Multi-Level Factors Related to Deficiencies in Psychosocial Care in Washington State Skilled Nursing Facilities

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Abstract

Multi-Level Factors Related to Deficiencies in Psychosocial Care in Washington State Skilled Nursing Facilities

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Persons living in skilled nursing facilities (SNF) have extensive psychosocial needs, yet the services provided to meet those needs appear insufficient. Facility social workers are recognized as the primary providers of psychosocial services in SNFs, but often report barriers interfering with their ability to furnish services to all residents who need them. This study utilizes a three-category quality assessment framework to assess specific factors that either enhance or hinder the provision of effective psychosocial services in Washington State SNFs.

A cross-sectional research design was employed merging two sources of data: responses to an investigator-developed questionnaire administered to Social Services Directors (SSDs) in participating SNFs ($N = 121$) and resident-centered state survey outcomes in psychosocial care-related areas obtained from the Online Survey and Certification Reporting (OSCAR) database. Ordinary least squares regression was utilized to assess the ability of facility structural factors, process factors, and SSD characteristics to predict the frequency of psychosocial services in five diverse service domains: care planning, resource and referral, administration and advocacy, assessment, and intervention. Hierarchical linear regression methods were utilized to assess the ability of structural factors, process factors, and SSD characteristics to predict the scope and severity of survey deficiencies in psychosocial care. Interaction terms were also included in the regression model to determine the potential moderating effect of service delivery on predictive multi-level factors.

Results indicate that structural factors, process factors, and SSD characteristics play only a limited role in predicting service frequency, although the size of the SSD's caseload is associated with frequency of care planning and intervention services. Four multi-level factors are associated with positive psychosocial care outcomes: low ownership turnover, more years of SSD experience in SNF social services, stronger SSD identification with the helper role, and paradoxically, lower priority attributed to residents' individualization needs at the facility level. This unexpected finding is possibly explained by a stronger focus on assessment services in lieu of intervention services within facilities that place a high priority on individualization needs. An additional finding is that the frequency of assessment services appears to moderate the impact of both ownership turnover and role identification on outcomes in psychosocial care.

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DEDICATION

To all the people who have ever worked, lived, or visited a loved one in a skilled nursing facility.

INTRODUCTION

Persons living in skilled nursing facilities (SNFs) have extensive psychosocial needs, yet the services provided to address those needs appear insufficient. Indeed, substantial evidence indicates SNF residents' psychosocial needs are generally not met (Vourlekis, Gelfand, & Greene, 1992a; Tirrito, 1996; O'Neill & Rosen, 1998; Parker-Oliver & Kurzejeski, 2003; Department of Health and Human Services, 2003). A recent study by the Office of Inspector General found that although 95 percent of persons living in SNFs had at least one psychosocial need such as depression, anxiety, sad mood, or behavioral symptoms, only 39 percent received all of the services deemed necessary to meet those needs. Moreover, 49 percent had psychosocial needs that were unrecognized as necessitating intervention by facility staff (DHHS, 2003). Facility social workers[1] have been recognized as the primary providers of SNF psychosocial services and both workload and knowledge barriers have been noted to interfere with their ability to meet residents' psychosocial needs (Tirrito, 1996; O'Neill & Rosen, 1998; DHHS, 2003, Parker-Oliver & Kurzejeski, 2003). However, specific factors that either enable psychosocial care or reduce the barriers to service delivery have yet to be explored. Furthermore, little is known about the connection between service provision and indicators of facility quality associated with resident outcomes, such as state survey inspection results.

This study examines predictive relationships among facility characteristics, social worker characteristics, psychosocial service delivery, and state survey deficiencies in psychosocial care in Washington State SNFs. Building on Donabedian's (1988) three-category quality assessment framework, this research assesses the independent and combined effects of organizational structure, organizational processes, and social worker characteristics on the frequency of psychosocial service delivery and associated survey inspection results. A better understanding of the influence these multi-level factors have

[1] The educational backgrounds of persons providing psychosocial services in SNFs vary considerably and not all have formal education in social work; however, the literature commonly refers to these individuals as "social workers." While use of this title is controversial in reference to individuals without professional social work training, it is utilized in this study to conform to standard terminology.

on resident outcomes may identify points of intervention leading to enhanced psychosocial care in SNFs. The study has the following specific aims:

1. To examine the effect of organizational structure, organizational processes, and social worker characteristics on the frequency of psychosocial services.
2. To examine the effects of organizational structure, organizational processes, and social worker characteristics on the scope and severity of survey deficiencies in psychosocial care-related areas.
3. To assess whether the frequency of psychosocial services moderates the effects of organizational structure, organizational processes, and social worker characteristics on the scope and severity of survey deficiencies in psychosocial care-related areas.

CHAPTER I: LITERATURE REVIEW AND CONCEPTUAL MODEL

Psychosocial Care

Psychosocial care refers to a range of services provided to address the psychological, social, and emotional aspects of SNF residents' human needs. According to standards developed by the National Association of Social Workers (2003), focal areas for psychosocial services in SNFs include:

- The social and emotional impact of physical or mental illness or disability,
- The preservation and enhancement of physical and social functioning,
- The promotion of the conditions essential to ensure maximum benefits from long-term health care services,
- The prevention of physical and mental illness and increased disability, and
- The promotion and maintenance of physical and mental health and an optimal quality of life.

As captured above, psychosocial care composes three distinct, but related domains: mental health, social services, and quality of life.

Mental Health

Many of residents' psychosocial needs stem from mental health conditions and considerable research highlights the extent of mental disorders in this population. For example, findings from the 1999 National Long Term Care Survey indicate that 65 percent of SNF residents have a psychiatric diagnosis. Indeed, the incidence of mental health conditions surpasses that of physical disorders such as heart disease and hypertension (Jones, 2002). Among specific conditions, 45 percent of persons living in SNFs have depression, 35 have personality disorders (Castle & Shea, 1997), 51 percent have dementia, and 17 percent have other behavioral disorders (Meeks, Jones, Tikhtman, & La Tourette, 2000). Furthermore, 66 percent exhibit some type of behavioral symptom such as continuous yelling, physical aggression, or resistance to care (Liptzin, 1992; Burns, Wagner, Taube, & Magaziner, 1993). Mental health issues are so extensive that these facilities have aptly been termed " the new mental health treatment centers for

older adults" (Spore, Smyer & Cohn, 1991) and there are more elders with mental health conditions in SNFs than there are in state psychiatric facilities (Jones, 2002).

At the same time, mounting evidence indicates that the provision of mental health services to this population is inadequate (Burns et al, 1993; Castle & Shea, 1997; Snowden, Piacitelli, & Koespell, 1998; Shea, Russo, & Myers, 2000; Parker-Oliver & Kurzejeski, 2003). For example, review of Medicare claims data indicates that 80 percent of SNF residents with known mental health conditions do not receive treatment from any licensed mental health professional (Smyer, Shea, & Strait, 1994). In addition, the American Geriatrics Society and the American Association of Geriatric Psychiatry (2003) note that residents who do receive mental health treatment are frequently misdiagnosed or under-diagnosed. Further service deficits include overuse of psychotropic medications, under use of non-pharmacological interventions, and poor follow-through with recommended interventions (Snowden, Piacitelli, & Koespell, 1998).

Given these limitations in mental health service delivery, social workers employed in SNFs have been deemed one of the primary providers addressing residents' mental health needs. However, limited knowledge of geriatric mental health among these practitioners may minimize the potential for high quality care. For example, one study found direct care workers in SNFs possessed more knowledge of older adult mental health than facility social workers (Tirrito, 1996). In addition, the majority of social workers sampled were unfamiliar with interventions to manage residents' behavioral symptoms; the least understood strategies were those used to reduce symptoms stemming from agitation and disorientation in the context of dementia. These findings are of concern given the high levels of dementia and behavioral issues among SNF residents; they suggest that the extent of social workers' geriatric mental health knowledge may be an important variable linked with outcomes in psychosocial care.

Social Services

Beyond residents' mental health needs, psychosocial care also includes the provision of services to address a wide variety of social issues, such as adjusting to loss and change, accessing financial resources, developing and nurturing relationships, and maximizing self-determination and empowerment. Services may also extend to the resident's family to enhance coping with their loved one's condition or assist them in navigating the nursing home environment (Vourlekis, Greene, Gefland, & Zlotnik, 1992b). Table 1 depicts the range of social services as described by the American Health Care Association (2006).

Table 1: *Common Social Services Provided in Skilled Nursing Facilities*

• Making arrangements for obtaining adaptive equipment, clothing, and personal items • Meeting the needs of residents who are grieving • Assisting staff to inform resident and those they designate about the resident's health status and health care choices and their ramifications • Assisting resident with financial and legal matters • Providing or arranging provision of needed counseling services • The provision or arrangements of interventions to address the following: o Behavioral symptoms o Presence of chronic disability, medical, or psychological conditions o Presence of legal or financial problems o Inability to cope with loss of function o Changes in family relationships, living arrangements, and/or resident's condition or functions o Abuse of alcohol or other drugs o Need for emotional support o Physical or chemical restraints o Lack of an effective family/support system o Resident-to-resident physical altercations o Depression o Difficulty with personal interaction and socialization skills	• Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet • Monitoring residents with mental disorders as defined by DSM-IV for progress in improving physical, mental and psychosocial functioning • Discharge planning services • Assisting resident to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions • Through the assessment and care planning process, identifying and seeking ways to support resident' individual needs • Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality • Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning • Making referrals and obtaining services from outside entities • Finding options that most meet the physical and emotional needs of each resident • The provision or arrangements of interventions to address chronic or acute pain • Implementing interventions to assist residents with mental disorders as defined by DSM-IV to meeting treatment goals

Similar to the service limitations noted in the mental health components of psychosocial care, shortfalls exist in the provision of services to address residents' broader psychosocial needs. As noted earlier, a study of psychosocial care conducted by the U.S. Office of Inspector General (OIG) revealed that while the majority of residents ($N = 299$) had at least one psychosocial need, 39 percent lacked adequate care plans to address those needs. Furthermore, even among residents with adequate care plans, 41 percent did not receive all services recommended by the plan and 5 percent received none of the recommended services (DHHS, 2003). These gaps in service delivery were evident in resident-focused outcomes: upon inspection by state surveyors, 15 percent of the facilities received deficiencies in medically-related social services.

The OIG study also found that 98 percent of facilities had social work staffing levels that met federal requirements, yet in spite of this, 45 percent of social workers reported barriers to providing sufficient psychosocial care. Barriers included not having enough time, having too much paperwork, insufficient staff, and numerous responsibilities beyond providing psychosocial services. These responsibilities "range[d] from running errands outside the facility to assisting with dining room arrangements to getting residents' eyeglasses fixed" (p. 13). Nursing home administrators interviewed also identified social workers' time constraints and paperwork demands as the primary obstacles to addressing residents' psychosocial needs. Professionals in the field echo the OIG findings with reports of similar difficulties. Fiske (2003) found "mountains of paperwork" and other administrative tasks reduced SNF social workers' ability to provide psychosocial services. O'Neill (2002) suggests social workers tend to be assigned inappropriate jobs that "draw [them] away from what they have been educated and trained to do" (p.3).

Paralleling the OIG findings and the profession's observations, several studies have documented challenges social workers face in delivering quality psychosocial services in SNFs. For example, the responsibility for ongoing completion of federally-mandated individualized assessments requires considerable time and leaves little room for psychosocial intervention; thus, SNF social workers practice under "severe time

constraints" (Vourlekis et al, 1992b, p. 67; Parker-Oliver & Kurzejeski, 2003). Indeed, time studies have revealed that SNF social workers have about 6 minutes per resident per day to address all psychosocial needs, including assessment, care planning, and intervention (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000). Furthermore, although psychosocial services typically fall within the auspices of social work, federal regulations actually stipulate that psychosocial care is the responsibility of the facility as a whole. This distinction has contributed to confusion and lack of accountability between residents' needs and facility staff members' individual responsibility for meeting those needs (Vourlekis et al, 1992b).

Given the above challenges, it is likely that important factors associated with outcomes in psychosocial care stem from the characteristics of the facility work environment and the priority ascribed to residents' psychosocial needs in the context of the social worker's job description. Indeed, social workers employed in facilities identified as providing best practice psychosocial care report that their expertise is well-utilized (Connolly, Nitsch, & Panicker, 2005). They also indicate feeling highly satisfied with their roles and functions, perceive that they are important members of the interdisciplinary team, and feel valued for both their skills and the services they provide (Vourlekis et al, 2005). Accordingly, correlates of SNF social workers' job satisfaction and intention to remain employed in long-term care facilities include job autonomy, supervisor support, and coworker support (Gleason-Wynn & Mindel, 1999). Building on these findings, central aspects of interest in this research include the extent of the social worker's autonomy in determining his or her own job priorities, the level of influence he or she has in facility decision-making related to psychosocial care, and the frequency he or she is able to provide specific psychosocial services.

Quality of Life

A third component of psychosocial care is overall quality of life, which captures residents' perspectives on their own well-being and living environment as well as their satisfaction with the medical or nursing care they receive (Vourlekis et al, 2005).

Although the quality of care and quality of life can be viewed as different constructs, the quality of care provided in SNFs is a major determinant of residents' quality of life (Challiner, Julious, Watson, & Philp, 1996); indeed, SNF residents appear to equate quality of care with quality of life. For example, residents believe quality of care depends on "a friendly, cheerful, and compassionate direct care staff" and also regard these staff attributes as necessities for quality of life (Logsdon, 2000, p. 133). In addition, residents report that meaningful activities, family involvement in their care, personal autonomy and choice, and the ability to function as independently as possible are key components related to both quality of care and quality of life (Logsdon). Similarly, Kane et al (2003) found residents' perceptions of quality of care include the following quality of life domains: comfort, functional competence, autonomy, dignity, privacy, individuality, meaningful activities, relationships, enjoyment, security, and spiritual well-being.

While facility residents are fairly clear on what quality of life and quality of care mean to them, these constructs have been difficult for both researchers and policymakers to define and are described primarily by their indicators. At the national level, regulators utilize twenty-four indicators of overall health to measure quality of care, as listed in Table 2 (Center for Health Systems Research and Analysis, 1999).

Table 2: *CMS Nursing Home Quality Indicators*

1. Incidence of new fractures	13. Prevalence of weight loss
2. Prevalence of falls	14. Prevalence of tube feeding
3. Prevalence of behavioral symptoms affecting others	15. Prevalence of dehydration
	16. Prevalence of bedfast residents
4. Prevalence of symptoms of depression	17. Incidence of decline in late-loss activities of daily living (ADLs)
5. Prevalence of depression with no antidepressant therapy	18. Incidence of decline in range of motion
6. Use of 9 or more different medications	19. Prevalence of antipsychotic use in absence of psychotic or related conditions
7. Incidence of cognitive impairment	
8. Prevalence of bladder or bowel incontinence	20. Prevalence of any antianxiety or hypnotic use
9. Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan	21. Prevalence of hypnotic use more than two times in the last week
10. Prevalence of indwelling catheters	22. Prevalence of daily physical restraints
11. Prevalence of fecal impaction	23. Prevalence of little or no activity
12. Prevalence of urinary tract infections	24. Prevalence of stage 1 – 4 pressure ulcers

Measures associated with these quality indicators have often been utilized as outcome variables in long-term care research. For example, Anderson, Issel, and McDaniel (2000) looked at the relationship between facility management practices and four quality outcomes: resident behavioral problems, use of physical restraints, complications of immobility, and fractures. Similarly, Anderson, Hsieh, and Su (1998) examined how facility's allocation of resources impacts several quality-related outcomes, including the percentage of residents displaying aggressive behaviors, in restraints, and with contractures, decubitus ulcers, dehydration, urinary tract infections, or fractures.

Another indicator commonly utilized in long-term care research is state survey inspection results. For example, Castle (2001a) and Castle and Myers (2006) examined factors associated with survey deficiencies in mental health-related areas. In addition, Graber and Sloane (1995) identified predictors related to survey deficiencies for misuse of physical restraints. Castle and Banaszak-Holl (2003) assessed the relationship between administrative resources and the number of survey deficiencies facilities received, while Harrington et al (2002) examined the effect of investor-ownership on the extent of survey deficiencies. Since there are several survey deficiency categories that relate to quality of care, quality of life, and psychosocial care, this outcome variable has strong potential for delineating factors associated with effective psychosocial services. In addition, since survey deficiencies are resident-focused, this measure would support evaluation of the impact multi-level factors have on residents' quality of life. Survey deficiencies and the survey process are further described in the methodology section of this paper.

Conceptual Framework

Given that the provision of psychosocial care is an aspect of overall quality of care and quality of life, correlates of these broader definitions of quality offer promising constructs for examining psychosocial service delivery and subsequent survey deficiencies. Myriad factors are associated with quality of care and quality of life in SNFs. Donabedian's (1988) quality assessment framework is often used in long-term

care research to delineate the relationships among the multiple indicators of quality (Spector & Takada, 1991; Aaronson, Zinn, & Rosko, 1994; Bravo, DeWals, Dubois, & Charpentier, 1999; Castle, 2001a). This framework divides predictors into three categories: organizational structure, organizational processes, and individual resident outcome variables. These categories are interrelated whereby effective organizational structures contribute to effective organizational processes, which then contribute to successful resident outcomes, as depicted in Figure 1. Structural variables refer to stable attributes of the facility's setting and its capacity to provide good care; process variables refer to methods used to deliver care and the overall facility milieu. Outcomes are the effects care has on residents' health status (Donabedian, 1988).

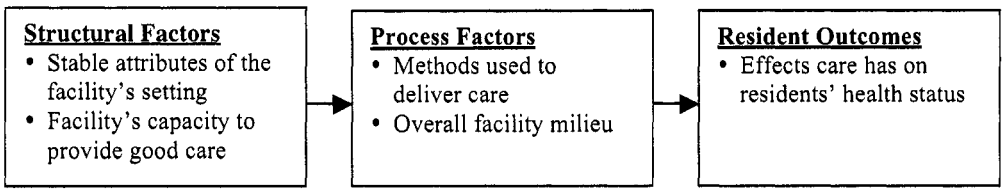

Figure 1: *Donabedian's Quality Assessment Model*

While Donabedian did not include an individual practitioner category in his original model, this study includes social work characteristics as components associated with the quality of psychosocial care. Although federal regulations stipulate the provision of psychosocial services is a facility-wide responsibility, the facility social worker is typically held responsible to insure that these services are provided (Parker-Oliver & Kurzejeski, 2003). As such, social worker attributes likely influence resident outcomes in psychosocial care along with organizational structure and processes. Key variables identified in the literature associated with each of these quality assessment categories, beyond those identified above, are described in further detail below.

Organizational Structure Factors

At the structural level, six key factors appear related to quality of care: ownership

turnover, ownership status, multi-facility chain affiliation, facility size, facility location, and the size of the social worker's caseload.

Ownership Turnover

Change at the organizational or management level often appears to disrupt care practices. For example, Castle (2000) found that over time higher Medicaid occupancy rates and changes in facility ownership are both associated with an increased usage of physical restraints. Furthermore, turnover of facility administrators is linked to negative outcomes for additional quality indicators, including catheterization rates, the extent of psychotropic drug use, and the incidence of pressure ulcers (Castle, 2001a). Administrator turnover also correlates with increased survey deficiencies in quality of care-related areas (Christensen & Beaver, 1996; Castle, 2001a). Similarly, turnover of nurse supervisors is noted to both limit the quality of care provided by nursing assistants and reduce their job satisfaction (Anderson, Corazzini, & McDaniel, 2004). Turnover of directors of nursing, directors of social services, and registered nurses is related to residents' lower satisfaction with the facility (Kruzich, Clinton, & Kelber, 1992). Conversely, organizational change focused on empowering direct care staff has been linked with reduced staff turnover and improvements in resident quality of life (Stone et al, 2002; Yeatts & Cready, 2007).

While including data on diverse multi-level organization change is not feasible for this study, assessing the impact of ownership turnover is a viable alternative and provides an important measure of change occurring at the highest organizational level and impacting all levels of the organization. By definition, ownership turnover captures the number of times a facility has changed ownership (i.e. been sold) since first being licensed through the Medicare and/or Medicaid program(s). Research indicates facility acquisition by another nursing home chain can be detrimental to residents' quality of life, especially when poor-performing chains purchase poor-performing facilities (Banaszak-Holl, Bera, Bowen, Baum, & Mitchell (2002). In addition, facilities that experience ownership changes may house residents with greater physical and mental health care

needs, have higher Medicaid occupancy rates, and receive more survey deficiencies than facilities that do not undergo ownership change (Castle, 2005).

Ownership Status

Facility ownership status, meaning whether a facility is non-profit, for-profit, or government-owned, is frequently linked with quality of care (Davis, 1991; Anderson, Issel, & McDaniel, 2003). For example, compared to for-profit facilities, non-profit facilities are found to provide more evaluation and treatment for mental health conditions (Castle & Shea, 1998), receive fewer mental health-related survey deficiencies (Castle & Myers, 2006), receive fewer overall survey deficiencies, and have higher levels of nurse staffing (Harrington, Woolhander, Mullan, Carrillo, & Himmelstein, 2002). In addition, interdisciplinary team members in non-profit facilities appear to have more ongoing discussions related to residents' advanced directive care planning (Bradley & Walker, 1998).

Multi-Facility Chain Affiliation

A multi-facility chain is defined as a system in which two or more facilities are owned, leased, sponsored, or managed by a single corporate entity (Alexander & Fennell, 1986). The largest multi-facility chains also tend to be for-profit, which has generated concern regarding the impact of chain affiliation on SNF quality of care. For example, Kruzich (2005) notes one possible drawback is that administrators of chain-affiliated facilities may be more inclined to focus on the needs of the corporation rather than the needs of the community. Research has found that chain-affiliated facilities tend to utilize physical restraints more frequently than facilities not affiliated with chains (Castle, 2000). In addition, facilities not belonging to corporate chains tend to have lower administrator turnover than facilities belonging to corporate chains (Castle, 2000), and as noted previously, lower administrator turnover is then associated with several positive quality indicators. Administrators in non-chain affiliated facilities have also been found to experience more decision-making autonomy in comparison to their counterparts in chain-

affiliated facilities; however, this relationship is influenced by the size of the corporate chain whereby administrators in smaller chains report greater decision-making autonomy than administrators in larger chains (Kruzich, 2005).

Facility Size

Although facility size is linked to quality of care, efforts to determine its influence have led to conflicting results. For example, one study found that after adjusting for the larger numbers of residents, the average number of survey deficiencies tends to increase with the number of beds in the facility (DHHS, 2001). Another study found that larger facilities have more difficulty caring for residents with cognitive deficits (Bravo et al, 1999), while a similar study noted that larger facilities tend to have a lower incidence of resident aggression and restraint use (Anderson et al, 2003). At the same time, larger facilities appear to adopt innovations in care delivery more readily than smaller facilities (Castle, 2001c).

Facility Location

Unfortunately, facilities assessed as providing lower quality care are more often located in less affluent communities and in communities of color. Furthermore, resident outcomes are influenced by nursing home bed supply and unemployment rates in the facility's vicinity (Mor, Zinn, Angelelli, Teno, & Miller (2004). Facilities that have greater access to community collaborators such as mental health agencies, laboratories, and physicians, and utilize those services score higher on measures of quality (Bravo et al, 1999). Given the challenges associated with providing social services in rural communities, when compared to social workers in urban SNFs, social workers in rural SNFs may experience additional barriers to psychosocial service delivery.

Social Worker Caseload

Nurse staffing ratios measure the nursing personnel work hours per resident-day and are commonly associated with quality of care. For example, facilities with higher

nurse staffing ratios receive fewer state survey deficiencies (Anderson et al, 1998; Harrington et al., 2000). While social work staffing ratios are rarely discussed in the literature, social work caseload or workload is a common construct, and represents the ratio of social workers to residents in the facility. As noted previously, workload pressures have been described as extreme in the field and it is likely that the number of residents whose psychosocial care the social worker must oversee relates to the quality of services provided. In addition, there is evidence that directors of social work have more influence on facility decision-making in facilities with more social workers on staff (Kruzich & Powell, 1995).

Organizational Process Factors

The majority of SNF social workers are solo practitioners (Tirrito, 1996; Parker-Oliver & Kurzejeski, 2003), thus they practice in host environments where organizational missions and values are defined by other professions (Dane & Simon, 1990). Challenges commonly encountered in host settings include managing value discrepancies among multiple disciplines, advocating with limited facility decision-making influence, and coping with role ambiguity combined with role strain. In the context of a host environment, six facility process factors are salient to the proposed study: social worker job autonomy, social worker influence, psychosocial service priorities, the frequency of psychosocial service delivery, supervisor support, and co-worker support.

Job Autonomy and Social Work Influence

Job autonomy refers to the social worker's freedom to determine his or her priorities for service delivery, while social work influence refers to the social worker's power to shape decision-making within the facility. Both constructs have been linked with indicators of quality. For example, greater social work job autonomy is associated with positive psychosocial care outcomes such as higher levels of resident satisfaction (Vourlekis et al, 2005). At the same time it is associated with increased job satisfaction and longevity in the field (Gleason-Wynn & Mindel, 1998). In facilities where the social

worker is more influential, residents report higher levels of satisfaction with their environment and with their caregivers (Kruzich et al, 1992). Furthermore, when social workers are able to influence decisions, they typically influence decisions that impact resident well-being, such as updating care plans to reflect changes in residents' conditions and transferring residents to and from the facility as their individual needs require (Kruzich & Powell).

Psychosocial Service Priorities

Psychosocial service priorities represent the services that are perceived as most important to the social worker's job responsibilities at the facility level and include services that the social worker provides and those that she or he oversees. Like all host settings, role ambiguity is characteristic of SNF social work and as previously noted, industry regulations do not specifically define the social work role. Given this reality, the values of more dominant professions may influence psychosocial service priorities such that services viewed by the social work profession as crucial for persons living in SNFs may not be regarded as important in terms of the social worker's job responsibilities (Dane & Simon, 1990; Clemens & Hays, 1997; Healy, 2003). For example, over half of SNF social workers sampled in Wisconsin reported that discussing the care of residents who were dying was not a significant component of their job (Fairchild-Remsen, 1992). Complicating role ambiguity, multidisciplinary team members' priorities for psychosocial care may not coincide with those of the social worker (Vourlekis et al., 1992b). For example, given SNF social workers' caseload demands, they may lack sufficient time to provide psychosocial services to all residents who need them (Vourlekis et al, 1992b; Harrington et al, 2000). As such, social workers tend to perceive residents' needs on a continuum, which allows them to triage service delivery to those with the greatest needs. Conversely, facility administrators more often view all residents' needs as equally important, setting the stage for role strain and unrealistic expectations, given the social worker's time constraints (Vourlekis et al, 1992a).

Frequency of Psychosocial Services

In light of the potential for diverse and conflicting priorities ascribed to residents' psychosocial needs, the services corresponding to those needs may not be the ones social workers most frequently provide or which consume the majority of their time (Vourlekis et al., 1992b). Thus, the frequency of psychosocial service delivery in relation to the social worker's caseload emerges as an additional factor that may influence the quality of psychosocial care. Findings from the 2003 OIG study that highlight current limitations in SNF psychosocial service delivery magnify the importance of this variable (DHHS, 2003). It is hypothesized that frequency of service delivery will moderate the effects of organizational structure and processes and social work characteristics in predicting the scope and severity of psychosocial-related deficiencies.

Supervisor Support and Co-worker Support

As noted above, supervisor support and co-worker support have been shown to influence social worker's job satisfaction and subsequent delivery of psychosocial services (Gleason-Wynn & Mindel, 1999). Furthermore, the provision of "excellent inspiring leadership" by facility administrators has been linked to facilities with higher quality performance (Greene, Graham, Haulotte, Nixon-Garcia, & Gleason-Wynn, 2005, p. 15). Supervisor support refers to the social worker's perception of the level of administrative understanding regarding his or her role and caseload demands as well as the extent of professional development opportunities provided; co-worker support refers to the social worker's perception of such elements as whether other staff members care about her or him as a person, take the his or her needs into consideration, and create a climate of trust.

Social Worker Characteristics

Five characteristics emerge as factors pertinent to the proposed study: social work educational background, SNF social work experience, interdisciplinary team skills, role identification, and geriatric mental health knowledge.

Educational Background and SNF Social Services Experience

SNF federal regulations define a qualified social worker as someone with a master's or bachelor's degree in social work from an accredited social work program, or someone with a bachelor's degree in a related field, such as rehabilitation counseling, who has also worked at least one year in a health care organization. However, persons meeting these qualifications are not consistently hired to fill social work positions and doing so is not required in facilities with less than 120 beds (Tirrito, 1996; O'Neill & Rosen, 1998; Parker-Oliver & Kurzejeski, 2003). Since 70 percent of U.S. facilities have less than 120 beds, one out of three SNF "social workers" does not have a college degree (Parker-Oliver & Kurzejeski) and half do not have degrees in either social work or a related discipline (Tirrito). It has been argued that professionally educated social workers are in the best position to effectively meets residents' psychosocial needs (O'Neill & Rosen). Indeed, differences by level of education have been noted in SNF social workers' knowledge of the process of aging (Parker-Oliver & Kurzejeski). As such, examining the relationship of between the educational qualifications of the person filling the social work role and deficiencies in psychosocial care may offer important insights into quality of care.

At the same time, in addition to educational background, it has been noted that the extent of experience in SNF social services is also a component of social workers' qualifications (Simons, 2007). Supporting this assertion, increasing years of experience among SNF directors of nursing has been linked to enhanced facility performance in several quality indicators (Anderson et al, 1998).

Interdisciplinary Team Skills

Managing the inherent difficulties of a host environment such as a SNF requires social workers to collaborate with multidisciplinary staff members (Dane & Simon, 1991). Interdisciplinary team skills are critical in order for social workers to support all staff members in addressing residents' psychosocial needs as mandated by federal

regulations. Moreover, interdisciplinary practice is becoming essential for all social workers working with older adults, the age group representing the vast majority of SNF residents (Rosen & Zlotnik, 2001). Collaboration with front-line workers who have daily contact with residents is especially important; examples of key front-line workers include nursing assistants and housekeepers. At the same time, facilities in which employees are able to work more collaboratively are associated with providing higher quality care. For example, involvement of nursing assistants in shift reports and resident care conferences is associated with higher quality of care and increased resident satisfaction (Kruzich, 2000). Furthermore, creating multidisciplinary work teams that are empowered to make decisions about care management has enhanced quality of care in Wellspring facilities (Stone et al., 2002).

Role Identification

Role identification is based on role identity theory, which asserts that an individual's behavior stems from her or his self-perception of performance in a variety of personal and professional roles (McCall & Simmons, 1978). Such self-identities are created through interaction with others, but also interact with underlying personality characteristics. In addition, they are hierarchical by order of importance, with the most important identity having the strongest influence on behavior. According to role identity theory, a social worker who perceives him or herself as having an important positive influence on residents' psychosocial care is more likely to provide quality services compared to a social worker who does not see him or herself as vital in that capacity. Given the inherit ambiguity of the social work role in SNFs and the association between role satisfaction and being valued for helping skills and services among social workers in best practice psychosocial care facilities (Vourlekis et al, 2005), it follows that the strength of the social worker's role identification may influence the quality of service delivery. Indeed, believing that they positively influence the nursing home environment and residents' well-being often provides meaning and motivation for SNF social workers' efforts (Gleason-Wynn & Mindel, 1999).

Geriatric Mental Health Knowledge

As noted previously, limitations have been identified regarding the extent of SNF social workers' knowledge of geriatric mental health care. As such, examining the social worker's understanding of residents' most common mental health-related needs may reveal important factors related to quality of psychosocial care and its relationship to resident outcomes.

Resident-Related Quality Outcomes

SNFs participating in the Medicare and/or Medicaid funding program(s) are held accountable to meet standards of quality specified in federal and state regulations. Onsite evaluations of each facility are conducted by the state survey agency under contract with the Center for Medicare and Medicaid Services (CMS) at least once during a 15-month interval and may occur more often if a complaint needs to be investigated. The primary goal of these evaluations is to ensure facility compliance with regulations stipulating the provision of quality care and resident safety (Harrington et al., 2000). While measurement weaknesses have been identified in the survey investigative process (General Accounting Office, 2003; Lee, Gajewski, Thompson, 2006), state survey results are commonly recognized as important indicators of facility quality. For example, state and federal governments have used items from survey results to develop online nursing home report cards (Harrington, O'Meara, Collier, & Schnelle, 2003), including the federal Nursing Home Compare information designed to foster consumer choice in long-term care decision-making (Mukamel & Spector, 2003).

Annual survey results detail facility deficiencies issued by the state survey agency. Deficiencies represent the survey agency's evaluation of quality-related problems existing within the facility: if a facility fails to meet specific standards or regulations, a deficiency is issued. Deficiencies vary by scope, or the number of residents affected, and severity, or the extent of actual or potential resident harm. There are two types of survey deficiencies: health deficiencies and life-safety deficiencies.

Life-safety deficiencies relate to the safety of the physical plant, while health deficiencies relate to quality of care and quality of life (AHCA, 2006). This study focuses on health deficiencies related to psychosocial care; these are specified further in the measurement section.

The results of state survey evaluations are typically considered resident-related quality outcomes. For example, to capture the impact of facility structure and process characteristics on residents' psychosocial well-being, Castle (2001b) utilized the number of mental health deficiencies as an outcome variable. Similarly, Grabowski (2001) utilized deficiencies in the care of pressure ulcers as a resident-centered outcome measure to assess the impact of Medicaid reimbursement on quality of care.

Limitations, however, have been noted in the using the number of survey deficiencies as a measure of quality. Comparing the extent of deficiencies by facility may not fully capture differences in quality since the number of deficiency citations may relate to both the quality of care provided by the facility and to characteristics of the resident population (Mukamel, 1997). In addition, the extent of quality differences between facilities cannot be determined via a simple count of deficiencies since neither the severity of regulatory noncompliance nor the number of residents affected is included. Given this limitation, the present study uses facility scope and severity weightings as an alternative survey outcome measure that may better distinguish the variability in quality across facilities; to date and to the investigator's knowledge, no other studies have employed this approach, although Castle (2005) employed the most problematic individual scope and severity categories (J, K, and L) as outcome variables.

Based on the relationships among variables of interest noted in the literature, the research questions presented in Chapter I translate into the following hypotheses:

1. Structural factors, process factors, and SSD characteristics will independently influence the frequency of psychosocial service delivery.
2. Process factors will have greater influence than structural factors and SSD characteristics on the scope and severity of deficiencies in psychosocial care.

3. Frequency of service delivery will moderate the influence of structural factors, process factors, and SSD characteristics on the scope and severity of deficiencies in psychosocial care.

Figure 2 depicts a conceptual model of the hypothesized relationships among structural factors, process factors, social worker characteristics, the frequency of psychosocial services, and resident-related outcome quality factors.

To test these hypotheses and to further examine predictive relationships among the factors presented above, facility-level data available from the Online Survey Certification and Reporting database was linked with primary data collected via a self-report questionnaire mailed to SNF social workers in Washington State facilities.

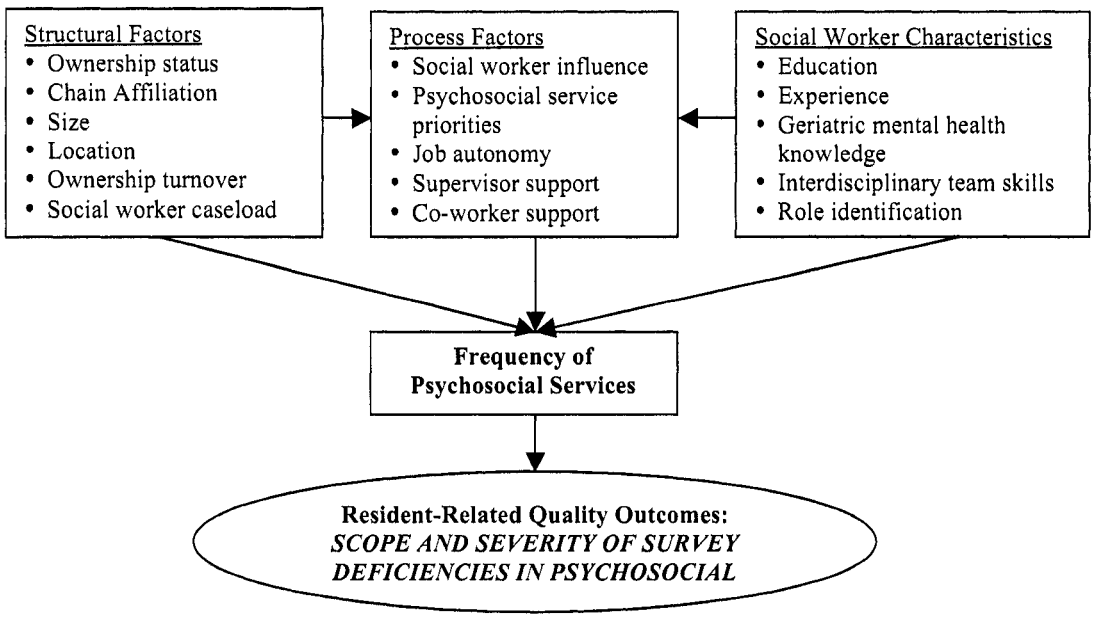

Figure 2: *Conceptual Model Depicting Relationships among Multi-Level Factors and the Scope and Severity of Survey Deficiencies in Psychosocial Care*

CHAPTER II: METHODOLOGY

Research Design

A single cross-sectional research design was utilized and merged two sources of data, one primary and one secondary. Primary data associated with facility organizational processes, social worker characteristics, and the frequency of psychosocial services were collected via a self-administered questionnaire mailed to all Social Service Directors (SSDs) in Washington State SNFs whose administrator authorized participation in the study. Primary data collection took place over an eight-week period in early 2006. Secondary data associated with facility organizational structure and psychosocial-related survey deficiencies were obtained from the Online Survey and Certification Reporting database (OSCAR) for Washington State for the years 2002-2004. OSCAR is a computerized national database of state survey inspection results, facility staffing information, and facility characteristics (Harrington et al., 2000). A combined data set was created that consisted of each SSD's questionnaire responses linked to a three-year history of his or her facility's state survey results, supporting analysis of relationships among SSDs' self-reports and past facility performance. Data collected on SSDs' facility tenure enabled the author to temporarily exclude from analysis any SSDs with less than one-year employment histories and facilitated examination of the implications posed by the one-year time lag between primary data collection and the final survey inspections recorded in OSCAR.

Data Sources

Social Services Director Questionnaire

A self-administered survey instrument was developed for data collection related to facility organizational processes, social workers characteristics, and the frequency of psychosocial service delivery. A copy of the survey instrument is included in Appendix A. The questionnaire contained five sections and utilized questions modified from the literature in addition to new questions developed by the author. Author-developed

questions supported further assessment of SSDs' role conflict and role ambiguity and gathered information on additional psychosocial service tasks not identified in the literature, but recommended by expert reviewers. The five questionnaire sections include: 1) priority of residents' psychosocial needs, 2) frequency of psychosocial service delivery, 3) SSD knowledge of geriatric mental health, 4) SSD work environment and professional characteristics, and 5) SSD demographics. Five researchers familiar with survey research and/or long-term care services assessed the content validity of the survey instrument, and it was pilot-tested by five MSWs employed in Washington State SNFs. To ensure the survey instrument was accessible to SSDs with diverse years of work experience, these five social workers represented practitioners whose practice experience ranged from several years to less than one year. Comments and suggestions from the researchers and practitioners were incorporated into the final instrument and some questions were modified from the original versions when recommended by the reviewers; specific modifications are described below.

Online Survey and Certification Reporting Database

Relative to this project, OSCAR includes data on facility size, ownership status, ownership turnover, chain affiliation, and facility location as well as the specific deficiencies cited during each survey period. It reports which regulation each deficiency has breached, the scope and severity of the deficiency, and the total number of deficiencies for each facility. OSCAR data is considered to accurately reflect both survey deficiencies issued by state surveyors and actual problems existing within facilities (Harrington et al., 2000), although there is some evidence that inter-rater reliability may be inconsistent among different survey teams (Lee, Gajewski, & Thompson (2006). As noted previously, OSCAR data are widely used by researchers as a secondary source of nursing home characteristics and resident-related quality outcome measures.

Information on facility organization structure and the scope and severity of state survey deficiencies in psychosocial care was obtained from the OSCAR for Washington State years 2002-2004. At least three years' worth of survey data is considered necessary

to sufficiently capture a facility's quality over time (AHCA, 2003); as such, survey results utilized in this study correspond to inspections that occurred during a three-year period from one to four years prior to collection of primary data via the SSD questionnaire. Limitations associated with a one-year time lag between final facility inspections and primary data collection are presented in the discussion section.

Independent Variables

Organizational Structure

County and zip code data for all sample facilities were obtained from OSCAR. Extrapolating from this information, *facility location* was determined using the rural-urban continuum codes available through the Economic Research Service (ERS) of the United States Department of Agriculture.[2] The ERS provides county rankings on a scale from 1 to 9 and employs three metropolitan codes and six non-metropolitan codes that account for each county's population and its proximity to an urban area. In this sample, several code categories contained few facilities, thus the nine rural-urban continuum codes were collapsed and facilities assigned to one of two categories to create a dichotomous variable: metropolitan, coded *1*, and non-metropolitan, coded *0*.

Facility ownership status refers to whether a facility is a for-profit organization, a non-profit organization, or a government-owned organization. Only two facilities in the sample were government-owned; these were included in the non-profit category, a strategy that has been utilized in previous research (Castle & Myers, 2006). This measure was treated as a dichotomous variable, for-profit facilities were coded *1* and non-profits coded *0*. *Multi-facility chain affiliation* is also a dichotomous variable that refers to whether a facility is operated by a multi-facility chain organization or not. Chain-affiliated facilities were coded *1* and non-chain-affiliated facilities were coded *0*. *Ownership turnover*, a continuous variable, refers to the number of times the facility has changed ownership (i.e. been sold) since its inception.

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[2] http://www.ers.usda.gov/data/RuralUrbanContinuumCodes/

Facility size was measured as a continuous variable representing the total number of licensed beds in the facility. *Social services caseload* is also a continuous variable, representing the ratio of social workers to facility residents and was created by dividing the average number of residents in the facility, as recorded in OSCAR, by the number of social workers in the facility, as obtained from the SSD questionnaire.

Organizational Processes

Variables of interest include SSD job autonomy, supervisor support, coworker support, SSD influence in facility decision-making, and the priority of residents' psychosocial needs in relation to the SSD's job description. All constructs are measured at the interval level.

Social work job autonomy was measured via a scale comprised of eight questions, two developed by the author and six derived from Gleason-Wynn and Mindel (1999) and Price (2004). Author-developed questions further addressed the extent of role conflict and ambiguity beyond that of the original measures. The questions utilize a six-point Likert scale ranging from *1* "strongly agree" to *6* "strongly disagree." Questions address the SSD's perception of concepts such as the clarity of his or her job responsibilities and the degree to which he or she is allowed to prioritize tasks independently. Gleason-Wynn and Mindel employed the original questions with a "reasonably representative" sample of 329 social workers practicing in Texas SNFs (p. 69). These researchers conducted confirmatory factor analysis to assess convergent validity of the results and found satisfactory model fit; factor loadings ranged from .567 to .822 for this construct.

Supervisor support was measured using a scale consisting of six questions based on Gleason-Wynn and Mindel (1999) and Price (2004) and used the same six-point Likert scale as social work job autonomy. Questions addressed concepts such as the SSD's perception of his or her supervisor's understanding of psychosocial service workload demands and the level of agreement between the SSD and his or her supervisor on psychosocial care priorities. Confirmatory factor analysis from Gleason-Wynn and Mindel's original sample found satisfactory model fit for the six items with factor

loadings ranging from .778 to .859.

Coworker support was measured with a scale comprised of eight questions, one developed by the author and seven derived from Gleason-Wynn and Mindel (1999) and Price (2004). The author-developed question further examined the degree of role conflict and ambiguity experienced by the SSDs. The questions utilized the same six-point Likert scale and assessed such concepts as the SSD's perceptions regarding the level of emotional support provided by coworkers and the extent to which coworkers created a trusting work environment.

SSD influence was measured via a scale containing three questions derived from Gleason-Wynn and Mindel (1999). Using the same six-point Likert scale, these questions focus on the SSD's assessment of his or her ability to influence decision-making within the facility.

Psychosocial service priorities were measured based on a series of items developed by Vourlekis et al (1992a) and Vourelekis et al (1992b). Respondents rated the priority, relative to their job responsibilities, of 27 psychosocial needs common among persons living in SNFs. Rather than the SSD's individual assessment of the priority of these needs, the questions aim to measure the priority of these needs at the facility level from the perspective of the SSD. Need priority was measured via a seven-point Likert scale ranging from *1* "lowest priority" to *7* "highest priority." As recommended by Vourlekis et al, social desirability bias was minimized by advising respondents that a low priority rating did not mean that a given resident need was unimportant in any absolute sense, but that it was less critical or urgent given the priorities of their overall job responsibilities. Example psychosocial needs included "The need to process feelings of loss that occur while residing in the facility" and "The need for recognition of and opportunity to express ethnic/cultural identity."

Vourlekis et al (1992a) developed the original list of resident psychosocial needs via consultation with nursing home experts, literature review, and expert feedback. Questions were utilized with SNF social workers, SNF social work consultants, and SNF administrators across a wide variety of facilities. The original measure contained 28

psychosocial needs, which were modified for the purposes of this study. Per recommendation of the expert reviewers, one question was separated into two questions, enabling the assessment of two different constructs. The original need, "recognition and opportunity for expression of religious/ethnic/cultural identity" was changed to "recognition of and opportunity to express religious/spiritual identity" and "recognition of and opportunity to express ethnic/cultural identity." The practitioner reviewers also recommended the inclusion of an additional question to capture respondents' views regarding the priority of residents' mental health needs and the elimination and/or combination of three questions they perceived as redundant or not applicable to SSDs' current scope of practice. In addition, several original questions were reworded to enhance readability and clarity of items per reviewers' recommendation. For example, "Opportunity and assistance as needed with access to activities and events within the home which are diverse enough to match each resident's capabilities and interests" was revised to "The need for activities and events in the facility that match individual capabilities and interests." In addition, the original word "importance" was changed to "priority" to better capture SSDs' triage of psychosocial needs and to further minimize social desirability bias.

SSD Characteristics

Variables of interest include educational level, years of experience working in a SNF social service position, geriatric mental health knowledge, interdisciplinary team skills, and role identification.

Education was measured via an ordinal variable with five categories: *0* no college degree, *1* bachelor's degree in a field other than social work, *2* master's degree in field other than social work, *3* BSW, and *4* MSW. For analysis, this variable was then collapsed to create a dichotomous variable, social work degree, coded *1*, and other, coded *0*. *Experience* was measured via a continuous variable that captured the number of years the SSD had provided social services in a SNF. The wording and presentation of questions was based on similar questions utilized with SNF social workers by Parker-

Oliver and Kurzejeski (2003).

Geriatric mental health knowledge is a continuous variable measured via a scale containing 25 true-false questions from the Mary Starke Harper Aging Knowledge Exam (MSHAKE) developed by Santo-Novak, Duncan, Grissom, and Powers (2001). This scale was originally designed to assess long-term care staff knowledge of basic aging, dementia, and older adult mental health. For the present study, a "not sure" category was added to the original true and false categories to reduce missing item response bias per expert reviewers' recommendation. Examples of true/false questions include "Alzheimer's disease usually has an abrupt onset" and "Thyroid problems are a medical cause of depression."

The MSHAKE was selected due to its applicability across diverse educational backgrounds, minimization of respondent burden, and the extensive assessment of validity conducted by the Santo-Novak et al. Two psychiatrists and two nurses developed initial questions and aimed to create items that reflected critical knowledge for all disciplines involved in elder care. Items were reviewed by three focus groups, pilot-tested by five individuals, scrutinized by 12 experts in various gerontology professions, and subjected to panel review to rate each questions' relevance and clarity as well as the comprehensiveness of the instrument as a whole. These researches utilized a pre-post design and standardized alphas ranged from 0.7206 on pre-test to 0.7084 at post-test.

The SSDs' *interdisciplinary team skills* were measured via seven questions modified from the Hospital Social Work Self-Efficacy Scale (Holden, Cuzzi, Rutter, Rosenberg, & Chernack, 1996). This measure includes a sub-scale for assessing social workers' team relations and has been tested with MSW students and professional social workers yielding a Chronbach's alpha of .90. It utilizes a six-item Likert scale ranging from *1* "strongly agree" to *6* "strongly disagree." Examples of areas addressed include the SSDs' assessment of his or her ability to work successfully with licensed nurses and manage emotions when team members blame him or her when things go wrong. Modifications were made to the original questions to reflect interdisciplinary team members commonly found in SNF environments.

Data on respondents' *role identification* was obtained using the role identity component of the Caregiver Role Identity Scale (Siebert & Siebert, 2005). This interval-level measure consists of 9 questions measured on a six-point Likert scale that again ranges from *1* "strongly disagree" to *6* "strongly agree." The original questions were developed as part of an 84-item inventory measuring various components of work and well-being among social workers in North Carolina. The items were constructed based on literature review, feedback from interdisciplinary focus groups, and recommendations from experts in the field of work and well-being. They were pilot-tested among a convenience sample of social workers and then utilized as a role identification measure among 1000 members of the North Carolina chapter of NASW; internal reliability of the scale was .81. Questions elicit information regarding respondents' role expectations for themselves as well as their perceptions of the role expectations others have of them. Example questions include "It is my responsibility to be helpful to family and friends" and "Being a helper or caregiver is who I am." The original scale used a five-point Likert scale; a six-point Likert scale was used in this study to create a cohesive instrument design with all questions in a section following the same format.

Dependent Variables

Frequency of Psychosocial Services

Service frequency was measured at the ordinal level based on items developed by Vourlekis et al (1992a) and Vourlekis et al (1992b). Respondents rated 27 common psychosocial services in terms of the average frequency in which they either provided those services or oversaw their provision. To better capture the frequency of service delivery in terms of time, scale anchors were changed from the original versions, which ran from "never" to "always," to a seven-point Likert scale with more time-specific anchors, namely "daily," "several times a week," "weekly", "several times a month," "monthly," "quarterly," and "rarely or never." Example psychosocial services items included "Help residents and their families cope with feelings of grief and loss" and "Collaborate with multidisciplinary staff to develop and/ or implement residents' care

plans."

Per practitioner reviewers' recommendation, four additional items were added to the original list of 23. Reviewers felt these items represented services that are currently provided more frequently by social services personnel compared to the time of the original Vourlekis et al (1992a and b) studies. Additional items included 1) arranging mental health services, 2) performing psychosocial assessments using tools beyond the federally-mandated Resident Assessment Instrument, 3) arranging hospice services, and 4) facilitating discharge planning. In addition, several of the early questions were reworded per reviewers' recommendations to enhance readability and clarity of items. To illustrate, "Empower residents and enable maximum choice in matters affecting them" was clarified by adding the phrase, " For example, providing information about durable power of attorney for health care."

Vourlekis el al (1992a) note the original list of common SNF psychosocial services was developed by a NASW work group in 1988. Questions were again utilized with SNF social workers, SNF social work consultants, and SNF administrators across a variety of facilities.

Scope and Severity of Psychosocial-Related Survey Deficiencies

As noted previously, data on psychosocial care deficiencies were collected from OSCAR using reports for 2002-2004. There are 189 potential health deficiencies, which include those related to psychosocial care. To facilitate the state survey agency's evaluation, individual deficiencies are labeled by F-tag numbers, which allow surveyors to link facility deficiencies with the specific regulation that deficiency violates. Thirty F-tags related to psychosocial care were identified for use in this research; these F-tags are listed in Table 3. Psychosocial care deficiencies were identified as those applying to residents' mental health needs, quality of life, residents' rights, and the assessment/care planning process. Full descriptions of the regulations associated with each F-tag are contained in Appendix C.

Psychosocial-related deficiencies for each facility were determined based on the

presence of one or more of the 30 F-tags in the facility's three-year OSCAR profile along with the scope and severity score received for that deficiency. Scope and severity was weighted for analysis using the Gannett News Service (GNS) scoring matrix, which assigns numeric values to each deficiency level and allows a total scope and severity score to be computed for each individual facility by adding the total of all weightings for all deficiencies appearing in its' OSCAR file. The GNS matrix is depicted in Table 4.

Table 3: *State Survey Deficiencies Related to Resident Outcomes in Psychosocial Care*

F-151:	Resident rights	F-246:	Accommodation of needs
F-155:	Advanced directives	F-247:	Room changes
F-157:	Notification of changes	F-250:	Medically-related social services
F-166:	Grievances	F-251:	Qualified social worker
F-201/203:	Transfer and discharge	F-252:	Homelike environment
F-221/222:	Physical and chemical restraints	F-272/274/ 276/278:	Comprehensive assessment
F-225	Hiring practices/abuse investigations	F-279:	Comprehensive care planning
		F-285	Preadmission screening
F-241	Dignity	F-319:	Anti-psychotic drugs
F-242:	Self-determination and participation	F-320:	Appropriate mental health and psychosocial treatment
F-243:	Participation in resident and family groups	F-329:	Unnecessary drugs
F-244:	Resident and family groups: grievances	F-330/331:	No unavoidable mental health problems

Table 4: *GNS Scope and Severity Scoring Matrix*

Severity	***Scope***		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J = 32	K = 45	L = 60
Actual harm that is not immediate jeopardy	G = 16	H = 22	I = 28
No actual harm but with potential for more than minimal harm that is not immediate jeopardy	D = 5	E = 8	F = 11[3]
Not actual harm but with potential for more than minimal harm	A = 0	B = 1	C = 3

Sampling

Facilities were identified via the Washington State Department of Social and Health Services' website directory of nursing homes.[4] This database provides public access to demographic information for all licensed facilities in the state including size, contact information, corporate affiliation, and ownership status. Since hospital-based SNFs have condensed lengths of stay and social work interventions focus on discharge planning rather than the whole spectrum of psychosocial services, these facilities were not included in the sample. In addition, since facilities that do not receive Medicare and/or Medicaid funding are not subject to federal regulations and the state survey process, these facilities were also excluded. Only 1.7 percent of SNFs in Washington State are not certified for Medicare and/or Medicaid (AHCA, 2004), while 7 percent are located in hospitals (CMS, 2005). During the data collection phase of this study, 235 SNFs in Washington State met the qualifications for inclusion in the sample. Social workers in two facilities pilot-tested the SSD questionnaire and were not included in the sampling frame, reducing it to 233 facilities.

An introductory letter describing the study and inviting facility participation was sent to all the administrators of the 233 free-standing SNFs certified by Medicare and/or Medicaid in Washington State. Thirty-one administrators requested that their facility not be included in the study; questionnaires were not sent to these facilities, leaving a

[3] Grey highlights indicate scores associated with substandard care.

[4] (http://www.adsa.dshs.wa.gov/Professional/NFDir/directory.asp).

participating sample of 202. Information was not solicited regarding administrators' reasons for opting out of participation, but a few administrators voluntarily supplied this information, explaining that the SSD was newly hired or too busy with paperwork and thus the administrator believed the SSD's completion of the questionnaire would interfere his or her job responsibilities.

Data Collection

The self-administered questionnaire was distributed to SSDs through a series of four mailings, as recommended by Dillman (2002). While larger facilities may have more than one social worker on staff, directing the survey to SSDs promoted feasibility of the study and targeted data-gathering efforts towards the social worker most knowledgeable about psychosocial service practices throughout the facility. To maximize the response rate, pre-letters were sent on University of Washington School of Social Work letterhead introducing the study, describing its importance, and requesting the SSD's assistance in obtaining information. The survey instrument and informed consent documentation followed one week later, reiterating the study's importance and inviting participation. To encourage timely response a small financial incentive ($5 Starbucks gift card) was offered to all participants who returned their survey postmarked within a two-week time period; Dillman (2000) suggests that as little as two dollars can increase response rates by 19 to 31 percentage points. Follow-up contacts included two additional mailings. At two weeks, a reminder postcard was sent to SSDs who had not yet returned their questionnaire; at four weeks a letter and replacement questionnaire were sent to non-responding SSDs. While a third contact via priority mailing at eight weeks was initially planned per Dillman's recommendation, the response rate was sufficient after the second mailing that a third mailing was deemed unnecessary. A 60 percent response rate was achieved, representing 121 SSDs. In previous survey studies involving SNF social workers, response rates have ranged from 44 to 90 percent (Vourlekis et al, 1992a; Greene, Vourlekis, Glefand, & Lewis, 1992; Tirrito, 1996; Gleason-Wynn & Mindel, 1999; Parker-Oliver & Kurzejeski, 2003). Statistical analysis

via analysis of variance and *t*-tests revealed no differences among non-respondent, participating, and non-participating facilities in terms of facility size, facility location, average number of residents, chain affiliation, ownership turnover, ownership status, number of state survey deficiencies, or the scope and severity of survey deficiencies.

Protection Of Human Subjects

Three issues were particularly salient for the protection of questionnaire respondents: the potential for psychosocial distress related to sensitive questions, maintenance of their anonymity from the researcher, and assurance of data confidentiality.

Sensitive questions are defined as those that seek information about socially undesirable behaviors, personal issues, or that otherwise elicit anxiety in survey respondents (Showmaker, Eichholz, & Skewes, 2002). Questions of specific concern regarding the SSDs focused on supervisor and co-worker support and the SSDs' competencies in interdisciplinary teamwork and geriatric mental health. Examples of sensitive questions include "My co-workers provide constructive feedback" and "My supervisor understands my workload demands." These questions were anticipated to be sensitive due to the anxiety associated with expressing negative feelings about a supervisor or co-worker and with demonstrating one's level of professional competence to a professional colleague. Magnifying these issues, many people are reluctant to answer sensitive questions even when assured of their anonymity, fearing that the questionnaire administrator at least will know their responses (Clark & Desharnais, 1998). Each of these factors were considered critical for the study, since the author, as a nursing home social work educator and consultant, is known personally by several of the SSDs in Washington State.

Expert and practitioner reviewers' recommendations to minimize respondent anxiety were incorporated in the questionnaire and consisted primarily of careful wording of questions. The level of anxiety associated with voluntary responses to questionnaire items of concern was anticipated to be minimal and short-lived, however, given the risks

posed to respondents' reputations and employability if a co-worker or supervisor were to inadvertently see any negative answers on the co-worker or supervisory support questions, respondents were explicitly instructed to complete the questionnaire in a location outside of their work environment. These instructions were included throughout the instrument itself and in all associated documentation.

In terms of protecting respondents' anonymity, special care was taken to assure investigator blindness to information linking individual questionnaires to their associated facilities. The researcher, who is familiar with Washington State facilities and knows the names of several SSDs working for specific facilities, feared being able to indirectly identify some survey respondents if any facility identification information, such as name or address, was included on the questionnaire or within the final data set. A dilemma was presented since the research design required a method of identification to enable linkage of individual questionnaires to their corresponding OSCAR data file. To address this issue, an identifier not familiar to the researcher, e.g. a facility vendor number, was utilized to link questionnaires to the OSCAR data file. However, facility vendor numbers can be entered into the DSHS nursing home directory to identify facilities; thus a second step was taken to further protect respondent identity and enhance their assurance of researcher anonymity. This second step guaranteed the researcher was blind to facility vendor numbers as follows:

1. Facility vendor numbers were noted on separate sheets of paper attached to each questionnaire, allowing complete removal of this page following linkage of the questionnaire with its corresponding OSCAR data file.
2. Rather than sending completed questionnaires directly to the investigator, respondents sent them via self-addressed stamped envelope to the data entry specialist, an individual without facility-specific knowledge.
3. The data entry specialist, rather than the investigator, input the data as each questionnaire was received and made the link to combine that data with its corresponding entry in the OSCAR database.
4. After making the final linkage, the vendor numbers were deleted from the file

and the questionnaire vendor number pages destroyed before providing these items to the investigator. As such, the investigator received both the complete data file and the original questionnaires without any facility or respondent identifiers.

To insure confidentiality of the data during the data entry phase, completed questionnaires and the OSCAR data file were kept in separate locked files cabinets. Following data entry, all study-related data were kept on computer disk in a locked file cabinet in the investigator's home office. A back-up copy of the data was uploaded to a secure file on the University of Washington's computer system and was only accessible to the investigator; owner-specific identification numbers and passwords were utilized to maintain security.

An implied consent procedure was used for this study since respondents' signatures on consent forms would be the only identifier disclosing their participation in the study. Consent documents described the methods utilized to protect respondents' anonymity as well as to protect the confidentiality of the data. Consent documents and all associated documentation are available in appendix B. The Human Subjects Division at the University of Washington approved all procedures for carrying out this investigation.

A ten-key data entry specialist entered the questionnaire data into a database designed by the author using *Statistical Package for the Social Sciences* (SPSS) version 11.5. Frequency distribution plots were used to identify obvious data entry errors, such as outliers, and identified errors corrected based on original questionnaire documents prior to beginning statistical analysis. In addition, since OSCAR data is known to include a percentage of errors, on average 2 percent duplicate facilities and up to 4 percent data entry errors, this database was also screened prior to analysis. As recommended by Castle (2001), duplicate facilities were identified by the data entry specialist and eliminated by using the facility vendor number and the survey date. When a vendor number appeared more than once in the data, the information associated with the most recent survey was

used; there were no duplicate survey dates. Again frequency distribution plots were used to identify obvious data entry errors, such as erroneous scope and severity weightings or outlying values more than two standard deviations above the mean. No data entry errors in OSCAR were identified; however, five respondent facilities were missing from the OSCAR database. Further analysis revealed two of these had new vendor numbers and three had closed.

CHAPTER III: RESULTS

Using SPSS, three levels of analysis were conducted in order to describe the sample, explore relationships between dependent and independent variables, and test hypotheses associated with each of the three research questions. The analytic methods utilized included 1) univariate analysis (frequencies, percentages, ranges, means, and standard deviations), 2) bivariate analysis (independent sample *t*-tests, analysis of variance, Pearson chi-square, and correlation), and multivariate analysis (ordinary least squares regression and hierarchical linear regression). Summary descriptions of the respondents, their facilities, and survey deficiencies are presented below, followed by a review of the SSD questionnaire results to provide a context for the findings associated with each of the three research hypothesis presented in Chapter II.

Respondent Profile

The sample was predominately female (92.5%) and white (88.3%). Ten percent of respondents were persons of color with Asian/Pacific Islanders representing 4.2 percent, Latino/as representing 4.2 percent, and other ethnicities representing 1.7 percent of the sample. Respondents' ages ranged from 26 to 62 with a median age of 45 years, thus the sample includes many "older" workers. Most respondents possessed a college degree (88.3%), with the modal category being a bachelor's degree in a discipline other than social work (36.7%). Psychology was the most common discipline. Respondents with an MSW degree (20.8%) or a BSW degree (15.0 %) comprised 35.8 percent of the sample. An additional 15.8 percent had a master's degree in a discipline other than social work, with counseling psychology being the most common discipline. While the larger percentage of MSWs compared to BSWs was not statistically significant ($\chi^2 = 1.14, p = .286$), the slight difference in size between these two groups is interesting given the challenges in attracting masters-level social workers to nursing home social work (Simons, 2006). Reasons for these results are unclear, but it may be that SSDs with MSW degrees completed the questionnaire more frequently than those with BSW degrees.

On the whole, respondents were experienced in both working within a SNF setting in any capacity and in working specifically within a social services capacity. Years of general SNF experience ranged from 0 to 33, with half of respondents having at least 9 years of experience (mean = 10.82). Years of social services experience ranged from 0 to 27.4, with half of respondents having at least 6 years of experience (mean = 7.91). The gap between respondents overall SNF experience and their social services experience reflects their tendency to assume SSD positions after first working in another capacity within the facility. SSDs most commonly worked in nursing, activities, or admissions/marketing prior to working in social services. Respondents had been working in their current facility from 1 month to 27 years, with an average of 5.22 years, and had been working in their present SSD position from 1 month to 25 years, with an average of 4.95 years. Hours worked per week ranged from 32 to 60 with an average 42.48-hour workweek. Forty percent of the sample worked more than 40 hours per week. Most of the SSDs practiced with at least one other social services employee (38.2%), while 30 percent were the sole employee in their department; an additional 29.1 percent worked with two to four other social services providers. The majority of respondents (65 %) earn between $30,001 and $50,000 annually; 12.5 percent earn more than $50,001 and 17.4 percent earn $30,000 or less. Respondent demographics are depicted in Table 5.

Table 5: *Respondent Demographics*		
	n	*%*
Gender		
Female	111	92.5
Male	9	7.5
Ethnicity		
Black/African American	0	0
Asian/Pacific Islander	5	4.2
Native American/Alaska Native	0	0
Latino/a	5	4.2
Caucasian	106	88.3
Other ethnicity	2	1.7
Age		
25-34	35	29.4
35-44	23	19.3
45-54	28	23.5
55-64	33	27.7
Declined to respond	2	1.7
Income		
$10,000 or less	1	0.8
$10,001 - $20,000	4	3.3
$20,001 - $30,000	16	13.3
$30,001 - $40,000	39	32/5
$40,001 - $50,000	39	32/5
$50,001 or more	15	12.5
Declined to respond	6	5.0
Education		
MSW	25	20.8
BSW	18	15.0
Other bachelors degree	44	36.7
Other masters degree	19	15.8
No college degree	14	11.7
Years of Experience	*Mean*	*SD*
Overall SNF	10.79	7.81
SNF social services	7.92	5.64
Current SNF	5.23	5.22
Current position	4.95	4.45

Facility Profile

The majority of facilities in the sample were for-profit (74.1%) and members of a multi-facility chain organization (62.9%). Forty-four multi-facility chains operate in Washington State; based on OSCAR data, five operate 43.13 percent of all multi-facility chain beds in Washington State. Non-profit facilities comprise 25.9 percent of the sample. Number of beds ranged from 4 to 224 with an average of 95.43 beds. In terms of size, 21.1 percent of facilities have 60 beds or less, 54.6 percent have between 61 and

120 beds, and 24.2 percent have more than 120 beds. The average number of residents over the three-year survey period was 82.65, representing facilities' tendencies to operate below capacity, with an average of 13.2 unfilled beds during the same period. The majority of facilities (61.8%) had a history of ownership changes since first becoming licensed by Medicare and/or Medicaid. Years of operation since licensure ranged from 4 to 40 with a median of 18 years; a positive relationship exists between years of operation and the number of ownership changes ($r = .356, p = .01$). The extent of ownership turnover ranged from 1 to 11 with 42 percent of facilities undergoing 2-5 changes since first becoming licensed; the average number of ownership changes was 2.17. Ownership turnover was more common in facilities operated by multi-facility chain organizations ($p = .006$) and in for-profit facilities ($p = .000$). In terms of SSD caseload, facilities in metropolitan areas employ more social services staff than facilities in non-metropolitan areas; however this difference does not correspond with smaller caseloads for SSDs employed by metropolitan facilities. On the other hand, non-profit facilities employ more social services staff than for-profit facilities and SSDs employed by non-profit facilities have significantly smaller caseloads than their for-profit counterparts ($p < .001$).

Survey Deficiencies

The total number of survey deficiencies and the scope and severity weightings in the 30 psychosocial care-related areas were individually summed for each facility across all three years of the survey period. In addition, the number of facilities receiving specific deficiencies in each of the 30 areas was also calculated along with the means and standard deviations for each category. The number of deficiencies in psychosocial care ranged from zero to 19, with an average of 5.95 deficiencies ($sd = 4.04$). Scope and severity weightings ranged from zero to 210 with an average of 40.7. Higher weightings correspond to poorer facility outcomes. The variability of scope and severity weightings across facilities was considerable, with a standard deviation of 35.92. The most common deficiencies in psychosocial care-related areas included F-tag 225: hiring practices/abuse investigations; F-tag 272: comprehensive assessments, F-tag 329: unnecessary drugs; F-

tag 241: dignity, F-tag 250: medically-related social services, F-tag 157: notification of changes, and F-tag 279: comprehensive care plans. In addition, repeat deficiencies[5] in hiring practices/abuse investigations and comprehensive assessment were also among the 10 most common deficiencies. 'D' level deficiencies are the most frequent with 63 percent of deficiencies receiving this scope and severity score. Table 6 depicts the percent of facilities receiving each F-tag and the means and standard deviations of the scope and severity weightings for each F-tag. Table 7 depicts the percentage of each scope and severity weighting assigned to the aggregate of deficiencies across all three years of the study period.

[5] Repeat deficiencies represent facility non-compliance with regulatory requirements for the same issue for more than one survey period, indicating problems inspectors noted in a previous survey have resurfaced or remained unresolved.

Table 6: *Percent of Facilities with Specific Deficiencies in Psychosocial Care*

Deficiency	Percentage of Facilities with Deficiency	Mean Scope and Severity Score	SD
1. F-tag 225: Hiring practices/abuse investigations	63.45	6.13	2.836
2. F-tag 272: Comprehensive assessment	56.72	6.56	3.990
3. F-tag 329: Unnecessary drugs	39.08	5.73	2.050
4. F-tag 241: Dignity	38.24	7.16	4.320
5. F-tag 279: Comprehensive care planning	29.83	6.37	2.588
6. F-tag 250: Medically related social services	27.73	6.89	3.840
7. F-tag 246: Accommodation of needs	25.21	5.75	1.137
8. F-tag 225 Repeat – hiring practices/abuse investigations	22.69	6.33	2.472
9. F-tag 157: Notification of changes	20.59	5.80	2.700
10. F-tag 272 Repeat – Comprehensive care planning	19.33	2.33	4.49
11. F-tag 252: Homelike environment	16.39	4.54	2.873
12. F-tag 221: Physical restraints	15.54	6.38	3.103
13. F-tag 278: Comprehensive assessment	13.45	5.09	2.388
14. F-tag 274: Assessment of significant changes	12.18	5.00	0
15. F-tag 166: Grievances	7.56	5.94	3.489
16. F-tag 285 Preadmission screening	5.88	5.29	2.27
17. F-tag 242: Self determination and participation	4.62	7.55	4.344
18. F-tag 331: Anti-psychotic medications	4.62	5.00	0
19. F-tag 155: Advanced directives	4.20	7.20	4.638
20. F-tag 244: Participation in groups – grievances	3.78	6.56	2.455
21. F-tag 330: Anti-psychotic medications	2.94	5.00	0
22. F-tag 151: Resident rights	2.94	9.57	6.347
23. F-tag 276: Comprehensive assessment	2.52	4.83	2.229
24. F-tag 247: Room changes	2.52	4.83	2.229
25. F-tag 222: Chemical restraints	1.68	10.5	6.351
26. F-tag 203: Orientation to transfer and discharge	1.26	5.00	0
27. F-tag 243: Participation in groups	0.84	5.00	0
28. F-tag 320: Avoidable mental health problems	0.42	5.00	0
29. F-tag 201: Transfer and discharge	0.42	3.00	0
30. F-tag 251: Qualified social worker	0	0	0

Table 7: *Percent of Deficiencies in Each Scope and Severity Category (N = 441)*

Severity	***Scope***		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J = 0.2%	K = 0	L = 0
Actual harm that is not immediate jeopardy	G = 4.8%	H = 0.7%	I = 0
No actual harm but with potential for more than minimal harm that is not immediate jeopardy	D = 63.0%	E = 26.3%	F = 0.2%[6]
Not actual harm but with potential for more than minimal harm	A = 0	B = 4.8%	C = 0

[6] Grey highlights indicate scores associated with substandard care.

Overview of Questionnaire Results

As noted above, 121 SSDs completed and returned the survey. Several of them wrote extensive comments in response to the survey's final question "Do you have any comments you would like to add related to your work in social services that apply to the content of this questionnaire?" Respondents' comments are included where they further illuminate study findings.

Priority of Psychosocial Needs

Among the 27 common psychosocial needs, SSDs perceive that facilities as a whole consider the following needs to be the highest priority for residents: 1) participating in discussions regarding their care and treatment, 2) receiving personalized behavioral management interventions, 3) having access to mental health services, 4) feeling secure that appropriate care will be provided during points of transition to, from, and within the facility, and 5) collaborating with family members regarding their care needs.

For data reduction in order to facilitate regression analysis, the 27 psychosocial need items were collapsed into five scales of related needs based on the author's substantive knowledge. The scales represent the following variables: 1) priority of resource and referral needs, 2) priority of empowerment and self-determination needs, 3) priority of individualization needs, 4) priority of psychosocial intervention needs, and 5) priority of relationship and socialization needs. As such, the priority of psychosocial needs construct is represented by five variables. Table 8 shows the individual items comprising each scale.

To calculate each scale, items for each concept were added together and the resulting sum divided by the number of items added. This calculation allowed each scale score to remain in the original range of the individual items and supported comparisons between scales. Missing data ranged from 4.13 percent to 6.61; mean scores for were substituted for all missing items to enable scale score calculation for all respondents as recommended by Hill (1997). To assess the scales' convergent validity, confirmatory

factor analysis was conducted; Hatcher (1994) suggests sample sizes of at least 100 are appropriate for CFA when most communalities are high and several variables load on each factor. CFA results reveal that factor loadings on all scales were greater than .40. Reliability coefficients ranged from .6926 to .8404.

Overall, the SSDs report psychosocial intervention services to be among those of highest priority in their facilities (mean = 5.62). Empowerment and self-determination needs (mean = 5.11) and resource and referral needs (mean = 5.10) are second in priority. One respondent's comments at the end of the questionnaire capture the importance of resident needs in these areas:

> *"Social Service[s]' goal is to help residents in need while [they are] here in the facility and when [they are] leaving – coordinating and facilitating [the information] they need to make decisions, providing a source of support and advocat[ing] for them, being their voice when needed."*

While none of the 27 psychosocial needs are considered to be a low priority, relative to the other domains, residents' socialization and relationship needs (mean = 4.69) and their individualization needs (mean = 4.67) are considered lower priorities. Table 8 displays the means, standard deviations, relative rankings, and factor loadings for all individual scale items.

Table 8: *Items Comprising Psychosocial Needs Categories; Descriptives, Priority Rankings, and Factor Loadings*

	Mean	SD	Rank	Factor Loading
Intervention needs (mean = 5.62)				
• Need to adjust to facility	5.42	1.259	10	.720
• Need to process feelings of loss	5.31	1.175	13	.782
• Need to cope with fears and anxieties	5.81	1.098	6	.838
• Need to prepare for and cope with death	4.98	1.489	17	.705
• Need for difficult behavior intervention	6.07	0.941	2	.488
• Emotional support for family members	5.67	1.167	6	.443
• Need for access to mental health	6.06	1.101	3	.497
Resource and referral needs (mean = 5.10)				
• Need to located and access financial resources	5.16	1.612	15	.498
• Need to replace personal belongings	4.30	1.555	24	.556
• Need for in-depth orientation to facility	4.21	1.653	26	.768
• Need for orientation to residents' rights	5.32	1.507	12	.740
• Need for assurance of appropriate care at transitions	5.94	1.077	4	.573
• Need for assurance that care and resources will be provided	5.68	1.282	7	.631
Empowerment and self-determination (mean = 5.11)				
• Need for choice in daily routine	5.18	1.418	14	.722
• Need for family collaboration	5.85	1.053	5	.680
• Need for independence in functioning	5.47	1.436	9	.706
• Need to contribute to nursing home community	4.28	1.525	25	.709
• Need to provide input into survey process	3.88	1.907	27	.684
• Need to provide feedback re: satisfaction with care	5.05	1.485	16	.682
• Need to participate in discussion re: care	6.09	0.974	1	.622
Individualization needs (mean = 4.67)				
• Need for individualized activities	4.30	1.806	23	.721
• Need to express religious/spiritual identity	4.83	1.626	19	.848
• Need to express cultural identity	4.70	1.615	20	.896
• Recognition of life history	4.85	1.424	18	.761
Socialization and relationship needs (mean = 4.71)				
• Need for relatedness and intimacy	5.38	1.574	11	.797
• Need for social and group interaction	4.35	1.615	22	.886
• Need to maintain contact with friends and community	4.39	1.661	2	.926

Frequency of Psychosocial Services

To allow comparison between the priority of psychosocial needs and the frequency of service delivery, all psychosocial service delivery items were reverse-coded. Among the 27 individual psychosocial services, SSDs report they engage in the following the most frequently: 1) completing psychosocial assessment via the federally mandated Minimum Data Set and Resident Assessment Protocols, 2) collaborating with multidisciplinary staff to develop resident care plans, 3) assessing factors contributing to residents' mood and behavioral symptoms, 4) providing psychosocial intervention to

reduce residents' emotional distress, and 5) facilitating of residents' adjustment to the facility and mediating issues of concern among residents, families, and staff (tie). On average, these six tasks are performed several times a week. It is important to note, however, that regulatory requirements themselves may influence the frequency at which these services are delivered. For example, all of the most frequent tasks are either specific or implied requirements within interpretive guidelines[7] for federal regulations related to medically-related social services, yet among the five least frequent tasks only one, updating facility policies and procedures, is a regulatory requirement per interpretive guidelines (AHCA, 2006).

For data reduction to facilitate regression analysis, the 27 psychosocial service items were collapsed into five scales based on the author's substantive knowledge. The scales measure the frequency of the following service domains: 1) psychosocial assessment tasks, 2) psychosocial intervention tasks, 3) care planning tasks, 4) resource and referral tasks, and 5) administrative and advocacy tasks. As such, the frequency of psychosocial services construct is represented by five variables. Table 9 shows the individual items comprising each scale.

To calculate each scale, items for each concept were again added together and the resulting sum divided by the number of items added. This calculation allowed each scale score to remain in the original range of the individual items and supported comparisons between scales. Missing data ranged from 1.65 percent to 6.61; mean scores were substituted for all missing items to enable scale score calculation for all respondents (Hill, 1997). Confirmatory factor analysis was again conducted to assess convergent validity. CFA reveals that factor loadings on all scales were greater than .50, with the exception of the resources and referral scale, which had 3 factor loadings less than .50. Reliability coefficients ranged from .5443 to 8252. Table 9 displays the means, standard deviations, relative rankings, and factor loadings for all individual scale items.

Results indicate that SSDs perform care planning tasks (mean = 5.59) and assessment-related tasks (mean = 5.56) the most frequently followed by, intervention

[7] Interpretive guidelines provide facility inspectors with specific information regarding indicators to look for to determine facility compliance with state and federal regulations.

tasks (mean = 5.03), resource and referral tasks (mean = 4.62), and administration and advocacy tasks (mean = 3.73). As with the priority of psychosocial needs variables, however, considerable variability exists among respondents as evidenced by large ranges and large standard deviations on all scales.

Table 9: *Items Comprising Service Frequency Categories; Descriptives, Frequency Rankings, and Factor Loadings*

	Mean	SD	Rank	Factor Loading
Care planning tasks (mean = 5.59)				
• Involve residents and families in care planning	5.30	1.481	12	.843
• Collaborate with multidisciplinary staff	5.83	1.414	2	.871
• Develop individualized care plans	5.64	1.420	7	.871
Resource and referral tasks (mean = 4.62)				
• Review appropriateness of admissions	4.74	2.336	23	.086
• Orient residents and families to facility	5.46	1.391	10	.488
• Assist to access financial resources	4.29	1.671	20	.723
• Provide linkages to community resources	5.47	1.239	9	.700
• Provide information to enable maximum choice	5.10	1.241	14	.781
• Arrange mental health services	4.32	1.279	19	.376
• Arrange hospice services	3.51	1.367	24	.556
• Plan and arrange discharges	5.38	1.468	11	.673
• Make arrangements for obtaining personal items	4.30	1.706	16	.654
Administrative and advocacy tasks (mean = 3.73)				
• Change facility policies and procedures	2.32	1.410	27	.677
• Participate in facility decision-making re: policy	3.18	1.893	25	.639
• Provide training and consultation	3.97	1.830	22	.666
• Advocate on an individual resident level	5.56	1.431	8	.815
• Advocate on a policy/program level	3.60	1.772	23	.829
Assessment tasks (mean = 5.56)				
• Psychosocial assessment via MDS/RAPs	6.01	1.681	1	.780
• Psychosocial assessment beyond MDS/RAPs	4.95	1.637	15	.857
• Assess factors related to mood and behavioral symptoms	5.73	1.204	3	.485
Intervention tasks (mean = 5.03)				
• Help cope with grief and loss	5.29	1.214	13	.686
• Provide psychosocial treatment to enhance individual functioning	4.44	1.966	15	.555
• Assist residents to adjust to facility	5.66	1.222	5	.699
• Mediate issues among residents, families, and staff	5.66	1.201	5	.777
• Intervene to reduce emotional distress	5.70	1.085	4	.853
• Provide crisis intervention	4.44	1.683	18	.519
• Help cope with death	4.00	1.366	21	.664

Knowledge of Geriatric Mental Health

As described previously in the measurement section, the scale of geriatric mental health knowledge consisted of 25 true and false questions, each with a "not sure" response choice. Correct responses were coded *1* and incorrect responses were coded *0*; "not sure" responses were coded as incorrect. The sum of correct responses was then utilized to create a total score, the lowest possible score being 0 and the highest possible being 25. One respondent did not complete this section and was therefore not included in the analysis; otherwise there was minimal missing data (0.83 percent). Six questions contained missing data with 1-3 respondents not answering the questions; mean scores were substituted for individual missing items to allow scale calculation for all respondents (Hill, 1997).

Overall scores ranged from 14-24. The mean score across all respondents was 20.63 ($sd = 2.362$), indicating as a whole the SSDs were knowledgeable regarding common geriatric mental health issues. However, there were several items that many SSDs answered incorrectly, suggesting patterns of more limited knowledge. The most frequently missed item asked whether or not persons of color are the most rapidly increasing segment of the older adult population; 82.6 percent of respondents answered this question incorrectly. The next four of the top five commonly missed questions focused on the characteristics of dementia. For example, 61.2 percent of respondents incorrectly answered "Persons with early-stage dementia often think 'someone is out to get them;'" 56.2 percent incorrectly answered "A persons with Alzheimer's disease can see and hear, but cannot recognize and understand;" 40.5 percent incorrectly answered "Persons with dementia frequently resist personal care and activities;" and 28.1 percent incorrectly answered "Reorienting an agitated dementia patient is helpful." These results are of concern given the extent of dementia and mental health conditions among SNF residents. They suggest that additional attention to SNF social workers' competencies in these areas is warranted.

Work Environment

Individual items for all work environment-related measures were recoded 0-5 for ease of scale interpretation and summed to create a total score. Missing data ranged from 1.65 percent to 5.79 percent. Mean scores were substituted for all missing responses to allow scale calculation for all respondents (Hill, 1997); Table 11 displays the extent of missing data for each measure.

Job Autonomy

Four of the eight scale items were reverse-coded for ease of interpretation. Possible scores range from 0 to 25, with 25 representing the highest possible job autonomy. The average score for respondents was 17.01, suggesting the SSDs as a whole have a moderately high level of autonomy in their work. However, there was considerable variability across respondents with scores ranging from 3 to 25 ($sd = 4.112$). In addition, there was considerable variability across individual scale items with mean scores ranging from 1.43 to 4.02.

Corresponding with the mean score for this scale, most respondents either agreed or strongly agreed they had high levels of both job autonomy (73.6%) and job flexibility (71.9%), as well as clear job responsibilities (70%) and regular opportunities to do the tasks they felt were most important (63.3%). However, it is critical to note that a large minority reported challenges in these areas. For example, 36.7 percent experience barriers in performing tasks they deemed as high priorities. In addition, 73.3 percent of SSDs reported the greatest level of disagreement with the statement, "I have enough time to get everything done on my job."

SSD Influence

One of the three items comprising this scale was reverse-coded for ease of interpretation. Possible scores range from 0 to 15, with 15 representing the highest possible level of influence. The average score was 9.9, which indicated that respondents generally reported a moderately high level of influence in their work. As with job autonomy, however, variability among respondents was considerable with individual

scores across the entire possible range ($sd = 3.337$).

The majority of respondents felt that they had the ability to independently organize and structure their work; 76 percent agreed or strongly agreed with the statement, "I have a great deal of influence in determining the procedures for my department." In addition, they generally felt more influential directing matters within their own department than they did influencing matters impacting the facility as a whole. For example, 40 percent expressed some level of agreement with the statement, "I have little say in how this facility operates" and 33.1 percent agreed that their suggestions for facility improvements were likely to be overlooked.

Supervisor Support

Possible scores in this six-item scale range from 0 to 30 with 30 representing the highest level of supervisor support. The average score was 21.02, indicating the SSDs generally felt supported by their supervisors to a moderately high extent. Again, there was considerable variability across individual respondents with scores ranging from 3 to 30 ($sd = 6.681$).

Respondents were most confident in their supervisors' decision-making ability, with 70.3 percent either agreeing or strongly agreeing that their supervisors exercised good judgment. In addition, the majority reported their supervisor was effective in helping them problem-solve (59.5%) and had similar ideas regarding how their work should be completed (54.6%). It is important to note, however, that a significant minority of respondents reported limitations in this area; 46.4 percent indicated they do not see eye-to-eye with their supervisor regarding how their work should be carried out. Furthermore, respondents were least convinced that their supervisor understood the ramifications of their workload; 52.6 expressed some level of disagreement with the statement, "My supervisor understands my workload demands." While 76.6 percent of SSDs reported receiving helpful on-the-job guidance from their supervisor, 21.6 percent disagreed that their supervisor effectively directed them in their work.

Most of the SSDs reported directly to the facility administrator (78.8%), while others reported to the Director of Nursing Services (11.5%) or to other disciplines such

as a Unit/Neighborhood Coordinator or an Assistant Administrator (9.3%). SSDs supervised by the facility administrator reported feeling considerably more supported than SSDs supervised by the Director of Nursing ($p = .000$). The mean support score for SSDs with administrator supervisors was 26, whereas for SSDs with Director of Nursing supervisors the mean support score was 20.15. In their comments, several respondents highlighted conflict in their facilities between social service personnel and nursing personnel. For example one respondent noted the following:

> *"I have problems working with the Director of Nursing at my facility, but not with any other department heads, staff, my supervisor, or other social workers."*

Another observed this:

> *"Nursing and Social Services tend to clash regarding resident rights, choices, etc."*

An additional respondent echoes the above remark:

> *"There is conflict with some resident advocacy [issues] versus [the] availability/willingess of staff to make accomodation [for residents' individual needs]."*

Coworker Support

Eight of the nine items comprising this scale were reverse-coded for ease of interpretation. Possible scores range from 0 to 45 with 45 representing the highest possible coworker support. Respondents' scores ranged from 7 to 44 with an average score of 31.06, indicating on the whole that the SSDs perceived a moderately high amount of support from coworkers. As with the above scale measures, there was considerable variability among respondents regarding their perceived level of support (*sd* = 7.735). In addition, SSDs working in facilities with higher numbers of ownership changes tended to feel less supported by their coworkers than SSDs working in facilities with more stable ownership histories ($p = .036$).

Mean scores on individual scale items ranged from .2.09 to 4.10, with SSDs feeling most strongly that coworkers cared about them as people and are available to provide emotional support when necessary. The majority of respondents agreed or

strongly agreed that they received constructive feedback from coworkers (57.5%) and an additional 30.8 percent somewhat agreed that this was the case. About half of the SSDs agreed or strongly agreed that their coworkers took their needs into consideration (50.8%), while 30.8 percent felt this was somewhat true. Similarly, about half of respondents agreed or strongly agreed that their coworkers creating a trusting environment (49.2%) and an additional 32.5 percent felt this was somewhat true. SSDs generally perceived that coworkers backed them up when things went wrong (68.3 percent), but many felt unsure that their coworkers held similar ideas about how the SSD's job should be done. For example, 59 percent of SSDs reported some level of disagreement that they and their coworkers had similar expectations regarding the scope of the SSD's work. Along these lines, one respondent had this to say:

> *"I don't think, in my experience anyway, that most staff members understand what Social Services does and also what we are not solely responsible for. It is an ongoing, education process to clarify what they can expect for social services"*

However, in terms of receiving conflicting requests from coworkers, 68.9 percent of SSDs reported that this did not occur often. Of those respondents who acknowledged difficulties in this area, the following comment captures a prime area of disagreement:

> *"It is difficult for nursing staff to accept a focus on psychosocial issues when [resident] behavior [problems] are involved. It seems they are more used to there being 'an answer' to a problem so they don't tend to see how lifestyle or copying mechanisms influence [difficult] behaviors."*

SSD Characteristics

As with the work environment measures, individual items for all scales related to SSD characteristics were recoded 0-5 for ease of interpretation and summed to create a total score. In addition they were reverse coded such that higher values would correspond to greater levels of the measures. Missing data ranged from 0.83 percent to 4.13 percent. Mean scores were substituted for missing responses to allow scale calculation for all respondents (Hill, 1997); Table 11 displays the extent of missing data for each measure.

Interdisciplinary Team Skills

Possible scores on this seven-item scale range from 0 to 35 with 35 corresponding to the highest level of interdisciplinary team skills. Respondents' scores ranged from 18 to 35 with an average score of 28.4 ($sd = 3.667$), indicating SSDs on the whole felt they have fairly effective skills in working with interdisciplinary teams.

Regarding individual scale items, SSDs appear most confident in their ability to work with mental health professionals; indeed 95 percent of the sample report agreeing or strongly agreeing with the statement "I can work successfully with mental health professionals providing services in my facility." The majority of respondents (80.2%) feel confident of their skills for working with supervisors, department heads (81.2%), and nursing assistants (80.2%), but feel somewhat less confident in their skills for working with licensed nurses (73.5%). This corresponds to the findings presented above regarding SSDs' reported challenges working with nurses as supervisors. Respondents convey the least amount of confidence in their ability to manage feelings when others blame them for things gone wrong; 34.7 percent of the sample report some level of difficulty dealing with team members' blame. However, blame appears more difficult to manage when facility residents or their family members are the source: 42.2 percent of respondents report some level of difficulty in this situation.

Role Identification

Possible scores on this nine-item scale range from 0 to 45 with 45 representing the highest level of role identification. Respondents' scores ranged from 13 to 45 with an average score of 32.21 ($sd = 6.516$), indicating respondents on the whole feel a moderately high identification with the helper or caregiver role.

In terms of individual scale items, respondents tend to identify with the role of natural helper; for example, 80.2 percent report having heard from others that they are natural helpers, 67.7 percent report friends typically turn to them for help with problems, 72.7 percent report colleagues turn to them for help with problems, and 70.3 percent report regularly helping members of their own family. Indeed, several respondents wrote

comments regarding the personal satisfaction they receive from their jobs. For example, one respondent described his or her feelings this way:

> *"I love my position within the facility, I do get frustrated at times, but I could not imagine my life without it... I truly love my job. I enjoy engaging the resident and their families."*

Others attested to the rewards of their work in conjunction with the personal characteristics required to be a successful SSD:

> *"You must love elderly and have an understanding for the job, hours; rewards can be wonderful – [a] smile, hug, just knowing you might [have] made a difference in their life."*

> *"You need to be a strong individual to be able to stand your ground advocating for others, thus [you] have to believe in what you do or you will [not] succeed."*

Table 10 displays the mean SSD characteristics, process variables, and key SSD demographics by each of the facility structural factors.

Table 10: *Mean SSD Characteristics, Process Variables, and Key Demographics by Facility Structural Factors*

	Facility Location		Ownership Status		Chain Affiliation		Ownership Turnover[a]		Facility Size[b]		
	Metro	*Non-metro*	*For profit*	*Non profit*	*Chain*	*Non-chain*	*Low*	*High*	*Small*	*Med*	*Large*
SSD experience	8.44	5.89	7.67	9.11	7.67	8.62	9.04	7.06	9.20	7.54	7.69
Number of social services staff	2.40	1.533*	2.03	3.00*	2.11	2.52	2.52	1.96*	1.75	2.25	2.81
Geriatric mental health knowledge	20.20	20.39	20.06	20.73	20.28	20.16	20.71	19.75*	20	20	20
Supervisor support	21.36	20.06	20.88	21.93	20.79	21.73	21.14	21.05	21	20	22
Coworker support	31.60	28.50	30.38	33.23	29.96	32.96*	32.86	29.12**	32	30	31
IDT skills	28.22	26.61	28.01	27.87	27.77	28.29	28.17	27.74	28	27	29
Role identification	32.19	33.11	32.95	30.57	32.48	32.11	31.93	32.63	32	32	33
Job autonomy	17.08	16.11	16.84	17.20	16.55	17.53	16.78	17.00	17	17	17
SSD Influence	9.97	9.72	9.64	10.77	9.45	10.67	10.47	9.33	10	10	9
Caseload size	72.55	69.94	78.31	54.64***	76.64	64.41	65.96	78.18*	41	75	98***
Social work degree	35.9%	33.3%	30.3%	48.4%	31.1%	41.3%	39.7%	32.2%	38.5%	33.9%	37.9%
Annual income (median category)	$40K-50K	$30K-40K	$30K-40K	$40K-50K	$40K-50K	$30K-40K	$40K-50K	$30K-40K	$30K-40K	$$30K-40K	$40K-50K

[a] low = below mean level (2.21), high = mean level and above

[b] small = 60 beds or less, med = 61=120 beds , large = more than 120 beds

*$p < .05$, **$p < .01$, ***$p < .001$

Research Hypotheses

In preparation for regression analysis, bivariate correlations were calculated to assess the presence of multicolinearity among variables of interest. Stevens (2002) notes that correlations above .70 suggest the presence of multicolinearity; all correlations between variables included in subsequent analysis were below .70. In addition, tolerance values for each regression equation were within limits recommended by Stevens. All variables were tested for skewness and kurtosis using the Kolmogorov-Smirnov Test with an alpha level of $p = .001$, a conservative value in small to moderate size samples (Tabachnick & Fidell, 1989). If the Kolmogorov-Smirnov Test was significant, the variable was transformed using a natural log. Transformed variables include ownership turnover, SSD experience, and all five frequency of service variables; tables display non-transformed variables for ease of interpretation. Table 11 presents means, standard deviations and/or frequencies as well as the extent of missing data for all variables included in the models.

Table 11: *Descriptive Statistics—All Variables in Regression Models*

Variable	Frequency/Scale	Mean	SD	Range	%Missing
STRUCTURAL FACTORS					
Ownership status	For-profit = 74.1% Non-profit = 25.9				4.13
Chain affiliation	Chain = 62.9% Non-chain = 37.1%				4.13
Number of beds		95.37	38.94	12-215	4.96
Facility location	Metropolitan = 84.5% Non-metropolitan = 15.5%				4.13
Ownership turnover		2.17	2.50	0-11	5.79
Social work caseload		72.88	34.67	4-180	14.05
PROCESS FACTORS					
Psychosocial service priorities (1-7, higher = higher priority)					
• Intervention needs		5.62	0.76	3.57-7.00	6.61
• Resource and referral needs		5.10	0.91	2.83-7.00	5.79
• Empowerment and self-determination needs		5.11	0.95	2.43-7.00	5.79
• Individualization needs		4.67	1.28	1.00-7.00	4.13
• Socialization and relationship needs		4.69	1.38	1.33-7.00	4.13
Social work influence	Scale 0-15 (Higher = more influence)	9.91	3.337	0-15	1.65
Job autonomy	Scale: 0-25 (Higher = more support)	17.01	4.112	3-25	4.13
Supervisor support	Scale 0-30 (Higher = more support)	21.02	6.681	3-30	4.13
Coworker support	Scale 0-45 (Higher = more support)	31.06	7.375	7-44	5.79
SOCIAL SERVICE DIRECTOR CHARACTERISTICS					
Education	Social work degree = 35.8 percent				1.65
Geriatric mental health knowledge	Scale: 0-25 (Higher = more knowledge)	20.63	2.362	14-24	0.83
Interdisciplinary team skills	Scale: 0-35 (Higher = more skills)	28.04	3.667	18-35	4.13
Role identification	Scale: 0-45 (Higher = stronger identity)	32.21	6.516	13-45	4.13
Years of SNF social services experience		7.922	5.640	0-27.4	1.65
FREQUENCY OF PSYCHOSOCIAL SERVICES					
Variable (Scale 1-7, higher = more frequent)		**Mean**	**SD**	**Range**	**%Missing**
Assessment		5.56	1.10	2.33-7.00	4.13
Intervention		5.03	0.93	2.86-7.00	5.78
Information and referral		4.62	0.85	2.44-6.67	4.96
Care planning		5.59	1.23	1.00-7.00	1.65
Administration and advocacy		3.73	1.22	1.40-6.40	6.61
SCOPE AND SEVERITY OF DEFICIENCIES		40.86	35.51	0-210	6.16

Hypothesis 1: Structural factors, process factors, and SSD characteristics will independently influence the frequency of psychosocial service delivery.

Structural Variables

Ordinary least squares regression was conducted to assess the structural variables' ability to predict the frequency of psychosocial service delivery across each of the five service frequency variables: care planning, resource and referral, administration and advocacy, assessment, and intervention. Structural variables included SSD caseload, facility location, chain affiliation, ownership status, ownership turnover, and facility size. Mahalanobis distance scores revealed no univariate or multivariate outliers, thus no cases were deleted from the analysis. Bivarate correlations are shown in Table 12.

Results indicate that structural factors are predictive of the frequency of service delivery in one domain, care planning, and explain 11.8 percent of the variance in the frequency at which care planning services are provided. SSD caseload is the strongest predictor such that care planning tends to occur more frequently as caseload size increases ($\beta = .239, p < .05$). None of the other models were statistically significant at the .05 level and none predicted more than 10 percent of the variance in service delivery. However, given its statistically significant regression coefficient, SSD caseload also appears to be related to the frequency of intervention services ($\beta = .306, p < .01$). As depicted in Table 15, intervention services tend to increase as the SSD's caseload increases. At the same time, facility size appears associated with the frequency of assessment services ($\beta = .225, p < .05$), whereby assessment occurs more frequently in larger facilities. These relationships are not surprising; it makes sense that being responsible for providing services to more residents would equate to more time being spent providing those services.

Process Variables

Ordinary least squares regression was conducted to assess the ability of the process variables to predict the frequency of psychosocial services delivery across each of the five service domains. Process variables included job autonomy, SSD influence,

supervisor support, and coworker support. Variables associated with the priority of resident needs were not included in the model due to the presence of multicolinearity between these scales and the service frequency scales. For example, higher priority of self-determination and empowerment needs corresponds to a higher frequency of resource and referral tasks ($r = .742, p < .01$). Bivariate correlations between variables included in the model are shown in Table 13.

Results indicate that process factors are predictive of service frequency in one area, administration and advocacy services, and explain 12.3 percent of the variance in frequency at which these tasks are performed. In addition, although the frequency of care planning regression model itself is not statistically significant, SSD influence appears associated with the frequency of care-planning tasks ($\beta = .238, p < .05$), whereby SSDs who report greater influence in their facilities also tend to engage in care planning tasks more frequently.

As shown in Table 15, job autonomy and SSD influence are the variables most strongly related to the frequency of administrative and advocacy services. Furthermore, the direction of results suggests a differential impact of SSD autonomy and SSD influence whereby SSDs who perform administrative and advocacy tasks the least frequently also tend to report the most job autonomy ($p = .005$), while SSDs who perform administrative and advocacy tasks the most frequently tend to report the highest level of influence in their facilities ($p = .000$). As such, SSDs with considerable discretion in determining their work priorities may not necessarily have correspondingly high levels of influence on facility decision-making.

SSD Characteristics

Ordinary least squares regression was conducted to assess whether SSD characteristics predicted the frequency of psychosocial service delivery across the five frequency of service domains. SSD characteristics variables included years of SNF social services experience, education (having a degree in social work or not), role identification, interdisciplinary team skills, and geriatric mental health knowledge. Bivariate correlations are depicted in Table 14.

Results indicate that SSD characteristics are generally not predictive of the frequency of service delivery; none of the five regression models were statistically significant at the .05 level and none predicted more than 8.3 percent of the variance in service delivery. However, the relationship between SSD characteristics and the frequency of intervention services approaches statistical significance ($p = .058$) and it is possible that with a larger sample this relationship would be statistically significant. In addition, given statistically significant regression coefficients, interdisciplinary team skills are associated with the frequency of service delivery in three domains: care planning, resource and referral, and psychosocial intervention. Having higher scores on the interdisciplinary team skills scale is related to performing these services more frequently. It is interesting that this relationship is not present in terms of assessment services as well considering federal mandates for multidisciplinary assessment in SNFs.

Given the limited ability of structural, process, and SSD characteristics to predict the frequency of service delivery, a fourth regression analysis was run to assess the relationship between frequency of service delivery and the scope and severity of survey deficiencies in psychosocial care. Results indicate no relationship between these constructs ($R^2 = .054, p = .228$). As such, it appears that frequency of service delivery, as measured here, is unrelated to psychosocial care deficiencies. However, another possibility is that a moderating relationship is occurring whereby underlying connections between variables are masked due to interactions between predictor and outcome variables; moderation may be a factor when an unexpectedly weak relationship exists between a predictor and outcome variable (Baron & Kenny, 1986). This possibility is examined below in conjunction with testing hypothesis 3. A third alternative is that the frequency of service delivery measures used in this study are not sensitive enough to capture any underlying relationship between service delivery and survey-related resident outcomes. This possibility is further elaborated on in the discussion section.

Table 12: *Bivariate Correlations Between Structural Variables and Frequency of Service Delivery Variables*

		1	2	3	4	5	6	7	8	9	10	11
1.	Facility location	1										
2.	Facility size	-.182	1									
3.	Multi-chain affiliation	.097	.038	1								
4.	Ownership status	.199*	.002	.419**	1							
5.	Ownership turnover	.181	-.029	.311**	.363**	1						
6.	SSD caseload	-.029	.514*	.178	.314**	.154	1					
7.	Care Planning Frequency	-.105	.211*	.050	.145	.102	.311**	1				
8.	Resource/Referral Frequency	-.046	.243**	.084	.096	.036	.290**	.458**	1			
9.	Administrative/Advocacy Frequency	-.044	.020	-.035	.038	-.110	.060	.329**	.526**	1		
10.	Assessment Frequency	.089	.272**	.087	.020	-.015	.183	.590**	.427**	.389**	1	
11.	Intervention Frequency	-.162	.090	.005	.072	-.048	.269**	.422**	.574**	.491**	.271**	1

*$p < .05$, **$p < .01$, ***$p < .001$

Table 13: *Bivariate Correlations Between Process Variables and Frequency of Service Delivery Variables*

		1	2	3	4	5	6	7	8	9
1.	Job autonomy	1								
2.	SSD influence	.581**	1							
3.	Supervisor support	.565**	.435**	1						
4.	Coworker support	.295**	.368**	.373**	1					
5.	Care planning frequency	-.130	.062	-.117	-.053	1				
6.	Resource/referral frequency	-.076	.020	-.081	.062	.458**	1			
7.	Administrative/advocacy frequency	-.040	.246**	.030	.074	.329**	.526**	1		
8.	Assessment frequency	-.036	.101	.007	-.095	.590**	.427**	.389**	1	
9.	Intervention frequency	-.081	-.006	-.075	.021	.422**	.574**	.491**	.271**	1

*$p < .05$, **$p < .01$, ***$p < .001$

Table 14: *Bivariate Correlations Between SSD Characteristics Variables and Frequency of Service Delivery Variables*

		1	2	3	4	5	6	7	8	9	10
1.	Experience	1									
2.	Social work degree	.019	1								
3.	Role identity	.091	-.049	1							
4.	IDT skills	.058	-.117	-.224*	1						
5.	MH knowledge	.272**	.176	-.027	-.016	1					
10.	Care planning frequency	.046	-.027	.018	.182	-.012	1				
11.	Resource/referral frequency	.011	-.034	.096	.208*	-.078	.458**	1			
12.	Administrative/advocacy frequency	.138	-.098	.116	.132	-.053	.329**	.526**	1		
13.	Assessment frequency	-.035	-.008	.002	.071	.059	.590**	.427**	.389**	1	
14.	Intervention frequency	.065	-.126	.066	.255**	-.035	.422**	.574**	.491**	.271**	1

*$p < .05$, **$p < .01$, ***$p < .001$

Hypothesis 2: Process factors will have a greater influence than structural factors and SSD characteristics on the scope and severity of deficiencies in psychosocial care.

Hierarchical linear regression was utilized to assess the ability of structural factors, process factors, and SSD characteristics to predict the scope and severity of survey deficiencies in psychosocial care and to assess whether process factors played the strongest role. Mahalanobis distance scores revealed two outliers and these two cases were deleted from the analysis. Tabachnick and Fidell (1996) recommend the following equation to determine the maximum number of predictors to generate a reliable regression equation: $N \geq 50 + 8k$, where k is the number of predictors. Three facilities did not have deficiency data in the OSCAR file, leaving a sample size of 116; thus it was possible to include 8 predictors in the regression equations. For data reduction and to aid in the selection of variables most likely to be predictive of the scope and severity of deficiencies, a bivariate correlation table was first created to assess the strength of relationships between all variables of interest. Variables with statistically significant correlations were chosen as well as those with the highest non-significant correlations to total eight predictors. The following variables were identified: ownership turnover, ownership status, facility location, SSD experience, role identification, supervisor support, SSD influence, and priority of individualization needs. It is important to note, however, that the risk of type I error increases as the number of tests are made, as such there is a potential that some correlations are significant only by chance (Yaffe, 2003). While SSD caseload appeared to be a potentially important predictor, the extent of missing data for this variable was high, 14.05 percent, and further restricted the sample size; thus this variable was not included in the regression models. A formatting error in the questionnaire's design may have contributed to the extent of missing data whereby the question "How many other social workers work at your facility?" was somewhat embedded in a series of questions and easily overlooked. This formatting anomaly is not visible in the attached instrument (see appendix A), as the original layout has been altered for document binding. Tables 16-18 show the bivariate correlations among variables at each level of interest.

The independent variable, scope and severity of survey deficiencies in psychosocial care, was calculated by first weighting, using the GNS scoring matrix, the scope and severity scores for each deficiency received by each facility over the three-year OSCAR survey period and then adding these weights together to create a composite score. For example, a facility that received two level 'D' deficiencies during 2002, one 'G' level deficiency during 2003, and three 'B' deficiencies during 2004 would have a total scope and severity weighting of 29. The higher the score, the worse a facility has performed in terms of compliance with state and federal regulations. Higher scores correspond to more serious problems placing greater numbers of residents at increased risk of harm.

Table 15: *Predictive Relationships among Structural, Process, and SSD Characteristic Variables and Frequency of Service Delivery*

	Care Planning Frequency	**Resource/Referral Frequency**	**Administrative/ Advocacy Frequency**	**Assessment Frequency**	**Intervention Frequency**
	Unstandardized/ Standardized Coefficients	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*
Structural Variables					
Facility location	-.336/-.099	-.237/-.012	-.431/-.026	1.148/.131	-2.852/-.166
Facility size	.003/.080	.032/.169	-.005/-.033	.019/.225*	-.020/-.126
Multi-chain affiliation	-.071/-.028	1.064/.069	-.436/-.034	.553/.083	-.147/-.011
Ownership status	.179/.063	-.034/-.002	1.360/.050	-.132/-.018	.656/.046
Ownership turnover	.039/.078	.045/.015	-.355/-.146	-.078/-.061	-.188/-.075
SSD caseload	.009/.239*	.041/.183	.009/.050	.008/.080	.058/.306**
R^2	**.118***	**.107**	**.023**	**.089**	**.099**
Process Variables					
Job autonomy	-.171/-.191	-.180/-.097	-.437/-.295*	-.100/-.125	-.173/-.109
SSD Influence	.263/.238*	.199/.087	.773/.423***	.206/.208	.153/.078
Supervisor support	-.046/-.083	-.103/-.090	.020/.022	.013/.026	-.060/-.061
Coworker support	-.031/-.062	.085/.083	.001/.002	-.069/-.153	.042/.047
R^2	**.051**	**.020**	**.123****	**.039**	**.015**
SSD Characteristics					
Experience	.016/.025	-.014/-.010	.165/.153	-.042/-.072	.064/.055
Social work degree	.021/.003	.019/.001	-.930/-.073	-.002/.000	-1.166/-.086
Role identity	.027/.048	.152/.130	.066/.070	.008/.017	.063/.063
IDT skills	.200/.199*	.521/.251**	.198/.119	.090/.099	.454/.255**
MH knowledge	-.020/-.016	-.086/-.033	-.209/-.100	.069/.061	-.083/-.037
R^2	**.040**	**.068**	**.053**	**.015**	**.083**

*$p < .05$, **$p < .01$, ***$p < .001$

Table 16: *Bivariate Correlations Structural Variables and Scope and Severity of Deficiencies in Psychosocial Care*

		1	2	3	4	5	6	7
1.	Scope and Severity of Deficiencies	1						
2.	Facility location	.144	1					
3.	Number of beds	.074	-.181*	1				
4.	Ownership turnover	.323**	.171	-.024	1			
5.	Chain affiliation	.059	.091	.055	.318**	1		
6.	Ownership status	.124	.195*	.021	.368**	.435**	1	
7.	SSD caseload	.167	-.037	.521**	.166	.195*	.323**	1

*$p < .05$, **$p < .01$, ***$p < .001$

Table 17: *Bivariate Correlations SSD Characteristics and Scope and Severity of Deficiencies in Psychosocial Care*

		1	2	3	4	5	6
1.	Scope & severity of deficiencies	1					
2.	Experience	-.287**	1				
3.	Geriatric MH knowledge	-.057	.272**	1			
4.	IDT skills	-.029	.058	-.016	1		
5.	Role identity	-.208*	.091	-.027	-.224*	1	
6.	Social work degree	.070	.014	.124	-.132	.046	1

*$p < .05$, **$p < .01$, ***$p < .001$

Table 18: *Bivariate Correlations Process Factors and Scope and Severity of Deficiencies in Psychosocial Care*

		1	2	3	4	5	6	7	8	9	10
1.	Scope & severity of deficiencies	1									
2.	Social work influence	-.214*	1								
3.	Job autonomy	-.103	.581**	1							
4.	Supervisor support	-.132	.435**	.565**	1						
5.	Coworker support	-.122	.368**	.295**	.373**	1					
6.	Priority of intervention needs	-.052	-.055	.056	.119	-.033	1				
7.	Priority of resource and referral needs	-.033	.130	.214*	.151	.256**	.551**	1			
8.	Priority of empowerment and self-determination needs	-.014	.116	.150	.177	.194*	.602**	.742**	1		
9.	Priority of individualization needs	.168	-.088	.043	.131	.096	.597**	.510**	.676**	1	
10.	Priority of socialization and relationship needs	.051	-.162	-.041	.035	.136	.503**	.549**	.698**	.715**	1

*$p < .05$, **$p < .01$, ***$p < .001$

To test the hypothesis that the process-level variables would be the most influential in predicting the scope and severity of survey deficiencies in psychosocial care, three regression models were created: the first examined the independent influence of the structural variables, the second examined the combined influence of the structural variables and the SSD characteristics, and the third examined the influence of the process level variables over and above the structural factors and SSD characteristics. Results for all three models are depicted in Table 19.

The structural variables ownership status, ownership turnover, and facility location account for 11.3 percent of the variance in the scope and severity of deficiencies in psychosocial care ($p = .004$). Ownership turnover is the most influential variable such that facilities with more changes of ownership are associated with receiving survey deficiencies of higher scope and severity ($\beta = .302, p < .01$).

Considering SSD characteristics in conjunction with structural variables accounts for an additional 9.7 percent of the variance in the scope and severity of survey deficiencies ($p = .000$). Ownership turnover remains influential ($\beta = .269, p < .01$) along with the extent of the SSD's experience in SNF social work ($\beta = -.205, p < .05$) and the SSD's level of role identification ($\beta = -.221, p < .05$). Facilities in which the SSD has fewer years of experience or a lower level of identification with the helper or caregiver role are associated with receiving survey deficiencies of higher scope and severity.

Adding process level variables to the structural variables and SSD characteristics accounts for an additional 5.4 percent of the variance in the scope and severity of deficiencies in psychosocial care ($p = .000$). With all variables in the model, 26.4 percent of the variance is explained; ownership turnover ($\beta = .223, p < .05$), years of experience in SNF social work ($\beta = -.208, p < .05$) and role identification ($\beta = -.231, p < .01$) remain influential and are joined by the priority of residents' individualization needs ($\beta = .172, p < .05$). The relationship between the scope and severity of survey deficiencies and ownership turnover, SSD experience, and role identification remain the same; interestingly, however, an SSD's report of working in an environment where residents' individualization needs are a high priority is associated with deficiencies of *greater* scope and severity.

Using the *F*-test of significance, the change in *R*-square from model to model was assessed; results indicate that *R*-square changes significantly from model 1 to model 2 (F= 7.03, $p < .01$), and from model 2 to model 3 (F = 2.73, $p < .05$). Given these results, process variables do add to the predictive power of the model, but given the small change in *R*-square for model 3, there is no support for the hypothesis that process level variables have the most influence in terms of the scope and severity of deficiencies in psychosocial care. Rather it appears that structural variables, specifically ownership turnover, and the SSD characteristics of years of experience in SNF social services and role identification, are the most influential.

Table 19: *Relationships between Multi-level Variables and the Scope and Severity of Deficiencies in Psychosocial Care*

	Regression Model 1	**Regression Model 2**	**Regression Model 3**
	Unstandardized/ Standardized Coefficients	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*
Structural Factors			
Ownership status	.796/.012	3.027/.044	3.055/.045
Ownership turnover	3.620/.302**	3.223/.269**	2.671/.223*
Facility location	7.426/.091	5.667/.069	6.478/.079
SSD Characteristics			
Experience		-1.072/-.205*	-1.087/-.208*
Role identity		-1.037/-.221*	-1.083/-.231**
Process Factors			
Supervisor support			-.661/-.145
SSD influence			-.551/-.062
Individualization priority			1.003/.172*
R^2	**.113****	**.210*****	**.264*****
R^2 **change.**		**.097****	**.054***
$^*p < .05$, $^{**}p < .01$, $^{***}p < .001$			

T-tests and chi-square analyses were next conducted to assess group differences across the four influential predictors: ownership turnover, SSD experience, role identification, and priority of residents' individualization needs. Results are depicted in Tables 20 and 21. Facilities with high ownership turnover, defined as turnover levels above the mean (2.17), tend to be for-profit ($p < .001$) and operated by multi-facility chains ($p < .001$). Furthermore, these facilities appear to receive survey deficiencies related to inadequate protection of residents' dignity and failure to provide medically-related social services more frequently than facilities with lower turnover. In addition, they also appear to receive repeat deficiencies in hiring practices/abuse reporting and in

comprehensive assessment more often ($p < .05$). At the same time, SSDs in high turnover facilities report larger caseloads ($p < .05$) than their counterparts in lower turnover facilities; they also report lower levels of coworker support ($p < .01$) and score somewhat lower in terms of geriatric mental health knowledge ($p < .05$).

SSDs with experience levels at or above the mean (7.92 years) tend to have smaller caseloads than SSDs with less experience ($p < .001$). In addition, they tend to be working in non-profit facilities and in facilities with lower ownership turnover ($p < .001$). They report higher levels of interdisciplinary team skills ($p < .05$), score somewhat better on knowledge of geriatric mental health ($p < .05$), and report providing psychosocial intervention services more frequently ($p < .01$). Even so, facilities with highly experienced SSDs are associated with receiving fewer survey deficiencies in two areas: failure to notify residents of changes in facility policies and procedures ($p < .05$) and lack of comprehensive assessment ($p < .05$).

SSDs who report high levels of role identification, defined as levels at or above the mean (32.31), are more likely to have a degree in social work than SSDs who report lower levels of role identification ($p < .05$). Facilities with SSDs who strongly identify with the helper role appear to receive fewer survey deficiencies for failure to accommodate residents' individual needs ($p < .005$). At the same time, SSDs with higher role identification indicate having lower levels of coworker support ($p < .05$) and feeling somewhat less confident in their interdisciplinary team skills ($p < .01$) compared to SSDs with lower role identification. While the reason for this discrepancy is unclear, the work and well-being literature notes that persons with strong role identification are at greater risk for work-related stress and burnout (Siebert & Siebert, 2005); among this sample, perceiving less coworker support and more challenges in working with interdisciplinary teams may be evidence of this pattern.

As discussed earlier, rather than the SSD's individual assessment of the priority of residents' psychosocial needs, the priority of need questions aim to measure priority at the facility level based on the perspective of the SSD. In the SSD's perception, facilities that view residents' individualization needs as higher priorities (at or above the mean of 14.69) tend to have experienced more ownership changes than facilities that view such

needs as lower priorities ($p < .05$). According to the SSDs, these facilities also view all other resident needs as higher in priority than low individualization priority facilities do ($p < .001$). In addition, more SSDs in high individualization priority facilities possess a degree in social work ($p < .05$) and these facilities tend to more frequently receive survey deficiencies in two areas: failure to provide comprehensive resident assessments and inadequate hiring practice/abuse investigations ($p < .05$).

Table 20: *Mean Group Differences in Structural Factors, Process Factors, SSD characteristics, and Scope and Severity Outcomes across Key Predictors*

	Ownership Turnover		SSD Experience		Role Identification		Priority Individualization Needs	
	Low	*High*	*Low*	*High*	*Low*	*High*	*Low*	*High*
Structural Variables								
Facility location (percent rural)	12.1%	19.3%	17.5%	13.6%	15.5%	15.5%	21%	11%
Facility size	96.34	93.05	99.88	90.92	94.67	95.97	99.02	92.21
Multi-chain affiliation (percent chain-affiliated)	46.6%	77.2%***	68.4%	54.2%	58.6%	63.8%	70%	64%
Ownership status (percent for-profit)	55.2%	94.7%***	77.2%	71.2%***	69%	79.3%	75%	73%
Ownership turnover			2.42	1.72***	1.78	2.37	1.56	2.49*
SSD caseload	65.96	78.18*	78.17	66.19*	69.08	75.23	73.43	71.02
Process Variables								
Job autonomy	16.78	17.00	16.54	17.31	17.43	16.43	16.77	17.06
SSD Influence	10.47	9.33	9.54	10.31	9.98	9.88	10.23	9.68
Supervisor support	21.14	21.05	21.16	21.15	21.83	20.48	20.74	21.51
Coworker support	32.86	29.12**	30.21	32.00	32.52	29.72*	31.28	30.98
Priority intervention needs	32.14	32.42	30.75	33.68	31.79	32.69	29.72	34.37***
Priority resource and referral needs	24.48	24.67	23.30	25.71	24.21	24.84	22.26	26.43***
Priority empowerment and self determination needs	28.43	28.98	27.42	29.76	28.67	28.55	25.02	31.63***
Priority individualization needs	14.10	15.14	13.68	15.42	14.84	14.29		
Priority socialization and relationship needs	10.59	11.35	10.44	11.41	11.33	10.53	8.38	13.08***
SSD Characteristics								
Education (% SW degree)	39.7	31.6	38.6	32.2	29.3	41.4*	26.4	42.9*
Experience	9.04	7.05			7.69	8.39	8.48	7.67
IDT skills	28.17	27.74	27.26	28.66*	28.93	27.02**	27.38	28.48
Geriatric mental health Knowledge	20.71	19.75*	19.65	20.80**	20.48	19.98	20.42	20.08
Role identification	31.93	32.63	31.77	32.88			33.30	31.52
Frequency of psychosocial services								
Care planning	13.48	14.00	13.51	13.97	13.97	13.52	13.89	13.62
Resource and referral	32.79	32.37	32.37	32.81*	32.10	33.09	31.96	33.13
Administration/advocacy	13.74	13.40	12.82	14.39	13.09	14.16	13.40	13.81
Assessment	13.71	13.54	13.93	13.37	13.95	13.34	14.30	13.10*
Intervention	28.29	27.96	26.84	29.42**	28.09	28.22	26.51	29.54**
Scope and Severity Weightings	32.24	44.04*	46.23	30.68**	43.95	32.69*	34.06%	41.90%*

*$p < .05$, **$p < .01$, ***$p < .001$

Table 21: *Group Differences in Top Ten Specific Survey Deficiencies across Key Predictors*

Specific Survey Deficiencies	Ownership Turnover		SSD Experience		Role Identity		Priority Individualization Needs	
	% facilities w/ deficiency/mean scope & severity score		*% facilities w/ deficiency/mean scope & severity score*		*% facilities w/ deficiency/mean scope & severity score*		*% facilities w/ deficiency/mean scope & severity score*	
	Low	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**
Hiring practices & abuse investigations	60.34% 5.84	63.16% 6.92	68.4% 6.71	54.2% 5.94	67.2% 6.83	55.2% 5.79	56.6% 5.34	65.1%* 7.12
Comprehensive assessment	53.45 8.09	68.42 6.49	68.4% 7.07	52.5% 7.34	65.5% 8.15	55.2% 6.03	49.1% 7.37	69.8%* 7.07
Unnecessary drugs	39.66 6.04	43.86 5.76	35.1% 5.82	22.0% 6.00	29.3% 5.96	27.6% 5.83	49.1% 5.65	34.9% 6.17
Dignity	32.76% 5.35	40.35% 7.75*	42.1% 7.2	30.5% 6.45	41.4% 6.92	31.0% 6.8	28.3% 8.12	42.9% 6.11
Medically-related social services	20.69% 7.00	36.84% 5.43*	31.6% 5.72	25.4% 6.33	29.3% 6.47	27.6% 5.5	24.5% 5.38	31.7% 6.40
Comprehensive care planning	27.59 7.06	29.31 5.71	68.4% 6.00	52.5% 6.86	65.5% 6.61	55.2% 6.06	26.4% 6.53	30.2% 6.20
Accommodation of needs	20.69% 5.50	29.82% 5.67	24.6% 5.75	25.4% 5.27	32.8% 5.67	17.2%* 5.46	28.3% 5.71	22.2% 5.43
Notification of changes	24.1% 1.19	24.6% 1.16	33.3% 1.21	16.9%* 1.40	29.3% 1.63	20.7% .98	22.6% 1.27	27.0 1.34
Repeat – hiring practices & abuse investigations	15.52% 5.89	29.82% 8.82*	24.6% 5.79	13.6% 5.75	17.2% 5.80	20.7% 5.75	17.0% 5.56	20.6% 5.92
Repeat – comprehensive assessment	15.5% 5.89	29.8%* 8.82	29.8 8.41	15.3* 6.67	22.4% 6.23	22.4% 9.38	17.0% 10.00	27.0% 6.65

*$p < .05$, **$p < .01$, ***$p < .001$

Hypothesis 3: Frequency of service delivery will moderate the influence of structural factors, process factors, and SSD characteristics on the scope and severity of deficiencies in psychosocial care.

A moderator variable influences the strength of the relationship between two other variables; in a moderated relationship the effect of an independent variable depends upon the value of the moderator variable (Baron & Kenny, 1986). Moderation may be a factor when an unexpectedly weak relationship exists between a predictor and outcome variable (Baron & Kenny), as noted in the relationship between the frequency of service delivery variables and the multi-level factors and the scope and severity of deficiencies in psychosocial care.

Given the weak relationships noted for hypothesis 1, the potential influence of psychosocial service frequency was first assessed by identifying connections between the multi-level factors and each of the five frequency variables in terms of their relationships with the scope and severity of deficiencies. To facilitate an understanding of potential underlying interactions, the sample was stratified into two groups across the five frequency of service domains. Groups consisted of respondents with service frequency levels below the mean (low frequency groups) and those with frequency levels at or above the mean (high frequency groups). Ordinary least squares regression analyses were run for each group to assess for a potential differential impact of each service frequency on the most influential predictor variables. Given Steven's (2001) recommendation of 15 subjects per predictor and the split sample sizes ranging from 50 to 65, four predictors could be included in the regression equations. This allowed the four influential variables from regression model 3 in the previous section to be utilized: ownership turnover, SSD experience, role identification, and priority of individualization needs. Results are depicted in Table 22.

Split sample analysis reveals that ownership turnover and role identification appear more strongly associated with survey outcomes when service frequency is in the lower range; however, when service frequency is in the higher range, SSD experience seems to play a stronger role. Yet for assessment and intervention services specifically

these relationships are somewhat different. For example, when assessment services are provided in the lower frequency range, SSD experience is also related to survey outcomes along with ownership turnover and role identification, but when assessment services are provided in the higher frequency range, none of the relationships with the key predictors are significant. Conversely, when intervention services occur in the lower frequency range, only ownership turnover seems to associated with survey outcomes, but when intervention services occur in the higher frequency range, ownership turnover, SSD experience, and role identity again appear linked to survey outcomes.

Findings from split sample analysis further indicate that the four key predictors explain more of the variability in scope and severity weightings for the low frequency groups than the high frequency groups. For example, in the low frequency groups, four *R*-squares range from .290 to .369, while in the high frequency groups all five *R*-squares range from .140 to .198. However, this pattern is reversed for the intervention domain, whereby the key predictors explain 33.7 percent of the variance in scope and severity weightings for the high frequency group, but only 13.3 percent for the low frequency group. The reason for this reversed effect is unclear, but it appears that assessment frequency and intervention frequency have divergent relationships with survey outcomes in addition to being influenced differently by the key predictors as noted above.

Another finding from split sample analysis is that priority of individualization needs, a significant predictor in hypothesis two, is no longer significant when respondents are stratified by service frequency, bringing into question the stability of this variable's predictive power.

Table 22: *Influence of Key Predictors on the Scope and Severity of Survey Deficiencies by Frequency of Service Delivery*

	Care Planning Frequency		**Resource/Referral Frequency**		**Administrative/ Advocacy Frequency**		**Assessment Frequency**		**Intervention Frequency**	
	Low (*n*=50)	High (*n*=65)	Low (*n*=57)	High (*n*=58)	Low (*n*=56)	High (*n*=59)	Low (*n*=62)	High (*n*=53)	Low (*n*=58)	High (*n*=57)
	Unstandardized/ Standardized Coefficients	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*
Ownership turnover	4.463/ .328*	2.638/ .236*	4.691/ .379**	2.111/ .184	4.499/ .352**	1.953/ .179	4.558/ .338**	2.013/ .201	3.267/ .286*	3.326/ .270*
Experience	-.629/ -.113	-1.392/ -.281*	-.906/ -.185	-1,561/ -.283*	-.931/ -.160	-1.223/ -.267*	-1.559/ -.245*	-1.001/ -.245	-.678/ -.148	-1.733/ -.292*
Role identity	-1.656/ -.326*	-.508/ -.115	-1.233/ -.249*	-1.017/ -.224	-1.594/ -.261*	-.569/ -.157	-2.205/ -.368***	-.181/ -.051	-.292/ -.068	-1.784/ -.347**
Individualization needs priority	.646/ .094	.931/ .178	.519/ .088	.648/ .110	.927/ .131	.580/ .120	1,274/ .195	.779/ .156	.360/ .059	.840/ .142
R^2	.292**	.198**	.290***	.198*	.311***	.140	.369***	.150	.133	.377***
$^*p < .05$, $^{**}p < .01$, $^{***}p < .001$										

Table 23: *Effect of the Interaction Between Frequency of Service Delivery and Key Predictors on the Scope and Severity of Survey Deficiencies*

	Care Planning Frequency	**Resource/Referral Frequency**	**Administrative/ Advocacy Frequency**	**Assessment Frequency**	**Intervention Frequency**
	Unstandardized/ Standardized Coefficients	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*	*Unstandardized/ Standardized Coefficients*
Ownership turnover interaction	-1.747/-.137	-2.417/-.174	-2.779/-.181	-4.097/-.286*	.193/.014
Experience interaction	.007/.002	-.557/-.106	-.390/-.076	.454/.092	-.703/-.133
Role identification interaction	.161/.088	.327/.191	.576/.332	1.070/.607*	-.439/-.252
Priority of individualization needs interaction	-.465/-.444	.136/.039	-.696/-.202	-1.340/-.357	1.330/.393
R^2	.258***	.260***	.249***	.303***	.264***
$^*p < .05$, $^{**}p < .01$, $^{***}p < .001$					

To further analyze any moderating influence of service frequency, interaction terms were next created to assess the differential impact of service frequency in the five domains across the four key predictors. Entering such interaction terms into the regression equation allows the researcher to test the difference between regression coefficients for two groups, which is a limitation of the split sample analysis above (Cohen, Cohen, West, & Aiken, 2002).

Results are shown in Table 23 and indicate that one of the psychosocial service domains, frequency of assessment services, may moderate the impact of both ownership turnover and role identity on the scope and severity of survey deficiencies. As noted via split sample analysis, when assessment services are provided at a lower frequency, ownership turnover and role identity appear to play a greater role in predicting scope and severity weightings than when assessment services are provided at a higher frequency. Unlike the split sample analysis, however, the interaction of SSD experience with frequency of assessment services is no longer significant.

In terms of the interaction between frequency of assessment services and ownership turnover, facilities with lower ownership turnover continue their tendency toward better scope and severity weightings when compared to facilities with higher ownership turnover. Nevertheless, among lower ownership turnover facilities a more frequent provision of assessment services is associated with poorer survey outcomes than a less frequent provision of assessment services. This relationship is reversed among higher ownership turnover facilities: provision of assessment services at a higher frequency is associated with better scope and severity weightings compared to provision of such services at lower frequencies. Figure 3 illustrates the difference in regression slopes for the each of the two groups.

Regarding the interaction between frequency of assessment services and role identification, among the higher frequency group, scope and severity weightings are similar regardless of the SSD's level of role identification. However, among the lower frequency group, the level of role identification is related to greater differences in survey outcomes whereby lower role identification among SSDs is associated with poorer scope

and severity weightings. Figure 4 illustrates the difference in regression slopes for each of the two groups.

In spite of these results, the cross-sectional nature of the research design combined with the use of past, rather than concurrent or future, survey outcomes does not allow clarification regarding the direction of these relationships. For example, it is not clear whether frequency of assessment impacts scope and severity weightings, regardless of its interaction with ownership turnover and role identification, or other circumstances contributing to scope and severity weightings also contribute to assessment frequency. Additional research utilizing a more rigorous design is needed in this area.

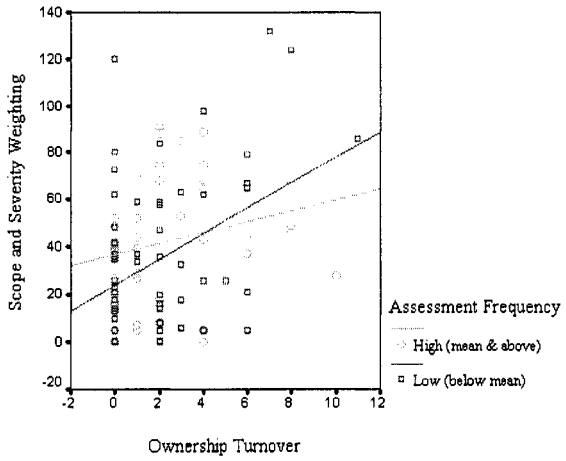

Figure 3: *Interaction Between Frequency of Service Delivery and Ownership Turnover*

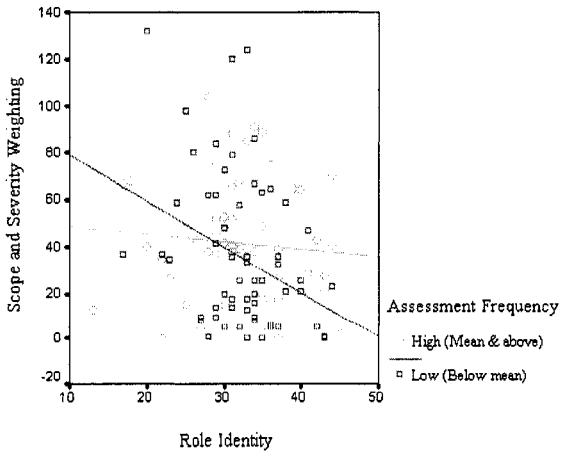

Figure 4: *Interaction Between Frequency of Service Delivery and Role Identity*

An additional regression analysis was then conducted to further assess the paradoxical finding between the priority of residents' individualization needs and the scope and severity of survey deficiencies. Results are displayed in Table 24 and indicate that SSDs who perceive that residents' individualization needs are higher priorities within their facility tend to provide assessment services more frequently, but intervention services *less* frequently, than their counterparts in facilities where such needs are perceived to be lower priorities ($p < .001$); this discrepancy is illustrated in Figure 5. Given this finding, it may be that the scope and severity of weightings in high individualization priority facilities are more associated with the lower frequency of intervention than the high priority placed on residents' individualization needs. Alternatively, factors associated with high scope and severity weightings may also be associated with lower intervention frequency.

Long-term care researchers have noted SNF social workers' responsibility for ongoing completion of federally-mandated individualized assessments requires considerable time and leaves little room for psychosocial intervention (Parker-Oliver & Kurzejeski, 2003). It may be that SSDs in high individualization priority facilities utilize the majority of their time assessing residents' individualized needs, precluding utilization of the assessment information to guide residents' care and enhance quality of life. Indeed, several respondents wrote lengthy comments on the final page of the questionnaire lamenting that paperwork burdens associated with psychosocial assessment hinder interaction with residents. One respondent had this to say:

> *"I find this a concern: With most SNFs that the paperwork, including the MDSs[8], outweighs interaction that should be happening in this setting with our residents."*

Another put it this way:

> *"I feel the state and federal expectations and having to do so many regulated forms is the biggest barrier in allowing Social Service to provide face-to-face contact with the people they serve."*

---

[8] Minimum Data Set, a federally-mandated assessment tool completed at regular interviews for each resident; assessment results guide care delivery and facility reimbursement.

The following respondents describes the specific nature of their paperwork burden and other job factors limiting resident interaction:

> *"The demands of paperwork [are] overwhelming. This week I have 20 MDSs, some RAPs[9], five care conferences, [and] other meeting obligations. [This does] not give much time to meet psychosocial needs of residents and families as well as I'd like to."*

Table 24: *Interaction between Service Frequency and Priority of Individualization Needs*

Assessment Frequency	
	Unstandardized/ Standardized Coefficients
Priority individualization needs	-.198/-.306***
Interaction priority individualization needs and assessment frequency	.334/.800***
R^2 = .607***	
Intervention Frequency	
Priority individualization needs	-.160/-.127*
Interaction priority individualization needs and intervention frequency	.636/.865***
R^2 = .646***	
*p < .05, **p < .01, ***p < .001	

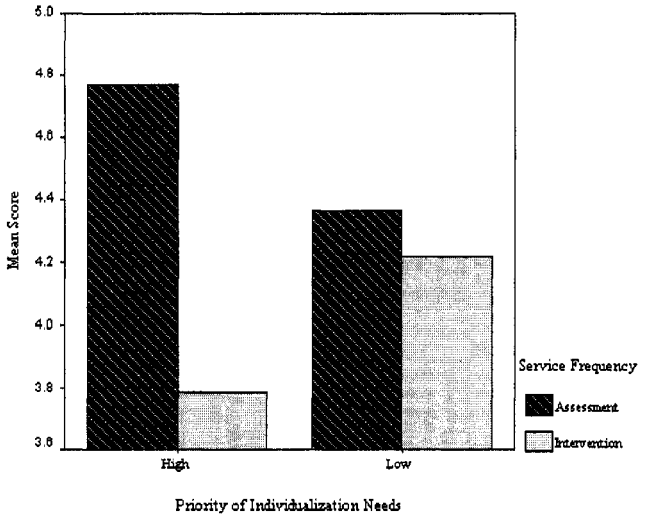

Figure 5: *Comparison of Service Frequency by Priority of Individualization Needs*

[9] Resident Assessment Protocols – An additional level of federally-mandated assessment accompanying the MDS and completed at regular intervals for each resident; based on concerns identified by the MDS assessment.

CHAPTER IV: DISCUSSION AND IMPLICATIONS

This research demonstrates that structural factors, process factors, and SSD characteristics are related to resident-focused state survey outcomes, with ownership turnover, SSD experience, SSD role identification, and the facility-level priority of residents' individualization needs having the strongest influence. Findings also support that the level of autonomy and influence SSDs feel they have within their facilities is associated with the frequency at which administrative and advocacy services are provided and caseload size is related to the frequency of care planning. In addition, results indicate that the frequency of assessment services may moderate the influence of both ownership turnover and role identification, whereby the scope and severity of survey deficiencies are more strongly influenced by ownership turnover and role identification in facilities where SSDs provide assessment services at lower frequency levels. A revised conceptual model presented in Figure 6 depicts the relationships among factors as suggested by this study.

Limitations

These research findings need to be interpreted in light of several limitations. For example, while survey deficiencies are commonly used as outcome variables in long-term care research, they have also been recognized as imperfect measures of quality. Differences in issuing nursing home deficiency citations are known to occur both between states and across survey teams within states (Day & Klein, 1987; Lee, Gajewski, & Thompson, 2006). This variation may stem from investigator practices more so than from actual differences in facility quality (Lee et al) and is a phenomenon present in Washington State facilities as well (Personal communication 04/10/07, Helen Sikov, MSW, nursing home administrator). Furthermore, comparing the extent of deficiencies by facility may not fully capture differences in quality since the number of deficiency citations may relate to both the quality of care provided by the facility and to characteristics of the resident population (Mukamel, 1997). The present study may have minimized this bias somewhat in that methods went beyond simple counts of survey

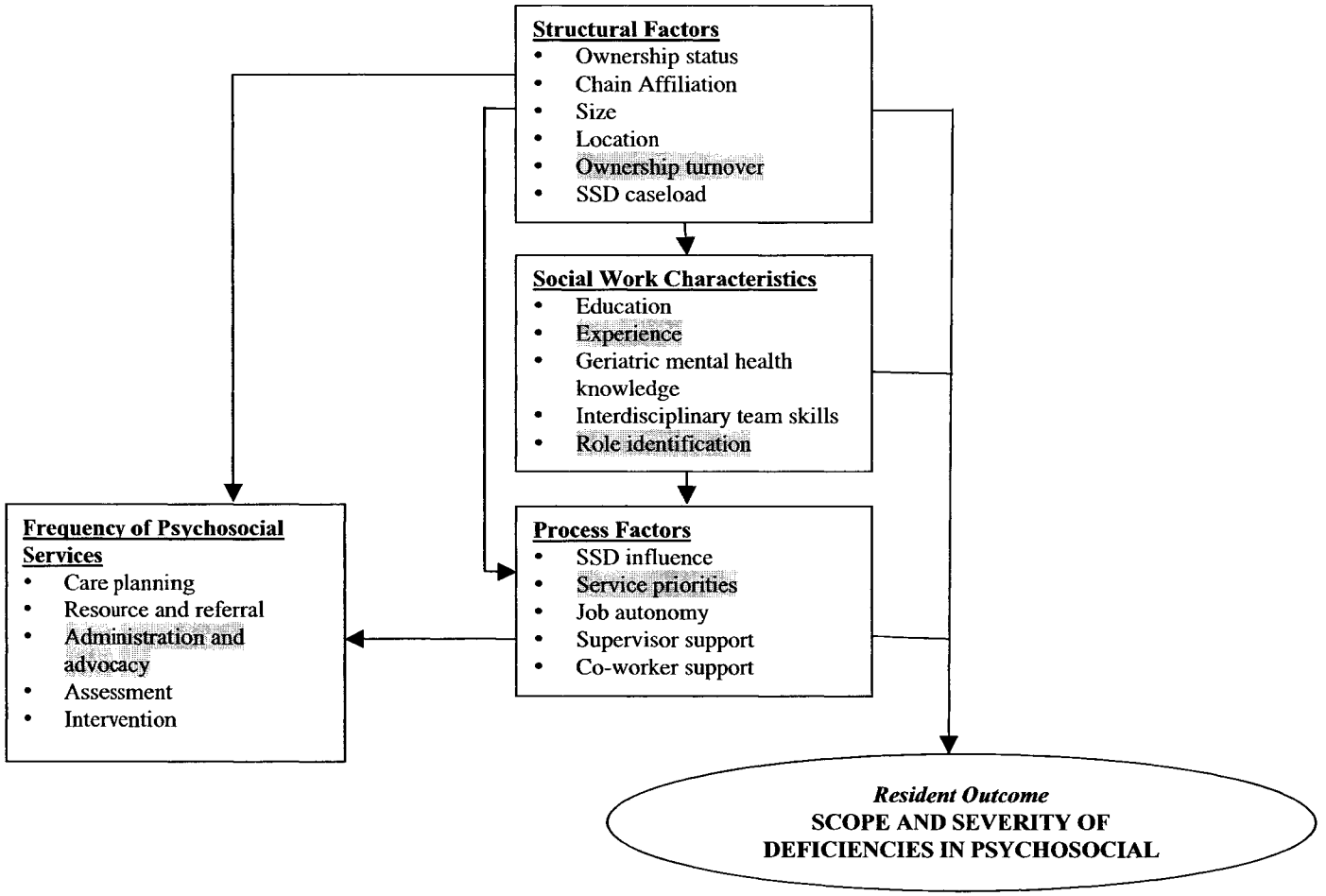

Figure 6: *Revised Conceptual Model Depicting Relationships among Multi-Level Factors and the Scope and Severity of Survey Deficiencies in Psychosocial Care*

deficiencies and utilized instead the scope and severity of deficiencies as an outcome variable, which is likely a more sensitive measure in capturing the variability across facilities.

Limitations in questionnaire measurement methods are also salient. For example, *frequency of service delivery* is a relatively weak measure that captures only whether services are provided on a time-interval basis. This variable does not capture the duration or intensity of service provision, nor does it assess service quality or how many residents are provided with the service. As an illustration, one SSD could provide a 5-minute individual counseling session to one resident one day each week, while another provides several 30-minute individual counseling sessions to a group of residents one day each week: both methods of service delivery would be categorized as "weekly" by this study's frequency measure, although the actual extent of service delivery is quite different.

The *priority of psychosocial needs* measure is similarly limited and does not necessarily capture the facilities' priorities. This measure relies on a single source of information, the SSDs' self-report, and thus triangulation of results is not possible.

In terms of the conceptual model itself, weaknesses in Donabedian's quality assessment framework have also been identified. One concern is the limited success previous investigators have had in actually demonstrating strong relationships between structural and process elements and outcome measures of quality (Anderson, Hsieh, & Su, 1998). For example, meta-analysis of Donabedian-based research revealed only 36% of studies (n = 75) were able to identify statistically significant relationships among these factors (Anderson et al.). While Anderson et al suggest methodological flaws may account for the lack of significant findings, Castle (2001a) suggests a prime weakness of employing structural criteria to capture facility quality is that facilities can meet structural standards without really influencing the quality of care. Indeed, quoting Donebedian himself, Castle notes structural variables "are rather blunt instruments in quality assessment" (p. 168). For example, federal regulations require facilities with more than 120 beds to employ a full-time qualified social worker, yet the presence of such a qualified person does not insure competency in geriatric mental health nor does it insure

that the social worker's job responsibilities reinforce utilization of skills and knowledge in geriatric mental health when they are present.

Process factors are also not without drawbacks, especially since they are often measured via documentation of the provision of care rather than by observation of the actual care being provided. For example, assessing the extent of psychotropic drug usage may be an indicator of facility process, yet the effective use of these drugs cannot be captured by a raw count of prescriptions or percentage of residents using them since effective use depends on how and if these drugs are used to improve residents' conditions (Castle, 2001a). Using an example from this research study, an SSD might report having considerable autonomy within a facility, but that autonomy may not necessarily enhance residents' psychosocial care outcomes. In other words, while structure and process aspects ensure a facility's capacity to provide quality care, they do not necessarily guarantee quality care (Kane & Kane, 1988).

An additional limitation of this research is generated by the time lag between the collection of facility inspection data for OSCAR and the collection of SSD data via the questionnaire. Data for state survey investigations utilized in this research were collected between January 2002 and December 2004; data for the SSD questionnaire were collected early in 2006. Due to this discrepancy, a portion of the sample was not employed by their corresponding facilities when the state survey investigations took place. Indeed, 25 percent of the sample fall into this category, reporting hire dates after December 2004, bringing into question the true strength of the predictive relationships identified. In further support of these findings, however, repeat analysis excluding respondents hired before December 2004 generated the same statistical results, except that the relationship between the priority of individualization needs and the scope and severity of survey deficiencies was not significant ($p = .128$). In addition, the R-square for the full regression model that included structural variables, SSD characteristics, and process variables was somewhat higher ($R^2 = .284$). A repeat analysis is planned utilizing 2005-2007 data when available.

Implications

In spite of the above limitations, these research findings suggest several intervention points for enhancing the quality of psychosocial care in SNFs. Potential improvement areas are discussed below for each influential predictor.

Ownership Turnover

OSCAR does not specify the reason for ownership change, whether a facility was sold related to poor performance or was acquired due to excellent performance (Castle, 2005). In addition, given the cross-sectional nature of the data, causality cannot be determined and the direction of influence is unclear as to whether facilities' provision of poorer quality care stimulates ownership turnover or ownership turnover contributes to poorer quality care. However, prior research suggests that a "turn-around scenario" is the most frequent category of ownership change whereby high-quality chains purchase low quality bargain-priced facilities and subsequently improve their performance (Banaszak-Holl et al., 2002). At the same time, ownership change often has a destabilizing effect on facilities' capacity for quality care provision; this is true even among high-quality chain/low-quality facility acquisitions, at least for the short term (Banaszak-Holl et al.). Furthermore, turnover at any organizational level apart from facility ownership appears to have detrimental effects on quality of care. For example, as mentioned previously, increased turnover of facility administrators is associated with several care concerns, including higher prevalence of physical restraints, catheterization, psychotropic drug use, and pressure ulcers as well as additional survey deficiencies in quality of care areas (Castle, 2001b). Currently there is limited research regarding the impact of ownership change on quality of care and facility practices; thus there is limited knowledge as to the mechanisms of negative influence or the specific manner in which such changes impact facility staff. This is an area for future research.

While it is unlikely that organizations can be persuaded to reduce the incidence of ownership changes, especially in the for-profit arena, strategies to minimize the negative impact of turnover are warranted. While the industry is already subject to considerable regulation, it has been recognized that regulation can be an effective means to motivate

change in facility practices (Weiner, 2003). As such, improvement may be prompted in this area though regulatory enhancement requiring organizational action plans to minimize the negative impact of ownership change. Further research is needed to delineate essential components and target areas of focus for such action plans. Alternatively, financial incentives could be made available to facility operators to encourage the implementation of change-management strategies; surplus funds collected via nursing home civil money penalties and fines may be a funding source for such an endeavor (Tsoukalas et al, 2006). In addition, mandatory survey team follow-up visits after an ownership change may help pinpoint early problems and aid in the prevention of declines in care quality (Banaszak-Holl et al, 2002).

SSD Experience

Again, due to the cross-sectional nature of the data, causality cannot be determined and it is not clear whether facilities with positive psychosocial survey outcomes are better able to attract experienced SSDs or experienced SSDs reinforce positive psychosocial survey outcomes. However, study results suggest that SSDs with more experience providing SNF social services may have a stronger capacity to provide quality psychosocial care. For example, interdisciplinary team skills ($p = .014$) and geriatric mental health knowledge ($p = .006$) both increase with increasing years of experience. In addition, having more years of experience is associated with more frequent provision of psychosocial intervention services ($p = .031$). As such, efforts to promote longevity in the field and retention of SSDs offer an additional method to enhance psychosocial care.

A connection exists between SNF social workers' job satisfaction and their intent to change jobs (Gleason-Wynn & Mindel, 1999); therefore taking steps to improve job satisfaction are likely to contribute to SSD longevity. Previous research has found organizational factors to be influential in determining job satisfaction and retention, specifically job autonomy, supervisor support, coworker support, and worker satisfaction with the client population (Gleason-Wynn & Mindel, 1999). Based on the current study's finding that SSDs who are supervised by the facility adminstrator report higher levels of

supervisor support than SSDs who are supervised by the director of nursing, it follows that the facility administrator has the strongest potential to provide a positive supervisory relationship for the SSD; this information can guide facility leaders in creating effective organizational charts.

Coupled with the finding that SSDs with fewer years of experience have much larger caseloads, supervisor support centered on such issues as workload and prioritizing job tasks appears especially critical. An overwhelming majority of the SSDs in this sample report having insufficient time to complete job duties and substantial number indicate their supervisor does not understand the demands of their resident caseload.

Role Identification

The relationship between the scope and severity of psychosocial care-related survey deficiencies and SSDs' level of identification with the helping or caregiving role was an unexpected finding. Again, while causation cannot be implied and it is possible that SSDs who strongly identify with being a helper are attracted to employment in higher quality facilities, it may also be that strong role identification is a protective factor and supports SSD longevity. However, it is also important to acknowledge the negative ramifications of high caregiver identity that have been identified in previous research: among social workers and other professional helpers, high scores on this measure are associated with greater vulnerability to depression, job burnout, professional impairment, and difficulty asking for help (Siebert & Siebert, 2005). The current study's findings coupled with this information can guide intervention methods in two ways. First, strategies can be employed to maximize SSDs' ability to identify with the helping components of their job responsibilities and second, role identification measures could be incorporated into evaluation protocols to enable supervisors to identify at-risk professionals for targeted self-care and stress-reduction efforts.

Since many SNF social workers are solo practitioners, resources offering opportunities to network with colleagues in other facilities would be beneficial and could potentially address both components of role identification noted above. The following respondent's description captures the solo practicioner's experience:

> *"I think being a social worker in a nursing home is a very lonely job. I have one girl in my department who was a nursing assistant, then central supply, medical records, etc. Everyone else has a whole department to support them. They can switch residents if they don't like them, talk about their caseload, and have someone who cares about what they eat for lunch...I have no one and all of the residents."*

Unfortunately, limited avenues for peer support for SNF social workers have been noted in the literature (Tirrito, 1996; Parker-Oliver & Kurzejeski, 2003) and additional development is needed in this area. Given the pattern of incorrect responses on the assessment of geriatric mental health knowlege exhibited by study respondents, a prime area to begin with is the development of continuing education addressing the charactersitics and progression of dementia as well as preparation for an increasingly culturally diverse resident population. Supervisor support for involvement in such activities is necessary since even when networking opportunities are available, SNF social workers have reported difficulty leaving work to attend them (Parker-Oliver & Kurzejeski, 2003).

Attention also needs to be paid to the lack of standardization of the nursing home social work role, which likely complicates SSD's professional identity. Although the quantitative component of the questionnaire suggests the bulk of respondents' feel their job responsibilities are clear, qualitative comments from several respondents' address challenges associated with the lack of clear job responsibilities and the variability of job requirements across facilities, for example:

> *"I have worked here for seven plus years as an Registered Physical Therapist, so [I] know all the staff, residents, medical community, resources, etc. However, there was literally almost no training and no corporate support/consultation for helping me learn this role, which has been difficult."*

> *"Being a social worker in a nursing home is misunderstood. The job requirements are not clear-cut. It is a position that should require a [professionally trained] social worker but, depending on the size [of the facility], anyone can be put in the position."*

"It would be nice to see a more standardized job descriptions for Social Services Directors. Each nursing facility seems to have different expectations for Social Services, and the jobs just 'evolve'."

Lack of clarity regarding the auspices of social work appears to contribute to the profession becoming a catch-all position for a variety of tasks, a trend that has also been noted by the profession (O'Neill, 2002). As an example, one respondent described it this way:

"Social Services is a very demanding position! It tends to be seen as 'when in doubt [about who should do a job], it is Social Services."

Priority of Individualization Needs

Given the questionable strength of this construct's relationship with psychosocial survey outcomes, application of this finding is tenuous at best and most readers would agree that greater attention to residents' individual needs and preferences is beneficial. However, the discrepancy between low individualization priority facilities and high individualization priority facilities in terms of the frequency of assessment versus the frequency of intervention is an important finding.

As noted above, paperwork burdens associated with federally-mandated assessment protocols are time-intensive and may limit the time available for psychosocial intervention. Facilities have a financial incentive for timely completion of assessments as assessment results drive reimbursement and facilities are subject to payment reductions for incomplete or late assessments. As such, assessment activities often take precedence over other tasks; the findings from this research study support this phenomenon since SSDs report that assessment-related tasks are among the most frequent compared to all other psychosocial services.

This discussion is in no way intended to minimize the importance of assessment; indeed, comprehensive assessment provides the foundation for appropriate and individualized intervention plans; yet at the same time, it appears that SSD attention to the provision of both assessment services and intervention services is associated with better resident-centered psychosocial outcomes. This association suggests the need for adaptations to afford SSDs additional opportunities to provide psychosocial intervention

services. In line with this recommendation, OIG findings related to psychosocial care found psychosocial intervention services to be the most frequently lacking in the facilities that they studied (DHHS, 2003). Ultimately, reduction in caseload sizes may need to be considered. Government time studies[10] currently underway may provide support for this option (CMS, 2007). The 120-bed rule was established nearly 20 years ago and SNF residents have changed since that time, becoming more complex, with higher acuity levels, and more intense psychosocial needs (DSHS, 2003). As such, SSD responsibilities have increased, making a 120-resident caseload unmanageable in the context of quality care. One respondent paints a picture of this situation:

> *"It is an ongoing challenge to meet the psychosocial needs of the residents with the demands of the paperwork aspect ever increasing. When I first started Social Services in long-term care there was no MDS and my true focus was the residents. I know the MDS is a valuable tool for assessment, but it does alter services one is able to provide. Balancing and prioritizing is constant. If I didn't love the elder population so much and believe in the need to advocate for them in the nursing home setting, the paperwork part of the job could drive me out of this setting."*

Another respondent commented:

> *"There are never enough hours at work to get the work done – the state requirement for documentation – assessments, MDS, are all valuable, but the [residents] need so much one-on-one and families are appearing more dysfunctional."*

Another option to create space for the provision of psychosocial intervention services is to revise SSD job descriptions to maximize attention to both assessment and intervention services. While on average SSDs report spending the bulk of their time on assessment, care planning and intervention, additional blocks of time may be targeted toward intervention services by limiting social services involvement in tasks that other professionals are positioned to handle. This would be especially important for the intervention services provided the least often according to this study, specifically, assisting residents to cope with grief and loss and providing psychosocial treatment to enhance individual functioning. For example, business office personnel might assist

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[10] Center for Medicare and Medicaid Services Staff Time and Resource Intensity Verification (STRIVE) Project

residents and families with Medicaid and Medicare procedures and housekeeping professionals might assist residents in locating missing possessions or obtaining personal items. The following respondent describes his/her method for sharing the load with other staff members:

> *"I have trained our licensed nurse care manager to do the general 'social work' stuff and I consult on harder cases."*

Indeed, one respondent, an MSW with several years of SNF social work experience and well-respected across Washington State,[11] perceives providing staff education regarding how to address residents' psychosocial needs is a critical role for SSDs; doing so would greatly expand SSDs' ability to meet residents' needs and be in keeping with the spirit of federal guidelines that assert the provision of medically-related social services as a facility-wide responsibility.

> *"I do a tremendous amount of personal learning and training of others in culture change...The work of the social workers can help to create a skilled facility which enhances an elder's well-being and helps them to continue to grow. The results will be decreased need of crisis intervention and conflict management resulting in increased time available to educate the team on how their work can enhance an elder's quality of life.*

Greater attention to residents' intervention needs could be also be secured through expanded use of contracted mental health providers, stronger partnerships between social services personnel and activity professionals to incorporate therapeutic-centered groups into regular facility event schedules, and enhanced utilization of community and resident volunteer natural helping networks.

CONCLUSION

Policymakers, regulators, and nursing home reform advocates are paying greater attention to the psychosocial needs of persons living in SNFs. Indeed, federal regulations have recently been revised to include an additional focus on outcomes indicative of resident psychosocial harm (AHCA, 2006). The heightened concern for residents' psychosocial well-being will likely continue to expand as the needs of the Baby Boom generation become preeminent. The results of this study suggest that both social work as

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[11] Respondent voluntarily revealed identity

a whole and social work education have roles to play in enhancing SNF psychosocial care.

The social work profession historically has not been significantly involved in addressing either macro or micro practice issues in SNFs; lack of attention to the needs of residents has been utilized as an example of social work neglect (Kosberg, 1973). While the reasons for poor commitment to this population are unclear, it has been suggested that professional values preclude employment in institutional and profit-minded environments (Kosberg). This study's findings that SSDs with social work degrees are more likely to be employed in non-profit facilities would seem to support this hypothesis. However, to enhance the quality of SNF psychosocial care, the profession must recognize that it is facility residents who are the focus of service, not the facilities in which they live. The profession must look beyond the walls of the institution and the motives of its top management to address the needs of the human element within.

Recent efforts by a group of multidisciplinary professionals signify movement in this direction. In December 2004, the Institute for the Advancement of Social Work Research sponsored a working conference to examine accomplishments related to psychosocial care since regulatory reforms initiated by the 1987 Ombudsman Reconciliation Act. Conference attendees also discussed methods "to outline a range of ways that the social work role in nursing homes could be more fully measured and implemented to improve residents' quality of care and quality of life (Zlotnik, 2005, p. ii). In response to this charge, the results of this study suggest areas of focus that may further the delineation of the SNF social work role as it relates to resident outcomes.

Given the association between ownership turnover and psychosocial service outcomes, it is an imperative that additional social work emphasis be placed on methods to enhance the facility milieu. Cultural change efforts have shown much promise in this area; for example, qualitative reports suggest facilities that are embracing the Eden Alternative have found normally withdrawn residents to be more responsive in the presence of facility pets (Thoesen-Coleman et al, 2002). While the present study did not find process factors to be strongly predictive of psychosocial care-related survey outcomes, it may be that ownership turnover is capturing the impact that facility work

environment and facility practices have on such outcomes. Indeed, practitioners have noted that ownership turnover is frequently accompanied by management turnover such that new owners bring with them new administrators and new directors of nursing. This changeover in management staff may have more influence on facility processes and outcomes than the ownership change itself (Mike Knox, geriatric case manager, personal communication, April 10, 2007). Social work expertise is needed to guide the development of methods to minimize the negative impact of organizational change on both staff and residents; such guidance is necessary at both the practice and the policy level. For example, social workers could liaison with industry leaders to craft intervention plans aimed at facilitating change strategies that are staff and resident-friendly. At the same time, they could also work with regulators to develop legislation encouraging facilities to engage in positive change management efforts. Such involvement, in turn, addresses the professions' social justice mission by targeting quality of life for vulnerable residents as well as quality of work life for SNF employees, the majority of whom are direct care workers, a group that is over-represented by women who have low educational attainment and are economically disadvantaged (Stone, 2001; Stone & Weiner, 2001).

Study findings related to the association between SSDs' role identification and psychosocial outcomes as well as the potential benefits of a dual focus on assessment and intervention services indicate the need to articulate clearly the role of social work in SNFs. While ongoing efforts have been made to specify this area of practice (Vourlekis, Bakke-Friedland, & Zlotnik, 1995; O'Neill & Rosen, 1998; Greene et al, 2005; Vourlekis, Zlotnik, & Simons, 2005), there is further work that is necessary. Most importantly, social work has meaningful contributions to make regarding realistic social work caseloads and the modes of service delivery that have the greatest influence on positive psychosocial care outcomes. This is especially true related to formulation of job descriptions that maximize attention to psychosocial care.

A caution, however, is warranted. While it has been argued that professionally educated social workers are in the best position to provide effective psychosocial services in SNFs (O'Neill & Rosen, 1998), it has also been acknowledged that there are

challenges to insuring an MSW or BSW is present in each facility. For example, researchers at CMS have noted, "it will take years to supply BSW and MSW manpower [sic] to over 17,000 nursing homes" (Connolly, Nitsch, & Panicker, 2005). Furthermore, facilities located in areas offering diverse job opportunities for gerontological social workers may have difficulty attracting professional social workers to SNF positions (Simons, 2006). Given this reality, it is vital for the profession to recognize that even though all SNF social services professionals fill a social work role, they are not all educated in social work. As such, it not feasible to expect that all SNF "social workers" will be influenced by the professions' values and practice guidelines regarding social workers' role in SNFs. Thus, what is most essential is translating the professions' recommendations into policy, which can then guide service delivery across multiple disciplines. Federal regulations were recently updated to further clarify the role of activities professionals in SNFs (AHCA, 2006); similar revisions are required to outline the social work role. Indeed, the profession is well-placed to craft role expectations aimed at enhancing psychosocial outcomes. For example, Greene (2005) has developed a series of SNF social work competencies that could inform the revision process and the AHCA (2006) has interpretive guidelines for quality medically-related social services that could be informative as well.

Study findings pinpointing the association between SSDs' years of experience and psychosocial outcomes mandate the profession to engage in formal outreach efforts to create connections with and among SNF practitioners, both social work professionals and para-professionals alike. Such connections could foster the additional support and the enhanced role identification vital for longevity in the field. Outreach could take the form of readily available educational opportunities designed to strengthen psychosocial assessment and intervention skills, provide information on practical work management strategies, effective communication tips, self-care techniques, and enhanced methods for interdisciplinary teamwork. In addition, on-going training regarding specific conditions common among SNF residents is also a necessity. This sample's limited knowledge of the characteristics of dementia is a key target area for both continuing education and the curricula in social work education programs. It is important to note that respondents with

social work degrees did not perform any better on the MSHAKE's dementia-related questions than respondent's without a social work degree, suggesting gerontological curriculum infusion efforts must expand to address the needs of cognitively impaired elders. The Council on Social Work Education's Master's Advanced Curriculum Project Gero Innovations Grant,[12] with its focus on infusing gerontological content into health, mental health, and substance abuse specializations, will provide an excellent conduit for introducing dementia-related practice information. While respondents' limited knowledge regarding the demographics associated with increasing cultural diversity among older adults is not indicative of lack of cultural competency, it suggests SNF practitioners may not be aware of the upcoming need to serve more residents from multiple cultures. Further research is needed in this area to determine areas of need related to cultural competency.

Facilitating connections and community among SNF practitioners will also foster longevity in the field. Since many SSDs are sole practitioners who are practicing in isolative host environments, resources to engage with colleagues in similar circumstances would be highly beneficial. As noted earlier, busy SSDs often are challenged to avail themselves of such resources when they are located off-site (Parker-Oliver &, Kurzejeski, 2003). As such, an online format may prove effective whereby practitioners could receive guidance from one another related to practice dilemmas, stay informed regarding latest advancements in the field, share tools to facilitate effective assessment and intervention, and post best practice success stories.

Demographics suggest the population of older adults requiring care in SNFs will increase in the near future. For example, among Veteran's Health Administration enrollees alone, a 20-25 percent increase in nursing home use is expected by 2012 (Kinosian, Stallard, & Weland, 2007). Social work involvement in interventions like those detailed above will pave the way to ensure quality psychosocial services for these vulnerable individuals.

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[12] www.gero-edcenter.org/mac

REFERENCES

Aaronson, W. E., Zinn, J. S., & Rosko, M. D. (1994). Do for- profit and not-for-profit nursing homes behave differently? *The Gerontologist, 34*(6), 775-786.

Alexander, J.A., & Fennell, M.L. (1986). Patterns of decision making in multi-hospital systems. *Journal of Health and Social Behavior, 27*(1), 14-27.

American Geriatrics Society and American Association for Geriatric Psychiatry. (2003). Consensus statement on improving the quality of mental health care in U.S. nursing homes: Management of depression and behavioral symptoms associated with dementia. *Journal of the American Geriatrics Society, 51*(9), 1287-129.

American Health Care Association. (2006). *The long term care survey, June 2006 edition.* Washington D.C.: Author.

American Health Care Association, Health Services Research and Evaluation. (2003). *Comparing nursing home quality performance: An evaluation of the basic method in nursing home ranking systems*. Retrieved 01/05/2005 from http://www.ahca.org.

American Health Care Association, Health Services Research and Evaluation. (2004). *The state long term health care sector 2003: Nursing homes, ICFs/MR, and government funding.* Retrieved 01/05/2005 from http://www.ahca.org.

Anderson, R.A., Corazzini, K.N., & MCDaniel, R.R. (2004). Complexity science and the dynamics of climate and communication: Reducing nursing home turnover. *The Gerontologist, 44*(3), 378-388.

Anderson, R.A., Hsieh, P., & Su, H. (1998). Resource allocation and resident outcomes in nursing homes: Comparisons between the best and the worst. *Research in Nursing and Health, 21*(4), 297-313.

Anderson, R.A., Issel, L.M., & McDaniel, R.R., Jr. (2003). Nursing homes as complex adaptive systems: Relationship between management practice and resident outcomes. *Nursing Research, 52*(1), 12-21.

Banaszak-Holl, M., Berta, W.B., Bowman, D.M., Baum, J.A.C., & Mitchell, W. (2002). The rise of human service chains: Antecedents to acquisitions and their effects on the quality of care in US nursing homes. *Managerial and Decision Economics, 23*(4/5), 261-282.

Baron, R.M., Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.

Bradley, E.H., & Walker, L.C. (1998). Education and advance care planning in nursing homes: The impact of ownership type. *Nonprofit and Voluntary Sector Quarterly, 27*(3), 339-357.

Bravo, G., DeWals, P., Dubois, M., & Charpentier, M. (1999). Correlates of care quality in long-term care facilities: A multilevel analysis. *Journals of Gerontology, 54B*(3), 180-188.

Burns, B.J., Wagner, H.R., Taube, J.E., & Magaziner, J. et al. (1993). Mental health service use by the elderly in nursing homes. *American Journal of Public health, 83*(3), 331-337.

Castle, N.G. (2000). Differences in nursing homes with increasing and decreasing use of physical restraints. *Medical Care, 38*(12), 1154 –1163.

Castle, N.G. (2001a). Administrator turnover and quality of care in nursing homes. *The Gerontologist, 41*(6), 757-767.

Castle, N.G. (2001b). Deficiency citations for mental health care in nursing homes. *Administration and Policy in Mental Health, 29*(2), 157-171.

Castle, N.G. (2001c). Innovations in nursing homes: Which facilities are the early adopters? *The Gerontologist, 41*(2), 161-172.

Castle, N.G. (2005). Nursing home closures, changes in ownership, and competition. *Inquiry, 42*(3), 281-292.

Castle, N.G; Banaszak-Holl, J. (2003). The effect of administrative resources on care in nursing homes. *Journal of Applied Gerontology, 22*(3), 405-424.

Castle, N., & Myers, S. (2006). Mental health care deficiency citations and nursing home staffing. *Administration and Policy in Mental Health and Mental Health Services Research, 33(*2), 215-225.

Castle, N.G. & Shea, D.G. (1997). Mental health services and the mortality of nursing homes residents. *Journal of Aging and Health, 9*(4), 157-169.

Center for Health Systems Research and Analysis, University of Wisconsin – Madison. (1999). *Facility guide for the nursing home quality indicators: National data system.* Madison, WI: Author.

Center for Medicare and Medicaid Services. (2001). *Nursing home data compendium.* Retrieved 11/27/04 from http://www.cms.hhs.gov/medicaid/survey-cert/datacomp.asp.

Centers for Medicare and Medicaid Services. (2002). *State operations manual, appendix PP: Survey procedures for long-term care facilities.* Retrieved 08/08/03 from http://cms.hhs.gov/manuals/Pub_07.asp.

Center for Medicare and Medicaid Services. (2005). *Nursing homes compare.* Retrieved 01/18/05 from www.medicare.gov/NHCompare/home.asp.

Centers for Medicare and Medicaid Services. (2007). *Skilled nursing facilities PPS time study.* Retrieved 04/10/07 from http://www.cms.hhs.gove/SNFPPS/10_TimeStudy.asp.

Challiner, Y., Julious, S., Watson, R., & Philp, I. (1996). Quality of care, quality of life and the relationship between them in long-term care institutions for the elderly. *International Journal of Geriatric Psychiatry, 11*(10), 883-888.

Christensen, C., & Beaver, S. (1996). Correlation between administrator turnover and survey results. *Journal of Long-Term Care Administration, 24*(2), 4-7.

Clark, S.J., & Desharnais, R.A. (1998). Honest answers to embarrassing questions: Detecting cheating in the randomized response model. *Psychological methods, 3*(2): 160-168.

Clemens, E., & Hays, H.E. (1997). Assessing and balancing elder risk, safety and autonomy: Decision-making practices of health care professionals. *Home Health Care Services Quarterly, 16*(3), 3-20.

Cohen, J., Cohen, P., West, S.G., & Aiken, L.S. (2002). *Applied multiple regression/correlation analysis for the behavioral sciences, 3rd edition.* Mahwah, NJ: Lawrence Erlbaum.

Connolly, B., Nitsch, J., Panicker, A. (2005). Regulatory approaches to measuring psychosocial service quality. In B. Vourlekis, J.L. Zlotnik, & K. Simons. *Evaluating social work services in nursing homes: Toward quality psychosocial care and its measurement. A report to the profession and blueprint for action, pp. 17-20.* Washington D.C.: Institute for the Advancement of Social Work Research.

Dane, B.O., & Simon, B.L. (1991). Resident guests: Social workers in host settings. *Social Work, 36*(3), 208-213.

Davis, M.A. (1990). On nursing home quality: A review and analysis. *Medical Care Review, 48*(2), 129-166.

Day, P., & Klein, R. (1987). Quality of institutional care and the elderly: Policy issues and options. *British Medical Journal, 7*, 384–387.

Department of Health and Human Services, Office of Inspector General. (2003). *Psychosocial services in skilled nursing facilities.* Retrieved 05/23/03 from http://www.oig.hhs.gov.oei-02-01-00610.pdf.

Dillman, D.A. (2000). *Mail and internet surveys: The tailored design method, 2nd edition.* New York: John Wiley and Sons, Inc.

Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association, 206*(12), 1743-1748.

Fairchild-Remsen, M. (1993). The role of the nursing home social worker in terminal care. *Journal of Gerontological Social Work, 19*(3/4), 193-205.

Fiske, H. (2002). Nursing home social work: Turnover turmoil. *Social work today, 2*(19): 10-12.

General Accounting Office. (2003). *Nursing home quality prevalence of serious problems, while declining, reinforces importance of enhanced oversight.* Accessed 02/27/07 from www.gao.gov/cgi-bin/getrpt?GAO-03-561.

Gleason-Wynn, P., & Mindel, H. (1999). A proposed model for predicting job satisfaction among nursing home social workers. *Journal of Gerontological Social Work, 32*(3), 65-79.

Graber, D.R., & Sloane, P.D. (1995). Nursing home survey deficiencies for physical restraint use. *Medical Care, 33*(10), 1051-1063.

Grabowski, D. (2001). Medicaid reimbursement and the quality of nursing home care. *Journal of Health Economics, 20*(4), 549-569.

Greene, R.R. (2005). Roles and function of nursing home social workers in the provision of psychosocial care. In B. Vourlekis, J.L. Zlotnik, & K. Simons, K. *Evaluating social work services in nursing homes: Toward quality psychosocial care and its measurement. A report to the profession and blueprint for action, pp. 13-14.* Washington D.C.: Institute for the Advancement of Social Work Research.

Greene, R.R., Graham, S.A., Haulotte, S.M., Nixon-Garcia, C., & Gleason-Wynn, P. (2005). *A state nursing home crisis: A consumer study in quality care.* Paper

presented at the 51st annual conference of the Council of Social Work Education, February-March, 2005, New York, New York.

Greene, R.R., Vourlekis, B.S., Gelfand, D.E., Lewis, J.S. (1992). Current realities: Practice and education needs of social workers in nursing homes. *Journal of Gerontological Social Work, 18*(3-4), 39-54.

Harrington, C., O'Meara, J., Collier, E., & Schnelle, J. F. (2003). Nursing indicators of quality in nursing homes. *Journal of Gerontological Nursing, 29*(10), 5–11.

Harrington, C., Woolhandler, S., Mullan, J., Carrillo, H., & Himmelstein, D.U. (2002). Does investor-ownership of nursing homes compromise the quality of care? *International Journal of Health Services, 32*(2), 315-325.

Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J., & Beutel, P. (2000). Nursing home staffing and its relationship to deficiencies. *Journal of Gerontology, 55B*(5), S278-S287.

Hatcher, L. (1994). *A step-by-step approach to using the SAS system for factor analysis and structural equation modeling.* Cary, NC: SAS Institute.

Healy, T.C. (2003). Ethical decision making: Pressure and uncertainty as complicating factors. *Health and Social Work, 28*(4), 293-301.

Hill, M.A. (1997). SPSS Missing Value Analysis. Chicago, IL: SPSS, Inc.

Holden, G., Cuzzi, L., Rutter, S., Rosenberg, G., & Chernack, P. (1996). The Hospital Social Work Self-Efficacy Scale: Initial development. *Research on Social Work Practice, 6*(3), 353-365.

Jones, A. (2002). The National Nursing Home Survey: 1999 summary. National Center for Health Statistics. *Vital Health Statistics 13*(152).

Kane, R.A., & Kane, R.L. (1988). Long-term care: Variations on a quality assurance theme. *Inquiry, 25*, 132–146.

Kane, R.A., Kling, K.C., Bershadksy, B., Kane, R.L., Giles, K., Degenholtz, H.B., & et al. (2003). Quality of life measures for nursing home residents. *Journals of Gerontology, 58A*(3), 240-248.

Kinosian, B., Stallard, E., & Wieland, D. (2007). Projected use of long-term care services by enrolled Veterans. *The Gerontologist, 47*(3), 356-364.

Kosberg, J.I. (1973). The nursing home: A social work paradox. *Social Work, 18*(2), 104-110.

Kruzich, J.M. (2000). Correlates of nursing home satisfaction. In J. Cohen-Mansfield, F. Ejaz, & P. Werner (Eds.). *Satisfaction surveys in long-term care.* New York: Springer Publishing.

Kruzich, J. (2005). Ownership, chain affiliation and administrator decision-making autonomy in long-term care facilities. *Administration in Social Work, 29*(1). 5-24.

Kruzich, J.M., Clinton, J.F., & Kelber, S.T. (1992). Personal and environmental influences on nursing home satisfaction. *The Gerontologist, 32*(3), 342-350.

Kruzich, J.M., & Powell, W.E. (1995). Decision-making influence: an empirical study of social workers in nursing homes. *Health and Social Work, 20*(3), 215-222.

Lee, R.H., Gajewski, B.J., Thompson, S. (2006). Reliability of the nursing home survey process: A simultaneous survey approach. *The Gerontologist, 46*(6), 772-780.

Liptzin, B. (1992). Nursing Home Care. In J.E. Birren, R. Sloane, R. Bruce, G.D. Cohen, N.R. Hooyman, B.D. Lebowitz, & et al. (Eds). *Handbook of mental health and aging, 2nd edition,* (pp. 603-890). San Diego, CA, US: Academic Press.

Logsdon, R.G. (2000). Enhancing quality of life in long-term care. In Molinari, V. (Ed), *Professional psychology in long-term care: A comprehensive guide* (pp. 133-159). New York: Hatherleigh Press.

McCall, G.J., & Simmons, J.L. (1978). The role-identity model. In *Identities and interactions: An examination of human associations in everyday life*, (pp. 1-288). New York: The Free Press.

Meeks, S., Jones, M.W., Tikhtman, V., & LaTourette, T. (2000). Mental health service in Kentucky nursing homes. *Journal of Clinical Geropsychology, 6*, 223-232.

Mor, V., Zinn, J., Angelelli, J., Teno, J.M., & Miller, S.C. (2004). Driven to tiers: Socioeconomic and racial disparities in the quality of nursing home care. *The Milbank Quarterly, 82*(2), 227-256.

Mukamel, D.B. (1997). Risk-adjusted outcome measures and quality of care in nursing homes. *Medical Care, 35*(4), 367-385.

Mukamel, D. B., & Spector, W. D. (2003). Quality report cards and nursing home quality. *The Gerontologist, 43*(Special Issue 2), 58–66.

National Association of Social Workers. (2003). *Standards for social work services in long-term care.* Washington, D.C.: Author.

O'Neill, J. (2002). Inappropriate tasks, lax enforcement, high turnover: Nursing home social work in doldrums. *NASW News,* (April). Washington D.C.: National Association of Social Workers.

O'Neill, J., & Rosen, A.L. (1998). *Professional social work services in skilled nursing facilities: Survey of current practice and recommendations.* Washington, DC: National Associational of Social workers.

Parker-Oliver, D., &, Kurzejeski, L.S. (2003). Nursing home social services: Policy and practice. *Social Work, 42*(2), 37-50.

Price, J. L. (2004). The development of a causal model of voluntary turnover. In R. Griffeth, & P. Hom (Eds.), *Innovative theory and empirical research on employee turnover* (pp. 3-32). Greenwich, CT: Information Age Publishing.

Rosen A.L., & Zlotnik, J.L. (2001). Demographics and reality: The "disconnect" in social work education. *Journal of Gerontological Social Work, 36*(3/4), 81-97.

Santo-Novak, D.A., Duncan, J.W., Grissom, K.R., & Powers, R.E. (2001). MSHAKE: A tool for measuring staff knowledge related to geriatric mental health. *Journal of Gerontological Nursing, 27*(2), 29-35.

Shea, D.G., Russo, P.A., Smyer, M.A. (2000). Use of mental health services by persons with mental illness in nursing facilities: Initial impacts of OBRA 87. *Journal of Aging and Health, 12*, 560-578.

Shoemaker, P.F., Eichholz, M., & Skewes, E.A. (2002). Item nonresponse: Distinguishing between don't know and refuse. *International Journal of Public Opinion Research, 14*(2): 193-201.

Siebert, D.C., & Siebert, C.F. (2005). The Caregiver Role Identity Scale: A validation study. *Research on Social Work Practice, 15*(3), 204-212.

Simons, K.V. (2006). Organization characteristics influencing nursing home social services directors' qualifications: A national study. *Health and Social Work, 31*(4), 266-274.

Smyer, M.A., Shea, D.G., & Streit, A. (1994). The provision and use of mental health services in nursing homes: Results from the National Medical Expenditure Survey. *American Journal of Public Health. 84*(2), 284-287.

Snowden, M., Piacitelli, J., Koepsell, T. (1998). Compliance with PASRR: Recommendations for Medicaid recipients in nursing homes. *Journal of the American Geriatrics Society, 46*, 1132-1136.

Spector, W.D., & Takada, H.A. (1991). Characteristics of nursing homes that affect resident outcomes. *Journal of Aging and Health, 3*, 427-454.

Spore, D., Smyer, M., & Cohn, M. (1991). Assessing nursing assistants' knowledge of behavioral approaches to mental health problems. *The Gerontologist, 31*(3), 309-317.

Stevens, J. (2002). *Applied multivariate statistics for the social sciences, 4th edition.* Mahway, NJ : Lawrence Erlbaum Associates.

Stone, R.I. (2001). Research on frontline workers in long-term care. *Generations, 25*(1), 49-57.

Stone, R. I., Reinhard, S.C., Bowers, B., Zimmerman, D. Phillips, C.D., Hawes, C., et al. (2002). *Evaluation of the Wellspring Model for improving nursing home quality.* New York: The Commonwealth Fund.

Stone, R.I., & Wiener, J.M. (2001). Who will care for us?: Addressing the long-term care workforce crisis. Retrieved 03/07/03 from http://aspe.hhs.gov/daltcp/reports/ltcwr.htm.

Tabachnick, B. G., & Fidell, L. S. (1989). *Using multivariate statistics, 2nd edition.* New York: Harper Collins Publishers.

Thoesen-Coleman, M., Looney, S., O'Brien, J., Ziegler, C., Pastorino, C.A., & Turner, C. (2002). The Eden Alternative: Findings after one year of implementation. *The Journals of Gerontology, 57A*(7), 422-427.

Tirrito, T. (1996). Mental health problems and behavioral disruptions in nursing homes: Are social workers prepared to provide needed services? *Journal of Gerontological Social Work, 27*(1/2), 73-86.

Tsoukalas, T., Rudder, C., Mollot, R.J., Shneman, M., Lee, H.Y., & Harrington, C. (2006). The collection and use of funds form civil money penalties and fines from nursing homes. *The Gerontologist, 46*(6), 759-771.

Vourlekis, B.S., Bakke-Friedland, K., & Zlotnik, J.L. (1995). Clinical indicators to assess the quality of social work services in nursing homes. *Social Work in Health Care, 22*(1), 81-93.

Vourlekis, B.S., Gelfand, D.E., & Greene, R.R. (1992a). Psychosocial needs and care in nursing homes: Comparison of views of social workers and home administrators. *The Gerontologist, 32*(1), 113-119.

Vourlekis, B.S., Greene, R.R., Gelfand, D.E., & Zlotnik, J.L. (1992b). Searching for the doable in nursing home social work practice. *Social Work in Health Care, 17*(3), 45-70.

Vourlekis, B., Zlotnik, J.L., Simons, K. (2005). *Evaluating social work services in nursing homes: Toward quality psychosocial care and its measurement. A report to the profession and blueprint for action.* Washington D.C.: Institute for the Advancement of Social Work Research.

Weiner, J.M. (2003). As assessment of strategies for improving quality of care in nursing homes. *The Gerontologist, 42*(Special Issue 1), 19-27.

Yaffee, R. (2003). *Common correlation and reliability analysis with SPSS for Windows.* Accessed 06/15/07 from http://www.nyu.edu/its/statistics/Docs/correlate.html.

Yeatts, D.E., & Cready, C.M. (2007). Consequences of empowered CNA teams in nursing home settings: A longitudinal assessment. *The Gerontologist, 47*(3), 323-339.

Zlotnik, J.L. (2005). Foreword. In B. Vourlekis, J.L. Zlotnik, & K. Simons. *Evaluating social work services in nursing homes: Toward quality psychosocial care and its measurement. A report to the profession and blueprint for action, p.ii.* Washington D.C.: Institute for the Advancement of Social Work Research.

APPENDIX A: FINAL SURVEY INSTRUMENT

Psychosocial Care in Skilled Nursing Facilities: A Survey of Social Services Directors in Washington State

A research project funded by the John A. Hartford Foundation and the Doctoral Fellows Program

School of Social Work
University of Washington

THE JOHN A. HARTFORD FOUNDATION 1929

I would like to thank the following individuals for their thoughtful comments regarding the content and development of this questionnaire:

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The Hearthstone Retirement Community

Dr. Kelsey Simons, PhD
Wayne State University

Marty Richards, MSW, LICSW
University of Washington

As I walk down the halls of my facility
I do not focus on the aging frail bodies
The diminished mental capacities
And the despair that many see
I see a man that survived the death march in the Philippines
A woman that campaigned for the women's right to vote
A mother that raised 13 children
I see little bits of history
They are our living treasures
Each and every one
The need – they want – they cry out
And I care
That's why I choose to be
A [social worker] in a long-term care facility...Anonymous

SECTION A

IN THIS SECTION I WOULD LIKE TO FIND OUT WHAT PRIORITY YOUR FACILITY WOULD ASSIGN TO MEETING COMMON RESIDENT PSYCHOSOCIAL NEEDS.

Instructions: On a scale from 1 to 7, with 1 meaning "LOWEST PRIORITY" and 7 meaning "HIGHEST PRIORITY," please rate the following resident psychosocial needs in terms of their importance to your job responsibilities. Please circle the number that corresponds to your answer.

Please note that a low priority rating does not mean that a given need is unimportant in any absolute sense, but that it is less critical or urgent given the priorities of your overall job responsibilities within the facility.

COMMON PSYCHOSOCIAL NEEDS

		Lowest Priority						Highest Priority
1.	The need to adjust to the move into the facility.	1	2	3	4	5	6	7
2.	The need to process feelings of loss that occur while residing in the facility.	1	2	3	4	5	6	7
3.	The need to cope with fears and anxieties that occur while residing in the facility.	1	2	3	4	5	6	7
4.	The need to prepare for and cope with death.	1	2	3	4	5	6	7
5.	The need to receive interventions that address the underlying emotional distress contributing to "difficult behaviors" such as aggression.	1	2	3	4	5	6	7
6.	The need to locate and access financial resources at any point during facility stay (for example, to apply for Medicaid benefits).	1	2	3	4	5	6	7
7.	The need for activities and events in the facility that match individual capabilities and interests.	1	2	3	4	5	6	7

	Lowest Priority						Highest Priority
8. The need to acquire or replace needed personal belongings or other practical transactions.	1	2	3	4	5	6	7
9. The need for choice concerning important daily routines.	1	2	3	4	5	6	7
10. The need for recognition of and opportunity to express religious/spiritual identity.	1	2	3	4	5	6	7
11. The need for recognition of and opportunity to express ethnic/cultural identity.	1	2	3	4	5	6	7
12. The need for recognition of individual life history.	1	2	3	4	5	6	7
13. The need for ongoing relatedness and intimacy with family and loved ones.	1	2	3	4	5	6	7
14. The need for emotional support for family members and significant others related to reactions to the resident's placement or condition.	1	2	3	4	5	6	7
15. The need for family collaboration in care planning and decision-making.	1	2	3	4	5	6	7
16. The need for access to mental health services to address conditions such as depression, psychosis, or schizophrenia.	1	2	3	4	5	6	7
17. The need for independence in functioning and the opportunity to do for oneself whenever possible, whatever the level of functioning.	1	2	3	4	5	6	7
18. The need for social and group interaction opportunities both inside and outside of the facility.	1	2	3	4	5	6	7
19. The need to maintain contact with friends, associates and community ties outside the facility.	1	2	3	4	5	6	7
20. The need to contribute to the life and functioning of the nursing home community.	1	2	3	4	5	6	7
21. The need for in-depth orientation to the facility, its staff, policies and procedures.	1	2	3	4	5	6	7

	Lowest Priority						**Highest Priority**
22. The need to provide input into facility survey/certification and accreditation process.	1	2	3	4	5	6	7
23. The need to provide feedback to facility personnel on level of satisfaction with facility care and services.	1	2	3	4	5	6	7
24. The need for discussion with the family and facility personnel concerning care management (such as during a care conference).	1	2	3	4	5	6	7
25. The need for assurance that appropriate care and services will be in place at points of transition whether into, within, or out of the facility (for example, room changes or discharges from the facility).	1	2	3	4	5	6	7
26. The need for assurance that care and resources that are supposed to be provided or available within the facility, in fact, are.	1	2	3	4	5	6	7

SECTION B

IN THIS SECTION I WOULD LIKE TO FIND OUT HOW OFTEN YOU PROVIDE VARIOUS PSYCHOSOCIAL SERVICES THAT MAY BE APPROPRIATE IN SKILLED NURSING FACILITIES.

Instructions: On a scale from 1 to 7, with 1 meaning "DAILY" and 7 meaning "RARELY OR NEVER," please rate the following psychosocial services by the frequency, on average, in which you provide them or oversee their provision. Please circle the number that corresponds to your answer.

COMMON PSYCHOSOCIAL SERVICES

		Daily	Several times a week	Weekly	Several times a month	Monthly	Quarterly	Rarely or Never
1.	Review the appropriateness of admissions applications and provide information and referral as needed.	1	2	3	4	5	6	7
2.	Perform comprehensive psychosocial assessments utilizing the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPS).	1	2	3	4	5	6	7
3.	Perform comprehensive psychosocial assessments utilizing assessment tools beyond the MDS and RAPS (For example the *Geriatric Depression Scale*).	1	2	3	4	5	6	7
4.	Help residents and their families cope with feelings of grief and loss.	1	2	3	4	5	6	7
5.	Orient residents and families to the facility, its services, its service limitations, and residents' rights.	1	2	3	4	5	6	7

		Daily	Several times a week	Weekly	Several times a month	Monthly	Quarterly	Rarely or Never
6.	Assist residents and families to access financial resources (for example, apply for Medicaid benefits).	1	2	3	4	5	6	7
7.	Involve residents and families in care planning, including their attendance at care conferences if desired.	1	2	3	4	5	6	7
8.	Collaborate with multidisciplinary staff to develop and/ or implement residents' care plans.	1	2	3	4	5	6	7
9.	Enhance residents' social functioning using psychosocial treatment interventions, such as group, brief individual, or family counseling.	1	2	3	4	5	6	7
10.	Develop individualized care plans to guide the provision of psychosocial services	1	2	3	4	5	6	7
11.	Assist residents to adapt to living in the facility.	1	2	3	4	5	6	7
12.	Mediate issues that arise between and among residents, family and staff.	1	2	3	4	5	6	7
13.	Intervene to reduce emotional distress of residents and families.	1	2	3	4	5	6	7
14.	Provide linkage to community resources by maintaining knowledge of other systems, making referrals and contacts, and identifying unmet needs.	1	2	3	4	5	6	7

	Daily	Several times a week	Weekly	Several times a month	Monthly	Quarterly	Rarely or Never
15. Empower residents and enable maximum choice in matters affecting them (for example, provide information about durable power of attorney for health care).	1	2	3	4	5	6	7
16. Provide crisis intervention.	1	2	3	4	5	6	7
17. Help residents, families, and staff prepare for and cope with death.	1	2	3	4	5	6	7
18. Arrange mental health services.	1	2	3	4	5	6	7
19. Arrange hospice services or services associated with comfort care or end-of-life care.	1	2	3	4	5	6	7
20. Assess underlying factors contributing to resident mood or behavioral symptoms	1	2	3	4	5	6	7
21. Change facility policy and practice to promote residents' individual choices and lifestyles.	1	2	3	4	5	6	7
22. Train and consult other staff or volunteers regarding psychosocial needs of individual residents and the resident group as a whole.	1	2	3	4	5	6	7
23. Advocate on an individual resident level.	1	2	3	4	5	6	7
24. Advocate on a policy and/or program level.	1	2	3	4	5	6	7
25. Participate in policy decision making which affects resident care and family involvement.	1	2	3	4	5	6	7

	Daily	Several times a week	Weekly	Several times a month	Monthly	Quarterly	Rarely or Never
26. Plan and arrange discharges to assure continuity of care following transfers out of the facility.	1	2	3	4	5	6	7
27. Make arrangements for obtaining adaptive equipment, clothing, and personal items.	1	2	3	4	5	6	7

28. In terms of psychosocial services that you may provide directly to residents, such as reducing emotional distress or enhancing social functioning, what is the most common way that you determine which residents require those services?

- ❑ Chart review
- ❑ Resident request
- ❑ Referral from other staff members
- ❑ Referral from family
- ❑ Observation and interaction with residents
- ❑ Facility policy and procedures
- ❑ Other, _____ Please specify

SECTION C

IN THIS SECTION I WOULD LIKE TO LEARN YOUR PERCEPTIONS REGARDING COMMON MENTAL HEALTH BELIEFS ASSOCIATED WITH PERSONS LIVING IN SKILLED NURSING FACILITIES.

Instructions: Check TRUE, FALSE or NOT SURE based on your perception of whether the statement is correct or not.

1.	Sudden weight loss is expected with elders.	_____ TRUE	_____ FALSE	_____ NOT SURE
2.	Most elders live independently in non-institutionalized settings.	_____ TRUE	_____ FALSE	_____ NOT SURE
3.	Delirium is typically a permanent condition with elders.	_____ TRUE	_____ FALSE	_____ NOT SURE
4.	In early dementia recent memory is usually lost while remote long-term memory is often spared.	_____ TRUE	_____ FALSE	_____ NOT SURE
5.	Persons with early-stage dementia often think "someone is out to get them."	_____ TRUE	_____ FALSE	_____ NOT SURE
6.	Mental illness is a normal part of aging.	_____ TRUE	_____ FALSE	_____ NOT SURE
7.	Most elders assess their health as good while managing at least one chronic disease condition.	_____ TRUE	_____ FALSE	_____ NOT SURE
8.	Persons of color are the most rapidly increasing segment of the elderly population.	_____ TRUE	_____ FALSE	_____ NOT SURE
9.	Elders who have fallen within the past year are at high risk for death due to injury.	_____ TRUE	_____ FALSE	_____ NOT SURE
10.	Speaking in a sharp, loud voice improves communication with most confused elders.	_____ TRUE	_____ FALSE	_____ NOT SURE
11.	A person with Alzheimer's disease can see and hear, but cannot recognize and understand.	_____ TRUE	_____ FALSE	_____ NOT SURE
12.	Persons with dementia frequently resist personal care activities.	_____ TRUE	_____ FALSE	_____ NOT SURE

13. Delirium usually has an abrupt onset. _____ TRUE _____ FALSE _____ NOT SURE

14. Thyroid problems are a medical cause of depression. _____ TRUE _____ FALSE _____ NOT SURE

15. Reorienting an agitated dementia patient is helpful. _____ TRUE _____ FALSE _____ NOT SURE

16. Older people normally become mean and stubborn. _____ TRUE _____ FALSE _____ NOT SURE

17. Alzheimer's disease usually has an abrupt onset. _____ TRUE _____ FALSE _____ NOT SURE

18. Restraining a person who tends to wander helps prevent injury or harm. _____ TRUE _____ FALSE _____ NOT SURE

19. Persons with advanced dementia are prone to choking and aspiration. _____ TRUE _____ FALSE _____ NOT SURE

20. A person who is wandering may be seeking the bathroom. _____ TRUE _____ FALSE _____ NOT SURE

21. Older persons are commonly less sensitive to medications. _____ TRUE _____ FALSE _____ NOT SURE

22. Elderly persons with mental disorders such as schizophrenia rarely develop dementia. _____ TRUE _____ FALSE _____ NOT SURE

23. Health problems can worsen the symptoms of mental illness. _____ TRUE _____ FALSE _____ NOT SURE

24. Some persons with dementia become more confused in the evening. _____ TRUE _____ FALSE _____ NOT SURE

25. Elders almost never commit suicide. _____ TRUE _____ FALSE _____ NOT SURE

CONGRATULATIONS! YOU HAVE ALMOST COMPLETED THIS QUESTIONNAIRE...

SECTION D

IN THIS SECTION I WOULD LIKE TO LEARN ABOUT YOUR WORK ENVIRONMENT AND THE PEOPLE THAT YOU WORK WITH.

REGARDING YOUR WORK ENVIRONMENT…

Instructions: Please indicate your level of agreement with the following statements regarding your work environment; circle the number that corresponds to your answer.

		Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1.	I have a great deal of flexibility in carrying out my job tasks.	1	2	3	4	5	6
2.	To a great extent, my job allows me to do the tasks I feel are important.	1	2	3	4	5	6
3.	I have a great deal of autonomy in my job.	1	2	3	4	5	6
4.	My job responsibilities are very clear to me.	1	2	3	4	5	6
5.	I have a great deal of influence in determining the procedures for my department.	1	2	3	4	5	6
6.	I have enough time to get everything done on my job.	1	2	3	4	5	6
7.	I have little say in how this facility operates.	1	2	3	4	5	6
8.	My suggestions for improving this facility are likely to be overlooked.	1	2	3	4	5	6
9.	I often find myself in situations where state and/or federal regulations (including resident rights) are in conflict.	1	2	3	4	5	6

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
10. When I find myself in situations where state and/or federal regulations or resident rights are in conflict, I receive support from others in my facility to guide my decision-making.	1	2	3	4	5	6

REGARDING YOUR SUPERVISOR...

Instructions: Please indicate your level of agreement with the following statements regarding your immediate supervisor. Please circle the number corresponding to your answer.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
11. My supervisor exercises good judgment.	1	2	3	4	5	6
12. My supervisor provides effective direction.	1	2	3	4	5	6
13. My supervisor motivates/inspires me.	1	2	3	4	5	6
14. My supervisor understands my workload demands.	1	2	3	4	5	6
15. My supervisor helps me with work-related problems.	1	2	3	4	5	6
16. My supervisor and I have the same ideas about how my job should be done.	1	2	3	4	5	6

17. My immediate supervisor is:
    - ❑ The facility administrator
    - ❑ The director of nursing
    - ❑ Other _____ Please specify

REGARDING YOUR CO-WORKERS...

Instructions: Please indicate your level of agreement with the following statements regarding your co-workers in the social services department and in other departments within the facility. Please circle the number corresponding to your answer.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
18. My co-workers care about me as a person.	1	2	3	4	5	6
19. My co-workers back me up if things go wrong.	1	2	3	4	5	6
20. My co-workers provide emotional support.	1	2	3	4	5	6
21. My co-workers take my needs into consideration.	1	2	3	4	5	6
22. My co-workers provide constructive feedback.	1	2	3	4	5	6
23. My co-workers create a climate of trust.	1	2	3	4	5	6
24. My co-workers and I have the same ideas about how my job should be done.	1	2	3	4	5	6
25. I often get conflicting requests from different co-workers.	1	2	3	4	5	6

REGARDING YOUR INTERDISCIPLINARY TEAM...

Instructions: Please indicate your level of agreement with the following statements regarding your work with members of the interdisciplinary team. "Successfully" means that you are able to work in a manner than an experienced supervisor would consider excellent. Please circle the number corresponding to your answer.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
26. I can work successfully with my supervisor.	1	2	3	4	5	6
27. I can work successfully with other department heads.	1	2	3	4	5	6
28. I can work successfully with licensed nursing staff.	1	2	3	4	5	6
29. I can work successfully with nursing assistants.	1	2	3	4	5	6

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
30. I can work successfully with mental health professionals providing services in my facility. ☐ *Check here if not applicable*	1	2	3	4	5	6
31. I can successfully manage the feelings that I have when team members blame me for things going wrong.	1	2	3	4	5	6
32. I can successfully manage the feelings that I have when residents and/or family blame me for things going wrong.	1	2	3	4	5	6

REGARDING YOUR OWN CHARACTERISTICS…

Instructions: Please indicate your level of agreement with the following statements regarding your personal characteristics. Please circle the number corresponding to your answer.

	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
33. I characterize myself as a rescuer.	1	2	3	4	5	6
34. It is difficult for me to tell friends or family that I cannot help.	1	2	3	4	5	6
35. I find it easier to care for others than myself.	1	2	3	4	5	6
36. It is my responsibility to be helpful to family and friends.	1	2	3	4	5	6
37. Friends frequently turn to me when they have problems.	1	2	3	4	5	6
38. Colleagues generally turn to me when they have problems.	1	2	3	4	5	6
39. I have heard from others that I am a natural helper or caregiver.	1	2	3	4	5	6

40. I regularly help my own family members with problems.	1	2	3	4	5	6

SECTION E

IN CONCLUSION, I WOULD LIKE TO FIND OUT SOME DEMOGRAPHIC INFORMATION ABOUT YOU AND YOUR WORK.

1. How long have you worked at your facility? _____ Years _____ Months

2. How long have you been in your current position? _____ Years _____ Months

3. On average, how many hours do you work per week? _____

4. How old are you? _____ Years

5. What is your gender? ☐ Female ☐ Male

6. What is your race/ethnicity?

   - ☐ Black/African American
   - ☐ Asian/Pacific Islander
   - ☐ Native American/Alaska Native
   - ☐ Latino/a
   - ☐ Caucasian
   - ☐ Other ethnicity _____ Please specify
   - ☐ I prefer not to answer this question

7. How many years of skilled nursing facility experience, in any position, do you have?

   _____ Years _____ Months

8. How many years of skilled nursing facility experience has been in Social Services?

   _____ Years _____ Months

9. What other positions have your filled in the nursing home?

   - ☐ Nursing
   - ☐ Clerical/support
   - ☐ Housekeeping/maintenance
   - ☐ Activities
   - ☐ Admissions/marketing
   - ☐ Social Service Designee
   - ☐ Other _____ Please specify

10. What level of education have you completed?

- ❑ GED
- ❑ High School diploma
- ❑ Some college or associate degree
- ❑ Bachelor's degree
  What area is it in? _____
- ❑ Master's degree
  What area is it in? _____

11. How many other social workers/social service personnel work in your facility? _____

12. What is your annual income before taxes?

- ❑ $10,000 or less
- ❑ $10,001 - $20,000
- ❑ $20,001 - $30,000
- ❑ $30,001 - $40,000
- ❑ $40,001 - $50,000
- ❑ $50,001 or more
- ❑ I prefer not to answer this question

13. Do you have any comments you would like to add related to your work in social services that apply to the content of this questionnaire? _____
_____
_____
_____
_____
_____
_____
_____

YOU HAVE NOW COMPLETED THIS QUESTIONNAIRE.
THANK YOU VERY MUCH FOR YOUR VALUABLE TIME AND INPUT!

Please return the completed questionnaire in the self-addressed stamped envelope provided to the following address:

Pudnik Software
20611 Bothell-Everett Hwy #E253
Bothell, WA 98012

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Facility vendor number _____

This page to be removed and destroyed following data entry

APPENDIX B: INFORMED CONSENT DOCUMENTATION

01/23/2006
«FacilityName»
«Address1»
«City»«State» «PostalCode»

Dear «Administrator»,

I am writing to let you know that in a few weeks I would like to send your facility's Social Services Director a packet of information regarding a dissertation research study I am initiating at the University of Washington School of Social Work. I obtained the name and address of your facility from the *Directory of Licensed Nursing Facilities* available on the Department of Social and Human Services' website*. The purpose of the study is to examine relationships among factors that influence the provision of psychosocial services in Washington State skilled nursing facilities and how those factors relate to state survey outcomes. **I would like to ask your permission to include your facility in this important research study.** Additional information is provided below that will help you decide whether you would like your facility to participate.

As you are already aware, persons living in skilled nursing facilities have extensive psychosocial needs such as depression, anxiety, sad mood, and/or behavioral symptoms, yet facility social workers often have tremendous workloads and may have difficulty providing or arranging psychosocial services for all residents who need them. I am hoping that the results of this study will ultimately help identify methods to enhance social workers' ability to meet residents' psychosocial needs. In addition, I am anticipating that it will suggest methods that will enable facilities to minimize their risk for survey deficiencies in psychosocial care.

STUDY PROCEDURES: Participation in this research study is voluntary and confidential. It involves the Social Services Director (SSD) completing a written questionnaire that is estimated to take 60 minutes. Questions focus on psychosocial services in the facility as well as the SSD's work environment, job characteristics, and occupational/educational background. Some of the questions are personally sensitive in nature and because of this, I would like the SSD to complete the questionnaire in a location other than her/his work setting. Here are two examples of sensitive questions that the survey contains:

41. My co-workers provide constructive feedback.
42. My co-workers create a climate of trust.

To facilitate analysis, completed questionnaires will be linked via facility vendor numbers to the corresponding facility record in my copy of the Online Survey Certification and Reporting (OSCAR) database. After this linkage is made, to maintain the confidentiality of SSDs and facilities, all vendor numbers will be deleted, thereby destroying all information linking individual facilities to their questionnaires. SSDs' individual responses will not be shared with anyone.

After reviewing the above information, I hope that you will support the inclusion of your facility in my study. However, **if you decide that you would prefer that your facility not be included, please let me know by checking the box below and returning this letter to me in the addressed envelope provided by February 01, 2006.** If you have any questions or concerns about this study, you are welcome to call me at 425-269-5237 or email me at rpb3@u.washington.edu. Please note that I cannot ensure the confidentiality of information sent via e-mail.

Thank you very much,

☐ Please do not include the above facility in this research study.

Robin Bonifas, MSW, LICSW, PhD(c)
John A. Hartford Doctoral Fellow in Geriatric Social Work

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* www1.dshs.wa.gov/geninfo/nh.html

UNIVERSITY OF WASHINGTON
SCHOOL OF SOCIAL WORK
4101 15TH AVENUE NE
SEATTLE, WA 98105-6299

[*name and address of facility*]
[*current date*]
Dear Social Services Director,

As you may recall from my recent introductory letter, I am writing to invite your participation in a dissertation research study I am conducting through the University of Washington School of Social Work. The purpose of the study is to examine relationships among important factors that influence the provision of psychosocial services in Washington State skilled nursing facilities and how those factors relate to state survey outcomes.

You are likely well aware that persons living in skilled nursing facilities have extensive psychosocial needs such as depression, anxiety, sad mood, and/or behavioral symptoms, yet facility social workers often have tremendous workloads and may have difficulty assuring that all residents' psychosocial needs are met. The results of this study may ultimately help identify points of intervention that will enhance social workers' ability to meet residents' psychosocial needs. In addition, results may suggest system changes that will enable facilities to minimize their risk for survey deficiencies in psychosocial care.

Further details regarding this study and associated procedures are presented in the attached information sheet. After reviewing the information sheet, if you would like to participate in this important research, please complete and return the questionnaire in the enclosed, postage-paid envelope. It will take about 60 minutes to complete. Given the sensitive nature of some of the questions, I would like you to complete the questionnaire outside of your work environment. Three additional reminders will be sent over the next two months to those who may have forgotten to send completed questionnaires. If participation in this study is not of interest to you and you desire no further contact from me, please let me know by returning the blank questionnaire.

If you have any questions or concerns about this study, you are welcome to call me at 425-269-5237 or e-mail me at rpb3@u.washington.edu. Please note that I cannot ensure the confidentiality of information sent via e-mail.

Thank you very much for your assistance!

Sincerely,

Robin Bonifas, MSW, LICSW
Doctoral Candidate

UNIVERSITY OF WASHINGTON
INFORMATION FORM

Factors Associated with Psychosocial Care in Washington State Skilled Nursing Facilities

Investigator: Robin P. Bonifas, MSW, LICSW, doctoral candidate
School of Social Work
Telephone: 425-269-5237
E-mail: rpb3@u.washington.edu*

Investigator's statement

I am asking you to participate in a research study. The purpose of this information form is to give you the information you will need to help you decide whether or not you would like to be in the study. Please read the form carefully. I encourage you to ask me questions about the purpose of the research, what I would ask you to do, the possible risks and benefits of participation, your rights as a volunteer, and anything else about the research or this form that is not clear. When all your questions have been answered, you can decide if you want to be in the study or not. This process is called 'informed consent.'

PURPOSE OF THE STUDY

This study is a research activity. I am interested in learning about factors that either enable or detract from skilled nursing facility social workers' ability to deliver effective psychosocial services and how those factors influence state survey outcomes. I am asking Social Service Directors in all Washington State free-standing facilities receiving Medicare and/or Medicaid funding to complete a questionnaire about psychosocial care in their facility, their work environment, job characteristics, and their occupational and educational background.

PROCEDURES

If you choose to be in this study, I would like you to fill out the enclosed questionnaire in a location other than your work environment. The questionnaire is estimated take about 45 minutes to complete and asks about the following things:

- The importance of specific psychosocial needs to your job responsibilities
- The types of psychosocial services you provide or oversee
- Your perceptions regarding common beliefs about older adults
- Your feelings about your work environment and the support provided by the people that you work with
- Your characteristics as a professional helper
- Your education and work experience

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* *Please note that I cannot ensure the confidentiality of information sent via e-mail.*

You do not have to answer every question and you may refuse to answer any questions that you do not want to answer.

After receiving your completed questionnaire, your responses will be linked to your facility's record in my copy of the Online Survey Certification and Reporting (OSCAR) database. This linkage will enable me to analyze how factors such as the size of your caseload and the level of support you receive from your supervisor and coworkers influence subsequent survey deficiencies, if any. OSCAR is a computerized database of state survey inspection results, facility staffing information, and facility characteristics. My copy of OSCAR includes data on Washington State facilities' resident census, case mix, and deficiencies cited during each survey period from 2002-2004. It reports whether a deficiency is issued for each survey item and the scope and severity of each deficiency, as well as the total number of deficiencies for each facility.

RISK, STRESS, OR DISCOMFORT

You may find some of the questions on the questionnaire to be personal or sensitive in nature. These items ask specifically about your work environment and the people with whom you work; you might feel anxious that your supervisor or coworkers might inadvertently see your responses. For this reason, **I would like you to complete the questionnaire in a location other than your facility** and I would suggest completing it at home. Examples of potentially sensitive questions include the following:

1. My supervisor understands my workload demands.

Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

2. My co-workers create a climate of trust.

Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

Again, you do not have to answer every question and you may refuse to answer any question that makes you feel uncomfortable.

BENEFITS OF THE STUDY

As you know, persons living in skilled nursing facilities have extensive psychosocial needs such as depression, anxiety, sad mood, and/or behavioral symptoms, yet facility social workers often have tremendous workloads and may have difficulty assuring all

residents' psychosocial needs are met. Study results may ultimately help identify points of intervention that will enhance social workers' ability to meet residents' psychosocial needs. In addition, results may suggest methods by which facilities can minimize their risk for survey deficiencies in psychosocial care. You may not directly benefit from taking part in this study.

OTHER INFORMATION

Although I hope that you will participate in this study, it is entirely voluntary. Your answers to all questions will be kept confidential and will be used only for statistical purposes. Only my assistant and I will have access to the questionnaire; my assistant will have access only during the data entry phase of the research. The questionnaire does not collect either your name or the name of your facility. It does include your facility vendor number so that my assistant can link your questionnaire with corresponding facility data in my copy of the OSCAR database. After this linkage is made, your facility vendor number will be deleted from the database and removed from the questionnaire so that no one, including me, will be able to identify which questionnaire came from which facility. Your answers will not be shared with anyone at your facility, the state survey agency, or others at the University of Washington.

Study results will be obtained by analyzing questionnaires and OSCAR data for Washington State as a whole. These results will be reported in my dissertation and in any subsequent publications and/or conference presentations, but again will focus on all of Washington State. In other words, individual responses associated with your questionnaire or your facility will neither be analyzed nor reported. If the results of this study are published or presented, I will not use your name or the name of your facility.

I would be happy to answer any questions you might have about this study now or in the future. Please feel free to call me at 425-269-5237 or e-mail me at rpb3@u.washington.edu.*

Information about the rights of individuals participating in research is available through the University of Washington Human Subjects Division (206) 543-0098.

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* *Please note that I cannot ensure the confidentiality of information sent via e-mail.*

A couple of weeks ago a questionnaire was mailed to you seeking information about your experiences with providing psychosocial care at your facility. This activity is a component of a University of Washington research study. The purpose of the study is to examine relationships among important factors influencing the provision of psychosocial services in Washington State skilled nursing facilities and how those factors relate to state survey outcomes.

If you have already completed and returned the questionnaire to me, please accept my sincere thanks. Your time and effort is most appreciated! If you have not yet completed and returned the questionnaire, this is a request to do so when you get home today; it will take approximately 45 minutes to complete. I am especially grateful for your help because it is only by asking people like you to share your experiences that I can understand the factors that support and hinder social workers from delivering effective psychosocial services to the skilled nursing facility residents who need them.

STUDY PROCEDURES: As you may recall from the earlier mailing, participation in this research study is voluntary and confidential. To facilitate analysis, your completed questionnaire will be linked via its vendor number to its corresponding record in my copy of the Washington State's Online Survey Certification and Reporting (OSCAR) database, creating one file of questionnaire responses and corresponding state survey data. At that point, to maintain your confidentiality and that of your facility, all vendor numbers will be deleted, thereby destroying all information linking your facility to your questionnaire. Your individual questionnaire responses will not be shared with anyone.

Since social workers in skilled nursing facilities are extremely busy people, I will be sending two additional reminders regarding participation in this important research study. If you do not wish to participate in the study and would like to opt out of re-contact, simply return your blank questionnaire in the stamped envelope provided in the initial packet.

If you do not receive a questionnaire, or if it was misplaced, or your if have questions about this research study either now or in the future, please feel free to call me at 425-269-5237. You may also email me at rpb3@u.washington.edu. Please be advised that I cannot guarantee the confidentiality of information set via e-mail.

Robin Bonifas, MSW, LICSW, Doctoral Candidate

[*name and address of facility*]
[*current date*]
Dear Social Services Director,

A few weeks ago, as a component of a research study at the University of Washington School of Social Work, I sent a questionnaire to you that asked about your experiences related to the provision of psychosocial services at your facility. To the best of my knowledge, it has not yet been returned and I just wanted to remind you of the opportunity to complete it at your earliest convenience. It will take about 45 minutes to complete.

The responses of other Social Services Directors who have already replied reflect a wide variety of priorities regarding residents' psychosocial needs.

I am writing again because of the importance that your questionnaire has for helping to get accurate results. Although I have sent questionnaires to every facility in the state, it's only by hearing from nearly everyone in the sample that I can be sure that the results are truly representative.

A comment on my survey procedures: Participation in this research study is voluntary and confidential. Your facility's vendor number appears on the questionnaire to enable linkage to its corresponding record in my copy of the Washington State's Online Survey Certification and Reporting (OSCAR) database. After this linkage is completed, all vendor numbers will be deleted to destroy the information linking your facility to your questionnaire. Protecting your confidentiality and that of your facility is very important to me, as well as to the University of Washington.

I hope that you will fill out and return the questionnaire soon, and I will be sending one more reminder letter before closing the study. If for any reason you prefer not to complete the questionnaire or desire no further contact from me, please let me know by returning the blank questionnaire in the enclosed stamped envelope.

If you have any questions, please feel free to contact me. The number where I can be reached is 425-269-5237. You may also e-mail me at rpb3@u.washington.edu. Please be advised that I cannot guarantee the confidentiality of information sent via e-mail.

Sincerely,

Robin Bonifas, MSW, LICSW, Doctoral Candidate

APPENDIX C: FULL DESCRIPTION OF SURVEY DEFICIENCY F-TAGS RELATED TO PSYCHOSOCIAL CARE[13]

[13] See the following reference for detailed description of federal regulations including specific definitions and interpretive guidelines: American Health Care Association (2006). *The Long Term Care Survey: June 2006 Edition.* Washington D.C.: Author.

F-tag 151: Exercise of Rights

1. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

F-tag 155: Advanced Directives

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.

F-tag 157: Notification of Changes

1. A facility must immediately inform the resident; consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is:
    a. An accident involving the resident which results in injury and has the potential for requiring physician intervention;
    b. A significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
    c. A need to alter treatment significantly (i.e. a need to discontinue an existing from of treatment due to adverse consequences, or to commence a new form of treatment); or
    d. A decision to transfer or discharge the resident from the facility.
2. The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when this is
    a. A change in room or roommate assignment; or
    b. A change in resident rights under Federal or State law or regulations.
3. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family members.

F-tag 166: Grievances

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

F-tag 201: Transfer and Discharge Requirements

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individual in the facility is endangered;
4. The heal of individuals in the facility would otherwise be endangered;
5. The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a say a the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or
6. The facility ceases to operate.

F-tag 203: Notice Before Transfer

Before a facility transfers or discharges a resident, the facility must

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
2. Record the reasons in the resident's clinical record; and
3. Include in the notice the items described in F-tag 203.

Timing of the notice

1. Except in situations when specified below, the notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged.
2. Notice may be made as soon as practicable before transfer or discharge when
    a. The safety of the individuals in the facility would be endangered;
    b. The health of individuals in the facility would be endangered;
    c. The resident's health improves sufficiently to allow a more immediate transfer or discharge;
    d. An immediate transfer or discharge is required by the resident's urgent medical needs; or
    e. A resident has not resided in the facility for 30 days.

Contents of the notice

3. The written notice specified above must include the following:
    a. The reason for transfer or discharge;
    b. The effective date of transfer of discharge;
    c. The location to which the resident is transferred or discharged;
    d. A statement that the resident has the right to appeal the action to the State;
    e. The name, address and telephone number of the State long term care ombudsman;
    f. For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of

developmental disabilities individuals established under Part C of the Developmental Disabilities assistance and Bill of Rights Act; and

g. For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

F-tag 221/222: Physical Restraints/Chemical Restraints

The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

F-tag 225: Hiring practices/abuse investigations

1. The facility must
    a. Not employ individuals who have been
        i. Found guilty of abusing, neglecting, or mistreating residents by a court of law, or
        ii. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
2. Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility state to the State nurse aide registry or licensing authorities.
3. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency).
4. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
5. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F-tag 241: Dignity

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

F-tag 242: Self-Determination and Participation

The resident has the right to

1. Choose activities, schedules, and health care consistent with his or her interests, assessment, and plans of care;
2. Interact with members of the community both inside and outside the facility; and
3. Make choices about aspects of his or her life in the facility that are significant to the resident.

F-tag 243: Participation in Resident and Family Groups

1. A resident has the right to organize and participate in resident groups in the facility;
2. A resident's family has the right to meet in the facility with the families of other residents in the facility;
3. The facility must provide a resident or family group, if one exists, with private space.
4. Staff or visitors may attend meetings at the group's invitation;
5. The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

F-tag 244: Participation in Resident and Family Groups -- Grievances

When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

F-tag 246: Accommodation of Needs

A resident has a right to resident and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

F-tag 247: Accommodation of needs – Room and Roommate Changes

A resident has a right to receive notice before the resident's room or roommate in the facility is changed.

F-tag 250: Social Services

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

F-tag 251: Qualified Social Worker

1. A facility with more than 120 beds must employ a qualified social worker on a full-time basis.
2. Qualifications of a social worker. A qualified social worker is an individual with

a. A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
b. One year of supervised social work experience in a health care setting working directly with individuals.

F-tag 252: Homelike Environment

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

F-tag 272: Resident Assessment/Comprehensive Assessment

1. The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.
2. Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:
    a. Identification and demographic information
    b. Customary routine
    c. Cognitive patterns
    d. Communication
    e. Vision
    f. Mood and behavior patterns
    g. Psychological well-being
    h. Physical functioning and structural problems.
    i. Continence
    j. Disease diagnosis and health conditions
    k. Dental and nutritional status
    l. Skin conditions
    m. Activity pursuits
    n. Medications
    o. Special treatments and procedures
    p. Discharge potential
    q. Documentation of summary information regarding the additional assessment preformed through the resident assessment protocols
    r. Documentation of participation in assessment.

F-tag 274: Resident Assessment: Significant Change

Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolved itself without further intervention by staff or by implementing standard disease-related clinical intervention, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both).

F-tag 276: Resident Assessment: Quarterly Review

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

F-tag 278: Resident Assessment: Accuracy

1. The assessment must accurately reflect the resident's status.
2. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
3. A registered nurse must sign and certify that the assessment is completed.
4. Each individual who completes a portion of the assessment must sing and certify the accuracy of the portion of the assessment.
5. Under Medicare and Medicaid, an individual who willfully and knowingly
    a. Certifies a material and false statement in a resident assessment in subject to a civil money penalty of not more than $1,000 for each assessment; or
    b. Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
6. Clinical disagreement does not constitute a material and false statement.

F-tag 279: Comprehensive Care Plans

1. A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.
2. The facility must develop a comprehensive care plan for each resident hat includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:
    a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.
    b. Any services that would otherwise be required, but are not provided due to the resident's exercise or rights, including the right to refuse treatment.

F-tag 285: Preadmission Screening

1. A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort.
2. Preadmission Screening for mentally ill individuals and individuals with mental retardation.
    a. A nursing facility must not admit, on or after January 1, 1989, any new residents with:
        i. Mental illness unless the State mental health authority has determined, based on an independent physical and metal

evaluation performed by a person or entity other than the State mental health authority, prior to admission;

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
2. If the individual requires such level of services, whether the individual requires specialized services for mental illness.

ii. Mental retardation, unless the State mental retardation or developmental disability authority has determined prior to admission

1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
2. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

F-tag 319/320: Mental and Psychosocial Functioning

Based on the comprehensive assessment of a resident, the facility must ensure that

1. A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem; and
2. A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdraw, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable.

F-tag 329: Unnecessary Drugs

1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
   a. In excessive dose (including duplicate therapy); or
   b. For excessive duration; or
   c. Without adequate monitoring; or
   d. Without adequate indications for its use; or
   e. In the presence of adverse consequences which indicate the dose should be reduces or discontinued; or
   f. Any combinations of the reasons above.

F-tag 330/331: Antipsychotic Drugs

Based on the comprehensive assessment of a resident, the facility must ensure that

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

2. Resident who use antipsychotic drugs receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Curriculum Vita
Robin P. Bonifas

EDUCATION

2001-present	**Doctoral Candidate**, School of Social Work, University of Washington; Degree expected August, 2007; Dissertation topic: *Factors Associated with Psychosocial-Related State Survey Deficiencies in Washington State Skilled Nursing Facilities*
2000	**Licensed Independent Clinical Social Worker**, Washington State
1992	**Master of Social Work**, University of Washington; Specialization: Health care and gerontology
1989	**Bachelor of Social Work**; **Bachelor of Arts, Psychology**, University of Washington

AREAS OF INTEREST

Social gerontology, long-term care, psychosocial care in skilled nursing facilities, social work education and leadership in gerontology, adjustment and resilience of older adults, elder abuse and neglect, formal and informal caregiver stress, job stress and burnout in the helping professions.

TEACHING EXPERIENCE

2004-present	**Teaching Associate,** UW School of Social Work; Courses taught: *Practicum Partnership Program Integrative Seminar (MSW), Social Work Practice in Long-Term Care Across the Lifespan (MSW), Introduction to Social Welfare Research (MSW), Social Welfare Research and Evaluation (MSW).*
2002-2004	**Teaching Assistant**, UW School of Social Work; Courses taught: *Caring for Persons with Life-Limiting Illness: A Life Span Approach (MSW), Social Welfare Practice (BSW).*
Winter 2003	**Teaching Practicum**, UW School of Social Work: *Generalist Meso Level Practice (MSW).*
Fall 2002	**Teaching Practicum**, UW School of Social Work: *Generalist Micro Level Practice (MSW)*
2001-present	**Instructor,** Resident Councils of Washington Continuing Education, Belfair, Washington; courses taught: *Basic Social Services Training Course, Beyond Basics Social Services Training Course, Activity Professionals Management Training: In-house Communication.*
2000-present	**Part-time Instructor**, Human Services Department, Highline Community College, Des Moines, Washington; courses taught: *Introduction to Human Services, Aging and Society, Introduction to Gerontology.*

RESEARCH EXPERIENCE

2007-present **Research Consultant**, Long Term Care Ombudsman Program Senior Medicare Patrol Grant: Develop telephone interview protocol for needs assessment related to advocacy among skilled nursing facility residents in Alaska; train and supervise telephone interviewers, data analysis and interpretation.

2006-present **Social Work Faculty Representative,** Interdisciplinary Outreach to the Underserved Senior Adult Population in King County, University of Washington School of Pharmacy: Develop and coordinate social work training component of multidisciplinary health training pilot program.

2005-present **Principal Investigator**, John A. Hartford Geriatric Social Work Doctoral Fellow. *Factors Associated with Psychosocial-Related State Survey Deficiencies in Washington State Skilled Nursing Facilities.*

2003-present **Research Assistant, Institute for Multigenerational Health, Development and Equality, UW School of Social Work:** Conduct literature reviews, facilitate quantitative data collection and analysis, website development; assist with research dissemination; coordinate educational events and faculty teamwork efforts within social work and across disciplines.

2002-2004 **Research Assistant, Gerontology Enrichment Project, UW School of Social Work:** Assisted with program development and evaluation for curriculum change project; conducted literature reviews, quantitative data collection and analysis, assisted with research dissemination; coordinated educational events and website development.

2001-2002 **Research Assistant, Curriculum Implementation Team, UW School of Social Work:** Assisted faculty team with MSW curricular change project integrating HBSE and diversity content into direct practice courses, assisted with syllabi review and development, identification and selection of diverse course readings.

PROFESSIONAL EXPERIENCE

2002-present **Clinical Supervisor, Private Practice:** Foster professional development and advancement of clinical practice skills for new social workers preparing for state licensure through individual and group modalities; focus on health care and gerontological practice.

2002-present **Social Services Consultant, Resident Councils of Washington, Belfair, Washington:** Evaluate psychosocial service delivery in Washington State skilled nursing facilities; provide guidance and expert recommendation to social workers and administrators to enhance regulatory compliance and the provision of quality of psychosocial care.

2001-2002 **Medical Social Worker, Geropsychiatry Unit, Auburn Regional Medical Center, Auburn, Washington:** Responsible for bi-monthly weekend social work coverage for hospital inpatient geropsychiatry unit.

Provided individual, group, and family counseling to older adults with acute mental health needs; also responsible for psychosocial assessment, treatment planning, crisis intervention, problem resolution, and discharge planning. Provided licensed supervision for MSWs preparing for state licensure.

1999-2002 **Director of Social Services, Regency at Renton Rehabilitation and Nursing Center, Renton, Washington:** Provided psychosocial services to resident and families of 119-bed skilled nursing facility via group and individual counseling, crisis intervention, resource identification, problem resolution, and discharge planning. Responsible for supervision, training, and evaluation of Social Service Assistants and MSW practicum students, training and orientation of new Social Services Directors for sister facilities; chair of Eden Alternative Steering Committee to implement facility cultural change to enhance quality of life for residents and staff.

1995-1999 **Director of Social Services/ Alzheimer's Unit Coordinator, Lemon Grove Nursing and Rehabilitation Center, Lemon Grove, California:** Responsible for social services delivery within 154-bed skilled nursing facility. Facilitated psychotropic/behavioral review team to minimize inappropriate usage of psychotropic medications. Screened admissions to and discharges from 24-bed secured Alzheimer's unit. Provided family, group, and individual counseling to facilitate adjustment to illness, loss, placement, and physical rehabilitation, with special attention to maximizing rehabilitation outcomes. Responsible for hiring, training, supervision, and evaluation of Social Services Assistants.

1990-1995 **Director of Social Services, Edmonds Rehabilitation and Healthcare Center, Edmonds, Washington:** Provided discharge planning for 98-bed skilled nursing facility, including 18-bed sub-acute rehabilitation unit. Responsible for assessment and care planning to address the psychosocial, emotional, and behavioral needs of facility residents; facilitated adjustment to illness, disability, and nursing home environment through family, group, and individual counseling.

PEER-REVIEWED PUBLICATIONS

Fredriksen-Goldsen, K.I., Bonifas, R.P., & Hooyman, N.R. (2006). Multigenerational practice: An innovative infusion approach. *Journal of Social Work Education, 42*(1), 25-36.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (2005). Multigenerational practice and curricular infusion. *Journal of Intergenerational Relationships, (3)*3, 83-99.

UNDER REVIEW

Bonifas, R.P., & Fredriksen-Goldsen, K.I. Recognizing the importance of aging skills and knowledge in social work practice: Effective strategies for MSW students. *Journal of Gerontological Social Work.*

OTHER PUBLICATIONS

Bonifas, R.P. (2003, September). 2003 NASW Washington Chapter Interest and Satisfaction Survey! Here is what we learned from you. *Currents: Newsletter of the Washington State Chapter of the National Association of Social Workers*, 19-20.

Bonifas, R.P. (2002, July). Older women as survivors of childhood sexual abuse. *Currents: Newsletter of the Washington State Chapter of the National Association of Social Workers*, 1,6.

Bonifas, R.P. (2002, July). Many factors contribute to abuse and neglect in skilled nursing facilities. *Currents: Newsletter of the Washington State Chapter of the National Association of Social Workers*, 11.

WORKS IN PROGRESS

Bonifas, R.P. The impact of didactic and experiential learning on students, attitudes towards long-term care and disability. To be submitted to the *Journal of Gerontology and Geriatrics Education.*

INVITED PRESENTATIONS

Bonifas, R.P. (April, 2007). *Psychosocial care in skilled nursing homes.* Paper presentation at the 31st Annual Oregon State University Gerontology Conference, Corvalis, Oregon.

PRESENTATIONS

Bonifas, R.P. (June, 2007). *Factors Influencing the Provision of Quality Psychosocial Services in Washington State Skilled Nursing Facilities.* Paper presentation at the 6th Hawaii International Conference on Social Sciences, Honolulu, Hawaii.

Bonifas, R.P. (December, 2006). *Psychosocial care in skilled nursing facilities: Multi-level factors related to effective service delivery.* Poster presentation at the 5th International Conference on Social Work in Health and Mental Health, Hong Kong, China.

Bonifas, R.P., & Fredriksen-Goldsen, K.I. (April, 2006). *Recognizing the Importance of Gerontological Practice Skills: Potential Strategies for MSW Students.* Poster presentation at the 1st Annual Gerontology Forum at the University of Washington, Seattle, Washington.

Bonifas, R.P., & Fredriksen-Goldsen, K.I. (February, 2006). *Recognizing the Importance of Gerontological Practice Skills: Potential Strategies for MSW Students.* Poster presentation at at the 52nd Annual Program Meeting of the Council on Social Work Education, Chicago, Illinois.

Bonifas, R.P. (November, 2005). *Ethical Challenges in Dealing with Aging.* Roundtable discussion at the 58th Annual Scientific Meeting of the Gerontological Society of America, Orlando, Florida.

Fredriksen-Goldsen, K.I., & Bonifas, R.P (November, 2005). *Gerontological and Multigenerational Social Work Practice: An Innovative Infusion Approach.* Paper presentation at the 58th Annual Scientific Meeting of the Gerontological Society of America, Orlando, Florida.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (February/March, 2005). *Resilience and AIDS caregiving: Predictors of health and well-being.* Paper presentation at the 51st Annual Program Meeting of the Council on Social Work Education, New York, New York.

Bonifas, R.P., & Fredriksen-Goldsen, K.I. (February/March , 2005). *Preparing MSW student for gerontological social work practice: A survey analysis.* Paper presentation at the 51st Annual Program Meeting of the Council on Social Work Education, New York, New York.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (February/March, 2005). *Preparing MSW students for changing demographics: Multigenerational curriculum infusion strategies.* Paper presentation at the 3rd National Gerontological Social Work Conference, New York, New York.

Bonifas, R.P., & Fredriksen-Goldsen, K.I. (January, 2005). *Gerontological social work: Research findings and next steps.* Paper presented at the Annual Conference for the Society for Social Work and Research, Miami, Florida.

Bonifas, R.P., & Fredriksen-Goldsen, K.I. (April, 2004). *Multigenerational social work practice.* Symposium conducted at the Annual Conference of the Washington State Chapter of the National Association of Social Workers, Tukwila, Washington.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (April, 2004). *Social work education for multigenerational practice.* Program exchange conducted at the Joint Conference of the American Society on Aging and the National Council on the Aging, San Francisco, California.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (February/March, 2004). *Enhancing MSW students' value of gerontological and multigenerational practice skills.* Paper presented at the Second National Gerontological Social Work Conference, Anaheim, California.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (February/March, 2004). *Multigenerational health, development and equality: An emerging practice model.* Paper presented at the 50th Annual Program Meeting of the Council on Social Work Education, Anaheim, California.

Fredriksen-Goldsen, K.I., & Bonifas, R.P. (March, 2003). *Overview of the Gerontology Enrichment Project.* Breakfast Symposium conducted at the Annual Conference National Association of Social Workers, Washington State Chapter Tukwila, Washington.

HONORS AND AWARDS

May 2007	J. Scott Briar Doctoral Award
March 2005	John A. Hartford Geriatric Social Work Doctoral Fellow
2003-2004	Huckabay Excellence in Teaching Fellowship

PROFESSIONAL AND COMMUNITY SERVICE

2005-present	Approved Clinical Social Work Supervisor, Washington State
2003-2006	Treasurer, Washington State Chapter, National Association of Social Workers (NASW)
2001-2003	Puget Sound Region Representative, Washington State Chapter, NASW
2000-present	Consultant/Advisory Board-Plus member, Resident Councils of Washington
1999-2006	Annual Conference Committee, Co-chair 2003; Washington State Chapter, NASW
1999-2001	Practicum Instructor, University of Washington, School of Social Work

PROFESSIONAL AFFILIATIONS

National Association of Social Workers
Council on Social Work Education
Association for Gerontology in Higher Education
Academy Health
American Society on Aging
Society for Social Work Research
Assoc. for Gerontology Education in Social Work
Gerontological Society of America

REFERENCES

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