Issues Brief

Long-term Care Staffing for Culture Change: Are Unions the Problem – or part of the Solution?

Introduction: The "culture change" movement to transform traditional nursing homes from medically oriented, hierarchical institutions into caring, supportive, nurturing communities has been growing over the past decade. Guiding principles include an emphasis on relationships between and among staff, residents and families. Focusing on person-centered care requires commitment from staff and the management of the facility to learn about each resident's lifestyle and personal choices and then modify, to the extent possible, the environment to accommodate those choices. The major challenge to achieving this standard of care is the availability and sustainability of the long-term care workforce, particularly direct care workers. In recent years, several studies have sounded the statistical cause for alarm, and some have offered a variety of approaches to address this issue. Curiously, health care facilities' owners and managers often resist the unionization of their workforce –citing concerns of control, flexibility and standards of care. Unions and Managers are often characterized as natural enemies, doing battle at the residents' expense.

For the past 7 years, a group of unionized nursing homes in N.Y.C. have been engaged in an experiment in labor-management partnership with the express goal of improving quality of care and life for nursing home residents. These facilities have implemented programs and practices that support person-centered care approaches. These efforts have resulted in improved clinical outcomes for residents and increased satisfaction of staff. This brief will describe the experiences of the Quality Care Community (the organization guiding this partnership), as gleaned from an 18-month case study supported by the Commonwealth Fund.

Long-Term Care Workforce Challenges:

Several sources document the dire current and projected needs for an adequate long-term care workforce. National turnover rates of direct care workers averages 76% - with vacancy rates at 12%[1]. Between 2002-2007 there has been an increase in the percentages

[1] "From Isolation to Integration", National Commission for Quality Long-Term Care, Dec. 3, 2007

of vacant positions nationwide[2]. Of all newly hired staff, 40-60% will leave their jobs within the first year; 80-90% within the first 2 years.[3] The costs to nursing facilities for recruitment and training new staff are currently estimated at more than $4 billion a year.[4] Almost 30% of CNAs live at or below the poverty line. Direct care workers themselves are often recipients of food stamps or Medicaid. Few jobs provide health coverage, benefits (sick or vacation days) or pensions. Opportunities for career growth and additional training are virtually non-existent.[5]

The 2007 Bureau of Labor Statistics estimates that our current demand for direct care workers exceeds 3 million people[6] Demographic predictions about needs in the coming decades are alarming. According to the Institute of Medicine, the number of older adults in the US is expected to almost double between 2005 – 2030[7]. Caring for this cohort will require an additional 1 million workers. While the demand for direct care workers is projected to increase 34% over the next 10 years – the population growth of the current labor pool (already inadequate to meet existing needs) of dcws (women between the ages of 25-54) is projected at only 1%.[8]

<u>Attracting, Stabilizing and Expanding the Direct Care Workforce:</u>

Several studies agree that "solutions" to this issue require at least the following:[9]

1. Adequate compensation: wages that can support a family; health insurance, predictable schedules
2. Training in clinical care issues as well as interpersonal skills; opportunities to share expertise, experience, ideas; career advancement
3. Supportive managers, mentors; work environments that encourage creativity, team-building, growth, continuous quality improvement

[2] "Growing Your Own Staff", Provider Magazine, October 2008
[3] Institute of Medicine report 2008
[4] Institute of Medicine report 2008
[5] "The Long-Term Care Workforce: Can the Crisis be Fixed?" – IFAS paper prepared for National Commission for Quality Long-Term Care, January 2007
[6] PHI Facts #1: Occupational Projections for Direct-Care Workers 2006-2016
[7] Institute of Medicine report 2008
[8] PHI Facts #1: Occupational Projections for Direct-Care Workers 2006-2016
[9] "Essential Elements of a Quality Job for Caregivers", PHI 2006

CNAs are more likely to stay in jobs when they perceive their pay, benefits and advancement opportunities as good. Organizations whose employees reported higher job satisfaction had lower turnover rates. Job satisfaction also included good supervision, defined as: respect, helping out, working to solve problems, providing helpful feedback.[10] The IOM report recommends increasing the pay and benefits of direct care workers, increasing their training and expanding their roles as members of health care teams. The National Commission for Quality LTC report provides examples of innovative programs that provide training and higher levels of compensation that have resulted in a more stable, satisfied workforce.[11]

The "Union" issue:

Traditional union organizing has historically focused on "bread and butter" issues that are reflected in the discussion above. Unions campaign for adequate salaries, paid days off for illness and vacation, health care benefits and retirement plans. These concerns are in perfect alignment with the findings and recommendations of the studies and organizations cited above. It begs the question, "Why wouldn't more long-term care facility owners and managers welcome unionization of their workforces?" Why the recent battle over the "Employee Free Choice Act"? Indeed the proposed EFCA legislation is vigorously opposed by many national healthcare organizations (AHCA, NCAL) as well as the US Chamber of Commerce.[12]

Arguments against unionization include the following:[13]

1. Unionized workers' interests would conflict with residents' (patients') best interests (Union members would care more about their schedules, etc. than the needs of residents)
2. Unionized workforce is too expensive – would force facilities to cut back or close
3. Unions would "formalize" employer-employee relationships – undermine "family" atmosphere desired under "culture change"

[10] "Solutions You Can Use" – Better Jobs Better Care report 2008
[11] "From Isolation to Integration" – Recommendations to Improve Quality in Long-Term care, National Commission for Quality Long-Term Care, Dec. 2007
[12] "Firestorm Brewing over Labor Bill", Provider magazine, January 2009
[13] "The Direct Support Workforce Crisis: Can Unions Help Resolve This?", Steven J. Taylor, Ph.D., Center on Human Policy, Syracuse University, February 2008

4. Unions would make it harder for management to discipline or terminate sub-standard staff
5. Union contracts are too rigid – make it more difficult to provide flexible, person-centered approach to care and organizational change.

The "Quality Care Community": An Experiment in Union-Management Partnership:

In 2002, New York City leaders of the League of Voluntary Nursing Homes and the Nursing Home Division of 1199SEIU had reached an impasse in negotiating a new collective bargaining agreement. Unable to agree on an approach to staffing ratios, they created the "Quality Care Committee" (renamed as the Quality Care *Community* in January 2009) as a mechanism to explore, learn about and develop new approaches to achieving quality care in the long term care facilities they represented. The Quality Care Community (QCC) has evolved into a movement to transform nursing homes, based on the values and principles of person-centered care. Its activities are guided by a Steering Committee, which is comprised of top leaders of the Continuing Care Leadership Coalition (CCLC),the association that represents over 100 voluntary nursing facilities in NY State, and the Nursing Home Division of 1199SEIU which represents over 40,000 nursing home staff. At both a central steering committee and facility-specific levels, management and labor representatives come together to discuss, argue, compromise and plan a joint vision of organizational change and how they will work together to achieve their goals. Organizational support for the QCC has been provided by the 1199SEIU/League Training & Employment Funds (TEF); specifically staff from its Labor Management Project and Nursing Home Training Division.

QCC activities have included: 9 city-wide conferences where labor-management teams of nursing home staff learn about person-centered care; on-site interdisciplinary training in gerontology, palliative care, leadership development, customer service; organizational development consultation; development of a field guide that includes best practices in areas of staff retention, team development, work redesign; pilot projects in 16 facilities that focused on creating new models of person-centered care.

Since 2003 over 40 nursing facilities have consistently participated in a wide range of QCC events. As individual facilities began to experience positive changes that resulted

from their Culture Change initiatives, nursing homes and individuals around the state and country became interested in this unique partnership approach. In 2006 the Training & Employment Funds received a grant from the Commonwealth Fund to utilize a case study approach to better understand this unique initiative.

Research Study:

The Commonwealth Fund study focused on examining the following questions:

1. How does this labor-management partnership work?
2. What are the partnership's essential elements for achieving person-centered care?
3. How can these efforts be sustained, expanded and replicated through evolving labor-management partnerships?

The project was designed and implemented by a team from Brandies University and Boston College (led by Christine Bishop, Ph.D.) Utilizing a Participatory Action Research approach, an Advisory Committee (comprised of union, worker and management representatives) helped to refine the design and select two facilities that would serve as case study sites for intensive interviews and observation.

In January 2007 site visits were conducted and almost 80 staff (management and frontline from day and evening shifts) were interviewed. Observations of daily care (meal time, activities) also took place. Interviews and observations were transcribed, coded and analyzed.

Findings:

How the Labor-Management Partnership Works:

Many respondents from both facilities talked about the importance of being part of the larger, city-wide movement for culture change – the Quality Care Community. Regular city-wide meetings afford staff (direct care and supervisory) opportunities for learning, sharing best practices and recommitting to the long, hard journey of organizational (and personal) change. Both facilities had also benefited from on-site, interdisciplinary training (provided by the TEF) in gerontology, customer service, and palliative care. These sessions reinforced the material and team-based approaches of the city-wide conferences. Bringing direct care and management staff together began to impact the day-to-day interpersonal relationships at the facility level. Interview

respondents talked about greater levels of comfort and trust as their neighborhood-based teams took on more responsibility for culture change.

As one direct care worker said, *"Since we've been working together, some supervisors now speak to me…Because of our committee work they share their concerns and we've learned to trust one another. Now we openly share our discomforts, our joys, our achievements."*

Essential Elements for Worker-Management Partnerships:

1. Commit to working together: Members of the QCC Steering Committee modeled this joint leadership approach – which was then reflected throughout both study sites. Each facility established its own steering committee and several other committees/groups to handle specific issues. Over time worker and management leadership adopted this joint approach as "the way we do things here".
2. Changing Management structures & roles: Both study facilities had histories of decades of operating in the traditional, hierarchical, medical-model fashion. Now management staff had to learn new ways of working that often involved pitching in to assist in direct care and relinquishing some decision-making responsibilities. A department head explained that, *"Management support of person-centered care is key to its success…Because upper management makes it clear they are committed to culture change, it frees up staff to be creative – to think outside the box."*
3. Union leadership support: Union leaders and members also had to adopt new roles. The organizers (shop stewards) and facility-based delegates struggled to find a new balance between protecting traditional workers' rights while engaging in new approaches to job descriptions, work design and decision-making. Seeing management change (see # 2 above) made it easier for union members to change. A union organizer said, *"Because we got person-centered care written in as part of our contract, I see this as a vital tool in problem solving…it has given our members a greater awareness of their responsibility as workers in the facility.*

Now it's not just 'I'm a worker', but 'I have an interest in this, I'm owning this. If it fails it means that I fail.'"

4. Enhanced roles of frontline workers: All of the frontline workers at both sites felt positive about the changes they had experienced. They embraced job expansion to help out their co-workers, collaborated across job titles and hierarchy in the interest of improving care. Frontline staff were the most enthusiastic supporters of culture change; particularly the housekeeping/environmental staff who spoke with great pride in now being able to feed, transport and support residents on their neighborhoods. A housekeeper reflected that *"Now I start my day by taking residents and helping with feeding and then my other job begins. I'm not required to help with transporting and recreation but I get paid back when other staff help clean up."*
5. Enhanced roles for residents & families: Although not included in the study design for interviews, the researchers observed significant differences in the staff's approach to these two groups. Opportunities for residents and families to express individual preferences (and have many of them met) were cited. Staff proudly provided several examples of how they were able to respond to particular requests and the positive impact this had on the overall atmosphere in their neighborhood.

<u>Sustaining Person-Centered Care:</u>

Interviewees acknowledged the progress they had made, but also expressed concern about the future. Current economic difficulties, coupled with state and federal budget projections are of concern to all staff – yet there is recognition that there is no turning back. Recommendations for sustaining and expanding PCC include the following:

1. Begin PCC by using model/pilot programs: This approach enables a neighborhood team to experiment, reflect and refine new ways of dining, bathing, etc. before rolling out to the other units.
2. Expand culture change to the entire facility: Pilots are valuable – but one facility cannot sustain two different approaches to care.

3. Move scheduling to the neighborhoods: Team-building and person-centered care would be strengthened through permanent assignments and enabling neighborhood staff to be responsible for scheduling vacations, days off and coverage. One administrator shared the following example: *"A year ago there were a lot of workers coming in late or just now showing up. We agreed to have the union talk to these folks one-on-one and learned that some people came all the way from Brooklyn and had to drop their child off at school first. So we agreed to push back their start time by half an hour. This was much better than going down the traditional disciplinary-grievance route."*
4. Ensure the PCC is a 24x7 operation: Engage staff on the evening and night shifts so that the approaches and values are consistent. A direct care staff observed, *"On days we have some more help from supervisors but at night it's different. This needs to spread. One day I left a bed unmade because I was helping with a birthday party and the evening shift got mad."*
5. Resources: Fostering change can be costly. These facilities benefited from the on-site training that also provided funds for replacement staff while the direct care staff were in class. It is anticipated that most facilities will be challenged to support continuous staff development and learning – yet it is essential to organizational change. One administrator expressed concern, *"The new governor talks about transforming nursing homes and finding alternatives, but I don't think he really understands. This isn't like making instant coffee…How do we reach this year's objectives with cuts in rates?"*
6. Don't expect uniformity: There is no cookie-cutter approach to developing and replicating person-centered care – even within one facility with several neighborhoods. Staff and resident personalities and capabilities vary by unit and each neighborhood must be able to forge its own path.
7. Take your time and don't rush the change process: Some management and worker leaders expressed concern that changes were taking place faster than staff could handle. They provided examples of "backsliding" or "institutional creep" – bringing back old practices of departmental silos and decision-making. Each

facility must develop ways of taking stock and evaluating its progress on a regular basis.

Revisiting the "Union" issue:

The QCC experiences provide evidence that unionization can contribute to achieving person-centered care by supporting a stable, trained workforce. Let's return to the arguments presented in Professor Taylor's paper (see p. 3).

1. *Union workers' interests and residents' interests conflict:*

   As staff work together and develop relationships with one another, the residents and their families, a sense of community and interdependence develops. When neighborhood-based teams are taught and empowered to modify their schedules (based on meeting the residents' personal daily life preferences), they often find they can meet other individual needs through more flexible work routines. Decentralizing decision-making, incorporating continuous quality improvement approaches to track clinical measures and surveying residents and staff satisfaction are approaches supported by union and long-term care managers.

2. *Union workforce too expensive:*

   A unionized workforce is often a more stable workforce. Facilities cannot sustain the costs (financial and clinical care) of continually recruiting, training and replacing staff. David Farrell has well documented the business case for culture change and the actual savings facilities realize by stabilizing their workforce. Person-centered care is predicated on consistent relationships between residents and direct care staff – and unionization is one way to achieve this goal.

3. *Unions "formalize" relationships:*

   Nursing home and Union leaders, who agree to identify and work on common interests in service of culture change principles, can create a more harmonious, cooperative environment. Learning how to engage in interest-based, rather than positional, problem-solving approaches fosters creative thinking and often leads to deeper, more supportive work relationships.

4. *Harder to discipline substandard staff:*

The number of actual formal grievances and arbitrations are reduced in Q.C.C. facilities. As trust, respect and collaborative project work becomes the norm, union and management leaders identify staff issues more quickly and often utilize informal approaches to "nip problems in the bud", rather than wait for situations to escalate. QCC leaders often agree on standards of care and performance for all staff.

5. *Union contracts too rigid*:

In 2008 a subset of 16 QCC facilities completed pilot projects that encouraged experimenting with flexible scheduling, work re-design and new job descriptions – all focused on deepening person-centered care and increasing staff satisfaction. Recent language in the latest CBA (Collective Bargaining Agreement) encourage continued flexibility and experimentation.

Conclusion:

The challenges facing the long-term care field are many and if we continue to only use the same old approaches – we are doomed to get the same old results. The Culture Change movement holds great promise for those receiving and providing care to physically frail and disabled individuals outside of their homes. Wellspring, the Pioneer Network, and Green House movements have encouraged new ways of thinking about how care is provided. It is time to re-imagine how we will create and sustain the workforce needed to provide that care. Promoting values and practices that support person-centered care, empowered work teams and high levels of resident, family and staff satisfaction can be complimentary to Union goals and concerns; actually Union-Management partnerships can provide the strong foundation for enduring change to occur.