AN ANALYSIS OF NURSING HOME STAFFING PATTERNS
AND THE IMPACT ON THE PROFESSION OF SOCIAL WORK

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ABSTRACT

The study examined social work staffing in nursing homes, and the types of services the facilities provide to address the psychosocial and mental health needs of the residents. The Omnibus Budget and Reconciliation Act of 1987 (OBRA) requires nursing homes with 120 or more beds to employ a qualified social worker, defined as having a bachelor's degree in social work or related field with one year of supervised, direct healthcare experience. Additionally, OBRA mandates nursing homes provide social services that allow for the highest level of mental and psychosocial well-being of every resident. Despite these mandates, the majority of nursing home residents do not have their psychosocial needs address, and planned as a part of care, or provided, even if part of the overall plan of care. Data were collected from a national sample of 1,423 nursing homes. Data analysis included frequency distributions to describe organizational characteristics, facility services, and social work staffing levels and organizational characteristics. A one-way analysis of variance (ANOVA) was conducted to examine the number of social workers and size of nursing home. A one-way multivariate extension of analysis of variance (MANOVA) was conducted to further examine nursing home size to three types of services provided to the residents.
Dedicated to

Marianne and in memory of my parents
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CHAPTER 1

INTRODUCTION

Increasingly, special interest groups and the federal government are focusing on the psychosocial needs of nursing home residents. At question is the quality of life of older adults in nursing facilities. Professional social workers trained to understand the individual in the social environment, are in a good position to address psychosocial needs of nursing facility residents through counseling and services. The current federal requirements for the number of social workers to nursing home beds only apply to facilities with 120 or more beds. Smaller facilities are not required to employ a staff person in social services. The National Association of Social Workers (NASW), the trade association for social work professionals, recommends that the individuals serving in the capacity of the social worker have received professional training in social work. Using a historical context, this study examines social work staffing patterns in nursing facilities, and the related types of services provided to residents using the National Nursing Home Survey conducted by the National Center for Health Statistics. This study examined social worker staffing and the types of services provided in the various nursing homes. In addition, the barriers to nursing homes meeting the psychosocial and mental health needs of residents were identified and recommendations were made to overcome these barriers.
CHAPTER 2

LITERATURE REVIEW

Historical Context

Understanding the evolution of institutional care for the elderly in our country must begin with a discussion of the historical development of the nursing home. In America the first attempts to provide assistance to the elderly were based on the English Poor Laws of 1601. All community charity in the new world has a foundation based in these laws, which were brought by the pilgrims to the new world (Stewart, 1976). These laws allowed for the pious in society to distinguish between the deserving and undeserving poor. The town elders decided which of the poorest citizens would receive assistance based solely on the perceived degree of their worthiness (Crowther, 1981). The elderly, who were physically unable to work due to ill health, were identified as the deserving poor (Katz, 1996). Society has evolved over the course of time, yet the basic premise of worthiness in providing care and assistance has remained unchanged.

During the early 1900’s elderly people in need of assistance were sent to live in almshouses, which were also known as poorhouses. In the poorhouse, there was no true separation of the elderly with care needs from younger poor people in need of shelter. Nursing homes, as we know them today, evolved from
these poorhouses, which in 1923 were serving 78,000 people over fifty-five years of age (U.S. Department of Health and Human Services, 1996). There were two views of the elderly in poorhouses. One view was that the elderly in poorhouses were not prudent in saving for their old age care. The second view focused on the elderly as being seriously ill and disabled, allowing them to be labeled as deserving of assistance (Vladeck, 1980).

Since there was no distinct government plan or program to manage the basic needs of the increasing number of elderly, informal support systems were developed to address this unmet need. Between 1900 and 1930, various charities were established within specific immigrant groups to help assist and support their elderly (Wagner, 2005). Immigrant services were efficient in meeting the needs of elders as they were based in the specific neighborhoods where the elders were located (Chambers, 1963). These services were efficient and practical until the economy required the movement of family members in order to find employment.

The need for health care and services for the elderly continued to grow along with the population. Throughout the 1930’s Americans endured the economic hardships of the Great Depression. The New Deal social welfare agenda put into place a safety net for older adults (Wilkerson, 2001). The New Deal promoted the idea of need based federal benefits for the elderly, which were to be provided through the Social Security program. This was the first federal
program designed to specifically provide financial assistance to older people and was signed into law on August 14, 1935 by President Franklin Delano Roosevelt.

The Social Security Act of 1935 established federal dollars for matching state grants, which were designed for the financial support of retired workers (Weaver, 1982). These state grants were part of Old Age Assistance and not available to the elderly living in public institutions, thereby successfully excluding financial assistance to residents of the poorhouse (Lubove, 1986). This exclusion of grants to residents of public institutions forced the development of private old age homes. An elderly person could live in a private old age home with others in an institutional setting, yet still qualify for Old Age Assistance (Weaver, 1982).

Public institutions were excluded from the Old Age Assistance until 1950 when The Social Security Act was amended. This amendment allowed payment to public institutions for the care of the elderly. For the first time, older persons residing in public and private institutions qualified for Old Age Assistance (Weaver, 1982). States participating in the elder care payment plan were required, by the amendment, to license nursing homes (Committee on Nursing Home Regulation, 1986). The Hill-Burton Act, which previously regulated the building of hospitals, was amended to provide government funds to nonprofit organizations specifically to construct skilled nursing homes (Sherwood, 1975).
Prior to 1950, institutional care was not the norm in America with care provided by families at home. Institutions were for the unwanted who did not have family to provide care. Nurses joined and worked for different organizations or societies of visiting nurses, which offered home care in metropolitan and rural areas across the country (Wilkerson, 2001). The visiting nurse survived until the institutional care boom at the end of World War II. Between 1950 and 1960 nursing homes exhibited large growth. Sudden growth in institutional care relates to the changes in government funding for elder care leading to the quick construction of nursing facilities (Brearley, 1975). As nursing home construction increased, the numbers of facilities increased and the public became more familiar with institutional care. Public perception of institutional care changed, with people looking toward facilities as the preferred method of caring for their elders (Johnson & Grant, 1985).

Nurses began working for nursing homes, which were becoming the primary source of nursing employment. Funding for home care, like the Metropolitan Life visiting nurse program, began to drop as the view for institutional medical care increased in popularity (Vladeck, 1980; Wilkerson, 2001). The public policy view was that it would be more prudent to provide care in a group institutional setting, rather than attempt to care for the individual sick and elderly in their homes. It was growing more difficult for the Metropolitan
Life visiting nurses to provide home care services, since the population
demographics were changing from small clustered areas to cities with an
expensive population (U.S. Department of Health and Human Services, 1996).
This demographic shift was based on economic need as younger family members
relocated for work, disbanding the common generational home (Chambers, 1963).

In 1956 an amendment to the Social Security Act continued to foster the
growth and development of nursing homes. A provision within the amendment
provided matching public assistance funds. These matching payments were
directed for the care of the medically frail elderly (Kollmann & Solomon, 2002).
The original Act capped payments made to the medical providers at the amount
paid to individuals. The 1956 amendment allowed for a change in payments, with
nursing homes paid at a rate that was higher than the previous individual rate.
This made the payments closer to the actual cost of providing care, or at the very
least more profitable for the facility (Vladeck, 1980).

The 1959 Housing Act created programs that caused the increase in “for
profit” nursing homes. These programs were administered by the Department of
Housing and Urban Development and were available to private, public and non-
profit nursing homes (Mendelson, 1974). This newly designed funding
encouraged and rewarded the construction boom of nursing homes without regard
to the purposeful design of the facility. The medical regulations stated in the Hill-Burton Act did not extend to nursing facility construction paid from Housing and Urban Development funds (Moss and Halamandaris, 1977).

Housing and Urban Development funds were readily available to nursing homes to pay for remodeling physical structures that were not originally designed to serve as nursing homes (Valdeck, 1980). Without the regulation of nursing homes under the Hill Burton Act, physical hazards and barriers for care delivery were abundant. In excluding nursing homes from the Hill-Burton Act, resident care and services varied greatly. This variation extended across physical environment, numbers of employed staff, education and professional training of staff, leading to large differences in care and services provided to residents (Johnson and Grant, 1985).

As the federal government increased the financial investment in facilities, there was a public outcry for nursing homes to focus on the quality of care and services provided to facility residents (Moss and Halamandaris, 1977). Several news items focusing on poor environmental conditions, fatal fires and accidents, and reports of maltreatment of nursing home residents were reported in different states. There were two fires in nursing homes in Missouri killing a large number of residents, with additional disasters related to noncompliance with state regulations reported in Ohio and New York (IOM, 1986).
These reports generated the need for governmental investigations. A special committee was appointed to examine nursing home care and services. Reports by the Special Committee on Aging revealed inconsistencies in nursing homes following the regulations and in the states' enforcement of the standards (Solon and Baney, 1955). Despite the licensure of nursing homes by each state, care provided was not standard from facility to facility. During 1959, a special Senate Committee investigation of nursing homes confirmed reports of resident abuse and neglect, including a lack of compliance with the regulations in place, and uncovered tragic circumstances resulting in resident death (Mendelson, 1974). The Senate report described terrible living conditions in many nursing homes. The report detailed the complete lack of care for the well-being of the residents and the poor quality of services provided in nursing homes (Vladeck, 1980).

Nursing home standards for licensure at the state level have been in place since the 1950s. The 1959 Senate Committee Report contained a common theme of accidents, general lack of care, variations in state standards, and lack of enforcement of state nursing home standards (IOM, 1986). The continued criticism of the provided services and the surmounting cost of care trumpeted the need for total nursing home reform through federal standards (United States General Accounting Office, 1999).
The most sweeping reform for the nursing home industry was the Nursing Home Reform Amendment to the Omnibus Budget Reconciliation Act of 1987 (OBRA, P.L. 100-203). This legislation mandated compliance with the requirements and mandated the development of a system to regulate the quality of care provided at each government funded nursing home through the use of a system of overall standards of care (Mukamel & Spector, 2003; Harrington, O’Meara, Kitchener, Simon, & Schnelle, 2003). Nursing homes are expected to address the quality of care and the quality of life of residents. Nursing home quality of care was defined as the physical care needs or nursing care provided to residents and the quality of life refers to the mental, emotional, and spiritual well-being of a resident (Noelker & Harel, 2000).

Nursing homes receiving federal payment for resident care and services must remain in compliance with the federal regulations established under the Omnibus Budget and Reconciliation Act (OBRA). Congress enacted the Omnibus Budget and Reconciliation Act of 1987 on December 22, 1987 after a comprehensive investigation in 1986 by the Institute of Medicine (IOM), which examined the actual care, treatment, and medical services provided to nursing home residents (Legislative history of PL 100-203). The 1986 IOM report was the leading force in the creation and adoption of OBRA’87, which was one of the first major revisions of the federal standards for nursing home care since the 1965
creation of the Medicare and Medicaid programs (Harrington, O’Meara, Kitchener, & Schnelle, 2003). These standards were the first to establish federal rights for nursing home residents and to provide every individual resident with written expectations of care. This provided the pathway for the development of a powerful consumer, with facilities required under the legislation to inform residents of their newly established rights.

For the past 30 years the government, who is the largest payor of nursing home care, has raised concerns with the low quality of care (Angelelli, Moor, Intrator, Feng, & Zinn, 2003; GAO, 1987, 1998; Grabowski, 2001; IOM 1986, 1998; US Senate, 1974, 1986; Walshe & Harrington, 2002). These issues persist in nursing homes today, where ongoing problems in the quality of care and the overall quality of life remain a challenge (Harrington, 2001; Walshe, 2001). Continual attempts were made by the federal government to increase the compliance of nursing homes in following the regulations. In 1998, the Nursing Home Oversight Improvement Program was adopted in an effort to improve nursing home quality through stricter enforcement of the regulations (GAO, 1999). Over the past decade and related to these reforms, small improvements have been shown in several quality of care areas: reduction in physical restraint usage, reduction in catheterization, and reduction in the prevalence of dehydration (Angelelli, Mor, Intrator, Feng, & Zinn, 2003; Wiener, 2003).
Social Work in Long Term Care Facilities

In the 2003 report by the Inspector General, state surveyors revealed that often nursing home residents are not provided the services of a qualified social worker, nor are their medical charts reviewed to ensure that their individual psychosocial needs are being met by the facility (USOIG, 2003). It was revealed that an overwhelming 45 percent of social workers interviewed for the 2003 OIG report, stated a frustration stemming from the inability to complete job tasks (USOIG, 2003). A report by the state of Missouri found that nursing homes were in violation of federal law requiring the employment of qualified social workers in the majority of nursing homes operating in the state (Parker-Oliver & Kurzefeski, 2003). This violation was reported after comprehensive interviews were conducted with nursing home social workers. In both of these reports, under staffed social workers were unable to provide psychosocial services to such a large number of residents in need of services, and unable to provide the quality services needed to address their problems.

Nursing home compliance in employing a qualified social worker is growing in importance, as the number of older adults in need of care is growing. At the estimated older population growth rate, the psychosocial well-being of those in need of nursing home care will be jeopardized. Research has shown that a large percentage of facility residents have not had mental health needs met
(Tirrito, 1996). This is a disturbing finding, since access to mental health services for nursing home residents was mandated in 1981 in the Nursing Home Reform Act (NHRA) and in 1987 with the Omnibus Reconciliation Budget Act (OBRA) (Burns, Wagner, Taube, Magziner, Permutt, & Landerman, 1993). The government has an obligation to clearly define social worker staffing in the nursing home at a level that would ensure the psychosocial needs of residents are met, and services are provided on a daily basis (Bartels, Moak, & Dums, 2002). Establishing regulations and standards for nursing home care remains an ongoing issue for the governmental agencies charged with facility oversight.

Social work in long-term care facilities has not been defined as to the specific nature of services provided, or the actual training necessary to provide professional service and care. In the 1970’s social workers were not regularly found as either employees or as consultants in nursing homes (Pearman & Searles, 1978). Only the physical needs of elderly nursing home residents were viewed as important with very few state regulations requiring the employment of social workers in the nursing home (Kosberg, 1973). During this time period, social workers employed in public and private agencies were encouraged to visit the nursing home to provide support for the residents. This idea of visiting social
workers was reflective of the reduced status of the professional social worker, and the standing of social work in nursing home practice (U.S. Department of Health, Education, and Welfare, 1961).

There is a reduced emphasis on the employment of formally educated social workers specifically dedicated to addressing the psychosocial health of the nursing home resident. This can partly be attributed to complacency of the social work profession itself. The first problem is that the role of the nursing home social worker is not centered on payment for direct service, like rehabilitation therapies (Wax, 1967; Fogel, 1993). The second issue is the lack of a legal requirement for social services in the nursing home, and the third problem is the lack of measurable outcomes for services (Olsen and Olsen, 1967; Fogel, 1993). The lack of advocacy for our own standards and professional advancement produce a politically apathetic environment with the regulatory agencies not caring about social work either (Bennis, Benne, and Chin, 1969; Streim, Beckwith, Arapakos, Banta, Dunn & Hoyer, 2002). As professional social workers, we advocate for others while ignoring the best interests and advancement of our own profession.

Public awareness of the conditions of nursing homes and the plight of the residents was the major catalyst for creating the federal quality of care standards, but no one is pushing for quality of life standards. In a 1970 report by the
American Pharmaceutical Association only 8 out of the 50 states required that social services be provided to meet the needs of nursing home residents (Braverman, 1970). In 1976, the Code of Federal Regulations covered seventeen categories of participation for nursing facilities, which encouraged nursing facilities to provide social services (405 C.F.R. § K, 1976). One of the largest influences in the industry of long-term care, the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87), has been the only statute to impact the practice of nursing home social work. OBRA requires nursing homes to meet the psychosocial needs of residents, while providing for their overall well-being (P.L. 100-203). OBRA expanded the focus from the physical aspects of care to include the quality of life as well as the quality of care. Nursing homes would now be required to provide services for residents with mental health issues at the facility or contact services outside the facility (Tirrito, 1996).

A small number of nursing home social workers are expected to provide services to the large number of older Americans seeking healthcare assistance in nursing homes. It is estimated that the nursing home social worker is the direct mental healthcare provider to roughly 1.6 million elderly in approximately 17,000 licensed nursing homes (U.S. Office of Inspector General, 2003). Nursing home social workers are permitted to be educated at the bachelor or master's level, hold a degree in another discipline, or trained on the job (O’Neill and
Rosen, 1998). The NASW standards, which are more rigid, require social workers to be formally educated in an accredited school of social work and graduated with a baccalaureate degree, or have accreditation from NASW, with two years of related healthcare experience, or meet the state requirements to be a social worker (NASW, 1993).

Under 42 CFR§483.15 (g)(2)(3)(i)(ii) nursing homes licensed for 120 or more Medicaid or Medicare beds must employ a full time, qualified social worker. This regulation is also called the 120 rule. The 120 rule only applies to large nursing facilities allowing non-social workers to provided inconsistent psychosocial services in smaller nursing homes. Federal law only requires large facilities to employ one social worker and excludes smaller nursing homes from employing any social worker. All nursing homes receiving federal monies should be required to provide equal service to their residents.

One study estimated that nursing home social workers are only able to interact with residents for approximately six minutes per resident day (Harrington, Zimmerman, Karon, Robinson, & Beutel, 1997). Few professionals, including highly educated social workers, would be able to address any issues, especially psychosocial needs in a six-minute interaction with a nursing home resident. In addition to limited resident interaction, long-term care social workers have few mental health referral options. Only 23% out of 100 nursing homes in Kentucky
reported referring residents to outside services, 24% of the homes employed a social worker, and 7 facilities reported no psychosocial or mental health services for residents (Meeks, Jones, Tikhtman, & La Tourette, 2000).

Not only is the lack of psychosocial services in nursing homes appalling, but facilities with 120 beds or larger are only required to staff one social worker. Currently, federal law for the number of full-time social workers employed is solely based on the number of skilled licensed beds that are in the nursing home. A five state study which included Florida, Illinois, Minnesota, New York, and Texas found that 43% of the 187 responding homes had one social service staff for a median facility bed size of 150 (Vourlekis, Bakke-Friedland, & Zlotnik, 1995). Staffing at this level may meet the standard of the regulation, but it is not sufficient to guarantee the quality of services to ensure that the psychosocial needs of skilled nursing residents are adequately met. These social worker staffing standards based on the number of licensed nursing beds ignore residents in smaller facilities, which are excluded by the 120 rule. Nursing home administrators and owners are reluctant to hire and staff social workers past the federal requirements.

Nursing home social workers provide psychosocial supportive counseling for residents and families, manage behavioral problems, and complete assessments (Peak, 2000; Iecovich, 2000; Vinton, Mazza, & Kim, 1998).
Additionally, the nursing home social worker may assist the resident by serving as a substitute family member, or provide counseling and emotional support to spouses or loved ones in the family network (Reinardy, 1999). Professional nursing home social workers can assist the resident to express feelings of loss in a positive manner, while offering coping strategies for life changes (Avorn, 1998). These activities were generalized with job roles and employment expectations not defined, so the work day tasks of the nursing home social worker vary greatly. Several factors contribute to this variation: different educational levels within the social service area, inconsistent training on issues facing the nursing home resident, the size of the facility, and the organizational environment specific to each facility (Vourlekis, Glefand, & Greene, 1992; Vourlekis, Greene, Glefand, & Zlotnik, 1992).

Certainly, the job duties and tasks of a social worker should be consistent and not vary in relation to the number of nursing home beds. Residents in both large and small nursing facilities should have psychosocial needs met to attain higher functioning and a sense of overall well-being. Several studies have examined mental health of nursing home residents. In one nursing home with 454 study participants, death was hastened in 59% of residents identified with a depressive disorder (Rover, German, Brant, Clark, Burton, & Folstein, 1991).
Mortality rates were found to be 8% lower in nursing home residents who had mental health visits by a social worker, when compared to other residents (Castle & Shea, 1997).

These studies support the idea that psychosocial and mental health needs of nursing home residents are as important as their physical health needs. Addressing the psychosocial needs of nursing home residents was to be the center of the 1987 Nursing Home Reform Act. The importance of the nursing home social worker was to have been a key point as stated in federal law. The intent of the law was to ensure that the psychosocial aspect of care should be part of the overall nursing home service (Williams, 1999). One way to ensure the intent of the regulation is met by facilities receiving federal monies for care is to require all nursing homes to adequately provide for qualified social work staff. Several suggestions to address the number of social workers employed in nursing homes have been proposed. The NASW has supported the need for all nursing facilities to provide professional social work services irregardless of facility size (O’Neil & Rosen, 1998). Another proposal suggests that social work staffing should be addressed by the same principles used to address nursing staffing, including the standardization of education and credentials (Parker-Oliver & Kurzejeski, 2003).

Social work practice in aging, as a profession, is being challenged. The desire to work with the elderly is not popular with social work students
(Takamura, 2001; Schigelone, 2003). It has been shown that there is a lack of focus on gerontological social work or geriatric curriculum in certain educational programs along with a difficulty in finding continuing education training for the nursing home social worker seeking to improve job skills (Gleason-Wynn, 1995; Scharlack, Damron-Rodriguez, Robinson, & Feldman, 2000). Over half of the members of the National Association of Social Workers reported a general lack of knowledge of aging and related issues (Peterson & Wendt, 1990). Even if nursing homes employ professional social workers, few report specific training in the practice area of aging (Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000; Tirrito, 1996). At this time, there is no geriatric standardized competency for nursing home social workers, although the 1990 amendment to OBRA requires geriatric training for nursing assistants (Tirrito, 1996).

Social work specialization in aging and the continued advancement of the social work aging professional should be questioned, as the need for this is growing. A slow decline has been reported in the number of students choosing social work as a profession (Kelchner, 2001). Parents, who were interviewed about their child’s professional choices, reported social work as the least favorable occupation (Winston & Stinson, 2004). Very few master’s degree social work students have an interest in aging practice or gerontology (Lennon, 1998). The practice area of aging was listed by less then 3% of NASW members
(Rosen & Zlotnik, 2001). Clear standards for the employment of professional social workers in skilled nursing facilities may spark new interest in this quickly growing population.

Previous studies have been conducted within specific states: Minnesota, Missouri and Wisconsin. These, though, do not provide a view of nursing home social work staffing practices that can be generalized across the country (Kruzich & Powell, 1995; Reinardy, 1999; Parker-Oliver & Kurzejeski, 2003). By examining nationwide data on social work staffing ratios in nursing homes, it is possible to generalize to all nursing homes, providing a clearer view as to the services provided to residents and compliance with the regulations. A clear picture of actual practice can only be gained by examining social work staffing, education, and services provided by nursing homes on a national level. The study examined social work staffing in nursing homes, and the types of services the facilities provide to address the psychosocial and mental health needs of the residents. A true understanding of nursing home staffing and services will foster future policy development, advocate change, and impact care standards.
CHAPTER 3

METHODS

Sample

This research was based on data collected as part of the larger National Nursing Home Survey (NNHS) investigating facility and resident characteristics. The NNHS is a longitudinal study conducted by the U.S. Department of Health and Human Services and the National Center for Health Statistics. The NNHS is a data set with a universe of 18,400 nursing homes operating in the United States, with information gathered from a sample of 1,423 nursing homes participating in the study. The 1,423 participating nursing facilities were certified by Medicare or Medicaid, or had a State license to operate as a nursing home. The nursing homes selected for study had a minimum of three licensed nursing home beds to be considered for the sample population.

The Facility Questionnaire data was gathered through personal interviews and self-enumerated questionnaires. Originally, the Survey consisted of three parts that were used to collect data on different aspects of the nursing homes. This study will only use data collected in the Facility Questionnaire Part One. Data was collected beginning July 1999 through December 1999. The 1999 NNHS is the most recent in the series study; therefore it contains the most current data applicable for this research.
Measures

The 1999 NNHS originally consisted of three parts: Part One, Facility Questionnaire; Part Two, Current Resident Questionnaire; and Part Three, Discharged Resident Questionnaire. Specifically data from Part One, Facility Questionnaire; Section E provided the research data. The Facility Questionnaire focused on topics like certification, availability of beds, number and type of employees, and provided services.

Facility Characteristics:

*Type of ownership*-Ownership is defined by tax status and shown as the categories profit or all others.

*Member of a chain or group*-The determination of facility as a member of a chain or group was made by the nursing home. This category was dichotomous: 1=Yes, 2=No.

*Beds available*- The number of beds available range from 3 to over 200. Four categories define the number of beds available: 1=3-49 beds, 2=50-99 beds, 3=100-199 beds, 4=200+ beds.

*Certification*-Facility certification was defined as an approved provider for payment of services through the state and federal Medicare and/or Medicaid programs. Four categories defined facility certification: 1=Both Medicare & Medicaid, 2=Medicare Only, 3=Medicaid Only, 4=Neither.
Beds certified under Medicare-The number of beds located in the nursing home certified for payment of services through the federal Medicare program. Three categories defined the number of Medicare certified beds: 1=1-49, 2=50-99, 3=100+.

Beds certified under Medicaid-The number of beds located in the nursing home certified for payment of services through the state and federal Medicaid program. Three categories defined the number of Medicaid certified beds: 1=1-49, 2=50-99, 3=100+.

Services provided

Mental health services-Mental health services were identified as services provided by the facility to address mental health needs of each resident. These were onsite services provided by a facility employee to residents in licensed nursing home beds. Mental health services were identified as dichotomous: 1=Yes, 2=No.

Social Services- Social services were identified as the services provided by the facility to address psychosocial needs of each resident. Social services were defined as onsite services provided by the facility to address a resident's overall psychosocial functioning. Social services were identified as dichotomous: 1=Yes, 2=No.
Emotional or mental health counseling—Services identified as emotional or mental health counseling provided to a facility resident by an individual without compensation for such service. This category was dichotomous: 01=Yes, 02=No.

Staffing Ratio:

Social Workers—The number of full-time employees with the job title of social worker.

Analysis

Descriptive statistics were used to examine differences in social worker employment in relation to facility characteristics and services provided to the nursing home residents. Frequency distributions were used to examine the facility characteristics, services provided, and staffing ratio. A one-way analysis of variance (ANOVA) was conducted to evaluate the relationship between number of social workers and size of nursing home. A one-way multivariate extension of analysis of variance (MANOVA) was conducted to determine the effect of nursing home size to three types of services (mental health services, social services, and emotional or mental health counseling) provided to the residents.
CHAPTER 4

RESULTS

The results were computed from data collected in the 1999 National Nursing Home Survey (NNHS), consisting of 1,423 participating homes. Data was collected using Part One of the Facility Questionnaire. The participating nursing homes are representative of the 18,400 facilities licensed to operate in the United States. Nursing homes participating in the sample needed to have three licensed nursing home beds to respond to the survey questions and participate in the data collection.

For facilities participating in the survey, 66% reported as meeting the criteria for identification as profit homes and 33% reported as non-profit nursing homes. More than half, 60% reported as members of a chain or group of nursing homes. Forty-six percent of facilities, the largest percentage of beds available, were in the range of 100-199 nursing home beds, followed by 28% of homes with 50-99 nursing home beds. The majority of nursing homes, 86% reported both Medicaid and Medicare certification for payment of care (see Table 1).
<table>
<thead>
<tr>
<th><strong>Type of Ownership</strong></th>
<th><strong>Percentage</strong></th>
<th><strong>Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit</td>
<td>66%</td>
<td>943</td>
</tr>
<tr>
<td>Non-profit</td>
<td>33%</td>
<td>480</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member of a Chain or Group</strong></th>
<th><strong>Percentage</strong></th>
<th><strong>Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60%</td>
<td>850</td>
</tr>
<tr>
<td>No</td>
<td>40%</td>
<td>570</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Beds Available</strong></th>
<th><strong>Percentage</strong></th>
<th><strong>Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3-49</td>
<td>5%</td>
<td>76</td>
</tr>
<tr>
<td>50-99</td>
<td>28%</td>
<td>392</td>
</tr>
<tr>
<td>100-199</td>
<td>46%</td>
<td>656</td>
</tr>
<tr>
<td>200 and over</td>
<td>21%</td>
<td>299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Certification</strong></th>
<th><strong>Percentage</strong></th>
<th><strong>Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare and Medicaid</td>
<td>86%</td>
<td>1219</td>
</tr>
<tr>
<td>Medicare Only</td>
<td>3%</td>
<td>37</td>
</tr>
<tr>
<td>Medicaid Only</td>
<td>9%</td>
<td>132</td>
</tr>
<tr>
<td>Neither</td>
<td>2%</td>
<td>35</td>
</tr>
</tbody>
</table>

**TABLE 1. Facility Characteristics**

(1423)
As shown in Table 2, comparisons were conducted of the services provided by the nursing home, identified as mental health services, social services, and emotional or mental health counseling, which contributed to the mental and psychosocial well-being of the residents. The majority of facilities, 98% reported providing social services, followed closely by mental health services provided at 82% of the nursing homes. Very few nursing homes, 12% reported providing emotional or mental health counseling.

<table>
<thead>
<tr>
<th>Type of Services</th>
<th>Nursing Home Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services Provided (Yes)</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>82%</td>
<td>1170</td>
<td>18%</td>
</tr>
<tr>
<td>Social Services</td>
<td>98%</td>
<td>1390</td>
<td>2%</td>
</tr>
<tr>
<td>Emotional/Mental Health Counseling</td>
<td>12%</td>
<td>177</td>
<td>88%</td>
</tr>
</tbody>
</table>

TABLE 2. Nursing Home Services Provided (1423)
Table 3 contains the reported number of full-time social workers employed in the facilities. Full-time social workers were defined as being employed on a full-time basis at the nursing home. The numbers of full-time equivalency or part-time employees were not included in this count. Only 20% of the nursing homes reported the employment of a full-time social worker. The remainder of the nursing homes responded as 7% having no full-time social workers, 8% with two full-time social workers, and 6% of homes reported three or more social workers.

<table>
<thead>
<tr>
<th>Number of Social Work staff Employed by the nursing home</th>
<th>Percent</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7%</td>
<td>106</td>
</tr>
<tr>
<td>One</td>
<td>20%</td>
<td>276</td>
</tr>
<tr>
<td>Two</td>
<td>8%</td>
<td>119</td>
</tr>
<tr>
<td>Three or more</td>
<td>6%</td>
<td>86</td>
</tr>
</tbody>
</table>

TABLE 3. Social Work Staffing
(1423)
Table 4 shows the number of social workers employed full-time in each type of nursing home compared by ownership. Ownership was dichotomous and represented by profit or non-profit status of the home. Profit nursing homes consecutively reported higher numbers of social work staff than non-profit facilities. Profit facilities reported 217 full-time social workers compared to 59 in non-profit homes. The profit facilities reported 73 homes as not having a full-time social worker compared to the 33 in non-profit homes. When examining three or more full-time social workers, these numbers were almost reversed between profit and non-profit homes.

<table>
<thead>
<tr>
<th>Number of Social Workers Employed Full-Time</th>
<th>Profit</th>
<th>Non-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>69% 73</td>
<td>32% 33</td>
</tr>
<tr>
<td>One</td>
<td>79% 217</td>
<td>22% 59</td>
</tr>
<tr>
<td>Two</td>
<td>67% 80</td>
<td>33% 39</td>
</tr>
<tr>
<td>Three or more</td>
<td>53% 34</td>
<td>48% 63</td>
</tr>
</tbody>
</table>

TABLE 4. Social Worker Employment by Nursing Home Ownership (N=1423)
As noted in Table 5, a one-way analysis of variance was conducted to evaluate the relationship between the numbers of full-time social workers by number of available nursing home beds. The independent variable was the number of available beds grouped in four categories: 3-49 beds, 50-99 beds, 100-199 beds, and 200 or more beds. The dependent variable was the number of full-time social workers. The ANOVA was significant, $F (3, 583) = 102.265$, $p > .001$. The result of the one-way ANOVA does support the hypothesis.

<table>
<thead>
<tr>
<th>Beds Available</th>
<th>M</th>
<th>SD</th>
<th>95% CI Lower</th>
<th>95% CI Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-49 Beds</td>
<td>.58</td>
<td>.55</td>
<td>.40</td>
<td>.77</td>
</tr>
<tr>
<td>50-99 Beds</td>
<td>.81</td>
<td>.61</td>
<td>.72</td>
<td>.91</td>
</tr>
<tr>
<td>100-199 Beds</td>
<td>1.33</td>
<td>.95</td>
<td>1.22</td>
<td>1.45</td>
</tr>
<tr>
<td>200 Beds and over</td>
<td>3.31</td>
<td>2.32</td>
<td>2.87</td>
<td>3.74</td>
</tr>
</tbody>
</table>

**TABLE 5. Differences among Number of Nursing Home Beds and Full-time Social Work Employees**

Nursing facilities were grouped by the number of nursing beds. Social services and social work employees differed in the small homes (3-49 beds and 50-99 beds) and the large facilities (100-199 beds and 200+ beds). The between groups difference is that large nursing homes provide more social services. Large nursing homes employed more social workers.
As seen in Table 6, a one-way multivariate analysis of variance (MANOVA) was conducted to determine the association of nursing home size (3-49 beds, 50-99 beds, 100-199 beds, and 200+ beds) on the dependent variables for three types of services, mental health services, social services, and emotional or mental health counseling. Significant differences were found between the nursing facilities, as defined by the number of available beds, to the types of services provided to the residents, \( F = (18, 349922.5) \ 5.984, p < .001 \). In Post Hoc tests, mental health services were significant with larger nursing homes more likely to provide this service. There were nonsignificant findings by number of beds, and type of resident services for social services, and mental health counseling, \( F (3, 1419) = 2.00, p > .05 \).

<table>
<thead>
<tr>
<th>Beds Available</th>
<th>Mental Health M</th>
<th>SD</th>
<th>Social Services M</th>
<th>SD</th>
<th>Emotional M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-49 Beds</td>
<td>1.33</td>
<td>.473</td>
<td>1.07</td>
<td>.250</td>
<td>1.88</td>
<td>.325</td>
</tr>
<tr>
<td>50-99 Beds</td>
<td>1.23</td>
<td>.419</td>
<td>1.02</td>
<td>.142</td>
<td>1.86</td>
<td>.348</td>
</tr>
<tr>
<td>100-199 Beds</td>
<td>1.15</td>
<td>.36</td>
<td>1.02</td>
<td>.145</td>
<td>1.88</td>
<td>.327</td>
</tr>
<tr>
<td>200 Beds and over</td>
<td>1.13</td>
<td>.382</td>
<td>1.02</td>
<td>.151</td>
<td>1.89</td>
<td>.314</td>
</tr>
</tbody>
</table>

**TABLE 6.** Means and Standard Deviations on the Dependent Variable for the Number of Nursing Home Beds Available
CHAPTER 5

DISCUSSION AND CONCLUSION

For profit nursing homes are more prevalent in the United States. Representatively, there were a higher number of for profit nursing homes in the study's population sample, with more than half of the facilities reporting for profit ownership status. A recent study reported identical ownership patterns with the majority of responses from predominately proprietary nursing homes (Harrington, et al., 2003). Government and public concerns stem from the large number of profit homes operating in the United States, as these facilities are working under tight economic periods with reduced budgets, and providing care for less reimbursement (GAO/HEHS, 1999).

In addition to getting payment for services from the government, personal dollars help finance long-term care. In 1998, older adults spent approximately 150 billion dollars for expenses related to long-term care (U.S. Health Care Financing Administration, 2000). Although this amount of personal spending is staggering, it cannot compare to the vast amount of government dollars allocated for long-term care. During 1998, over 40 billion Medicaid dollars and more than 10 billion Medicare dollars were paid to nursing homes for care and services of the elderly (Centers for Medicare and Medicaid Services,
2004). Improvements in quality of psychosocial care will not happen unless based on an increase in financial reimbursement, or at a minimum, unbundling social services from the facility per diem rate (IOM, 1986).

Additionally, a sector of the general public, in conjunction with private organizations, supports the initiative to legislate for higher care and staffing standards. This expectation for quality services and stringent standards is attached to government money for care (U.S. General Accounting Office, 2002b). As the older adult population continues to grow in size, they have the loudest and most persistent voice for change, and through this voice, may achieve a better quality of mental health and psychosocial services (U.S. General Accounting Office, 2002a).

Mandated services for psychosocial and mental health care should not depend on the size of the nursing home. The mean size of nursing homes for both profit and non-profit facilities was 100 to 199 beds. The Centers for Medicare and Medicaid Services report that nationally, 100 to 200 bed nursing homes are the average size for facilities (www.medicare.gov). These medium size nursing homes are of great importance since a selection of these facilities are excluded by the 120 rule. Clearly, if the most common nursing homes are not mandated to employ a full-time social worker, then the law, which was designed to provide for psychosocial and mental health needs of the facility residents, is not being met.
If government dollars are funding long-term care through the Medicare and Medicaid programs, then the majority of facilities should be compelled, at minimum to be in compliance with the regulatory standards. Looking at the research sample, dually certified nursing homes are more prevalent than those certified for either Medicare or Medicaid alone. Dually certified nursing homes are able to provide both skilled and non-skilled care and services in the same area and bed. These beds are often referred to as “swing” beds as the payor of care can change while the resident remains in the same bed. Dual certification or swing beds allow the nursing home to receive payments from both the Medicare and Medicaid programs (Grabowski, 2001). It would be worth considering what should be done differently to connect this funding to compliance with federal law.

Social services fall within the scope of nursing home law. In the National Nursing Home Survey social services were defined as onsite services designed to meet the psychosocial needs of residents. There is no clear indication of the education, or training of the provider of these services. Additionally, there is no standard definition of the nursing home services encompassed within the term “social services”.

Under the Omnibus Budget and Reconciliation Act of 1987 (OBRA) nursing homes must maintain the highest practicable level for the mental and psychosocial well-being of the residents. The majority of nursing homes reported
providing social services to residents. Therefore, this may not be representative of actual services provided by the facility to improve or maintain resident psychosocial well-being. There is no specific set of required services, and with the vague language in the standards, it would be plausible to incorporate specific guidelines and structured language to define appropriate services.

Types of services were studied across both profit and non-profit nursing homes. These findings showed that mental health services were provided less frequently than social services. In 2003, the Office of the Inspector General released a report detailing the lack of mental health services in nursing homes. The Inspector General reported that 95 percent of residents could benefit from mental health services, but the nursing homes plan services for less than half of those residents (U.S. Department Health & Human Services, 2003).

Very few nursing homes reported providing emotional or mental health counseling to their residents. This finding was consistent with a previous study that reported a low percentage of nursing home residents were offered mental health counseling from a licensed professional (Castle & Shea, 1997). Further, the majority of nursing home residents with a care plan for mental health counseling are not provided this service (Department of Health & Human
Services, 2003). The ominous fact is, not only are residents not getting mental health counseling, nursing homes are intentionally planning mental health counseling as a viable social service option, then not providing the service.

In this study, a very small section of nursing homes had zero listed as the number of social workers employed. The nursing homes in this study that reported no social workers were relatively small with 3 to 49 available beds. This finding is interesting as it is supported by the findings in one study and differs from the results in another study. A majority of small sized nursing homes under 100 beds, found that the majority of smaller nursing homes were found to employ a full-time social worker (Department of Health & Human Services, 2003). Another finding reported small nursing homes did not employ a qualified social worker (Burnes, Wagner, Taube, Magaziner, Permutt, & Landerman, 1993). Social work staffing in small facilities may fall between these reported findings, even when these nursing homes are excluded from the mandate. In this sample, the nursing homes that reported no full-time social work employees were considered to be extraneous and extremely small in number of available beds and therefore excluded from the 120 rule.

A lack of service delivery by social workers was associated with work day constraints of time and unrelated employment duties, making social workers unable to meet resident needs (Kelchner, 2001). When reviewing the findings, a
lack of time to provide services could relate to the need for more social work employees in the nursing home. Only 20 percent of the facilities reported employment of a full-time social worker and contradicts a recent finding that over half of nursing homes employed one full-time social worker (Parker-Oliver & Kurzejeski, 2003). Profit nursing homes were more likely to employ at least one social worker. Speculation with this finding may not center on regulatory compliance, but on the social worker as a marketing draw to increase the number of private pay residents (Kruzich & Powell, 1995). Also, the social worker may serve as the mental health care service provider. A previous study indicated that nursing home services offered to the residents for psychosocial functioning were given by other non-mental health professionals (Burns, Wagner, Taube, Magaziner, Pulmutt, & Landerman, 1993).

As the financial sector changes reimbursement and revenue continues to decline, private pay residents are crucial to ensure a profit in a rigid economy. Non-profit facilities fell vastly behind the profit nursing homes in all categories for the employment of social workers. This finding is consistent with a recent study that reported that for profit nursing homes provide only mandated services, while non-profit facilities were more willing to spend monies to benefit the residents (Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2003).
Another challenge to social services in nursing homes was the 1999 change to Medicare payment for services. Social work services provided in skilled nursing facilities were no longer allowed as a Medicare reimbursed expense (U.S. Department of Health & Human Services, 1999). Skilled nursing homes were no longer able to bill Medicare for clinical social work and mental health care. Nursing homes received bundled payment for these services, so mental health care provided by a social worker came out of the facility Medicare per diem rate (U.S Department of Health and Human Services, 2001). This is a conundrum with regulatory standards requiring the prevision of mental health services and resident psychosocial well-being, while the policy changes serve as a disincentive to facilities to provide these services.

A limitation of this study was that the types of services were not compared by nursing home ownership. Other research has shown that profit facilities restrict finances for extra services, and have a history of non-compliance with the standards (Chou, 2002; Grabowski & Hirth, 2003). The most profound limitation for this study was the coding of the response for the number of nursing home beds. The National Center for Health Statistics (NCHS) categorized each open response for question 3, condensing the original responses to four categories comprised of a range of the number of available beds from three to over 200, providing four general facility sizes. The raw data scores for number of beds
available were categorized by NCHS to protect the identification of the participating facilities. As this is a tenant of research ethics, the public use of the data is greatly restricted, which is an issue confronting nursing home research.

Public access to research data is needed to develop new policies or advance established ones. Government funded national studies, like the National Nursing Home Survey, provide this valuable information, yet the data remains restricted from public access, limiting research use. Continued financial investment of government dollars to fund long-term care research should involve a collaboration of agencies, interested parties, and researchers. These groups should work in tandem gathering data for a clearer understanding of nursing home resident need and actual facility practice, which is crucial for quality psychosocial care at the end of life (Kane, 2003). Decisive changes in policy, standards, system delivery, and services are made using government funded research and collected data (Kemper, 2003).

One area suggested for policy change is the number of social workers employed in nursing homes. The need for a social worker is not restricted to facilities at or over 120 beds. Social services are a basic resident right and must be provided by all nursing homes. There are numerous philosophies that have been advanced for a reasonable case, client, or resident load. Any nursing home receiving government dollars for resident care should employ a full-time social
worker. It would be worth requiring facilities to employ one full-time social worker per 50 nursing home beds. The proposed change to the mandated requirement could allow social workers, as licensed professionals, to contribute to resident psychosocial care.

An area for further research centers on the job duties and employment tasks of the nursing home social worker. Standardized employment roles could assist the provision of social services across all nursing homes. Nursing home social workers employment tasks could allow for structured resident counseling or visiting time. This structured contact time could increase the delivery of professional mental health services, which are not being provided to the majority of nursing home residents. At best, a true and accurate picture of social work services could lead to the standardization of nursing home social work practice in all facilities.

Additionally, stricter social work employment policies could increase compliance with current nursing home law, with equal social services in all facilities. The original intent of the Omnibus Budget and Reconciliation Act of 1987 (OBRA) was to mandate nursing homes to provide services that would meet the psychosocial and mental health need of every resident. Additionally, OBRA regulates nursing home social services to meet the highest level of mental and psychosocial well-being of every resident. Almost twenty years have passed...
since OBRA was passed without a true improvement in nursing home care and
services. Certainly, the general scope of these mandates permit nursing homes to
be noncompliant in providing quality services. Until long-term care standards are
specifically written to contain a structured framework of necessary services,
resident mental health and psychosocial needs will remain unmet.
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