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FACTORS THAT INFLUENCE AN ADMINISTRATOR'S PERCEPTION OF WHAT THEY CONSIDER IMPORTANT IN JOB KNOWLEDGE AND HOW THOSE PERCEPTIONS IMPACT QUALITY OF CARE.

By

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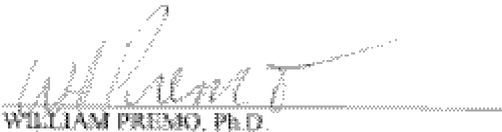

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Abstract

The purpose of this study was to examine a nursing home administrator's perception on what they consider important in job knowledge and if those perceptions were influenced by the type of facility (e.g., for profit/non-for-profit, single/multi-facility, and/or government owned) in which they work. The second purpose of this study was to examine the relationship between those same perceptions and quality of care. The results of this study indicated no significant relationship between the administrator's perceptions of what they thought was important in job knowledge and to the type of facility in which they worked. The same was true for the relationship between their perceptions of what was important in job knowledge and quality of care. Finally, there was no real significant relationship between the administrator characteristics and their perceptions of what is important in job knowledge. The results of the questionnaire did reveal that *knowledge of certification survey process as well as scope and severity ratings and plan of correction process and knowledge of regulatory requirements affecting nursing home reimbursement* had the highest average scores (4.81 and 4.72 respectively). The results also revealed that the knowledge areas in leadership and management were the most important followed in order of mean scores by human resources, finance, resident care and the physical environment. The study revealed an influence that seemed to have transcended the characteristics of the organization (e.g., types of facility) and the characteristics of the individual administrator (e.g., education, experience and background). That influence seemed to be compliance with federal and state regulations and the funding derived from that compliance. This has some potentially significant ramifications for future research especially if the scope of influence is examined.

Dedication

The writing of this dissertation is the final step in a four-year journey that could have not been possible without the inspiration and support of my family. To my dear wife Annette, my children Vincent, Chelsea and Gerred I dedicate this work. I would also like to dedicate this work to Roberta and Tony my mom and dad, who started me on this journey way before I knew what journey I was on.

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CHAPTER 1: INTRODUCTION

Background of the Study

One of the more significant issues in long-term care skilled nursing facilities is the duality of meeting the regulatory requirements while at the same time meeting the needs of the consumers in a quality manner. The nursing home administrator faces significant obstacles of change both externally (e.g., regulations and reimbursement issues) and internally (e.g., staffing shortages and multi-faceted services). It is in this atmosphere of high regulations and seemingly constant change where the nursing home administrator has to effectively operate.

The focus of nursing facilities prior to the 1980s was to provide for basic care needs often referred to as "custodial care." Care needs included basic medical care, activities of daily living (grooming, bathing, dining, and dressing) and basic social needs. This of course drastically changed with the introduction of the prospective payment system for hospital Medicare reimbursement (early 1980s) and the increased influence of managed health care. The changes in reimbursement significantly altered the length of stay and pushed services that were common in hospitals to nursing facilities. Many facilities became or added sub-acute rehabilitation centers offering extensive physical and occupational therapy. Nursing home care acuity levels rose drastically. With the change in care needs came a change in staffing and services offered. Nursing home administrators were faced with growing operational complexities. The next significant change occurred in 1987 when the skilled nursing facility licensure inspection survey drastically changed from routine mostly paper compliance to an in-depth consumer/resident based survey process. Since then change in the long-term care industry has been occurring at a brisk rate. In the early 1990s the introduction of the Minimum Data Set (MDS-part of a resident assessment process) was introduced. Every nursing home

resident is evaluated using the MDS and that data is submitted electronically to the state. The information is not only used as part of the certification and monitoring process but it is also used by the Centers for Medicare and Medicaid Services (CMS) quality care initiative and reimbursement criteria. As the nursing home industry continues to change and adapt (e.g., continuum of care facilities and the growth of assisted living) the nursing home administrator has to adapt to meet those changes. That may be difficult for those who perceive the industry as it was just a short time ago. In an article called *Going Pro*, Brunk (1998) explains that administrators of 30 years ago didn't worry about college degrees, specialized training, or certification. Their need for accountability was much less and competition between facilities was practically non-existent.

In 1967 Congress had passed legislation that every nursing home administrator be licensed by 1970. In 1970 the National Association of Boards of Examiners of Nursing Home Administrators (NAB) was formed to establish standards for licensure and practice. In 1986 the American College of Health Care Administrators (ACHCA) developed standards of practice. The Omnibus Budget Reconciliation Act (OBRA) of 1987 laid the ground work for sweeping reforms in the long-term care industry. One of the requirements stated that by 1992 all nursing home administrators hold at least a bachelor's degree in order to qualify for licensure however not all states have met this requirement (Brunk, 1998). For example Michigan requires a bachelor's degree or a Michigan registered nurse (RN) license with experience and course work. Wisconsin requires education from an approved program and a one year internship. Minnesota does require a bachelor's degree (Long Term Education.com, n.d.).

All administrators are required to be proficient in an established set of skills and job knowledge. This set of skills is measured through the successful completion of a nationally standardized licensing exam. This national nursing home administrator exam is administered by the NAB. "The purpose of the licensing

examination is to protect the public by ensuring that entry-level nursing home administrators have mastered a specific body of knowledge and can demonstrate the skills and abilities essential to competent practice within the profession" (NAB, 2005, p. 2). The NAB periodically updates the exam competencies by surveying professionals in the field. For 2005 the NAB updated the five main competency areas to reflect what seemed to be the current needed areas of skills and job knowledge. The five areas include (a) Resident care and quality of life, (b) Human resources, (c) Finance, (d) Physical environment and atmosphere and (e) Leadership and management.

Brunk (1998) found that 52% of nursing home administrators surveyed had a bachelor's degree and 35% had some form of post- graduate degree. Singh (1997) in a similar study found the most common field of education/training was business administration and other common fields included nursing and health care administration. Singh also reported for those surveyed 69% of the administrators had at least a bachelor's degree with 22% of those having a graduate degree. Murphy (2004) in a survey of nursing home administrators in Iowa found the average age of the responding administrators was 47, the average years licensed was 12 and the average years in the facility was 3 years. The range of training, education and experience indicates that nursing home administrators come from a wide variety of backgrounds and experiences. The average years in the same facility may indicate an issue with job security. This diversity along with the type of facility where they work may have an influence on their effectiveness as a leader which may have an influence on the overall effectiveness of the organization.

Leadership has been examined as a specific set of traits or attributes commonly found in effective leaders. Several studies have completed a descriptive analysis of attributes that describe effective leaders as well as corresponding effective organizations (Bennis & Nanus, 1997; Collins, 2001). Leadership studies seem to focus on identifying those attributes that describe a

leader especially those with a senior level of authority (Judge, Piccolo, & Ilies, 2004; Yukl, Gordon, & Taber, 2002; Yukl, 2002). However, the leadership of a skilled nursing facility (i.e., nursing home administrator) is not necessarily the same senior manager that is described in many of the studies mentioned above. A nursing home administrator, especially in multi-facility organizations (those organizations that have more than 2 or more facilities) may report to a regional director who in turn may report to a vice-president of operations who is subordinate to the president or chief executive officer of the organization. In that aspect a nursing home administrator could be considered middle-management; where their operating decisions are made only with the input and approval of upper management. In contrast nursing home administrators in county facilities or those who are not part of a multi-facility organization may have an entirely different organizational management structure, where the nursing home administrator reports directly to a board of directors or a government body. In that situation the administrator may have more autonomy in overseeing the operations of the facility.

Business organizations are effective because of what, is it because of its leadership, product, services, or being in the right market at the right time? It can be implied that any one of these factors may have a significant impact on organizational effectiveness. Organizational effectiveness may also be a result of how the organization functions as an integrated form where its systems and processes are greater than the sum of its individual parts (or in this case the individuals that make up the organization). Based on antidotal observation there seems to be some similarity in how an organization behaves and aspects of an individual's behavior.

Observations of an individual's behavior, any individual will reveal a set pattern of behaviors that the individual uses in response to a particular demand. These patterns of behavior

seem to be a natural part of the learning process as well as a natural way we cope with the multitude of challenges we face in our daily lives. The assumption that an individual has a set of behavioral routines (those actions that are considered typical response patterns for a particular situation or event) can be easily observed every-time we watch a sporting event, every time we drive a car, or any other similar action that requires consistent and often times repetitive actions (Fabbri, 1997).

The explanation of an individual's behavioral routines may also help in explaining the routine actions of groups, especially structured organizations. At least that is the premise underlying this study. For an organization a behavioral routine is an underlying part of an organization's culture and it impacts many aspects of organizational dynamics such as leadership effectiveness (as well as leadership self-efficacy), problem-solving processes, and prioritization of goals and objectives.

What makes an organization successful? The answer could be in the consistency of their systems and processes. However, an over reliance in consistency might lead to rigid adherence to processes that may no longer be successful. Traditional views of work (probably stemming back to Taylor's scientific management) stressed that work tasks should be a step-wise process that promotes efficiency, quality and increased productivity. This pervasive perception of how work should be accomplished permeates in just about every type of job in just about every type of organization. This is not a baseless assumption. It goes back to what was previously stated about how we function as individuals. Our lives are molded on systematic behavior routines, from our abilities to communicate using an established set of rules to how we learn most of our everyday skills such as typing on a keyboard. Just as individuals are creatures of routine and

patterns of behavior so are organizations. Organizations are extensions of the ideas and routines of the members of that organization. An organization will have varying degrees of established systems and processes. Those systems and processes (i.e., organizational routines) will be formulated within the context of both formal and informal organizational dynamics. Influences that effect (modulate) those routines can be categorized similarly to the external and internal modulators that influence individual behaviors (but for an organization it could be: market trends, worker shortages, regulatory compliance and leadership effectiveness).

Leadership effectiveness is one of the prime modulating factors to understanding an organization's behavior routine. Leadership effectiveness can be measured through several different variables such as an organization's success including profitability, growth and efficiency. Leadership can also be measured through the behaviors observed by his/her followers. Leadership behavior, that is those actions that employees observe by their leaders, is one aspect that can effect employee's perceptions about their work. Bohn and Grafton (2002) described an aspect of organizational effectiveness as organizational efficacy. Bohn and Grafton examined the relationship of leadership behavior and organizational efficacy. Bohn (2002, as cited in Bohn & Grafton) stated:

> Organizational efficacy (OE) is a generative capacity within an organization to cope effectively with the demands, challenges, stressors and opportunities it encounters within the business environment. It exists as an aggregated judgment of an organization's individual members about their (1) sense of collective capacities, (2) sense of mission or purpose, and (3) a sense of resilience. (p.65)

The results of the Bohn and Grafton (2002) study demonstrated that leadership behavior does have an impact on organizational efficacy. By their actions leaders have the potential of fostering change in employees' perceptions of how effective they are within the organization.

Statement of the Problem

One of the more significant issues facing long-term care administrators is the need to adapt to sometimes rapid change. It would be a benefit for leadership to be able to identify and be aware of what influences their self-efficacy as well as their perceptions of their own job skills and knowledge. If the actions of a leader have a potential of influencing followers' perceptions of organizational efficacy than it may be assumed there are factors that influence leadership perception on organizational efficacy.

Purpose of the Study

The purpose of this study was to examine leadership perceptions on what they consider important in job knowledge and if those perceptions are influenced by the type of facility ownership (e.g., for-profit, not-for-profit, multi-facility, single ownership, government owned). The second purpose of this study was to examine the relationship between those same perceptions and quality of care. Included but not a direct purpose of this study was to look at an administrator's characteristics (age, education, gender and experience) and to see if that had an influence on what they perceived as important in job knowledge.

Research Hypotheses

Hypothesis 1: There may be a difference between what the administrator perceives as important in job knowledge to the type of facility where they work. Hypothesis 2: There may be relationship between what the administrator perceives as important in job knowledge to resident

quality of care. Hypothesis 3: There may be a relationship between administrator characteristics (education, experience and/or gender) and what they perceive as important in job knowledge.

Nature of the Study

This study focused on the quantitative analysis of data from two main sources of information. The first was the analysis of the survey data collected from the *Administrators Job Knowledge Questionnaire*. The questionnaire was specifically developed for this study. The other data source was the information publicly available from Nursing Home Compare and Online Survey, Certification, and Reporting (OSCAR) data (CMS, n.d.). This data base includes identifying information of the facilities used in this study and their survey inspection (i.e. quality of care) information.

Significance of the Study

There are several underlying issues that give this study significance. The first and most basic was a supposed movement in a research direction (i.e., organizational behavioral routine). This study is the first in a series of studies that will further define an organization behavioral routine. As it was explained earlier understanding what influences (modulates) a behavioral routine can have a significant impact on the effectiveness of an individual's treatment (personal observations). So to can it be said that understanding what influences an organization's behavioral routines will have a significant impact on the effectiveness of treating (or more precisely changing) an organization. In an applied sense the significance of identifying factors

that may influence leadership perception especially in regards to what they deem important in job knowledge will improve their awareness. In regards to the population being studied (nursing home administrators) this may assist them in overcoming those perceptions when they need to address and adapt to change.

Definition of Terms

Activities of daily living. They include basic care areas such as grooming, bathing, dressing, eating and toileting. It may also include basic social and communication skills.

Center for Medicare and Medicaid Services (CMS). This is a federal agency that is part of the U.S. Department of Health & Human Services. In regards to long-term care it regulates Medicare and Medicaid services and reimbursement as well as fostering quality of care initiatives such as Nursing Home Quality Initiative which includes Nursing Home Compare.

Medicaid. This is a state administered program that is funded by a combination of state and federal funds. It is a program that is available to individuals that meet certain eligibility requirements such as income and disability. Services include most medical expenses including long-term care. The majority of persons covered are children of low-income families.

Medicare. This is a federally funded program that is available to persons over 65 years of age, those under 65 with certain disabilities and those with end-stage renal diseases. There are now several parts of Medicare. Medicare Part A is the basic entitlement program that covers basic hospital and long-term care services up to a certain amount of days. Medicare Part B is supplemental covering other services such as physician care. Medicare Part C which is now called Medicare Advantage and Medicare Part D which is the drug benefit plan are both new

programs. Medicare is currently in transition from the traditional fee-for-service to a managed health care model. It is also moving more to privatization in the next few decades.

Minimum Data Set. The MDS is a scored screening tool that forms the basis for the resident comprehensive assessment. Federal regulations require that a comprehensive assessment be completed for each resident on a prescribed scheduled basis. The MDS is made up of the following domains: delirium, cognitive loss, visual functions, communication, activities of daily living (ADL)/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, feeding tubes, dehydration/fluid maintenance, dental care, pressure sores, psychotropic drug use and physical Restraints (Won, Morris, Nonemaker & Lipsitz,1999).

Nursing home administrator. A protected title that denotes the individual is licensed by their respective state agency. Although licensure may differ from state to state all require successful completion of the national exam. Other necessary qualifications could include successfully passing the state exam, an approved education, internship/experience and continuing education.

Nursing Home Compare. This is a service of CMS that was implemented as part of the Nursing Home Quality Initiative in 2004. That purpose of Nursing Home Compare is two fold. The first is to provide a resource for consumers to examine the quality of a particular nursing facility. The second purpose is to promote change in those facilities that are not meeting the necessary standards. The data is derived from the state survey information as well as the MDS data information. The data can also be accessed and downloaded in spreadsheet and flat file formats for research and analysis.

Omnibus Budget Reconciliation Act of 1987. For the purposes of this study the OBRA Act of 1987 was a demarcation in the nursing home industry that changed the survey process from predominately paper compliance to an outcomes based process. These changes lead to further regulatory changes including the start of the comprehensive resident assessment (e.g., MDS) and the submission of that information to the state. That same information is now part of the survey inspection process. The survey inspection is mandatory for all facilities participating in Medicare and Medicaid. It is performed by state inspectors approximately every 12 months. The inspections occur unannounced. Those facilities that are found out of compliance are required to correct the citations. Significant compliance issues could result in monetary fines and removal from participating in Medicare/Medicaid programs. Since the majority of skilled nursing facilities rely on Medicaid and Medicare reimbursement removal from participation could effectively close the facility.

Online Survey, Certification, and Reporting (OSCAR). CMS maintains this data base which includes information from all data collected by surveys during the inspection certification process. It is the data source for Nursing Home Compare.

Skilled nursing facility (SNF). A skilled nursing facility denotes a nursing home that provides 24 hour nursing care which may include rehabilitative and therapy services. For the purposes of this study a SNF is also certified to provide services for Medicaid and Medicare recipients. For that reason they are subject to the survey inspection process.

Assumptions

Based on the methodology of this study it was assumed that an adequate number of respondents will be able to complete the survey online. That means out of the 1231 requests to participate in a survey sent to facilities in Michigan, Wisconsin and Minnesota that at least 50% (615) will have responded and complete the survey (see Methodology: Target Population). It is also assumed based on the regulatory requirements that every facility contacted would have had a licensed nursing home administrator managing that facility.

Limitations

This study discussed a very broad theoretical viewpoint about understanding an organization in a similar light as one would look at an individual's behavior. It is a somewhat significant leap from that underlying premise to the purpose of this study, unless it is understood this is just one part of understanding the larger picture. That larger picture can only get clearer when each part is examined. Another limitation to this study was direct applicability, although improved awareness of leadership perceptions may have an impact it is not as major of an application such as from designing a specific treatment model or program. The basis of this study relied heavily in the basic premise of adding to the scientific knowledge of behavior. The American Psychological Association (APA) (2002): "Ethical Principles of Psychologists and Code of Conduct" state: "Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society" (p. 3).

In more practical matters the limitations of this study first included the limits of the population surveyed. As previously mentioned nursing home administrators may not be considered a representative group that would define leadership or management theory. The group was chosen partly because of this writer's special interest in long-term care and because of the licensure requirement of all nursing home administrators. This writer knows of no other nationally identified group of leaders that require licensure in order to work in their field. One final potential limitation was the use of just the facilities from Michigan, Wisconsin, and Minnesota. The choice was made partly from them having similar numbers of facilities listed in the CMS OSCAR data and because they are geographically closes. The difference in the state licensure requirements may have an impact on the results. Examination of the potential differences may have to be done.

CHAPTER 2: LITERATURE REVIEW

Quality of service and the inroad of regulatory standards

About the turn of the 20 century, a public movement began to improve the rest homes for the infirmed. Citizens began organizing support and funding for facilities that cared for the aged and infirmed. Through the years and especially after the enactment of the Social Security Act in 1935, nursing homes became more prevalent. In the early 1950s the federal government required states to develop licensure for nursing homes in order to receive funding (Emerzian & Stampp, 1993). This established the beginning of the relationship between meeting federal and state requirements and funding. As the care and treatment of the aged and infirmed became more complicated due to changes in medical services, so was the need to establish acceptable practices for care (Williams & Torrens, 1999).

The evolution of accountability is an evolution that began several years ago, when the government decided to strengthen nursing home regulations. Two major government enactments drastically changed the focus of government involvement in the overseeing of nursing home operations. These enactments were the Medicare and Medicaid programs which began in the mid 1960s. Up until that time no other venture by the federal government matched this effort to provide funding for medical services. Medicare is federally funded and operated program for persons over 65, disabled individuals receiving Social Security benefits and persons with end stage renal disease. Medicaid is a federally funded program that is managed by each state for persons who meet income requirements (Williams & Torrens, 1999).

In order to control how the funding of these programs were utilized the federal government began looking at ways to monitor and enforce program utilization. In 1967,