990's, physician absence is still a concern at Facility B. The Principal Investigator of the original study writes, "In my current study, we have been collecting data in two proprietary nursing homes, each of which has a medical director. During the 18 months of data collection, I have never seen the medical directors of these two facilities, despite my being in the nursing homes weekly, during the daytime and evening hours" (Kayser-Jones, 1997). Thus, the absence of physicians remains an issue at Facility B.

Beliefs about Physician Care

Statements by patients and family members, both in interviews and observation, showed an expectation that physicians will do everything in their power to treat their patients. One husband commented about his care for his wife in the nursing home: "I just assumed that she would be taken care of, that everything would be done for her." Some patients and their families expressed a trust in their physician and the care they were receiving. Their comments revealed a belief that the physician was in control and doing all he or she could for them, as one patient commented: "No necessity to talk with them [doctors]. They will give me the best care they can." The son of

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another patient stated, "We proceed on the assumption that he [the doctor] will do whatever is called for.... We just assume that he will do what needs to be done." One patient was disillusioned when he discovered otherwise, stating: "Life in this nursing home is horrifying. I cannot believe that anything remotely connected to the medical world could be this atrocious."

Patients and families attributed a certain mystery and authority to physicians and medicine. They emphasized the specialized knowledge of physicians, with remarks typical of these: "I wouldn't know what to talk to him about....I don't know anything about the medical stuff"; "Medical terms are hard to understand-- you really must rely on your doctor"; "I don't really mix with them [doctors]...I'm supposed to be a patient"; and "I just do what they [doctors] want me to do...."

In fact, some patients and families held this trust in the physicians despite the reality that many patients complained of having little or no contact with their physicians and of receiving inadequate medical care. Ironically, the son who was quoted above, saying, "he [the doctor] will do whatever is called for.... We just assume that he will do what needs to be done," stated later in his interview about the same physician, "He's always on his way out," and does not have time to discuss his mother's treatment or care.

Psycho-Social Care

In addition to the nursing and medical dimensions to quality of care, psycho-social dimensions of care were examined in the data. Presented here are several categories of psycho-social and emotional care that were found in the data: meaningful activities, verbal abuse and theft, and sensitivity to patient needs.

Meaningful Activities

While some patients at both facilities complained of the lack of meaningful activities, this was more prominent in the interview data from Facility B than in interviews from Facility A. While one patient stated she was "dumped" in her chair and left for hours and another complained of boredom, many of Facility A patients described participating in clubs and activities that gave them enjoyment and helped the time pass. A patient's son, in his interview, explained that his mother attended a weekly art workshop at Facility A and started to paint. He said that his mother had never painted before doing so at Facility A and that everyone told him his mother's paintings were beautiful. Another woman, a patient, attended "pleasure endeavors," a weekly group which meets to paint, write poetry, garden or anything else the patients suggest. In their interviews, patients described Russian club, visitor's groups, and other social and religious activities they found meaningful at Facility A.

In contrast, the patients at Facility B did not mention activities and, more importantly, complained more in their interviews, of being lonely,

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isolated, and bored. One patient stated, "Sometimes I go for days without really taking to anyone." Another patient at Facility B described his time in the facility when he was not receiving direct nursing care:

There aren't enough people to take care of everybody. I always feel like I'm bothering them. They keep me up too long in the chair. The problem is I get so bored-- look at all these people lined up against the wall just staring into space.

Another patient described:

No one gives a damn around here. You just go from moment to moment. Go for a walk down the hall, rest from the walk, get ready for a meal, take a rest, get ready for supper. That's what it's all about.

Still another patient eloquently stated, "It is very depressing here, a waste of time. I am like a beautiful painting in an art gallery-- people watching, but doing nothing-- and I am doing nothing."

Observations of the patients made by research assistants supported the above interview findings. For example, a research assistant described the dayroom when lunch was served, saying, "Staff were helping patients in the dayroom who were sitting at tables-- even together-- there was isolation." Not only did this describe the mealtime experience, for patients sat all day in the day room at Facility B without interacting. They walked together in the halls, separately. Even in their rooms, there was little interaction or developed relationships between residents.

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Verbal Abuse and Theft

Verbal abuse and theft are both assaults on the patient's sense of security and psycho-social health in the nursing home. In interviews and during observation, verbal abuse and theft were mentioned as problems by patients and families in both nursing homes, but more prominently in Facility B. Patients at Facility B described how the nursing staff spoke rudely and inappropriately to them, as one woman exclaimed, "I want to be treated kindly and like a human being— not yelled at and told, 'Go to your room!'" Another patient described asking a nurse's aide to help her roll her sleeves up, to which the aide responded, "Shut-up! Shut-up!" In another example from an interview, a son recalled a time when he had trouble feeding his mother at Facility B. To obtain some help, he signaled to one of the CNAs. In response, the CNA yelled, "What do you want NOW?" The son stated that he was concerned that if the CNAs would talk that way while he was in the nursing home, how must they speak when he was not there.

Patients at both nursing homes stated that personal items had been stolen from them. At Facility B patients stated items, such as, clothing (including underwear, a woman's dress), make-up, a book of poetry written by the patient, and Christmas presents were stolen from them. At Facility A, patients reported theft of money, clothing, candy, lipsticks, and lighters. Patients were affected by theft as one granddaughter explained:

I know everybody knows theft occurs, but I don't know if they really understand how it debilitates old people. It morally debilitates them

1. *Phragmites australis* (Cav.) Trin. ex Steud.

and tells them they are not in a good place. Many people come here and they have few possessions to begin with and the nursing home will not take any responsibility for their possessions. Theft undermines their hope.

Another patient described that the fear of theft prevented her from bringing her personal belongings to the nursing home.

Sensitivity to Patient Needs

Being sensitive to patients means being attentive to their individual needs. Sometimes it was the little things that meant the difference between a patient feeling at home and cared for or isolated and ignored. Insensitivity toward patients was observed at Facility B. For example, at Facility B, patients described having their water containers placed where they cannot reach them and calendars posted too far to read. Some nurses were extremely insensitive to patients, as in the following example one patient described: "It is disgraceful here [at Facility B]-- the nurses are unkind and really crude. You won't believe this, but they will take my roommate's bedpan after a bowel movement and show it to me on the way to the bathroom and laugh." In Mrs. Pelman's Case #3, it was observed that while the patient was vomiting in her bed, the DON stood straight and quiet with her clipboard at the foot of the bed. She did not speak to or touch Mrs. Pelman.

There were examples of sensitive care observed at both facilities, such as when several Filipino nurses brought in Filipino food for a Filipino man who was not eating well. In another case, an assistant Activities Director

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brought chocolate chip cookies to a bedbound patient who used to enjoy participating in activities. The patients were very touched by these signs of caring; it made a difference. One woman at Facility A described attentive care, saying, "I want to be taken care of. I expect good care. [Good care] means doing things for you that you want done. It means personal care-- just what you need." Another woman summarized this, saying, "It's not so much in the care for you, but in the caring for you."

Lack of Chairs

It was noted again and again by the patients, researchers, and family members that there was a lack of chairs in the facilities. Patients complained of uncomfortable wheelchairs. One woman went back to bed because her wheelchair was so uncomfortable. Most of the patients' rooms do not have any other seating option besides the wheelchair or the bed. For family members, they noted that there was no place to sit when visiting their relative. One daughter complained of her severe arthritis and the difficulty in standing while she visited her mother at Facility B. The research assistants described having to sit on the patient's beds, or even on the floor to conduct interviews with the patients. The lack of chairs, thus, was a barrier to adequate psycho-social care, as long or intimate visits with patients were difficult to conduct.

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Social Constructions and Care

Social constructions of reality are definitions of reality that have become accepted as factual regardless of their actual validity. Social constructions of aging are related to specific perceptions of the aging process or of elderly people that are held by society. In the nursing home, they were important because they had implications for the structure and provision of care to patients. The data in this study revealed that social constructions of aging and the aged were present in both nursing homes. The four social constructions of aging reported here are: depression and debilitation are normal parts of aging; elderly patients are not deserving of a quality life; elderly patients do not have feelings; and the nursing home is a frightening place to be avoided.

Depression and Debilitation are Normal Parts of Aging

The social construction of aging as a time of depression and debilitation was seen in the data in the lack of treatment that depressed elderly patients received. Several patients in both facilities expressed wishes to die, and often these wishes were attributed to old age, rather than a medical or psychological condition requiring treatment. A physician resisted treating the depression of a non-responsive 83 year old man at Facility B, until the nurse kept pressuring him. With the anti-depressive medication, the patient interacted with the nurses, participated in activities, and ate more at meals. Further, his expressed wishes to die ceased with the medication.

In another case, a patient followed with an acute illness at Facility A presented signs of possible depression. The principal investigator brought this to the physician's attention. She wrote in her AIE field notes:

I suggested to the physician that I wondered if this patient might be depressed because he did not talk a great deal to the doctors and wondered if his uncooperativeness, as described by the nursing and medical staff, might be due to a depression. The [physician on the case] more or less laughed at that and said, "What's wrong with being depressed. I'm depressed half the time." He did not take that seriously. The physician did not respond to this concern, and the patient was neither assessed or treated for depression.

A Facility B physician described how depression can be easily mistaken for a symptom of age, and how he was able to reverse this conception just in time to treat one of his patients. His patient, a woman followed for an AIE at Facility B, began eating poorly and having pain. The patient told the physician, "I want to die." The physician explained, "I thought she meant it." He visited the patient on Christmas eve, and she continued to state her desire to die. In response to the patient's death wishes, the physician decided not to transfer the patient to the acute hospital and ordered pain medication instead. He was not on-call over Christmas so left orders with his associate that if his patient did get worse, she should be transferred to the acute hospital. The patient's condition declined, and she was transferred. The physician commented on this case: "That was a close one because I really thought that

she wanted to die.... It turned out that she had a UTI, she was dehydrated, and depressed. Once she started feeling better, she wasn't at all interested in dying; then she very much wanted to live."

From the patient's perspective, depression was often the result of the poor nursing home environment, as the following patients' comments from their interviews show. A 65 year old woman at Facility B cried, "I pray everyday to die. I'm so lonesome here. I'm so mistreated here." Others despaired: "I feel trapped here-- I can't go anyplace;" "I feel like this is worse than prison...;" "I consider this place a jail-- you can't get out;" and "It's like you're at the end of the world." Improvements in these patients' environments were not made to help relieve their depression.

Similar to depression, physical debilitation was at times, attributed to old age by physicians and nurses, rather than the result of an illness that might be treated. In one of the acute illness episodes in which the patient died of pneumonia at Facility A, the physician recorded two additional "immediate causes" of death on the death certificate: failure to thrive and advanced age. In the final summary for another patient who died at Facility A, the physician listed "general debility" as one of the final diagnoses.

Elderly Patients are Not Deserving of a Quality Life

The data showed that associations were made between the worth of the elderly and the money earned from their care. For example, when a physician quoted earlier was asked if he liked taking care of elderly patients, he responded:

No. You spend two to three [times] as much time with them as you do with other patients, and you're paid half. It takes a long time for them to get undressed and dressed. I like old people. Some of my best friends are old. It's okay to be with them socially, but taking care of them is hard and less remunerative. When you don't do procedures, the amount the government pays is so much less. I've been in this office since 1970. When I started the rent was \$350 for each of us. It's \$1,500 for each of us now. The nurse then made \$400 a month, now she makes \$1,600 a month. I wish I were rich and could practice without charging patients.

In this example, the physician assigned a monetary value to the worth of the elderly person. Here, by raising the issue of getting dressed and undressed, the physician devalued the worth of elderly patients. He was concerned that if the patients take too long getting dressed and undressed in his patient rooms, it would reduce his overall patient capacity and earning potential.

In another example, age was a factor in the physician's assessment of quality of life and the treatment that was warranted for a patient. In his interview, a Facility A physician described one of his patients with severe COPD. The physician transferred his patient "numerous times" to the acute hospital for treatment; however, he explained: "If this had been an elderly patient, 80 years old, I would not send him to [hospital name]." Another physician, at Facility B, explained that he often treated symptomatically if an evaluation would cause the patient more distress, or if he were unlikely to

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treat the problem discovered upon evaluation anyway. For example, he told the researcher that he might give a nursing home elderly patient an antidiarrheal, relieving the symptoms. Then, he told the researcher what he would do if she were his patient, saying: "Now, if you came in with symptoms, I would pursue it very aggressively because you're young, you have a high quality of life, and you have a lot of life ahead of you." The assumption revealed here was that this physician believed that quality of life diminishes as one's years progress.

Patients and families were sensitive and aware of such negative conceptions of aging and some criticized it, arguing that the elderly deserve more. For example, one patient pointed to his devaluation in spite of his contributions to the country, stating: "After all the hell of the depression, and World War II- I helped pioneer this country- I can't even read the newspaper because I don't have the right glasses." One son complained: "Old people are neglected in the United States. She [his mother] should be taken care of for free." Although, his father had served in two wars and his mother's health insurance ceased at 65 years of age, the family must pay for nursing home care out of pocket. The son viewed this as neglect. Another family member commented that "America has yet to learn how to deal with the elderly." She explained that the attitude is often-- "They've lived their life and how much more attention do you want them to have?" Other elderly patients internalized this social construction of aging, questioning, as an example, "At the age of 70, why should they keep me alive?"

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A few physicians reported that these negative constructions of aging and the elderly had permeated their medical training, as one physician described: "When you are an intern you really hate old people." He explained the term 'gomer' meaning, "Get out of my emergency room," that was used often in reference to elderly patients. He continued, stating, "When you're an intern, an old patient means work because they are really sick and they've got a lot of problems. When you're a doctor, when you're a practicing physician, it means money." These statements demonstrated the objectification and devaluation of elderly patients.

In the physician interviews included in this study, almost one-half of Facility B physicians and one-third of Facility A physicians reported that age affected their decision of whether or to what extent to treat a patient. An RN discussed a woman at Facility B who was in poor condition and dying, but who also suffered from a decubitus ulcer. The RN explained that the doctor was not treating the bed sore because he believed the patient would die anyway. Thus, despite the profuse drainage from the ulcer that was coming through the dressing, the physician had not ordered anything to make this patient more comfortable. While the nurse in this case should also be accountable for patient neglect, the physician's care was mitigated by the social construction of the elderly patient. Similarly, in Reverend Jenkin's Case #4, the physician withheld IV hydration, in part, because the patient was going to die anyway in a few days.

Elderly Patients do not have Feelings

Another social construction of the aged found in the data was that elderly patients do not have feelings. This is important because the ability to feel emotions is a particularly human attribute. Therefore, treating the elderly patients as if they do not have feelings, challenges their "humanness." For example, in observation notes, "jokes" were sometimes made at the expense of elderly patients. These comments came from staff, visitors, and even other patients. For example, the researcher reported the following situation at Facility A: "a neatly dressed man who looked like he was ready for golf came springing by a man in a wheelchair, huddled over, waiting for the dentist, not talking to anyone who passed. Golfer said to him as he made for the door, 'Hi sport. Keeping you busy?' and continued out whistling 'I Get No Kick from Champagne.'" When a female patient complained of not feeling well to another patient, a man, he responded: "You need a boyfriend." On the third floor of Facility B, a nurse's aide was walking a patient, who walked very slowly. As they passed the nurses' station, the aide said to another nurse, "I'm taking him dancing." This nurse may not have had hurtful intentions, simply making light of the day after day care responsibilities; however, the comment may have been hurtful to the patient, poignantly pointing to his losses while he tried simply to make a trip down the hall.

The Nursing Home is a Frightening Place to be Avoided

Some physicians and administrative nurses viewed the nursing home as a frightening place to be avoided. While this perception of the nursing home may be substantiated with reality, it may be mistakenly overgeneralized to all nursing homes and may have negative consequences for improving quality care, as will be explained further in the discussion chapter. The following are a few examples illustrating this negative perception of the nursing home.

When the DON at Facility B, described earlier, said that he hoped he would never end up living in a nursing home, it was not only poor leadership and a poor example for his staff, it revealed a general negative perspective about nursing homes that permeated the facility. In another example, a physician was discussing a patient in the hospital who died of liver failure right before being transferred to the nursing home, stating: "He was about to be transferred to the nursing home so it was an opportune time [his death], if you look at it that way." Again, it was a relief that the patient had avoided the nursing home. When a doctoral nursing student in gerontology was showing a family around Facility B, she commented, "There is an odor but you've got to expect that." Nursing homes are not always malodorous, as was found at Facility A, where even the heavy care ward did not smell of urine. These negative comments revealed the low expectations even health care professionals held for nursing home care.

Policy and Care

Governmental Oversight

One dimension of regulation that influenced patient care was the state survey process. Several nurses and physicians at both nursing homes criticized the state regulatory surveys that were intended to assure quality care. A primary criticism was that state surveyors seemed to be "going through the motions" when investigating the facility. For example, a state representative investigating Facility B was a long-time friend of the Director of Nursing. When the representative saw the DON, she assured her, "Don't worry about the visit today. I have a lot of respect for you. I'm sure you're doing a good job. This is just something that I have to go through but don't be concerned about it." The Assistant Director of Nursing, however, was very troubled by the care at Facility B (to the point of her resignation after only a few months employment) and had hoped the investigation would make the facility accountable for its quality infringements. She expressed disappointed that, in the end, this state surveyor was simply "going through the motions."

Additionally, staff at both facilities complained in their interviews that mostly investigators used patient charts as their primary source of information, and that this might provide a misleading representation of their nursing home. There was an incident at Facility A in which a state physician was sent to evaluate a situation where a patient had died because the blood for her transfusion allegedly had not arrived on time. The case was more

Abstract

complicated than this, but the point important here is that when the state conducted its investigation, many felt it was misleading and unfair to the facility and the physicians involved. One physician described the problem:

He [state physician] didn't ask anybody about it [the incident]-- whose notes and names were on the chart, what the circumstances were. We felt the whole thing was typical stupid bureaucracy. I mean, if I were a surveying doctor and I saw something-- You can't always get all the information right from what [is written in the chart]-- there are a lot of little peripheral nuances that go along in everything that doesn't get written down. ... You really have to talk to people to know what the truth, the real circumstances were. This was done just on a paper review and I felt the whole thing was preposterous, really preposterous.

This incident did not encourage respect for regulations and regulatory boards.

Additionally, the survey process seemed to contribute to the pressure facilities experienced to keep patients' charts in order, even while ignoring the real issues of patient care. For example, a nurse at Facility B explained the difficulty in getting some physicians to make their monthly visits to their patients. As a part of facility quality assurance, this nurse checked each patient's chart once a month to record whether the patient received a physician visit. If they had not, then the nurse called the physician twice. If there was still no response, the medical director came in and signed off the monthly orders in the chart. In the end, the charts were in order for a state

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

review, but the actual problem of physicians not visiting had not even been addressed.

Reverend Jenkin's Case #4 is another illustration where charting regulations may have obscured the actual care the patient received. The administration and nursing staff at Facility B were not troubled by the discrepancy between the patient's care needs and the orders that were given. Rather than focusing on the lack of hydration, for example, they focused on the patient's chart and meeting regulations. Specifically, to the nurse's relief, a 'Do not weigh' order was obtained because the facility did not have a bed scale. The order was to appease charting regulations and not to address the needs of the patient, as evidenced by the nurse's final remark, "We'll be covered then." The physician guaranteed that the patient's chart was not blemished with bed sores. The facility avoided the risk of citation by not giving IV hydration to a patient in non-certified bed. Clearly, hidden behind the ordered chart, obscured by adherence to regulations, was a person lacking adequate medical and nursing care.

Another complaint about the state regulatory process was that surveyors were not cognizant of or sensitive to the specific situation of the nursing home. One physician discussed why he thought the regulatory system was inadequate:

I don't think that the state survey teams that evaluate really do their job properly. [They do] not know an institution of this size [referring to Facility A] because there are only one or two in the state. The nurses

that come and survey here, and I've questioned them some, if they've ever worked in an institution like this, and many of them have not. The doctors pass judgment on, perhaps, what they read on the chart and progress notes without asking the doctors who are available what happened or what it was about because no matter how hard you try, you can't write everything down; you can't put all of your thought processes down. Judgments are passed by people who I feel are not qualified to make the judgments.

This physician continued to describe a case where a state examiner came for a facility assessment and marked the facility down because one of the patients was not wearing socks. The examiner asked the nurse why this patient did not have socks when they were required to do so by state code. The nurses explained, "This patient is demented. He won't leave any socks on. He pulls them off as soon as you put them on." The examiner responded, "All normal people wear socks." This remark, besides being an insult to the patient and the elderly in general, illustrated how surveyors were not always sensitive to the individual needs of the patients or facility.

DRGs

As introduced in the background section, the Medicare prospective payment system pays a set reimbursement for the hospital treatment of specific diagnosis-related groups (DRGs). While the relationship between DRGs, shorter hospital stays, and sicker nursing home admissions has been demonstrated in other literature (e.g., Harrington et al., 1993; Guterman and

[illegible]

1. *Phragmites australis* (Cav.) Trin. ex Steud.

associates, 1988), this regulatory dimension was not substantiated in the data here. However, the role of DRGs in influencing patient care was mentioned by three facility physicians and in several of the nursing home administration and organization interviews completed, indicating that this issue deserves more attention, but these data did not specifically address this.

For example, the three physicians who mentioned DRGs in their interviews described experiencing pressure from acute facilities to discharge their patients to the nursing home. One physician described:

It is very hard not to be influenced by the whole DRG process and utilization review. You start out being brave and saying you are going to resist but you end up giving in....They tell you that you should be discharging the patient. They tell you that if the claim is denied, the hospital will be billed. The hospital can appeal but they don't. It is very uncomfortable if you are not cooperative.

In a 1997 interview with Tom Moore, Executive Director of the Wisconsin Health Care Association, he described the implementation of DRGs as a time when, "we found ourselves with a new type of patient who needed skills that we'd never had to provide."

In a 1997 interview with the Assistant Medical Director (AMD) at Facility A, he explained the time of DRGs similarly. He added that currently, the capitated rate structure used in managed care has continued the effect of DRGs. The hospital bed has been transformed from an earning center to a "cost center...every expense on the patient is a cost." The AMD suggested that

"in some ways there is even more emphasis on getting people out of acute beds and into nursing homes.... There is a push to move people out quickly."

Findings from Interviews with Officials from Nursing Home Organizations

A Decade of Change

All five officials, interviewed in 1996-97, emphasized that many changes have occurred in the nursing home industry over the last decade. The three most mentioned changes were: improvements in care resulting from the 1987 OBRA Nursing Home Reform Act, increasing age and acuity of nursing home patients, and the increased expansion and complexity of nursing home services.

Changes in the quality of patient care that respondents attributed to the OBRA 1987 were the introduction of the Minimum Data Set used for resident assessment and care coordination, increased training requirements for nursing assistants, the decrease in restraint use, and an overall increased focus on quality of life rather than just quality of care. Sara Green Burger of the National Citizens' Council for Nursing Home Reform (NCCNHR) discussed the Health Care Financing Administration's support of research in residents' quality of life, exclaiming, "This is exciting to see the regulatory side getting into quality of life." These changes were presented as improvements in patient care across settings.

Three of the five officials, however, stated that regardless of improvements in specific areas, an overall increase in quality has not

happened. They attributed this, primarily, to problems with the regulatory enforcement system. Pat McGinnis, J. D., Executive Director of the California Advocates for Nursing Home Care Reform (CANHCR), emphasized this concern, saying, "Laws are great, but the enforcement system must be one that is comprehensive and that works." This is why, she explained, the CANHCR focuses the majority of energy on citing and enforcing regulatory requirements in the nursing home. Howard Bedlin, Vice President for Public Policy and Advocacy at the National Council on Aging concurred with this, saying, "You can have the most wonderful regulation, but if it's not enforced...." Tom Moore, Executive Director of the Wisconsin Health Care Association (formerly the Wisconsin Nursing Home Care Association), cited another reason for the lack of patient care improvements. He suggested that low reimbursement for Medicaid/Medicare does not provide the resources to accomplish the improvements in care. He explained, "Regulatory demands have not been met with a concomitant commitment to fund these requirements.... [this has] an obvious impact on quality. Something's got to give."

A change in the nursing home patient population was the second change emphasized. All five respondents noted the increasing age and acuity level of the patient population.

The third change reported was the increasing complexity of nursing home services. All five officials referred to the expansion of new services offered by nursing homes, for example, skilled and assisted living, subacute

and dementia care units. They also discussed the increasing corporate nature of the nursing home industry and the complexity of the funding mechanisms in managed care.

Factors in Quality of Care

The respondents were asked about their view on the influence of structural factors (e.g., regulation, reimbursement, ownership) on quality of care in the nursing home. Four or five officials cited the following as influential factors in nursing home quality: regulation, staffing levels and training, ageism, and medical model of care. Ownership and reimbursement were discussed as influential but not as determinants of care. Toby Edelman, a lawyer with the National Senior Citizens Law Center, explained, "The industry has persuaded people to believe that they [nursing homes] don't get enough money," but the issue is rather one of accountability not amount of reimbursement. She advocated, "Facilities [must be] accountable for the money they receive. Give them 90 percent of the rate and then give them the rest when they meet the survey requirements." With ownership, all respondents discussed differences between non-profits and for profits, but disagreed on the extent to which it was the explanation of quality of care differences. Ms. Burger stated the importance of nursing leadership, staffing, and philosophy of care, adding, "If that's in place even if it's a non-profit or a for profit, good care can be given." The next chapter will return to these officials' discussion of the influence of structural factors as the factors are discussed in light of the findings presented in this chapter.

CHAPTER V: Discussion

In analyzing the acute illness episodes, interviews with, and observations of patients, families, nurses, and physicians, this study found that patients at Facility A received a higher quality of care than patients at Facility B. Differences between facilities were found along three dimensions of quality care examined: nursing care, medical care, and psycho-social care. The data analyzed were collected in 1986-1987, prior to the implementation of the Nursing Home Reform Act, OBRA 1987. Thus, where available, studies that evaluate quality of care post OBRA 1987 are discussed in relation to these particular dimensions. This chapter will provide a brief summary of the study's findings followed by a theoretical discussion examining the political-economic context in which this care occurred.

Quality of Care Dimensions

Nursing care was one dimension in which care differences were found between both facilities. The nursing staff at Facility A expressed more satisfaction with their work environment, including job security (higher wages, advancement opportunities, low turnover) and strong leadership and supervision, than their counterparts at Facility B. Facility A nurses experienced better relationships with ward physicians and were included more in care decisions. They knew their patients well and were observed providing attentive care, for both the physical and psycho-social needs of patients. Fewer concerns were raised regarding nursing care or staffing levels

at Facility A, than at Facility B. At Facility A, there was a clear, patient-centered philosophy of care supported by the nursing leadership that contributed to the quality patient care nurses provided.

These findings regarding nursing care are consistent with research studies examining ownership and quality care. Although the degree to which ownership status affects quality care in nursing homes is still a major debate, research has shown that nonprofit facilities are associated with higher nurse staffing levels, higher wages, and lower turnover, characteristics identified at Facility A (Aaronson, Zinn, & Rosko, 1994; Hawes & Phillips, 1986; Holtmann & Idson, 1991; Munroe, 1990; Nyman, 1988; Strahan, 1987). Associations found here between higher quality and higher staffing, low turnover, and stronger nursing supervision are also supported by the literature. Several studies have illustrated the effects of understaffing on quality of care (Aaronson, 1994; Institute of Medicine, 1996; Kayser-Jones & Schell, 1997; Munroe, 1990; Nyman, 1988). The findings regarding leadership, supervision, and care are consistent with research that has shown that effective nursing leadership facilitates the care provider's work motivation and performance (Institute of Medicine, 1986), and that inadequate supervision can compromise quality (Kayser-Jones, & Schell, 1997).

OBRA 1987 established requirements for increased nurse aide training and for 24-hour licensed nursing services, including RN coverage 8 consecutive hours a day, 7 days a week. Current research suggests that although improvements have been made in these areas, the question

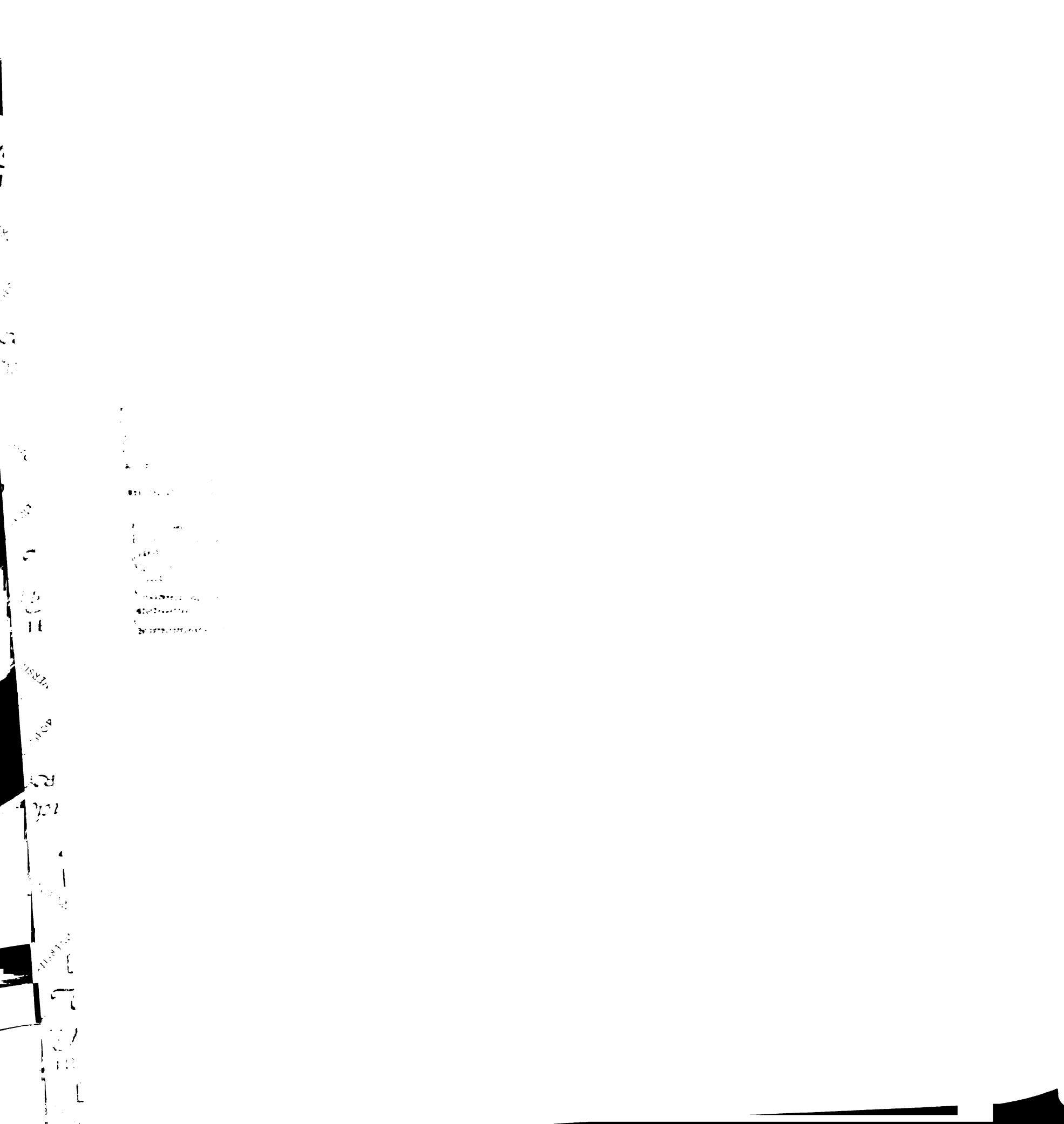


remains whether these changes are adequate (Institute of Medicine, 1996; Marek, Rantz, Fagin, & Krejci, 1996). Some argue that OBRA 1987 requirements still result in inadequate staffing levels and compromised quality of nursing (Francese & Mohler, 1994; Maas, Buckwalter, & Specht, 1995; Mohler, 1993). During 1991-1995, approximately 7 percent of facilities were given deficiencies for insufficient staff to provide appropriate resident care (Harrington, Carrillo, Thollaug, & Summers, 1997). In 1991, 13 percent of facilities were cited for inadequate registered nurse staffing, declining to only 2.5 percent in 1995. This improvement is dramatic; however, deficiencies in care still exist. When nearly 20 percent of facilities in 1995 received citations for assaults on resident dignity, pressure sores, and accidents (Harrington, Carrillo, Thollaug, et al., 1997), the question remains whether staffing improvements necessarily reflect adequate staffing.

Medical care was the second dimension of quality in which differences were found between Facility A and Facility B. While physicians at both facilities discussed barriers to providing quality care (i.e., low reimbursement, poor nurse-physician communication, inconvenience, limited medical resources, inadequate medical training), Facility A physicians experienced fewer of these barriers than their Facility B counterparts. Facility A physicians visited their patients more frequently, responded by telephone or on rounds more quickly, and visited more quickly after being informed of their patients' symptoms than Facility B physicians. Fewer patients at Facility A than at Facility B were transferred to the hospital for treatment of an acute illness,

and more Facility A patients received auxiliary medical services in-house. This was expected as Facility A had the on-site services available to patients. More of the acute illness cases at Facility A were resolved, while more questions or concerns were raised about the treatment and death of patients at Facility B. Overall, Facility A patients with acute illness symptoms were seen quickly by the physician, treated appropriately, with their acute illness resolving soon after its onset. In contrast, patients' acute illness trajectories at Facility B often involved delays in physicians' telephone response and visits, delays in treatment or questions on the adequacy of treatment, transfers out of the nursing home, fewer resolved conditions, and more concerns raised regarding patients' deaths.

Many studies have identified the inadequate or inappropriate medical care received by nursing home residents (Kane & Kane, 1987; Karuza & Katz, 1994; Kayser-Jones, 1989; Moseley, 1994). The barriers to providing quality care identified in this study are similar to those found in other studies examining physicians' attitudes toward nursing home care. In several studies, reasons cited by physicians for low participation in nursing home care were excessive paperwork, low and delayed reimbursement, inconvenience, and loss of physician authority (Kane, 1993; Miller, Lowenstein, & Winston, 1976; Mitchell & Hewes, 1986; Paulson, 1987). In another study cited in a review by Kane (1993), nursing home medical directors reported similar barriers to attracting and maintaining physicians in nursing homes, such as inadequate and delayed compensation, excessive paperwork, and the regulatory



environment. Literature investigating these barriers across ownership status (i.e., for-profit, nonprofit) nursing homes could not be located. Additionally, no comparative research on barriers was available for facilities where physicians are house-staff, as they are at Facility A, and for facilities where physicians are attending only, based outside the nursing home, as is the structure of physician services at Facility B.

The absence of physicians in nursing homes, including practicing medicine by telephone, is a phenomenon that has been identified in other proprietary facilities (Diamond, 1990; Kayser-Jones, 1982; Kayser-Jones, 1995). In another study, physicians were found to have frequent contact and involvement with their patients in a nonprofit facility with ward physicians on staff (Foner, 1994a). However, in Foner's (1994) setting, while the status of physicians was high, their contribution to patient care management was limited in the face of a strong nursing hierarchy. These findings are consistent with the comparison made between Facility A and Facility B.

A study investigating the structure and provision of physician services in skilled nursing facilities in New York state (N=353) found that the majority of facilities had open medical staff organizations, where the residents were assigned to community physicians who were neither salaried nor employed by the nursing facility (Karuza & Katz, 1994). This was in contrast to a closed medical staff where none of the residents were cared for by community physicians. The New York study found that physicians in closed facilities were more likely to visit their patients frequently, be on-site daily, and

provide cross coverage for acute care and emergency calls when the assigned physician was unavailable. These findings are consistent with what was found at Facility A, as Karuza and Katz (1994) conclude: "Having higher resident to physician ratios and having closed staffing patterns were significantly related to daily physician coverage, faster response times to emergencies, more in-services, more frequent participation of physicians in team meetings, and cross coverage" (p. 790). In another study examining physician response to notification of acute problems in nursing homes, evaluation and treatment of acute conditions and infection control were sometimes complicated by the lack of physician coverage (Zimmer & Watson, 1991). While this suggests a closed medical organization is associated with higher quality care, research has not been conducted on specific resident care outcomes in relation to medical organization. Future research focusing on this aspect of quality care would assist the improvement of physician services and the treatment of acute illness in the nursing home.

The third dimension of quality care examined in this study was psycho-social care, the psychological and emotional components of care. Overall, the findings showed that more psycho-social care was provided to patients at Facility A than Facility B. Patients were more involved with activities at Facility A, participating in social, cultural, religious, and intellectual events. Whereas, patients at Facility B complained more of boredom, loneliness, and doing nothing. Nurses at Facility A viewed their patients as family and often advocated for their patients' needs. Despite the supportive psycho-social

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environment at Facility A, insensitivity to patients' needs, verbal abuse, and theft occurred at both Facility A and Facility B.

Other research on nursing homes supports the finding that psycho-social care has been insufficient for residents' needs (Gubrium, 1975; Kayser-Jones, 1990a; Shield, 1988). While OBRA 1987 emphasized the dignity of residents and residents' rights, a substantial proportion of facilities still had deficiencies in these areas in 1995. For example, 20 percent of facilities in 1995 were given deficiencies in failing to maintain the dignity of residents, and over 14 percent for not providing residents with activities that meet the physical, mental, and psycho-social well-being needs of the residents (Harrington, Carrillo, Thollaug, et al., 1997). This is no improvement from 1991, when 20 percent of facilities violated resident dignity, and 13 percent violated appropriate provision of activities.

Thus, within each of the dimensions of care examined-- nursing, medical, and psycho-social-- quality differences were identified between facilities. Both the similarities and differences between facilities need to be understood in order to improve care. The chapter now turns to a theoretical discussion in which the political economy of aging and organizational theory inform the discussion of these two nursing homes.

The Political Economy of Aging

In the political economy perspective, the interrelationship between politics and policy, economics, and society is studied, with a focus on the interaction of the polity and economy in the distribution of social goods (Walton, 1979). The political economy perspective draws from the conflict model of society, in which social change and social order are explained as the result of the dominance of some over others, the outcomes of conflict and power struggles (Estes, 1979; Estes, Linkins, & Binney, 1996). Estes (1979) expanded the political-economy perspective and the study of aging by exploring the relationship between the political-economy and social constructions of aging produced and reproduced by the "aging enterprise." In the political economy approach to the study of aging, the structural context of aging is examined and "the dependency of the elderly is understood as a social product of the market and the social relations it produces" (Estes, 1991, p. 21). Thus, "medical care, social service, and income policy are understood to reflect the outcomes of power struggles that benefit the factions that dominate resources such as money, ideas, and political organization" (Estes et al., 1996, p. 347).

The political economy perspective is useful in the examination of organizations, such as the nursing home. This perspective helps identify and analyze the relationship of the organization to its external and internal constraints and controls (Zald, 1970). The distribution of power and dependence in relationships within and outside of the organization is a

central component of the political economy of the nursing home. In this resource dependency perspective, the relationship between the organization and its external and internal political economy is examined for the degree to which a particular social actor controls access and use of the resources on which others depend (Pfeffer, 1981). The resources involved need not only be monetary, but may include physical resources, information, or social legitimacy (Pfeffer & Salancik, 1978).

The Political Economy of Facility A and Facility B

Ownership

Many of the differences found between the two nursing homes can be understood in light of their different ownership structure. Facility B is a for-profit nursing home, owned by a large health care corporation. Facility A is a nonprofit, city and county owned nursing home. This difference in ownership creates two distinct organizational climates, containing diverging motives and accountability. For example, Facility A is accountable to the public, the tax-payers, and to the city and county governments. The motive functioning at Facility A is to secure enough revenue from the government through the city fund and Medicaid to serve its clients. Facility B, in contrast, is a for-profit facility accountable to the corporate office and stock-holders; Facility B must secure profit earnings to survive in the marketplace.

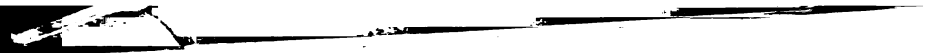
Due to the distinctive ownership types, Facility A and Facility B are then dependent on resources from separate external entities. While both

facilities rely on government moneys and both are subject to government regulation, Facility A is more accountable to the city and county government, and Facility B to its share-holders. As stipulated in the resource dependency perspective, these are power relationships in which the state and private industry are shaping the nature of the organization, here the nursing home. Concluding a discussion of the profit motive and nonprofit institutions, Gray (1991) writes:

There are advantages, therefore, in having health care institutions whose accountability structure does not require generation of profit levels that are satisfactory to investors, who always have the option of putting their capital elsewhere. Dependence on investor ownership makes the availability of capital-intensive health services...less certain than does dependence on nonprofit organizations, particularly those that have a long-standing role in their communities (p. 333).

Gray (1991) suggests that an organization's performance may be viewed as a "series of compromises among the interests of the various parties to which the organization is accountable" (p. 12). Therefore, both Facility A and Facility B are subject to a complex system of accountability shaped, in part, by the presence or absence of a profit motive.

Other studies (Hawes & Phillips, 1986; Holtman & Idson, 1991; Johnson, Cowles, & Simmens, 1996; Strahan, 1987) have found that securing profit in proprietary facilities is often done by maintaining lower patient care costs, including low nursing staff levels and wages, few licensed staff, and



poor or absent patient equipment. Results from one study found that counties in which proprietary facilities held the greater market share, there was a lower rate of RN use and more use of labor-saving practices (Zinn, 1993). Zinn (1993) suggests that these "[r]esults also provide some additional evidence for the relevance of the profit incentive in the staffing and practice decisions of proprietary facilities" (p. 727). Similarly, Facility B was found to have a lower ratio of nurses to patients, higher turnover, and lower wages paid to its nurses than at Facility A. Consistent with these findings, Facility A provided more direct patient services including, staff physicians who visited patients more frequently and a greater availability of auxiliary and acute care services (such as lab, x-ray, acute care ward).

It is not surprising then, that in addition to the variation in staff levels, wages, and equipment, it was also shown that the priorities in the two nursing homes' philosophy of care differed. At the core of the philosophy of care identified at Facility A was the priority of patient-centered care, a goal aligned with the mission of the government to provide city health services to their elderly. In contrast, the priority of Facility B's philosophy emphasized cost containment, a goal in alignment with the goal of the corporation-- to maximize profit.

Currently, however, there has been some shift in these priorities at Facility A. Until the past few years, supplemental funding from the city has been readily available to subsidize Medicaid and Medicare payments. Thus, Facility A has been able to provide a higher ratio of nurses to patients, lower



turnover, and higher wages paid to its nurses. This resulted in, as shown in the findings, a strong nursing leadership and philosophy of care, good relationships between nurses and physicians, and nurses who are involved and know their patients well. When city supplemental funding was not approved in 1995, cost containment became a priority and the nursing staff were significantly cut. As the DON of 40 years described, the effects of these cuts on care quality are already evident.

Estes and Alford (1990) argue that the nonprofit sector must be included in an analysis of political and economic crises and the state. During the 1980's, the economic policies of President Reagan supported the accumulation of profit and increased competition, through de-regulation, corporate tax reductions, and increased public subsidies for the for-profit market. These policies favored proprietary medical care and highly medicalized services (high tech, acute care). Nonprofits were then subject to reduced government funding and increased competition in the market. This was seen at Facility A when funding was cut, the nonprofit facility began to resemble the for-profit organization in its level of quality care. Consequently, Facility A may be an example of organizational isomorphism (DiMaggio and Powell, 1983). However, the DON at Facility A was hopeful that rather than a permanent shift in quality, Facility A was simply in a "hiatus" that would quickly be reformed through internal and budgetary restructuring. The facility is responding to the staffing cuts by trying to redesign the workload assigned to particular staff positions. They are hoping that this staffing crisis

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1. The purpose of this document is to provide information on the status of the project.

2. The project is currently in the planning stage.

3. The project is expected to be completed by the end of the year.

4. The project is being funded by the government.

5. The project is being managed by the project manager.

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or "hiatus" will end when work responsibilities are reorganized. For example, the responsibilities of each position in the facility, from the laundry personnel to the head nurses is being examined to determine if a reorganization of job tasks might improve efficiency, even with a smaller staff.

However, the crisis of the nonprofit sector is more than economic, it is also a crisis of legitimacy (Estes & Alford, 1990; Estes, Binney, & Bergthold, 1989; Gray, 1993). Gray (1993) explains that due to the increased commercialization of health care, nonprofits must compete with for-profits for funds and for legitimacy. Nonprofits, when competing with for-profits, are often judged as less efficient, despite the fact that research does not support that perception. The weight given to the value of efficiency and the private market, further undermines the nonprofit sector's legitimacy and promotes further funding cuts for nonprofit health care institutions. Further study might examine changes in the organization and quality of care at Facility A as it confronts these political and economic challenges.

While there appears to be an association between tax status and the differences in quality found, a causal relationship between ownership and quality cannot be proven from these data. The degree to which ownership structure influences quality care is still debated. Marmor et al. (1987) summarized literature showing that while for-profit nursing homes provide care with average costs 5 to 15 percent lower than their nonprofit counterparts, proprietary facilities are disproportionately represented among

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institutions offering the lowest quality care. In a concluding point, they suggest caution in weighing the influence of organizational form too heavily:

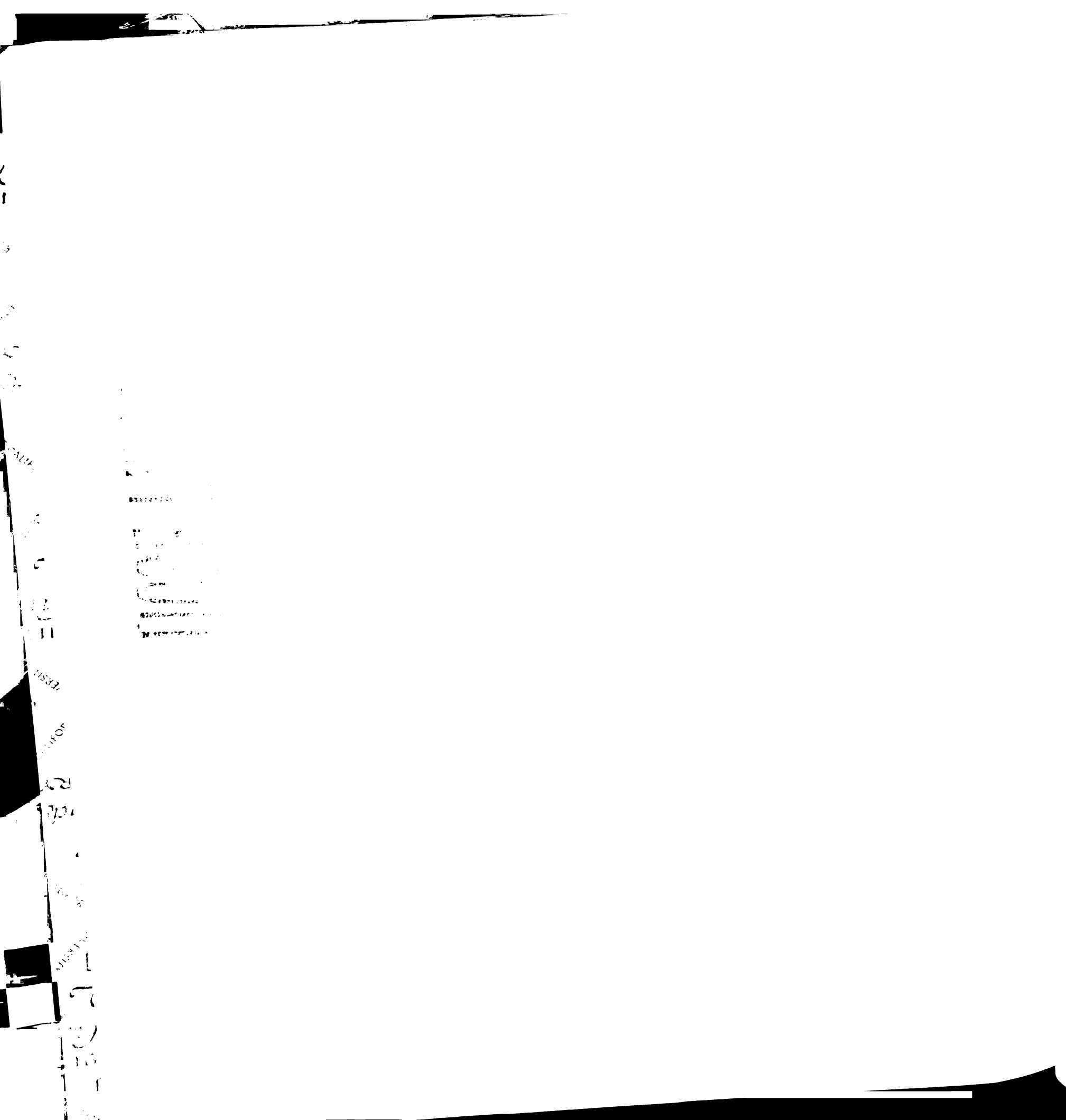
...factors other than the legal form of organization-- whether nonprofit, profit, or governmental-- have dominated the shape of American medicine and still do. To date, who pays for whose health care and how, the number and distribution of physicians and nurses, the organizational characteristics of payers and providers, and the larger political and economic environment-- all these factors dwarf changes in corporate form in giving shape to how doctors, patients, and health insurance interact (p. 234).

The next sections will discuss some of these other factors.

Financing and Reimbursement

Disparity in Government Funding

While ownership affects the funding sources in the nursing home, the license status of the facility is equally influential. Facility A, as a hospital-based long-term care provider, receives a higher reimbursement from public insurance programs than Facility B receives, a facility licensed only for skilled nursing. For example, Facility A receives a per diem Medicaid reimbursement of approximately \$211.00, compared to \$93.00 received by Facility B. This issue was not apparent in the data from the original study and was first mentioned by the Assistant Medical Director (AMD) at Facility A during my initial meeting with him. He explained the two categories of skilled nursing facilities, "Distinct Part" and "Freestanding." Freestanding



nursing homes are independent facilities, whereas, distinct facilities are those which reside within a hospital-- meaning, a hospital has a distinct part for long-term skilled nursing care. Facility A, as a distinct part facility, receives a higher Medicaid reimbursement rate. This is due to the higher acuity level of patients in the acute care setting and those transferred from the acute ward into skilled nursing at Facility A. The AMD explained, however, that these "extra" funds are absorbed by direct patient care, as evidenced by the average \$21.00 Facility A is still short when caring for Medicaid patients.

While a conclusive statement cannot be made from these data on the relationship of reimbursement to quality of care, the association of the two must be explored. Intuitively, logic might argue that the more funding a facility receives, the better quality it could provide. Strikingly, Facility A provided more staff and services for their patients than Facility B. Nurses at Facility A were paid higher wages, contributing to job satisfaction, staff continuity, and nursing leadership. This was not seen at Facility B. In this exploratory study of two facilities, there appears to be an association between the amount of reimbursement and quality of care.

Thus, further study must not only examine the role of ownership in the provision of quality care, but include the amount of financing the nursing home receives. This study indicates that there is an interaction between ownership and reimbursement that should be explored further. It is important to question whether higher quality care at Facility A was the result of its non-profit status or rather the higher reimbursement rate Facility A

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Figure 1 *Continued*

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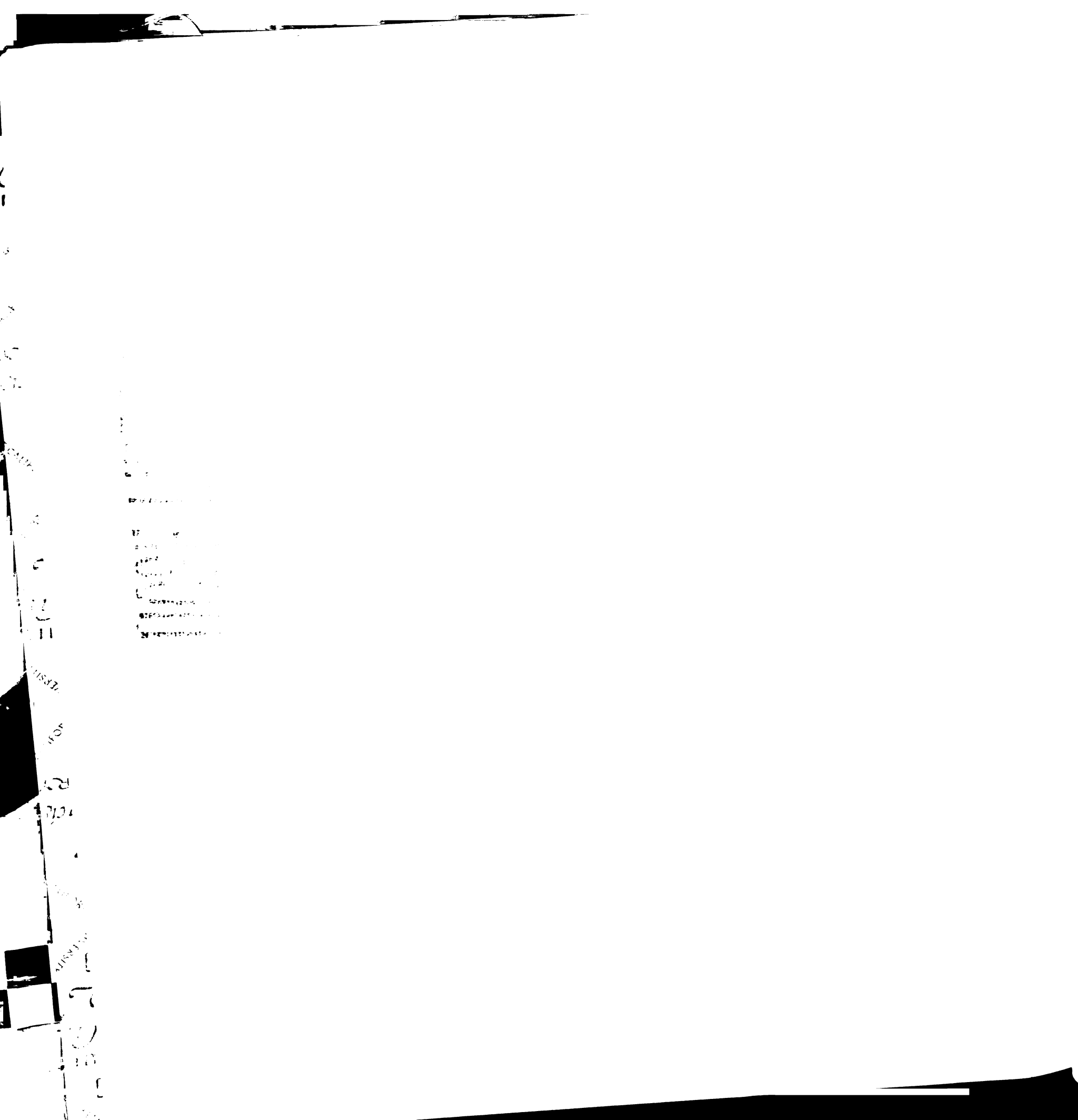
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received as an institution licensed for acute care. While these data do not provide information on this, further study might assess how patient care at Facility B would be affected with a similar increase in Medicaid reimbursement rates.

Reimbursement and Physician Services

As has been explained, Facility A and Facility B differ in the structure and financing of their physician services. Facility A is a closed organization with full-time, in-house, staff physicians, and Facility B has an open model using community based physicians to provide services to its patients. Physicians at Facility A receive a salary from the facility; where as, Facility B physicians are reimbursed privately through government (Medicare/Medicaid) or private insurance. With the government rate, as discussed above, being lower than reimbursement rates for services provided in office or acute care settings, Facility B physicians perceived this as a barrier to providing care in the nursing home. The data revealed that this difference in reimbursement policy embedded in the nursing home financing structure was associated with differences in patient care.

With their salaries not being directly affected by the rate or amount of reimbursement, Facility A physicians lacked the same incentives Facility B physicians had to visit fewer times and for shorter amounts of time. In fact, not being constrained by reimbursement policy seemed to positively influence patient care. For example, as salaried staff, physicians at Facility A could visit their patients as many times as they wanted or needed, for the



same income. In the acute illness cases analyzed, physicians at Facility A saw their patients more often and responded more immediately to acute illness reports by nurses than physicians at Facility B. Additionally, they were more likely to note a developing problem when they saw the patient daily. Several physicians at Facility A visited their patients daily, and some described daily casual visits to their patients just to say 'hello' or see how they were feeling. These doctors examined their patients when they expressed discomfort or when the nurses brought a concern to the physician's attention. At Facility B, with physicians in the nursing home for brief periods of time and with the frequent turnover of nursing staff, there were fewer opportunities for nurses and physicians to develop strong, collaborative relationships with regard to patient care.

Another positive effect of having house physician staff not constrained by reimbursement policy was that the treatment by telephone, prominent at Facility B, was nearly nonexistent at Facility A. As was apparent in the AIE's, Facility B physician visits were sometimes replaced with telephone calls between the nurses and the physician. With low reimbursement rates and no salary guarantee, it was not surprising to find that patients were treated over the telephone. Kayser-Jones (1995) identified and labeled this phenomena in the original study as "The Practice of Medicine by Telephone." She discussed many of the implications of telephone practice on patient care, including physicians not seeing the patient's declining condition with their own eye's which might alter diagnostic or treatment decisions; nurses not always



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| Name | Address |
|-------------|-------------|
| John Doe | 123 Main St |
| Jane Smith | 456 Elm St |
| Bob Johnson | 789 Oak St |



presenting reliable information about the patient's case over the telephone; and rushed and often rude physician-nurse telephone interactions.

In the cases analyzed, when nurses put in a call for the physician relating to a patient's condition, the physicians sometimes gave an initial telephone order, but it was followed-up by a visit often within the hour, depending on the urgency of the condition. When reimbursement was removed as an issue in care provision, in combination with the physician being physically located at the nursing home, the amount of telephone practice found at Facility A was minimal in comparison with Facility B. This was evidenced in the acute illness cases analyzed in which Facility A physicians rarely made telephone orders without first coming to examine the patient. In these cases, they spent more time with the patients and less time on the telephone. The opposite was evident in the Facility B cases.

Physicians at both facilities expressed concerns about the high cost of treating nursing home patients. Many reported that cost influences their decisions of whether or not or to what extent to treat nursing home patients that develop acute illnesses. Physicians at Facility B reported that low reimbursement was a concern for them or a barrier in providing quality care to patients, while Facility A physicians did not express this difficulty due to the different financing structure of physician services. Thus, the financing and reimbursement of physician care in the facilities seems associated with the provision of quality care.

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1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

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Another issue that arises from this difference in physician services relates to accountability. When physicians are salaried by the institution, they are accountable to the institution. The institution holds the resource on which the physician is dependent-- their wage. Thus in applying a resource dependency perspective, the physicians would provide better care to secure their resources. The institution is therefore in a position of power relative to the physician staff. In contrast, at Facility B, the physicians reimbursed by the state, who come and go when they choose, are less accountable to the facility. When physicians were delinquent in their monthly visits, Facility B nursing staff (as shown in the findings) called the physician several times and would eventually have the Medical Director sign off on the patients' monthly orders. This was done to prevent any citations for violations of nursing home regulation. Should a facility be cited for this, it is the institution, not the individual physician, who is held accountable to the state. Thus, in this context, physicians are not dependent on the nursing home or patients for their resources in the same way as Facility A physicians are. With less power over the physician, it is conceivable that quality of physician services would be compromised, as evidenced at Facility B.

Nursing Home Labor

Another aspect of the political-economy of an organization is the relationship between the labor and the administration (as representatives of the owner). As has been described, the nurses at Facility A earn higher wages, have more job security, hold more positions of leadership, and have better



1. The first part of the document is a list of names and addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Thomas White. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; and 101 Pine Street, New York, NY 10004.

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relationships with physicians than nurses at Facility B. It was not surprising, under these conditions, that the average length of employment of the nurses interviewed at Facility A was considerably longer than that at Facility B. The contrast in the work environments of the two facilities helps explain why many Facility A nurses expressed greater satisfaction with their position and work environment than Facility B nurses.

With nurses themselves dissatisfied with patient care at Facility B, it was also not surprising to find a greater number of concerns raised about the quality of nursing care at Facility B provided during the acute illness episodes (AIEs). Recall, in 15 cases (100%) at Facility A, no concerns about nursing care were raised by the patients or families, RAs, or the project physician; whereas at Facility B, in 9 cases (60%) concerns were raised. The nurses' perceptions, along with poor wages and poor leadership, contributed to greater turnover and perpetuated an environment where quality care was compromised.

Furthermore, at Facility A, the organization of nursing care, the low turnover rate, and higher job satisfaction created an environment that supported nursing leadership and supervision. The positive nursing leadership seemed to contribute to positive relationships among the nursing staff. Nurses were empowered and held more power in their position in the facility. Thus, they had more ability to supervise patients and other nurses.

Once again, the political-economic perspective is useful here in theorizing about the context of the nursing staff. If a Marxian analysis is explored, consider the nurse the laborer and the product a well-cared for

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1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

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patient. The means of production is the act of the nurse providing quality care, all of the activities involved with this process. Marx (1963) described a state of "alienation" in which the worker loses control over his product, where the worker is not able to exert power over the process of production or the product (Giddens, 1971; Scott, 1981). With nurses at Facility B producing care in a dissatisfying, unsupportive, and disempowered work environment, quality care to patients (the product) may come to exist "independently, outside himself [the laborer], and alien to him" (Marx, 1963, quoted in Scott, 1981, pp. 294-95). This perspective offers one explanation for why nurses at Facility A were more involved with the care of their patients, knew the details of their cases well, and viewed themselves as family to the patients.

The strong nursing leadership at Facility A supported and advocated a patient-centered philosophy of care that seemed to contribute to a higher morale among the staff nurses. With the strong philosophy, nurses felt a sense of achievement and satisfaction when they provided quality care to their patients. One RN explained that for dependent patients the progress was very slow. When there was improvement though, no matter how small, "That makes the staff happy because we feel that we have obtained our goals. It makes us feel happy."

Knowing their patients well was a priority for nurses at Facility A. As illustrated, many RNs and NAs emphasized the importance of knowing patients well in order to notice subtle changes. When nurses did not know their patients well, they risked missing these subtle changes in their condition

and could not attend to patient needs in the same way as with patients they knew well. Facility B patients, such as Reverend Jenkins, who were denied basic elements of quality care (hydration, in this case), may have received a different level of care had they resided at Facility A, where nursing leadership and supervision with a pro-life stance were strong. Thus, the influence of strong nursing leadership and financially secure positions contributed to a lower level of alienation in Facility A nurses. They were less alienated both from their product-- the cared for patient, and the production of quality care.

In addition to lack of leadership and poor wages, it is suggested here that the understaffing at Facility B perpetuated the alienation of nursing staff and patients in the nursing home. With fewer nurses to provide the necessary care, Facility B nurses, as illustrated in the findings, often felt stretched to meet the needs of their patients. This environment did not strengthen relationships between patients and nurses and did not support the provision of quality care. For example, the understaffing of nurses led to the degrading and distressing situation of Mrs. Pelman waiting for a nurse to take her to the bathroom. Clearly, here, more staff, in addition to better leadership and supervision, could have prevented this. In a nursing home environment however, where costs are minimized and staff levels are kept low, such situations are likely to become problems. It is further ironic that this patient was recovering from a bowel obstruction and was to avoid constipation, but now could not get to the bathroom. A patient who must wait and fears being incontinent may hold their bowel, perhaps like a toddler

who holds back their B.M., and this could increase the risk of constipation. This incident was not just an assault on the woman's dignity, but a potential health risk as well. While eventually, Mrs. Pelman's condition improved there were many problems with the care she received. In the underpaid, understaffed, disempowered, and alienated situation of Facility B nurses, these examples of poor care should not be unexpected.

This discussion builds on Diamond's (1992) description of nursing homes as "bureaucratic organizations founded on specific relations of power." In his study, Diamond (1992) examines the work experience of nursing aides in a nursing home in which he also worked as an aide. The majority of the nursing aides in his facility were women of color, many from Third World countries, as one resident referred to said: "It's like the United Nations in here" (p. 39). Diamond describes the oppressive situation of the nurses who are underpaid, understaffed, and unacknowledged, "working in a multinational corporate context, in which the health care system of advanced capitalist societies depends on the work of Third World women" (p. 42). Although Diamond does not discuss alienation specifically in his study, he explains how care becomes commodified under these conditions:

In the context of being made into a business, caregiving becomes something that is bought and sold.... It entails the enforcement of certain power relations and means of production so that those who live in nursing homes and those who tend to them can be made into commodities and cost-accountable units (p. 172).

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These inequitable power relations he describes between patients and nurses and nurses and the administration were similar to those found at Facility B.

Medicalization

In addition to the power and resource dependency of labor relationships within the nursing home, it is important to explore the relationship between quality care and larger social institutions, such as medicine. As defined by Conrad (1992), "medicalization occurs when a medical frame or definition has been applied to understand or manage a problem..." (p. 211). While the predominant focus in studies of medicalization has been on nonmedical problems that have been medicalized, Conrad (1992) argues that all problems that come to be defined in medical terms must be included. Medicalization is a process within the political-economic context in that the extent to which medicalization exists in a social issue or in an environment represents the determining and defining power of medicine over that entity. For the purpose of this study, only certain aspects of medical care are examined, such as medical treatment of acute illness, care provided by physicians, and medical auxiliary services. Other areas within the medical model, such as rehabilitation services, were not within the context of this study; however, more examination of the strengths and limitations of these services is important.

To understand the degree to which Facility A and Facility B were sites of medicalization the following will be discussed: the organization of care according to a medical model and the constructions of health and aging that

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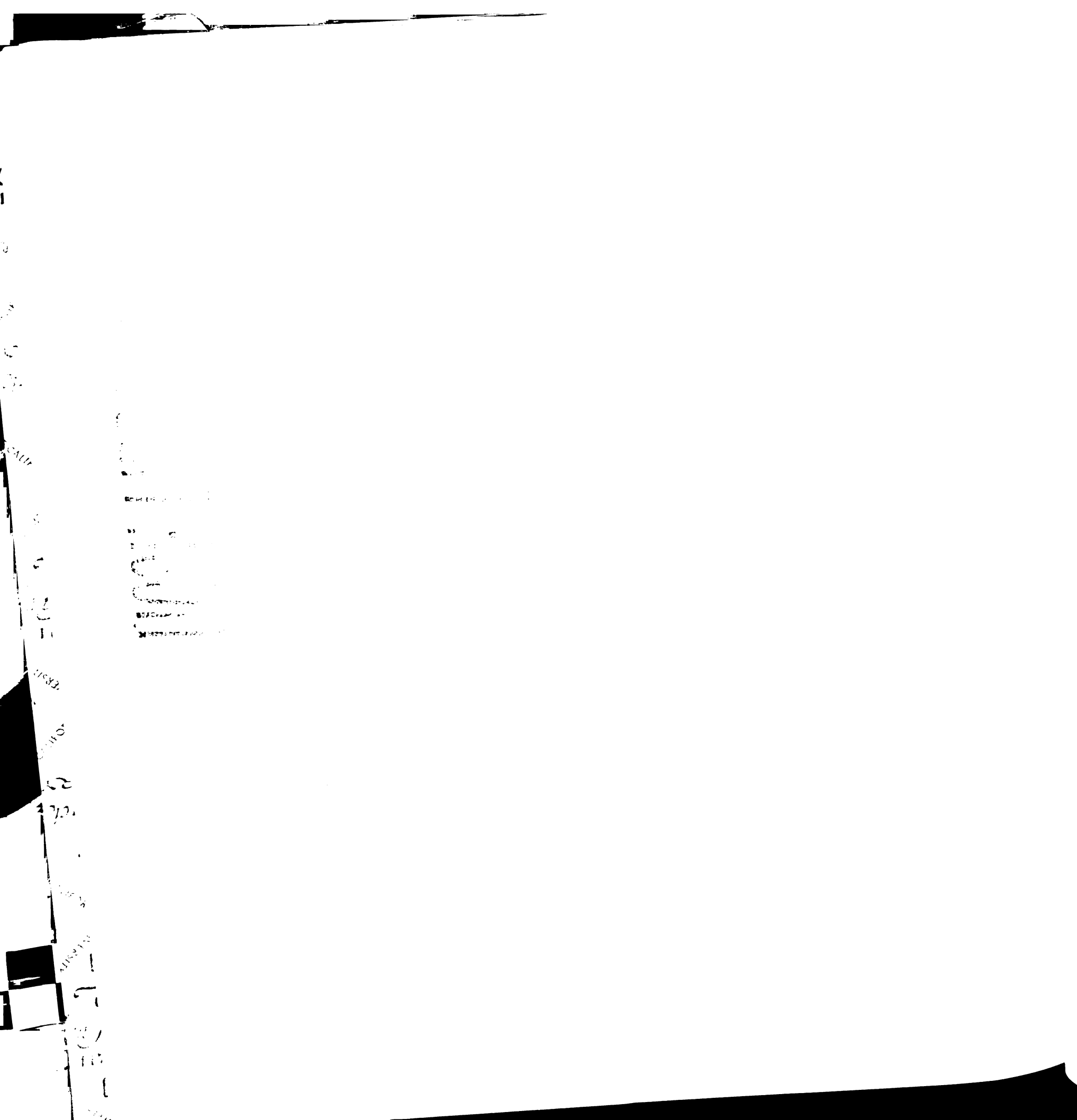
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are defined by and reproduced by a medical model of care. Paradoxically, each facility attempted to provide a home-like, nurse centered, long-term chronic care setting; yet, over-medicalization resulted from dominating medical values and constructions. Ironically though, behind these medicalized care priorities, images, and expectations in the nursing home, lay a very under-medicalized institution, lacking adequate physician care, medical specialties, services, and equipment. Thus, when the over-medicalization in the nursing home is discussed, it does not imply that patients receive sufficient medical care and resources.

Over-Medicalization

Lack of Psycho-Social Care

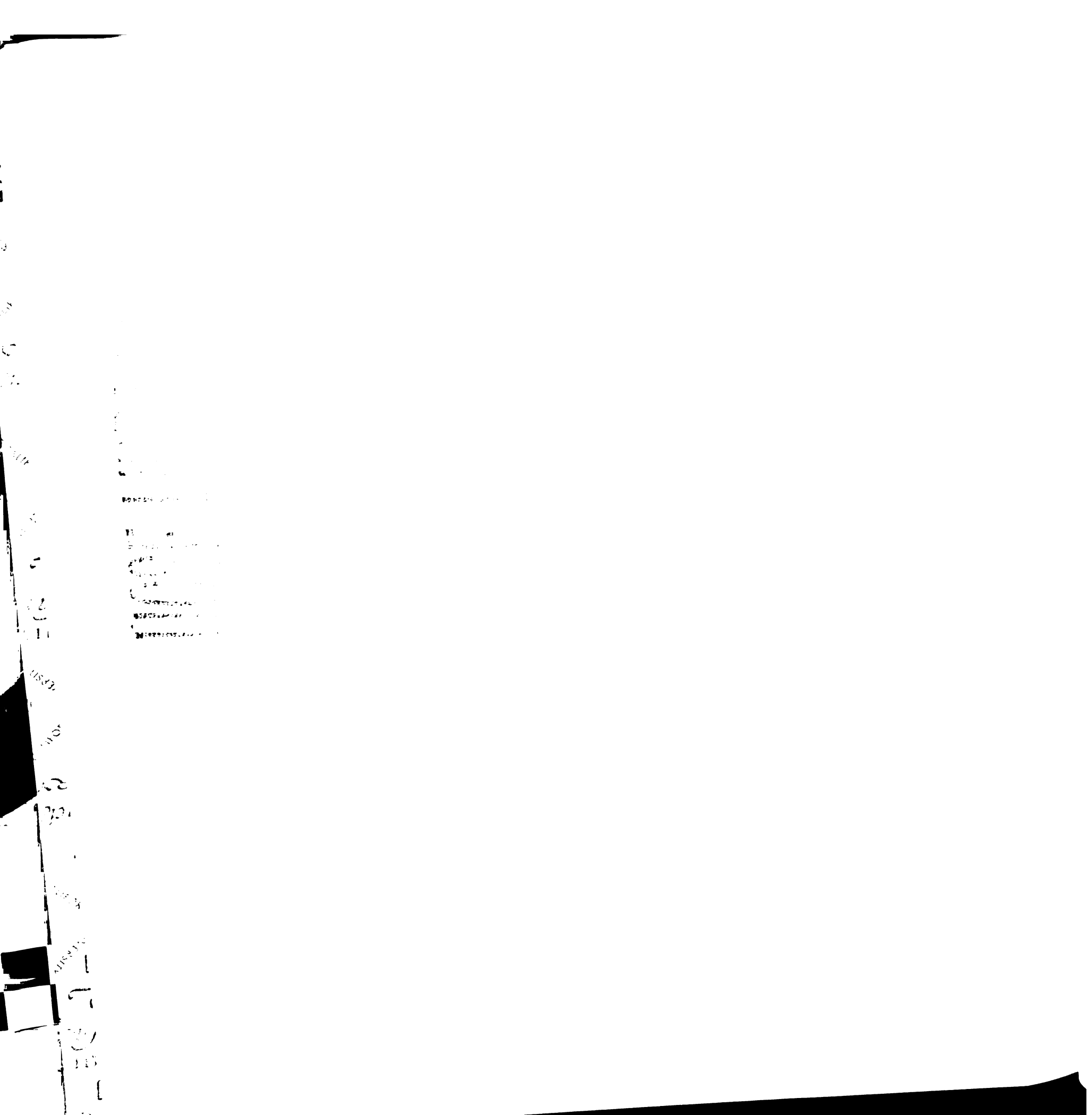
As the findings illustrated, psycho-social care was not adequately provided at Facility B. With the staff time constrained by understaffing and patients with increasing needs, nurses had to prioritize their patient care needs. It is argued here that the organization of the nursing home as a medical institution, promotes an environment in which medical needs of patients are prioritized over their psycho-social and emotional needs. For Facility B patients, this seemed to contribute to their dissatisfaction with quality of life in the nursing home, with many expressing their boredom, loneliness, and isolation. While medical needs may be more critical for the patients survival, it is suggested here that the degree of neglect of psycho-social needs was detrimental to Facility B patients.



In the medical model, nursing home residents are 'patients' and patients are in a medical institution to receive medical care. In Facility B, there was no expectation that "patients" would interact or socialize with one another-- they are patients, there to receive treatment. Being a "patient" does not involve social dining or walking or being sick together. If the nursing home were truly a "home" these relationships would be facilitated or encouraged by the staff, and there would be more activities that encouraged interaction. Additionally, the physical structure of the nursing home could be altered, for example, providing more room in the patients' rooms for chairs, a provision that would encourage independence and interaction (with visitors), rather than dependence (bedbound) and physical discomfort, as described in the findings.

While patients at both facilities confronted problems of theft, abuse, and insensitivity of nurses, this was more prevalent at Facility B. These assaults on the patients were likely to injure their psycho-social well-being, undermining any emphasis on psycho-social care and well-being. Patients who feared bringing personal items into their rooms only to be stolen, consequently lived in rooms resembling those of the hospital room rather than the home. Kayser-Jones (1981) found that theft was more prevalent in the American, for-profit facility she investigated than in the Scottish facility. As one reason for this finding, she offers the following:

...because the staff at Pacific Manor [the American facility] infantilize, depersonalize, and dehumanize patients, they are not likely to develop

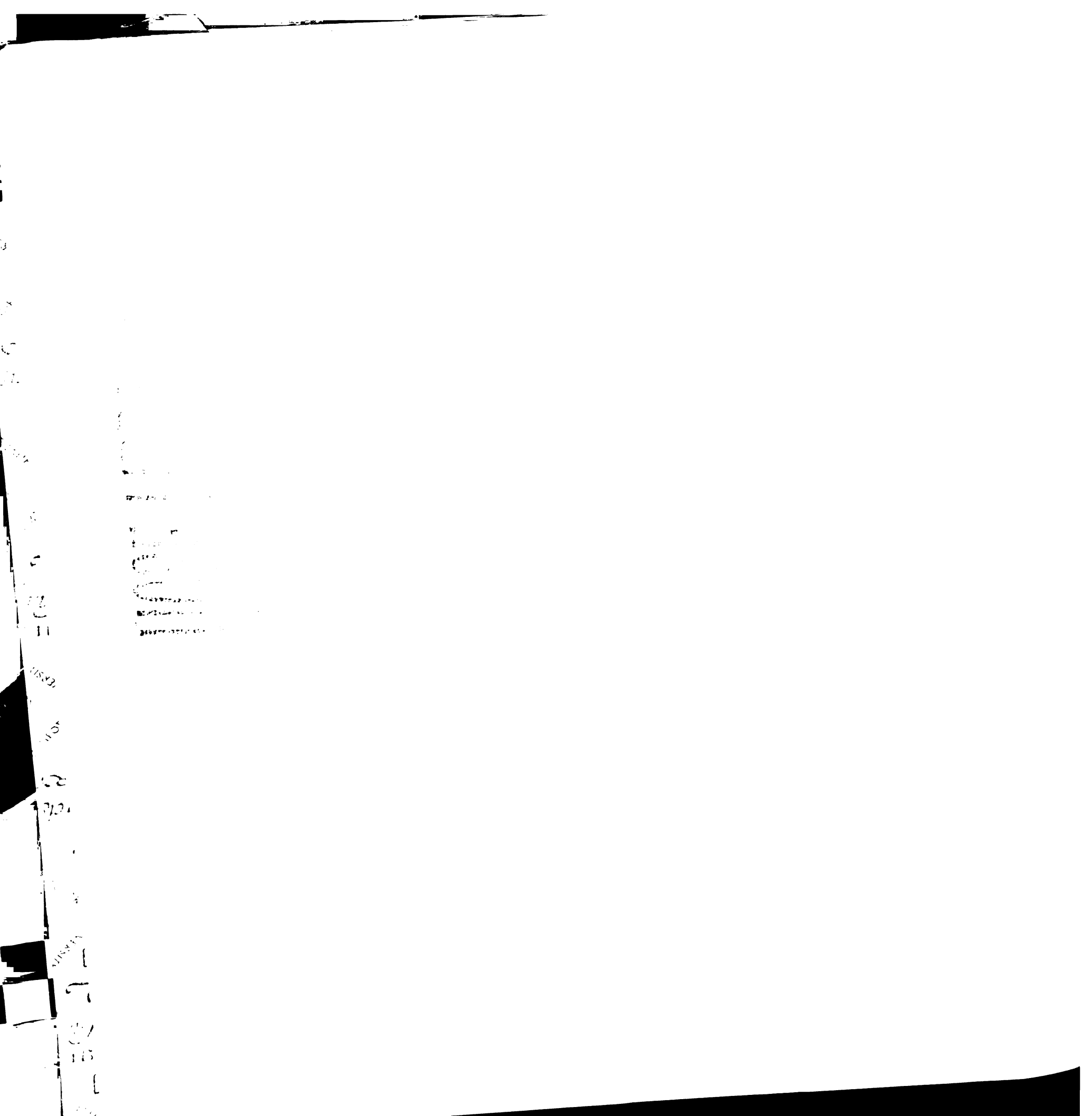


personal relationships with them. It becomes easy for staff to steal from a "childlike, nonperson, nonhuman" who has no rights (p. 54). The alienation of the nurse laborer from her product, as was described above, is consistent with Kayser-Jones' findings. Thus, the medicalized priorities and the disadvantaged, alienating work environment intersect to inhibit the provision of quality psycho-social care to patients.

While Facility A patients were also victims of theft and abuse, their daily psycho-social needs were attended to more, with more staff time available to patients and more meaningful activities provided by the facility. The difference here may once again be understood in light of the contrasted philosophy of care in each facility. Consistent with the earlier literature cited on differences in for-profit and nonprofit nursing homes, Facility A provided more services for its patients. In the 1980's, Facility A's patient-centered priorities were not impinged on by cost-containment objectives; however, Facility B's priorities of profit and cost-containment influenced the organization of care. Thus, the relationship between profit, ownership, and the promotion of medicalization is exemplified in these findings.

Physician Authority

Another aspect of the organization of care in the two facilities lies in the professional roles of the nurses and physicians. The physician-centered organization of care at Facility B, where physicians held the power to make orders and prescribe, despite their physical absence from the facility, promoted a medical model that did not always attend to the patients' needs. This was

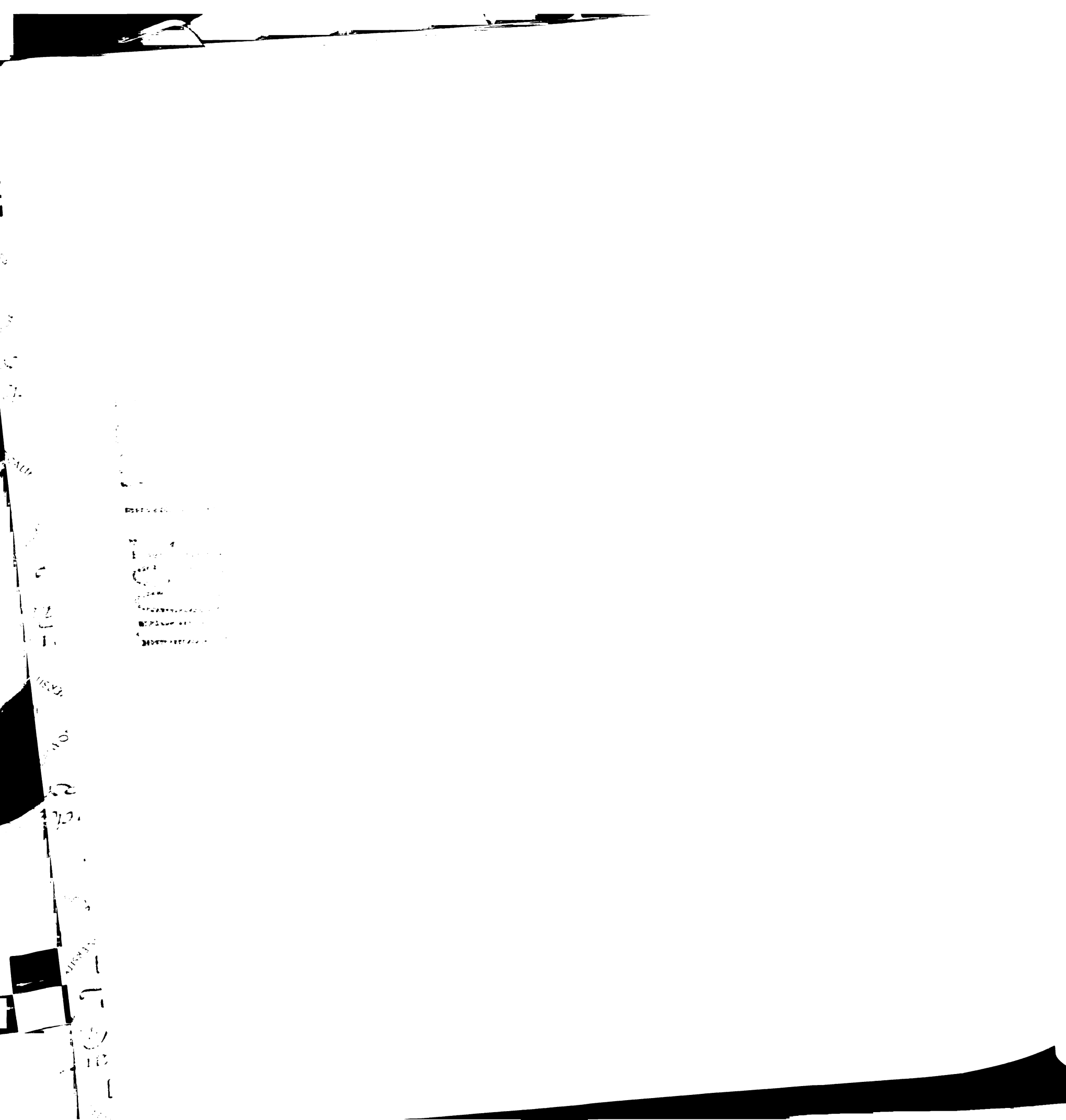


seen in the acute illness cases where patients sometimes waited hours or days for their physician to respond. While this is an example of the inadequate provision of medical services at Facility B, it does not alter the regulations that require physicians to be gate-keepers of care, nor the strong view of physician authority held by patients and families. Thus, regardless of the reality of care provision, the medicalized policies controlling prescriptive power and care orders and the construction of the physician as an authority reproduced an over-medicalized environment.

The data revealed that many patients and family members believed and trusted their physician was doing what was best for them, even if he or she never visited. Zola (1990) described the assumption that what is dominated by medicine is assumed to be good, or for the good of the patient. This can be seen here where, as medical agents, physicians are assumed to be providing good care to their patients, and as a medical institution, the nursing home is assumed to be providing quality care.

This construction of physicians as infallible is another example of the paradoxical nature of medicalization in the nursing home. Physicians are assumed to be providing quality of care, thus are given the autonomy to provide minimal care. Thus, the over-medicalized construction of physicians results in inadequate medical care. Gray (1991) discusses this further:

...a profession's ability to win and retain a high degree of autonomy depends on more than political power (a function of numbers, money, and prestige) and the esoteric nature of the knowledge that is involved.



It also rests on the plausibility of the claim that individual practitioners act primarily in the client's interest and that the organized profession acts primarily in the public interest (p. 171).

This was seen in Facility B, where physicians held the power, patients perceived them as trustworthy, and physician accountability was not enforced. Patients, dependent on physicians for care (the resource) and having the least power, comply with dominant perceptions of medical authority. Gray (1991) suggests that in these situations, "Trust has in many ways substituted for more formal mechanisms of accountability," regardless of its effectiveness as a mechanism (p. 13). Finally, these assumptions of quality or adequate medical care produced and reproduced by the medicalized construction of the nursing home obscure the reality that this may be a facade. Rather, Facility B, and to a lesser extent, Facility A were under-medicalized institutions as will be discussed.

Social Construction of Aging

Estes (1979) explains the relationship of social constructions of aging and the experience of aging:

The experience of old age is dependent in large part upon how others react to the aged; that is, social context and cultural meanings are important. Meanings are crucial in influencing how growing old is experienced by the aging in any given society; these meanings are shaped through interaction of the aged with the individuals, organizations, and institutions that comprise the social context (p. 14).



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Estes (1979) describes the sources and consequences of defining old age as a problem in society. The social construction of aging as a medical problem is one related aspect of the medicalization of aging discussed further by Estes and Binney (1991). The medicalization of aging has occurred when aging is thought of in terms of medical problems or when medical conditions are viewed as normal, inevitable parts of aging. For example, the Facility A physicians who reported as the immediate cause of death for two patients, "failure to thrive and advanced age" and "general debility" constructed age as a medical problem, one that even causes death. It is more likely that these two patients died from an undiagnosed or neglected medical condition that may have been complicated by their advanced age.

The findings also illustrated the dangers in viewing depression and debilitation as normal parts of aging. This is important because when depression and physical debilitation were viewed as normal or unavoidable parts of aging, then the elderly depressed patients risked not receiving the treatment they needed. This was seen in the case where a Facility B patient was depressed and expressed a wish to die. Her physician, based on these death wishes, did not transfer her to the acute hospital despite symptoms warranting a transfer. The physician assumed that the depression was a part of his patient's aging and could not be resolved. However, when an on-call physician covered him over the weekend, he transferred the patient to the hospital where she was diagnosed with a urinary tract infection and dehydration (both contributing to the depression and death wishes). When



these conditions were resolved, the patient returned to Facility B and "very much wanted to live." The patient's physician was tremendously relieved that his patient was treated, stating, "That was a close one...I really thought she wanted to die...."

This finding is consistent with findings in other studies that have examined the influence of medicalized constructions of aging on the quality of life or quality of care of elderly people. Estes et al. (1984) describe how the construction of the elderly as "ill" has created a societal expectation that all elderly should take on the role of a sick person. Thus, elderly are expected to withdraw from society, reduce their social and occupational responsibilities, and become dependent on others. Lyman (1993) found that the medical model and construction of the aged with Alzheimer's Disease had negative consequences for care provision, including iatrogenic illness, dependency, and infantilization. Raphael et al. (1995) argue that frailty is a social construction emphasizing a biomedical and individualistic approach to aging. They suggest that many studies of frail elderly have ignored the social and environmental factors that produce frailty and have defined frailty as an inevitable part of aging. This, they continue, has limited the range and availability of interventions to prevent or reverse physical decline. A similar argument is made here regarding the physical, cognitive, and emotional decline of patients in the nursing home.

Thus, this conception of aging obscures what may be potential environmental or external causes of depression by normalizing the elderly

patient's condition. In this way, these constructions may benefit those in business and power. First, non-treatment or neglect may be excused when the physical and social decline of elderly patients is perceived as normal or inevitable. Second, if age is a medical condition that requires intervention then medicalized institutions, such as the nursing home, and medicalized professionals, such as physicians, must be supported to provide intervention. Thus, these social constructions reproduce a medicalized organization of care and reinforce the power held by physicians in the nursing home.

Under-Medicalization

As discussed, the medical model of care and medical definitions were found to influence the environment and provision of care in the nursing home. However, as expected, this study found that the under-medicalization of services and care was equally problematic for patients in the nursing home. Other research has found that medical care and services are inadequately provided in the nursing home (e.g., Kayser-Jones, 1990a; Kayser-Jones et al., 1989; Harrington et al., 1995; Moseley, 1994); however no studies have explored the paradoxical situation of the nursing home as a site of competing processes of over- and under-medicalization. Here also, a resource-dependency perspective will provide insight into this dimension of the political-economy of nursing homes.

Absence of Physicians

The presence of physicians in the nursing home is important to the provision of quality care. Physicians provide assessment, evaluation, and

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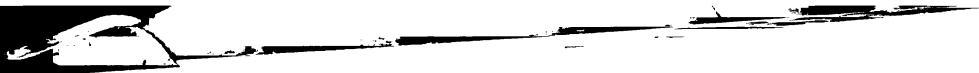
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treatment of acute health care concerns that arise in their patients, while monitoring and managing the care of the chronically ill. Physicians work along with nurses to follow through on care plans for their patients. When physicians are not sufficiently present in the nursing home and nurses can not compensate for their absence, patients' care may be jeopardized. This was a significant problem at Facility B, where the nurses had to rope and lasso even the Medical Director in to visit his patients. This raises questions about the standard of patient-centered care in this facility.

As previously discussed, there appear to be negative consequences to the absence of physicians in the nursing home that were found in the data, such as poor nurse-doctor relationships; poor communication among physicians and nurses, patients, and families; and delayed or inappropriate treatment. For example, in the AIE case example where a Facility A physician waited two days before visiting his patient with a probable small bowel obstruction, the physician on the study's research team claimed that with a small bowel obstruction, it was "unreasonable to allow one day to go by without doing anything as was done here."

Consequently, some Facility B physicians were less aware of the complex factors influencing their patients' care in the nursing home, such as the physician who stated that nursing staff turnover does not influence patient care. His comment demonstrated the degree to which this physician was removed from issues in the nursing home and from the knowledge that structural factors are constantly influencing patient care. Staff turnover, in



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actuality, had destructive consequences for elderly patients in the nursing home, as discussed in the prior section on turnover and labor issues. In those facilities where staff turn over or leave often, patients must continually readjust to new staff, and staff must continually be trained on patients' preferences and needs. For a physician to say that the care provided is just a "simple skill" and that it "does not matter who does that" indicates a lack of understanding of the residents' needs and the skill required to care for them.

Currently, physician absence continues to be problematic in Facility B, while the structure of physician care at Facility A remains strong. Kayser-Jones (1997) described that in her most recent study, in the same nursing home (Facility B), physicians were still rarely seen in the facility. In contrast, at Facility A, the majority of the physician staff has changed since the original study was conducted; however, the structure and number of house and on-call physicians remains the same.

Limited Physician Control

While the in the above section it was suggested that physician authority was influential in the nursing home. Physicians at both Facility A and Facility B complained of the limited control they had over their patients, treatment decisions, and the nursing home environment. At Facility A, this resulted from the strong nursing leadership and staff. While Facility A physicians were more involved with their patients, visiting them more frequently than Facility B physicians, they described that they were often powerless over treatment and care decisions regarding their patients.

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Traditional medical environments are physician-centered, but at Facility A, it was the nurses who held much of the control over patient care and treatment decisions. Many physicians accepted this as part of the structure of Facility A, but others described an impotence they felt in the face of the nurses' power. While it may be in the patients' best interest to have a nurse-centered institution of care, the physicians' perceptions and experiences of impotence is an interesting aspect of under-medicalization worthy of discussion.

Nurse-centered care may be an aspect of under-medicalization or may represent, rather, a shift in the locus of medicalization. In other words, was medical care inadequate at Facility A or did the nurses compensate for the diminished role of the physician, providing adequate medical and nursing care? It is suggested here that the lack of physician power at Facility A is not indicative of an underprovision of medical care, but rather a shift in medical providers from physicians to nurses. As more nursing homes strengthen their nursing staff or utilize gerontological nurse practitioners in the future, it will be interesting to see whether they retain a nursing model of care or embrace and reproduce a medical model in the nursing home.

At Facility B, physicians believed their power was limited by regulation, reimbursement, and the drive for profit. As discussed above in regard to the nursing staff at Facility B, the owners and share-holders committed to securing profit, shape the organization of care at Facility B. Thus, in the interest of low costs, physicians are not staff members at Facility B; their compensation comes from private or public insurance. Further, as

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the data revealed, low compensation for services was a barrier to quality cited by physicians. The reimbursement structure did not provide any incentive to visit patients more frequently or improve care quality. Thus, physicians maintained a distant relationship with the nursing home and the patients, with a low accountability for quality care and low compensation for minimal care. Perhaps, with more resources, incentives, and fewer financial barriers, physicians would not associate monetary value with the worth of elderly persons.

The case of Reverend Jenkins, who was admitted to a non-Medicare bed at Facility B despite the possibility of needing IV hydration, dramatically illustrates the confluence of structural factors upon patient care in Facility B, and the physicians' perception of limited power within this context. In an analysis of this case in a prior paper, Weiner & Kayser-Jones (1989) show how priorities in patient care can become skewed as physicians act defensively, protecting themselves and the institutions in which they practice. Here, the physician was accountable to the policies of both the hospital and the nursing home, while it was the patient who lacked protection. The pressure of regulations trapped this physician into a difficult dilemma with his patient. DRGs forced Reverend Jenkins out of the hospital, while Medicare staffing regulations kept him from a bed where he could receive adequate care. Although, the Reverend's physician knew he would die in only a few days, this factor still forced him to endure the stress of a transfer from the hospital

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to the nursing home, where he could not even continue his hydration therapy.

The physician was criticized for his lack of compassion and concern toward his patient by the facility social worker and the researcher on the case. While compassion and concern must be priorities in caring for patients, this case also illustrates the physician's impotence in the face of the pressures of profit and regulations. His response may be better understood in light of these forces that have removed from him the ultimate decision of his patient's care.

Inadequate Medical Training

Another aspect of under-medicalization was the inadequate medical training physicians received in medical school. Some physicians from both Facility A and Facility B complained of being ill-prepared to care for the needs of the elderly, nursing home patient. As was presented in the data, physicians explained that the medical model, focusing on interventions and cures, was not always applicable to the nursing home population with a high level of chronic illness, requiring long-term care management. These physicians lacked geriatric training and training that emphasized patient comfort and maintenance rather than curing or healing. This exemplifies another paradox at play in the nursing home in that the over-medicalized model of physician training inadequately prepares physicians for the nursing home, resulting in further under-medicalization of care.

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In his 1997 interview, the Assistant Medical Director (AMD) of Facility A described the current staff as being "more professionally focused on geriatrics," due to the increased opportunities to receive training in geriatric specialization. He stated that this has contributed to improvements in physician care. As geriatric education increases for physicians, it will be important to study the affect this has on quality care and the structure of the nursing home.

Inadequate Medical Services

Another aspect of under-medicalization, also found primarily at Facility B, was the inadequate medical resources and services available on location. The medical services available on-site at Facility B did not keep pace with the rising complex medical needs of the patients. Facility A, due to its larger patient population, physician staff, and acute care license had many auxiliary medical services, such as, laboratory, pharmacy, radiology that were absent at Facility B. For example, due to the lack of x-ray services on-site at Facility B, the patient with the small bowel obstruction had to wait for an evaluative x-ray, a further delay in evaluation and treatment. In addition, medical equipment, such as geri-chairs, electric wheelchairs, and bed controls were found to be absent, lacking, or in poor condition. In the above AIE case, the malfunctioning bed crank put the patient's life at risk, by multiplying the risk of aspiration pneumonia as she vomited in a horizontal position. Thus, Facility B was a medical institution that in its drive to earn a profit

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compromised on necessary medical resources, while serving a patient population with increasing medical needs.

Social Constructions of Aging

As was already discussed, the definitions of aging and the aged permeating the nursing home influenced the provision of quality care. Some, as was seen in the last section, produced and reproduced the over-medicalized environment in the nursing home. Others, were both causes and consequences of the under-medicalization of care. The social construction of the elderly as not being worthy of a quality life can be understood as a contributing factor in the lack of treatment of elderly nursing home patients. Some physicians at both facilities were affected by this social construction of aging that perceived a diminished quality of life as a natural or normal part of aging and permitted it to influence treatment and care decisions regarding their patients. The case where a Facility B physician did not treat his patient's puss-filled bed sore because he knew the patient would die soon is one example of illness and aging defined as an unworthy state, where a patient no longer deserves improvements in quality of life. Here, the consequences of this construction of aging and illness is that the patient was denied treatment that may have provided some relief in her final days of life.

Another example is the controversial case of Reverend Jenkins. It is true that this patient was going to die anyway, and perhaps the physician was right that even without hydration, it would only be a few days. However, the last few days of the Reverend's life may have been made more comfortable

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with extra attention and care from the nurses, perhaps offering ice-chips by mouth when the IV was discontinued. The social construction of the aged as sick, dependent and unworthy of a quality life, and the construction of the nursing home as an institution for sick, old, undeserving people thus not subject to the same standard as other health care institutions, blinds us to the real question of human rights, when basic life care, like hydration, is withheld from an elderly man in his last few days of life, in the name of regulations and profit.

In this chapter, there are three core areas of discussion. First, a discussion of the findings in relation to current literature and research reveals that even where more recent improvements in quality have been achieved, nursing homes face similar structural barriers to providing quality nursing, medical, and psycho-social care to those that they did a decade ago. Second, a comparison between a nonprofit and for-profit nursing home enables a discussion about the role of ownership, profit, and philosophy in the organization of care. Finally, a political-economic perspective, including a discussion of social constructions and medicalization, provides a lens for understanding the relationship among health professionals, patients, and the organization; and where these relationships are situated within the larger structural context of the nursing home. This discussion illuminated factors in the political-economy and their relationship with the care provided day to day in the nursing home.

Keywords: *depression, mood, mood disorder, mood disorder with anxiety, mood disorder without anxiety, mood disorder with anxiety, mood disorder without anxiety, mood disorder with anxiety, mood disorder without anxiety*

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CHAPTER VI: Conclusion

This study was a political-economic analysis of factors influencing the provision of quality care in the nursing home. It was expected that structural factors, such as ownership, financing, labor, regulation, and medicalization have created a challenging context in which nursing, medical, and psycho-social care are provided to elderly patients. Through the comparison of two nursing homes with several distinct differences in ownership and the organization of nursing and medical care, the relationship between quality and these factors was explored. As a contribution to gerontology and sociology, the political-economy perspective was applied to power and resource relationships both internal and external to the nursing home. Medicalization and the social constructions of aging were dimensions of the political economy of the nursing home that provided fruitful analysis and discussion.

Limitations of the Study

The most important limitation of the study findings stems from the small sample size of two facilities. Facility B is representative of many forprofit corporate owned nursing homes; however, Facility A is somewhat unique in its large size, mix of care licenses, and closed physician organization. Further, as mentioned, the disparity in Medicaid per diem reimbursement rates is large between the two facilities. Thus, the generalizability of these findings is limited by the study size and distinct

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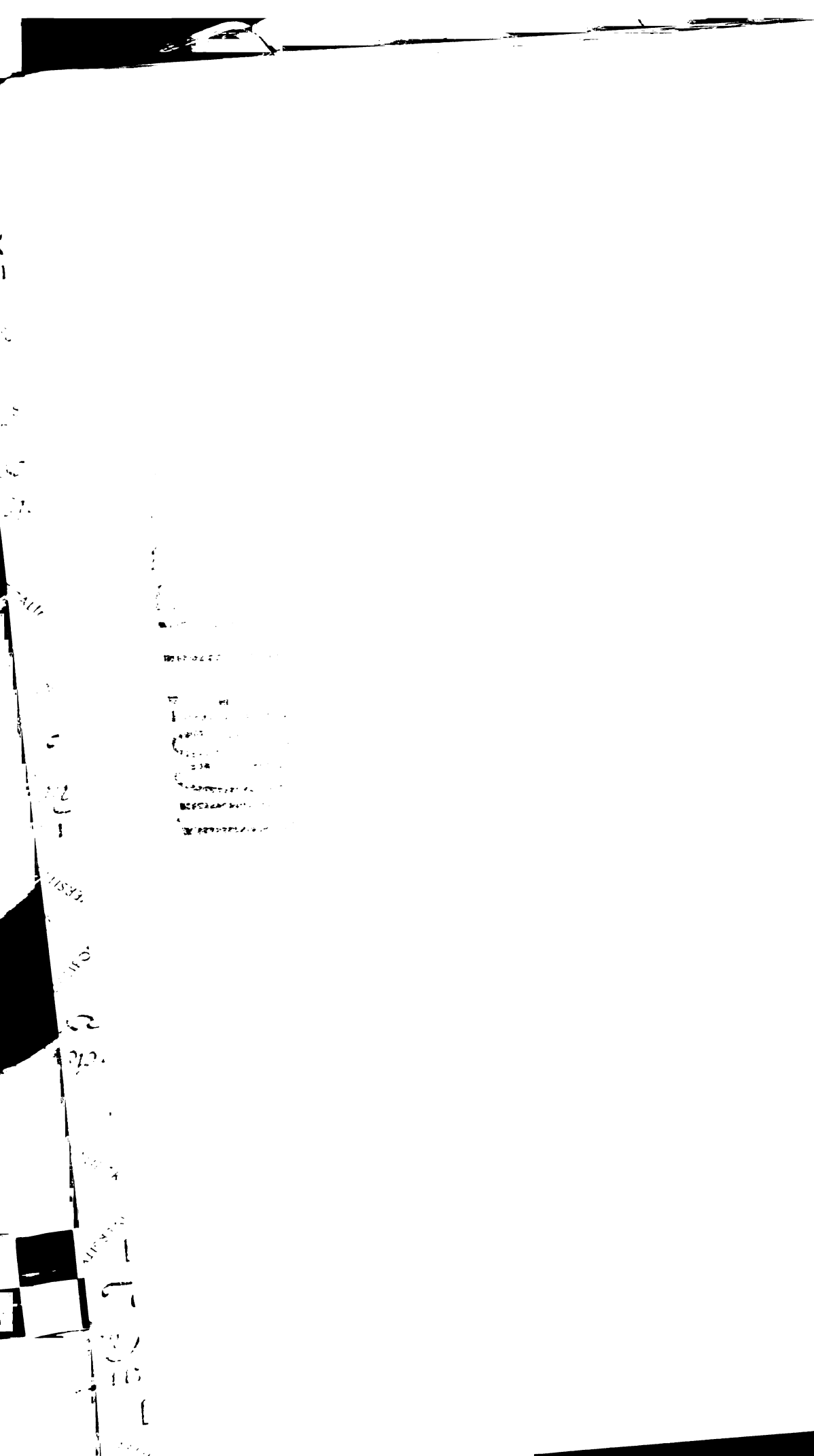
features of the facilities, including the reimbursement differences between them. However, it is suggested that the value in this comparison lies in what can be learned from the differences, in what possibilities are discovered for restructuring the context of nursing home care. Further, as a site of high quality care, despite its uniqueness, Facility A must be studied as a potential model for replicating high quality care.

An additional limitation is that these data are now a decade old. While this may call the data relevancy into question, interviews completed in 1997 with leaders in state and national nursing home organizations suggest that while years have passed and changes have occurred, the nursing home of today still confronts many of the same issues presented in the findings of this study. Further, a key element of this study was not in identifying every influential factor of quality care, but in investigating the relationship between the nursing home and its structural context. The increased knowledge and understanding about this political-economic relationship gained from this study will be applicable to future research on nursing home care in the United States, regardless of the era.

Contributions of the Study

Quality of Care in Nursing Homes

This study contributes to the increasing understanding of quality care in the nursing home. As a nonprofit, government owned nursing home, Facility A was found to provide a higher level of quality care than Facility B, a



for-profit, corporate nursing home. While past research has indicated, similarly, that nonprofits provide better care because they spend more on direct patient services, this study augments this work by incorporating new variables such as nursing leadership, care philosophy, physician organization, the medical model, and definitions of illness and aging.

Higher wages and job stability at Facility A contributed to lower turnover. This, in turn, facilitated the evolution of strong nursing staff leadership and supervision and nurses who knew their patients well. A strong patient-centered philosophy of care was advocated and modeled by the nursing staff and reinforced by the nonprofit philosophy of patient before profit. The closed physician staff at Facility A increased the accessibility of physicians and the quickness of their response to acute illness symptoms of their patients. The open staff organization at Facility B increased barriers for physicians providing quality care, such as low reimbursement and travel inconvenience. By examining these aspects of care, this study contributes to the empirical knowledge of nursing home quality.

Although Facility A was affected by the same societal views of aging that penetrated Facility B, and Facility A patients were similarly victimized by theft and occasional verbal abuse, overall the care provided by both doctors and nurses was found to be better in Facility A. In their daily lives, patients at Facility A were more satisfied with their care, their relationships, and their activities. When an acute illness occurred, they were treated more often, more quickly, and without as many transfers to the hospital. Nurses and

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physicians at Facility A were more satisfied with their work environments and perceived fewer barriers to providing quality care than those at Facility B. Through examination of the social, political, and economic factors these differences were better understood.

These findings contribute further to the discussion of the role of tax status and profit in quality of care. Furthermore, they question the role of reimbursement in the provision of quality of care. While these debates will not be resolved based on these findings, the contribution is building on these ideas and advancing the discussion.

These findings also advance the understanding of the interrelationship between quality of care issues. Many quality issues are contingent upon others. For example, it is not enough to study outcomes, such as number of bedsores in a facility, without examining other related areas, such as staffing, supervision, physician involvement. This study broadens the study of acute illness episodes and quality of care deficiencies by examining related dimensions of care in the nursing home.

Sociological Theory

The political-economy framework guided this study and contributed to these findings and analysis by emphasizing the examination of economic and regulatory policies, the role of profit and cost-containment, and social values about aging that are situated in the external context of the nursing home and their relationship with patient care issues inside the nursing home, such as psycho-social care, treatment of illness, and staffing levels. The political-

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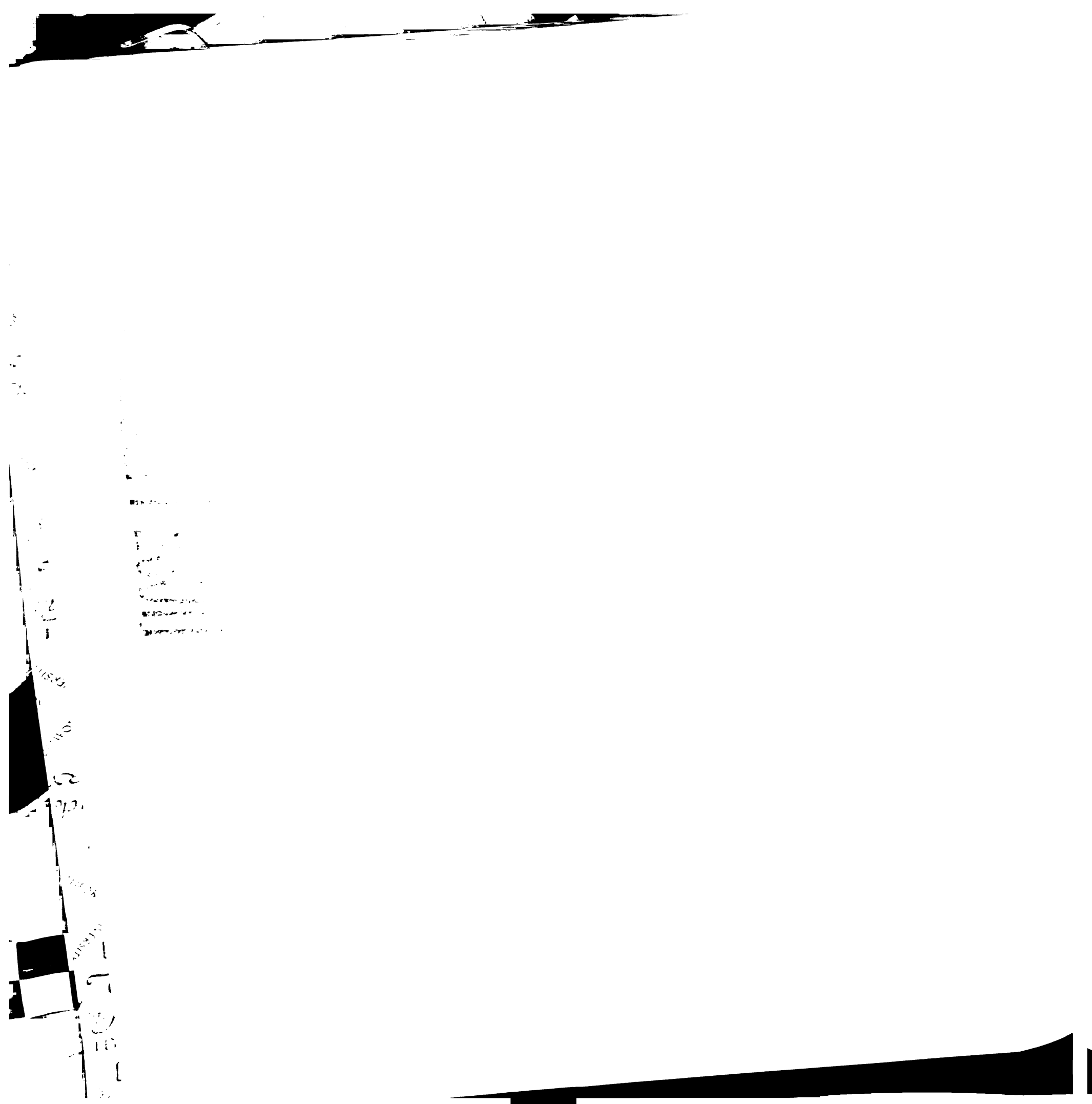
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economy perspective is useful in that it emphasizes the interrelationships of structural variables in the influence on organizations and systems. While many studies have highlighted deficiencies in nursing home quality of care few have understood these deficiencies in light of the political-economy of the nursing home. This work builds on those studies by broadening the analysis to consider the larger social-political-economic factors influencing patient care. Additionally, this study builds on the work of those who have addressed issues of structure in noncomparative studies by now comparing two facilities that are different in their ownership and care organization.

An important contribution here is that day to day events and caregiving within the nursing home is shaped by the intersection of many social, economic, and political forces, such as financing, profit, organizational structure, leadership, power, and social constructions. This study extends the use of the political-economy perspective, traditionally used for macro-level analysis, to include the examination of apparently micro-level issues in the nursing home. Thus, the concept of internal and external political-economies was expanded to apply to the nursing home.

This study also contributes to the discussion within organizational theory pertaining to power and resources within organizations. Resource dependency was a useful perspective in identifying and understanding the relationships within the internal and external political-economy of the nursing home, examining monetary resources, legitimacy, and accountability.



Future Research

Future research should expand the structural context examined here and include current dimensions of the political economy. For example, managed care has dramatically shifted the organization of health care in the last decade. Its effect on the distribution of power and resources and the organization of nursing home care must be further explored. In the 1996-97 interviews completed with the administration of Facility A, the DON, the Medical Director, and the Assistant Medical Director (AMD) all mentioned the increasing acuity of the facility's patients as a challenge in providing quality care. The three respondents agreed that the patient level of acuity has continued to increase through the ten years, into the current time. Two sources of this were discussed. First, the effect of DRG's continues to be felt at Facility A, as patients are discharged quicker and sicker from acute care hospitals. The patients at Facility A have more complex medical conditions, in addition to increased psychiatric diagnoses. The second source of the increased acuity is the managed care funding mechanism. The AMD pointed out that with capitation an acute bed is now viewed as a "cost center," meaning a cost accrued to the hospital, thus the incentive remains the same as under DRGs-- to transfer the patient out quickly.

Another example is the introduction of waiver programs that permit nursing homes to provide a continuum of services for capitated rates. This will affect many of the variables examined here, including financing

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incentives and the lack of medical services or resources on-site. The Medical Director at Facility A explained in her 1996 interview that this site would be entering into an integrated health care system with the city's public health department. This change was to alter their funding mechanisms, patient composition, and services. These changes are large variations from the Facility A and Facility B of ten years ago; however, it is suggested that the framework used here would be helpful in understanding these more current changes.

Finally, as was discussed, some research has highlighted the positive changes resulting from OBRA 1987 regulations. More research, however, questions the adequacy of these regulations and critiques the enforcement process behind the regulations. As Marek et al. (1996) assert:

While some intentions of OBRA 1987 may have been accomplished the question remains, have we achieved a level of care, quality, and services which approaches an acceptable level or merely reached the "floor"? In the current political climate there is cause for concern. If the OBRA 1987 regulations are repealed or weakened in the name of "cost containment," we may soon find that staffing and quality will quickly fall through the "floor". Some of our nation's most vulnerable will once again be subjected to inadequate care and the suffering that results from inadequate staffing (p. 39).

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Nursing homes around the country receive citations for poor care quality month after month as can be seen in newsletters published by advocacy organizations. Thus, despite stronger regulations, these questions remain.

Concluding Remarks

This research calls into question the organization of nursing home care and the social constructions of aging in our society. It examines how social, political, and economic forces continue to produce poor quality of care. Long-term care reform must account for these structural influences. Implementing isolated regulation changes may not be enough without changes in the larger structure and organization of the nursing home, including its financing systems, regulation enforcement, physician and nursing care organization, to name a few.

The population continues to age, with the baby boomer generation just around the corner from retirement. Technology and medicine continue to extend life beyond the point where we have determined how to provide or maintain a quality existence. The structure of the health care system is changing rapidly without a guarantee on where change will cease and who will hold the power. Posters pledging "Residents Rights" now decorate every nursing home lobby, proclaiming an ideal for which we must strive while simultaneously distracting us from the realities of poor care still occurring down the corridor. The role of the nursing home in caring for our elderly must continue to be questioned. The care provided must be improved

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through changes in accountability, meaningful regulation and enforcement, and increased education for nursing staff and physicians. Shifts must occur in our societal definitions of aging and illness. With these changes and an increased understanding of the relationship of the nursing home to the political economy, perhaps we can provide our elderly with care that fosters independence and dignity.

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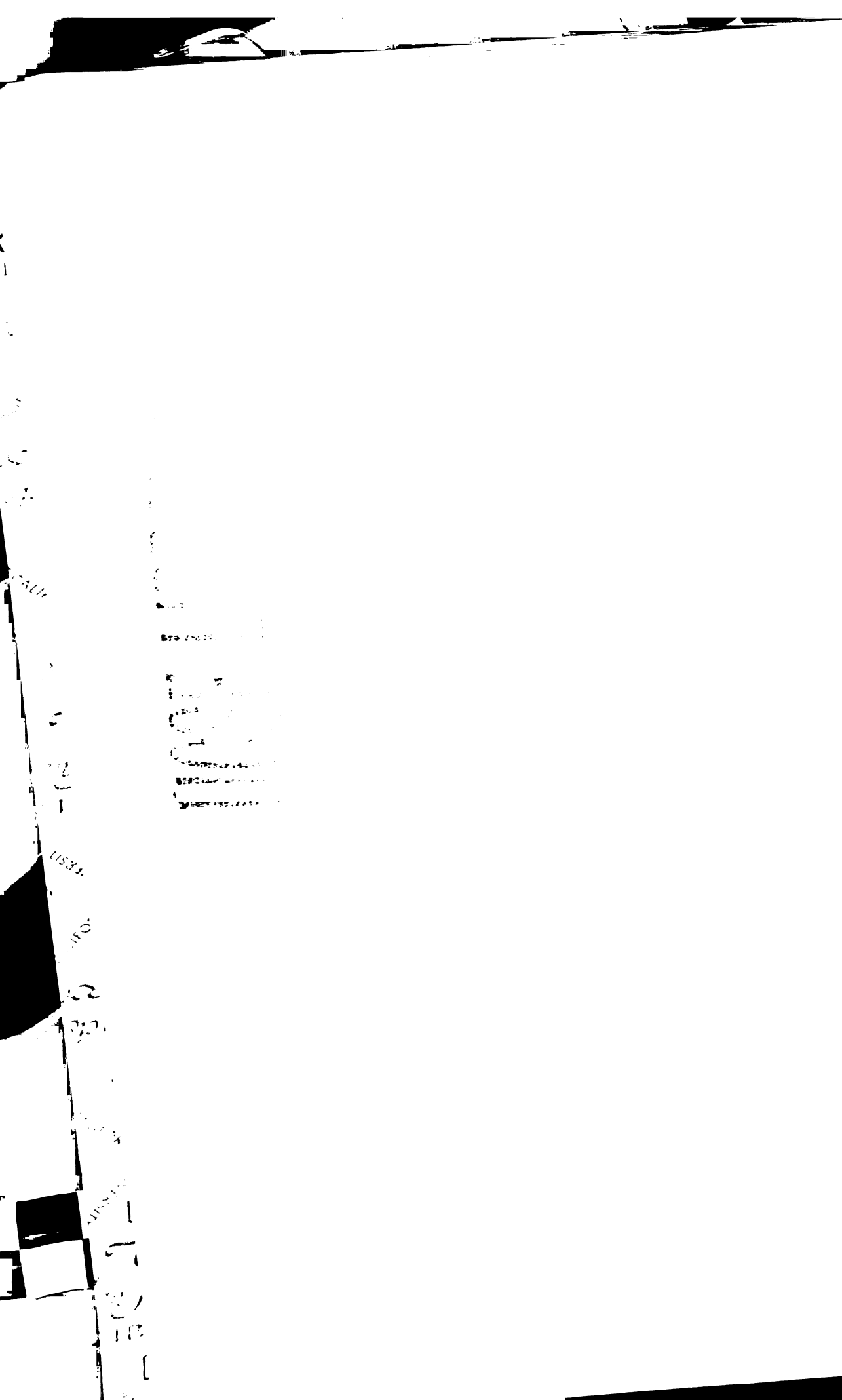
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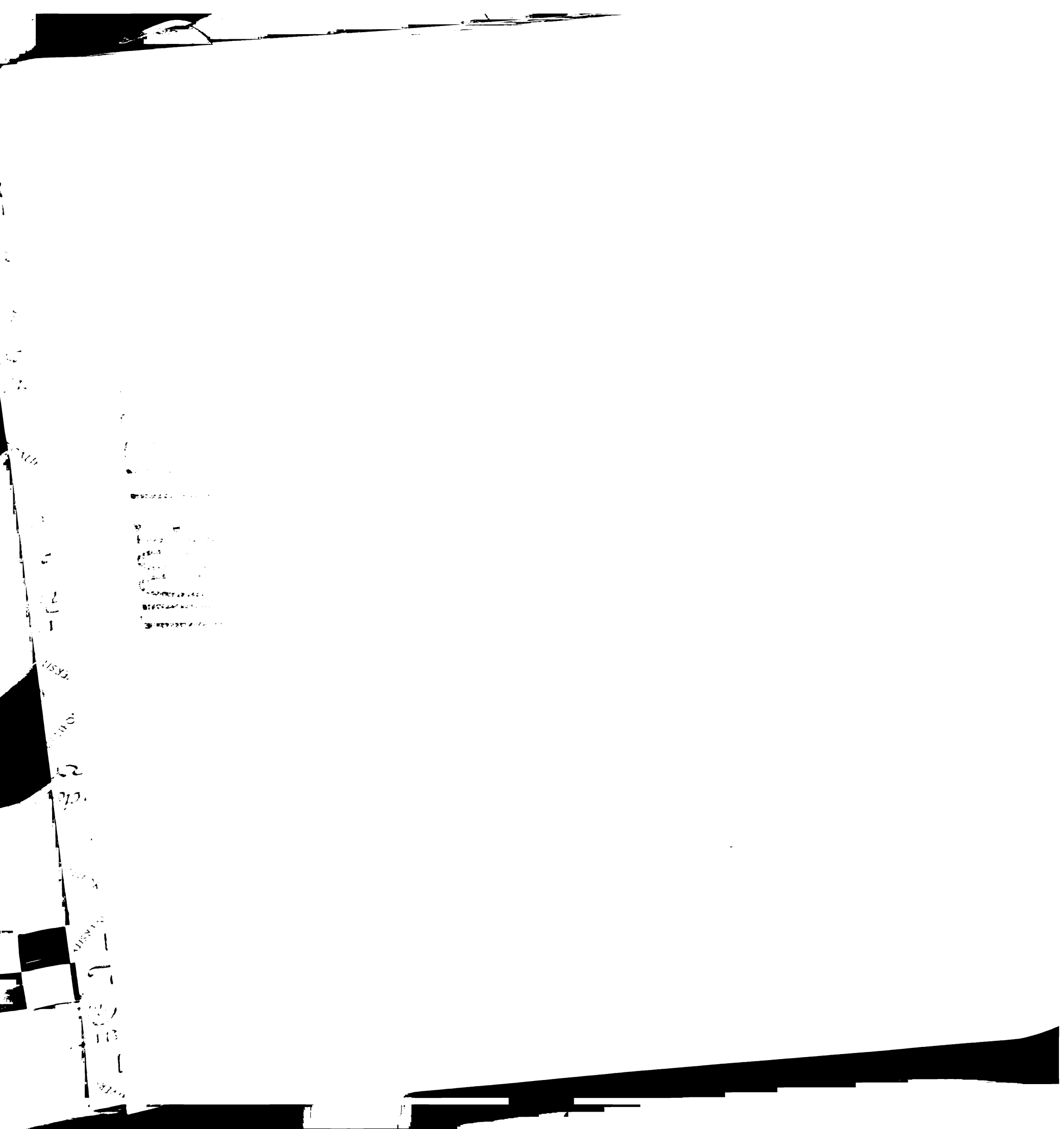
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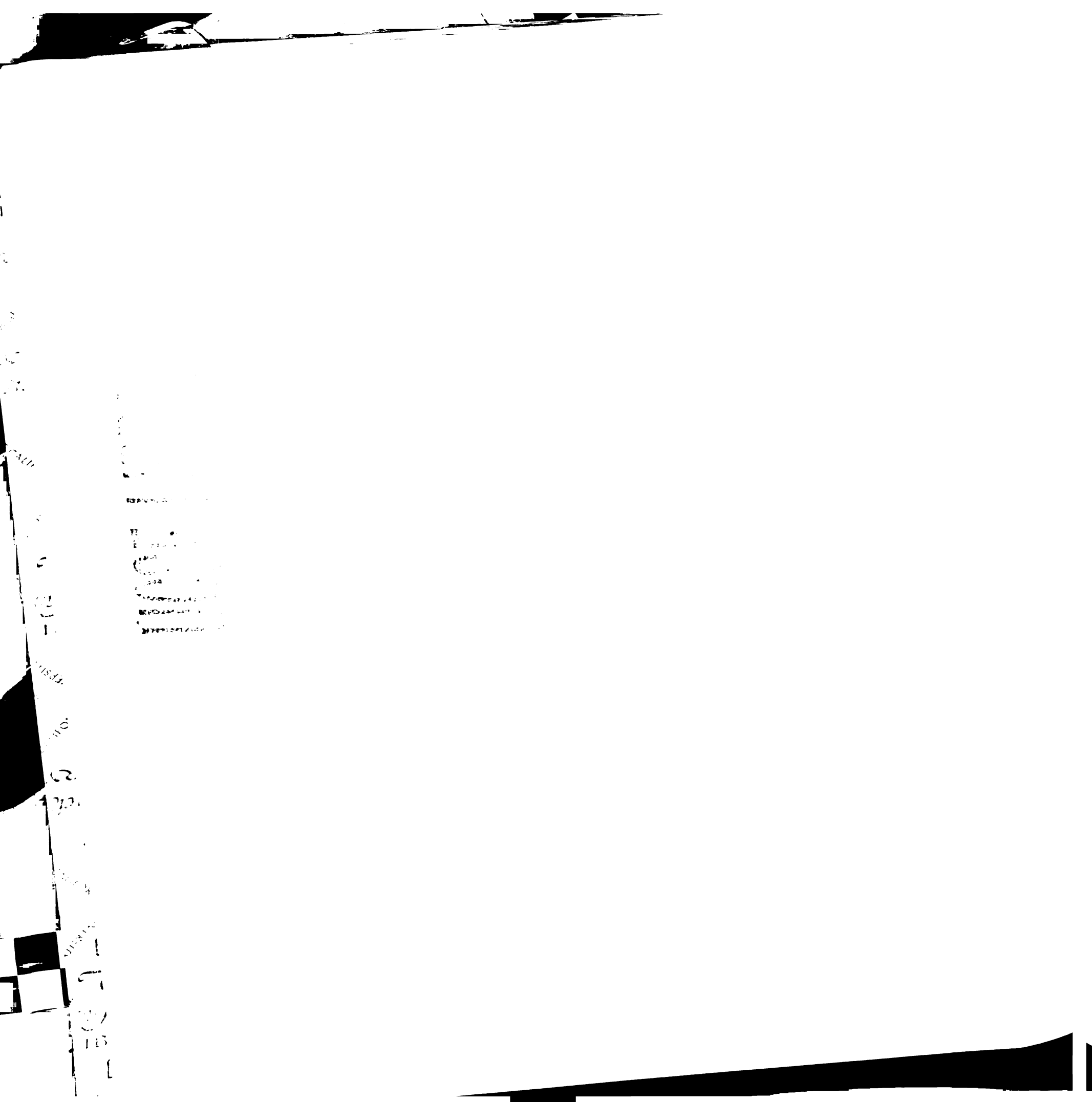
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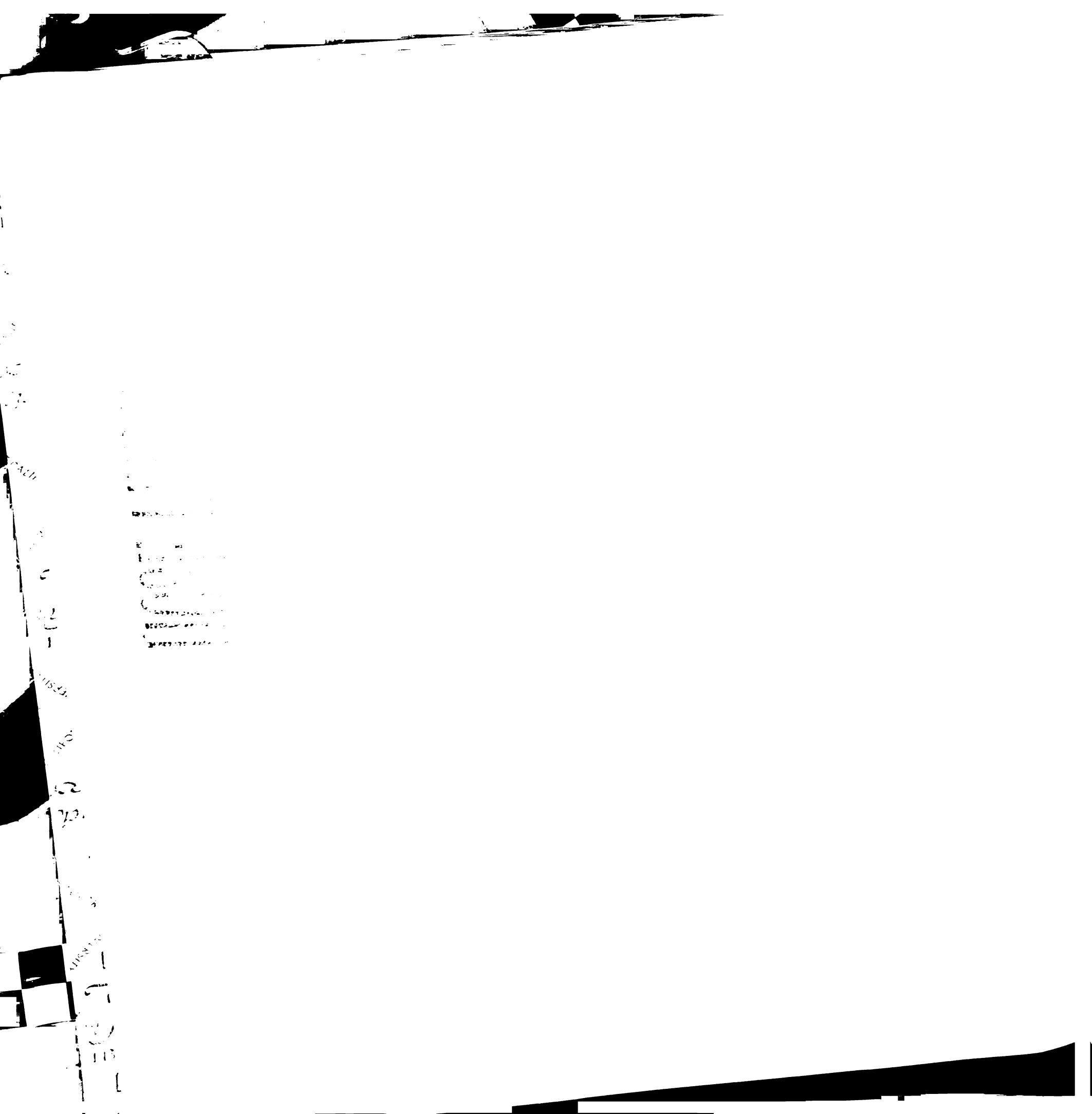
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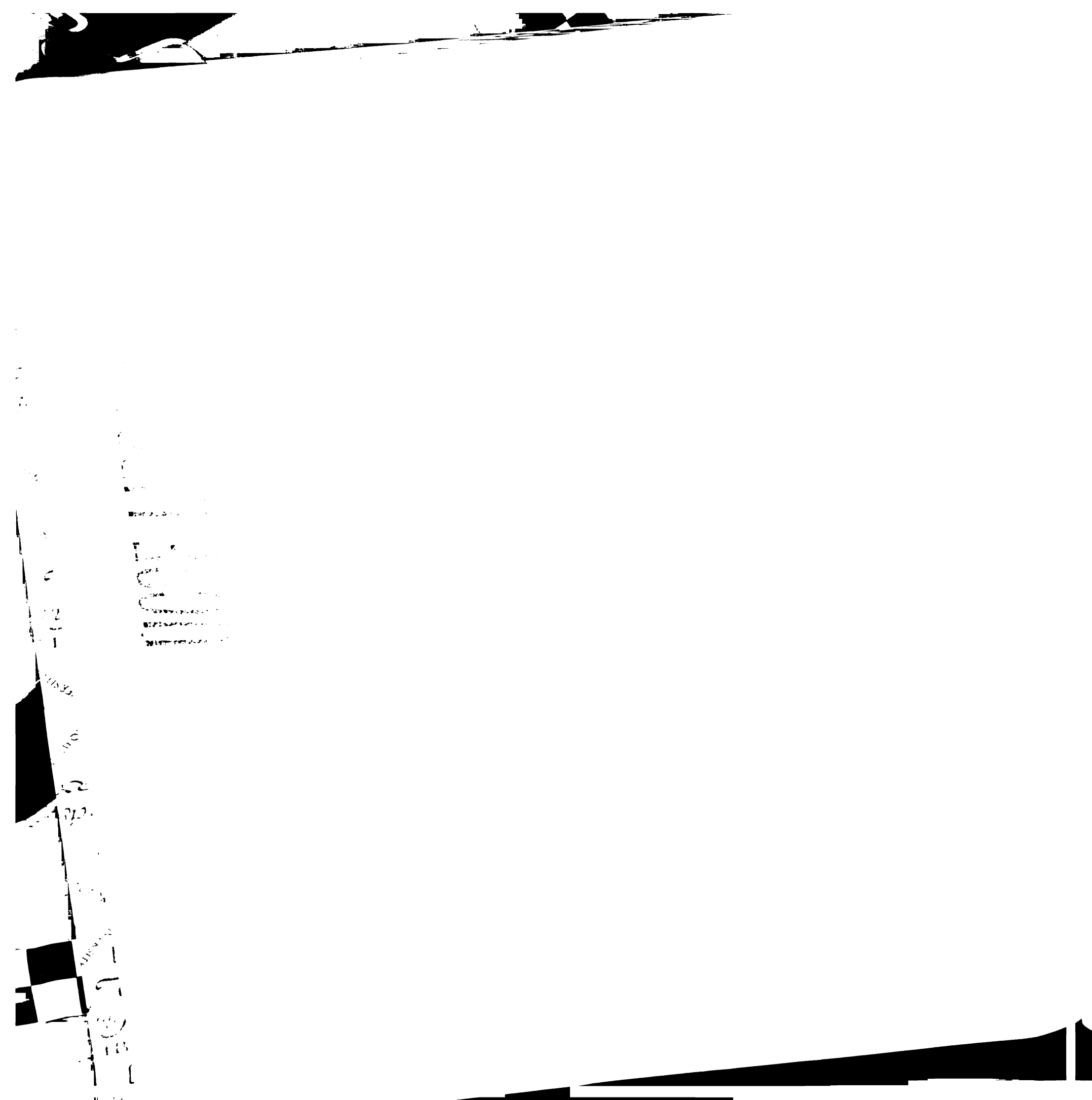
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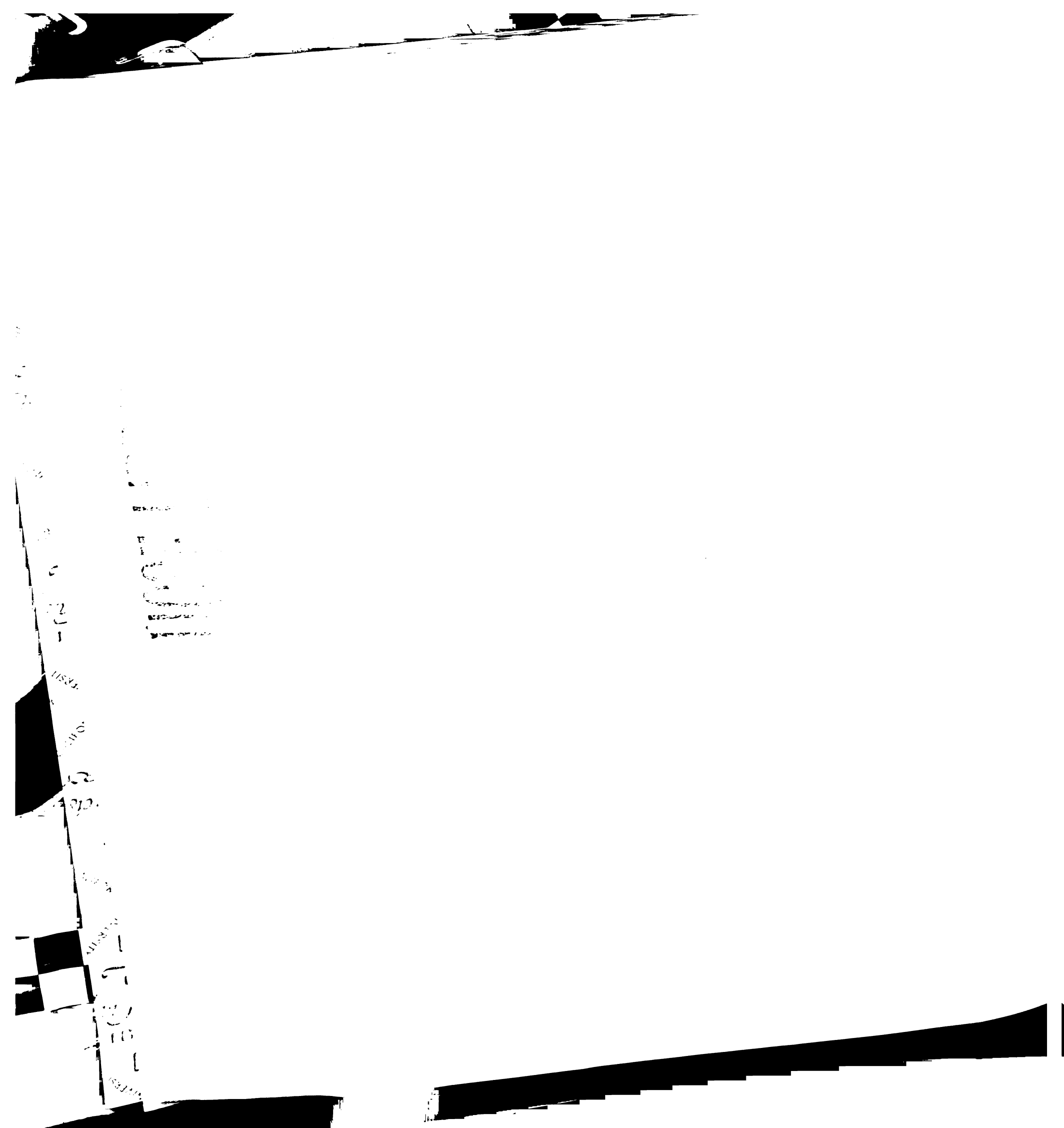
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