

A Labor-Management Partnership for Person-Centered Care in Nursing Homes: A Case Study

Final Report

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A Labor-Management Partnership for Person-Centered Care in Nursing Homes: A Case Study

Executive Summary

This report presents a structured description of an initiative by organized labor and management to change the way people live and work in nursing homes. There is much that needs changing, since it is widely acknowledged that nursing homes in the U.S. are seldom good places to live or work. It is common practice for residents to be treated as patients whose lives must conform to regulations and institutional routines about when they get up, what they wear, when and what they eat, who can touch them and who cannot, and more. Frontline workers who help them bathe and dress, clean their rooms, do their laundry, and cook their food are managed like production workers, who have set jobs to do in the assembly line of care. It is a hierarchical world of departments where policies and practices are conceived and coordinated at the top and not the bottom, since frontline workers are seen as pieceworkers who have little or nothing to say about how to care for individual residents. Study after study has shown that most workers are poorly paid and do not feel respected. Dissatisfaction, absenteeism, and turnover are high, and quality of care suffers. Given the rapid aging of the population and concomitant increases in chronic illness and disability, there are few issues more important in health care than changing how we care for citizens residing in nursing homes.

The nursing home reform initiative in New York City

The labor management initiative on which we report is based in New York City, which has some of the biggest nursing homes in the country. 1199SEIU represents over 40,000 frontline nursing home workers (certified nursing assistants or CNAs, food service workers, housekeepers, and laundry workers), as well as nurses, social workers, and recreation therapists in some homes. In 2002, the union began to talk with the Continuing Care Leadership Coalition, a trade association with a membership of over 100 nonprofit nursing homes that is a part of the Greater New York Hospital Association (GNYHA) about changing the culture of living and working in its member nursing homes towards a more person-centered approach.

"Culture change" and "person-centered care" (PCC) are labels for several widely heralded reform efforts by nursing home providers that have been underway for more than a decade in the U.S. The core of these initiatives is typically to form smaller neighborhoods or communities within larger nursing homes, to give more autonomy to the communities in organizing jobs and care, and to involve both residents and frontline workers in decisions. The PCC movement is consistent with parallel initiatives for more choice and autonomy for citizens receiving long-term care in the community, but the nursing home change efforts have not had the same federal and state backing. Regrettably, the provider-driven efforts have had a difficult time finding a foothold in more than a handful of vanguard settings. Bringing PCC to numerous large nursing

homes in New York City, and doing so through a labor-management partnership, could therefore represent a substantial step forward in PCC reform.

In pursuit of the PCC vision, in 2003 the union and the CCLC formed a partnership called the Quality Care Committee (QCC). Organizational support for the QCC was provided by the 1199SEIU Training and Employment Funds (TEF). Specifically, staff from the TEF's Labor Management Project and the Nursing Home Training Division helped to facilitate and implement the goals articulated in the Collective Bargaining Agreement. The activities of the QCC have resulted in significant culture change initiatives in over 40 nursing homes over a five-year period. The QCC has held numerous city-wide forums, sent workers to national conferences and PCC homes in other regions, and paid for intensive off-site and on-site training of interdisciplinary teams of workers from the participating homes.

Study methods

In this study, a team of researchers from Brandeis University and Boston College partnered with the QCC to assess how their initiative is creating PCC in the participating nursing homes. Using a participatory action research model, we formed a Research Advisory Committee (RAC) of union, worker, and management representatives to help refine the study design, frame research questions that are important to the participants, choose homes for intensive case studies, and interpret findings. To understand how the QCC works, the research team attended several QCC meetings and city-wide conferences and also reviewed materials on the training efforts. We then met with the RAC and developed the following study questions:

- How does the labor-management partnership work?
- What are the partnership's essential elements for achieving PCC?
- How can PCC be sustained, expanded, and replicated through evolving labor-management partnerships?

We decided to seek case study sites that had been involved with QCC training for at least two years, had implemented PCC practices, and had functioning labor-management committees. The RAC recommended ten nursing homes that met these criteria, and researchers telephoned a union and a management representative in each of them to learn more about their PCC efforts. We completed both interviews in eight homes, and confirmed that PCC efforts were underway in all of them. Three homes stood out in terms of the extent of PCC efforts and labor-management partnership. From these we chose two (NH1 and NH2) that provide contrast in terms of size and affiliation.

Nursing Home 1 is an approximately 350-bed nursing home on the edge of the City that is part of a multi-site hospital-nursing home system. Located in a relatively well-off area, NH1 had PCC initiatives before 2003, but the QCC spurred them to first form a pilot community and then divide the entire nursing home into 7 communities 18 months

before our visit. In 2003, 2004, and 2005 NH1 sent 69 staff to QCC customer service training.

Nursing Home 2 is a stand-alone nursing home with more than 700 beds that also provides a range of community-based and housing programs to its multi-ethnic neighborhood. Like NH1, interests and initiatives in PCC predated the QCC, but change efforts accelerated when they sent 444 staff to customer service and pain management training in 2004 (143 were trained in 2003 and 2005). The pilot PCC community includes two 34-bed units on different floors.

Site visits were conducted in January 2007. In each homes, we visited the most advanced PCC community. We interviewed 37 individuals in NH1 and 34 in NH2. Respondents included all categories of frontline staff (including union delegates), management, and the union organizers assigned to the homes. Most interviews and observations were on the day shift, but evening shift workers were included also.

Findings

How does the QCC work?

The QCC's labor-management partnership model integrates three important learning and system-change components. The first is teaching and learning about the broader context of long-term care or “macro” learning. This approach brings together teams of staff from each home (frontline workers, nurses, managers, union representatives, etc.) to learn about and engage in discussions on overarching issues affecting long-term care (including financing, city and state policy developments, best practices from other states, national changes in relevant legislation, etc.), and also to share progress with one another. The tenor of these day-long conferences is a mix of specific information, policy discussions, and pep rally.

The second component is intensive, off-unit trainings that include interdisciplinary teams of frontline workers, professionals, and managers. The training is designed to build both skills and integrated approaches to providing care. The homes pick from the topics offered (e.g., gerontology, palliative care, customer service). The training consists of a total of 5-6 full days of classroom learning over a 2-3 month period, thus supporting and encouraging on-the-job testing of newly-acquired skills and practices.

The third component is the day-to-day on-the-job implementation of new knowledge, roles and relationships towards promoting PCC and integrating the team-building that emerges from the first two approaches. This is meant to expand the practices to other staff and solidify implementation.

What are the Labor-Management Partnership's essential elements for achieving PCC?

Even in the most advanced of the QCC nursing homes, PCC is clearly a work in progress and perhaps a more complex and challenging undertaking than many of the participants had expected at the outset. At the time of our visit to NH1, for example, management

had just completed a series of focus groups with managers that were said to have given the message, "We are moving too fast." We quickly learned not to expect to hear about miracle transformations of labor-management relationships or of the organization of care. However, we did see evidence of important and fundamental changes underway. Actions in five areas seemed essential to the QCC's model of creating PCC: management/union partnership, management change, union change, worker buy-in, and resident buy-in.

1. Management/union work together:

The change effort was conducted jointly by management and the union in an explicit and open manner. At the city level, the joint effort was embodied in the QCC and the extensive training activities and resources it made available to individual nursing homes. The two study nursing homes participated in the city-wide effort, and both had several committees of managers and workers to handle specific issues at the nursing home and unit level. These committees did not always function smoothly or to the satisfaction of both sides, but there were examples of good process and substantive successes to which participants could point. In short, the common commitment to PCC, and the joint work on training and implementation showed that the two sides needed to work together and could do so.

2. Management changes

Although the QCC initiative is a joint labor-management effort, it was widely acknowledged that management is responsible for planning and implementing how PCC actually happens. In both study homes, management carved "communities" out of the larger nursing home and created a new management position called "community coordinator" to break down departmental silos and work with residents and workers to reorganize routines to honor residents' preferences. This brought management face-to-face with what seemed to be the most difficult challenge: revamping existing management structures and roles. Especially in NH1, it proved difficult for top managers and department heads to cede authority and responsibility to the communities, and when this happened, it sapped efficiency and effectiveness.

Management in both nursing homes used two initiatives to try to create communities and "flatten" management: setting an example by pitching in to help on the units (e.g., to feed and transport residents), and moving food to the floor. When managers pitched in, it was noticed by frontline workers, but when they stopped, it was noticed, too. A considerable amount of goodwill appeared to be available at a relatively low cost. Moving the serving of food to the floor was a major initiative in both homes, as it required both physical renovations and changes in staffing, job descriptions, and operations in multiple departments. In these two homes it became the centerpiece of changes in how frontline workers collaborated with one another to tailor care to residents' needs, and how workers related to residents. Moving the dining initiative to additional units/communities was the next management initiative on the agenda of both study homes.

3. Union support for PCC

Union support for management's PCC initiatives was crucial to moving forward. The union was personified in the study homes by the organizer (a union employee who works with several homes) and unpaid delegates (frontline workers in specific job categories, analogous to shop stewards in some other unions). They had to figure out how to maintain the union's role as protector of workers' interests, even as the union was transitioning to a stance of flexibility and partnership with management rather than just enforcing contract provisions.

One major issue was allowing expanded job descriptions for union (and other) workers, which was clearly a practice that could be stopped by invoking the contract. In both homes the union encouraged individual workers to decide for themselves whether to take on expanded roles; and when the great majority did, the issue was largely defused. Another issue was scheduling shifts and days off according to seniority in the community rather than seniority in the nursing home. Having staff permanently assigned to the community was seen as crucial to building teams and relationships with residents, but it was difficult to maintain if scheduling was managed elsewhere. Most union representatives seemed ready to be flexible on these issues, as long as members participated in the decisions.

Workers were aware that the union supported PCC efforts, and this seemed to make for a safer space for experimentation. The space was safer yet, since the rest of the structure of union protections of workers - job security, benefits, wages - remained in place. Nevertheless, the relatively small number of workers who complained about expanded job roles (e.g., a few told interviewers that PCC means "more (work) for less") opened union representatives to accusations of being "in bed" with management. When there were bumps in the road, for example when management seemed to stop pitching in as promised, union representatives seemed to hear about it from at least some workers. The issue of seniority and local scheduling was only beginning to be tackled in the two study homes.

4. The responses of frontline workers

The fourth essential element in the success of PCC was frontline workers' responses to the space that management and the union created for developing PCC. All types of frontline workers in both homes strongly supported the changes - nearly unanimously. Workers bought into the PCC concepts (we heard "it's all about the residents" over and over); they embraced job expansion to help out their coworkers ("just do it" was the mantra); and they collaborated across job titles and hierarchy in the interest of improving care. The community framework also gave frontline workers a chance to voice their opinions and to take initiative as leaders, and they appreciated the opportunities and the respect that came with this. The most remarkable transformations in both homes were among housekeepers, who recast themselves from being seen as mop pushers and spill cleaners to respected team members who could feed and transport residents and answer call bells. They beamed when talking about their satisfaction with having relationships with residents.

5. The role of residents and families in PCC.

Residents of nursing homes are either physically or cognitively debilitated (or both), but they have preferences and can express them. Although our study did not include interviews with residents, we heard about and saw their participation in PCC through observations and interviews with staff. The PCC initiatives opened the space to hear and try to honor those preferences. It seemed to be fulfilling for staff to be able to respond, and residents were said to appreciate the effort. We heard that residents, staff, and families were happy to have dining be more homelike and to have residents have personal and caring relationships with a broader range of staff. A particularly telling example was that the PCC unit in NH2 was said to have defused the "tug of war" over bathing and getting out of bed that existed in the units of the nursing home that were not yet practicing PCC.

How can PCC be sustained, expanded, and replicated?

Respondents could only speculate on what lies ahead, and on how best to sustain, expand, and replicate their PCC initiatives. We have synthesized seven points from their insights into the future - the first four relatively specific and the last three more general. In fact, there is a tension between the first and the last, reflecting the complex, developmental nature of transitioning existing nursing homes to PCC.

1. Expand to the whole nursing home

Pilots are valuable, but you cannot indefinitely run the new system within the old. At some point the decision needs to be made to go nursing home-wide or to abandon the PCC effort.

2. Roll PCC out using model programs

To go nursing home-wide, there must be models to roll out from the pilots into new neighborhoods. For both nursing homes, dining was a core component of the roll-out, but they also had other models, e.g., an "It's your call" video to show that everyone can answer residents' call bells.

3. Move scheduling to the communities

Team building and resident-centered care could be much stronger with "permanent assignment" of staff to communities (which is happening and not a problem with the union contract), as well as scheduling vacations and coverage at the unit rather than the nursing home level (which is more challenging to implement).

4. Bring PCC to the evening and night shifts

In both nursing homes we heard that PCC was less developed and less supported on the evening and night shifts, and that there were conflicts between shifts. Smooth transitions of care and person-centered divisions of labor across shifts are important to PCC.

5. Find resources

Fostering change is expensive, particularly in terms of paid, off-unit training with backfill on the units, as well as renovation of space to accommodate more homelike dining. To consolidate and expand changes, homes will need to continue to find funding beyond standard reimbursement.

6. Don't expect uniformity

Numerous respondents cautioned that there is no cookie-cutter approach to developing and replicating PCC, even within a single nursing home. Staff and resident personalities and capabilities vary by unit, so each community should be allowed to take a slightly different path.

7. Slow down and consolidate before moving on

Both union and management informants from NH1 (which had gone nursing home-wide with PCC) worried that changes were taking place faster than staff could understand. Others warned that "backsliding" and "institutional creep" were bringing back old practices of not pitching in or asserting departmental authority over communities. Creating PCC in existing nursing homes is clearly a long-term project, in which steps forward (e.g., items 1-4 above) must be balanced by stock taking.

Conclusion

As academic researchers we come away from this study humbled by the efforts of the managers, union staff, professionals, and frontline workers we encountered in the two study homes and in the broader city-wide effort. We are hesitant to draw conclusions about their achievements and shortfalls from our brief study of two homes. On the one hand an evaluator could be pessimistic: After several years trying, neither nursing home has successfully transformed itself into a PCC nursing home, and each faces years of hard work ahead. From our interviews with representatives of the other six candidate nursing homes for the case studies, only one appears as advanced as these two. We assume the other 30 homes are even less far along.

On the other hand, it is clearly not easy to transform large nursing homes. The participants have made real and important changes that they liked and that they valued - in their nursing homes, in their working relationships, and in how they treat residents. Frontline workers particularly appeared to thrive on PCC in terms of making contributions to care and practices, and in terms of the recognition and dignity their expanded roles brought them. The participants have learned a great deal, and they have a model for sharing their learning with one another. It is not a cheap model, but it is difficult to see how one could do this on the cheap and succeed.

The 1199SEIU and Continuing Care Leadership Coalition face the challenge of bringing along their own large institutions and outside supporters (e.g., state funders of training). They plan to continue macro and nursing home-level training, and they are developing ways to support PCC practices in the union contract. The most recently negotiated

contract (Jan. 2007) includes language to accommodate PCC experimentation with new job descriptions and more flexible work rules. In May, the QCC launched a 17-nursing home demonstration of new PCC initiatives that use "interest-based problem solving" as a way to approach labor-management discussions.

Learning from the QCC's initiatives in PCC will continue to evolve and emerge in New York as well as at least ten other states where the union is partnering with employers, advocacy groups and other stakeholders to form partnerships with the goal of improving quality care, funding, and training for nursing homes. We hope that the lessons learned and recommendations in this case study will contribute to these initiatives.

I. Introduction

A. Background

Problems in long-term care

As birth rates fall and life expectancies rise in the United States, the number of persons who are 65 and older is growing rapidly - from 12.4 percent of the population in 2000 to a projected 19.6 percent by 2030. In 2000, 4.6 million elders, or 4.5 percent of the 65+ population, resided in nursing homes [17 p. 162]. The group that is most likely to require formal care—those aged 85 and over—is projected to increase from 4.7 million in 2003 to 9.6 million in 2030 [17 p.6]. To meet the rising demand for care the Bureau of Labor Statistics projects that the long-term care workforce (employees in nursing homes, and residential care facilities, and in home health) will grow by 36.8% percent between 2004 and 2014, from 3.6 million to 4.9 million workers [computed by the authors from 33]. The largest increase in employment (56 percent) is projected to occur among home health aides, but the largest single category of workers (1.8 million in 2014) will be nursing home aides, orderlies, and attendants [19].

The projected employment growth in direct-care occupations reflects not only the increasing number of older persons in need of care, but also high turnover in the direct-care workforce. Direct-care jobs are typically physically and emotionally demanding, yet are low-paid and are less likely to provide benefits like health insurance, pensions, or child care.[‡] Nursing-home aides have the third highest injury rate among U.S. workers, so any shortfalls in health insurance are problematic.

Staffing shortages affect quality of care. The Centers for Medicare and Medicaid Services found that understaffing “severely affected quality” in 54 percent of nursing homes in the United States. This includes care that is unsafe for workers and residents, lack of continuity, and denial of care [18 p. 15]. Forty states reported in a 1999 survey of ombudsmen that aide shortages were “critical.” High turnover—more than 100 percent annually in nursing homes in some states—exacerbates staff shortages and quality problems [34, p.8,10] .

Another factor in high turnover and low quality in nursing homes is the top-down, industrial model of organization and management. In most long-term care (LTC) nursing homes, FLWs work in rigidly defined jobs that offer little opportunity for new learning or

[‡] Only 45.4% of the nation’s nursing assistants receive health insurance coverage through their employers. Although 84% worked at nursing homes where health insurance plan was offered, 46% of those offered insurance did not sign up for the employer’s plan, most often because of the plan costs that workers were expected to contribute. Nursing assistants also gain health insurance from government programs and through family members, so 80.2% reported some type of health insurance coverage in 2004. Sixty percent of nursing assistants reported that they received a pension benefit from their employers, but only 6% had any paid childcare. [Authors’ calculations, population weighted estimates from the 2004 National Nursing Assistant Survey, 27].

chance to explore individual interests and potential. Dissatisfaction is widespread, and workers report that they do not feel respected by managers and supervisors. Nursing homes are operated on schedules that force workers and residents into routines that meet the needs of the nursing home rather than those who work and live there.

The person-centered care (PCC) approach

The over-arching theme to the reform of long-term care for at least the last decade has been the creation of helping models that are more respectful of the preferences and choices of service users. In the community, the theme has been pursued by the independent living movement, strengthened by the 1990 Americans with Disabilities Act, focused by the 1999 Olmstead decision of the Supreme Court, and institutionalized at the state level by the Real Choices initiative and its successors.

In institutional LTC settings, however, progress towards user choice and autonomy has been more elusive, in part since there is no public initiative analogous to ADA/Olmstead/Real Choices. Instead, public resources and policy have focused on quality, which has been institutionalized in the MDS assessment and the Nursing Home Compare Website as "quality of care" rather than "quality of life." Aside from reductions in the use of restraints, the quality indicators are medical, nursing, and rehabilitative in nature.

The public sector focus on quality of care has left the field for improving quality of life for nursing home residents open to the industry itself. Under the rubric of "culture change" or "person-centered care" (PCC), providers have attempted to redesign nursing home services to make it more like home [1, 3, 4, 16, 22, 24, 28, 31, 32, 36]. The pressure to deinstitutionalize nursing home care comes from the nursing home market itself, as more elders with economic resources seek care at home or in assisted living facilities. A movement has arisen to promote person centered care, complete with charismatic leaders, consultants, and supportive organizations. New practices have been developed in response to the simple but powerful idea that nursing home care need not dehumanize the elders who receive it. Specific practices have emerged from intense rethinking of options for life in the nursing home at the most basic level, and support residents' choices and preferences about their wake-sleep cycles; food selection and dining times; mode of bathing; and death and dying [see for example 29].

Providers have produced several promising models (e.g., Green Houses, Eden Alternative, Regenerative Communities, and Wellspring) and visitors flock to view these examples. Nursing home personnel can learn about them at conferences, continuing education sessions, and through consultants. The federally-funded state Quality Improvement Organizations (QIOs) were tasked with spreading culture change as part of their nursing home quality initiative [5]. But the PCC models have been difficult to replicate, and personnel who learn about the specific practices find them challenging to implement when they return to their own nursing home settings. The vast majority of nursing homes are stuck in industrial/medical models of care, which can generally meet quality of care standards, but which rely on top-down, command-style production of care that leave frontline staff alienated and residents the objects rather than the subjects of life

in nursing homes [10]. Nursing home leaders are beginning to include person-centered care in their vision statements, but it is something else again to bring a full array of real PCC practices, and the spirit behind them, to the nursing home resident on the traditional nursing home unit. Even leaders who are convinced that care must change have found it difficult to influence the practices of the hands-on care providers on the unit.

Some observers have concluded that involvement of the front-line workers themselves is the key to the transition to person-centered care [8-10]. Front-line workers are directly responsible for how care is provided, and under the best of circumstances build supportive relationships with the elders they care for. Yet many direct care workers in nursing homes are paid low wages for strenuous and dirty work, and often feel disrespect from supervisors and society at large [2, 7]. Efforts to support front-line workers have been part of some PCC initiatives, by for example including direct care workers in planning PCC implementation, focus on consistent assignment, and the development of a new “universal worker” job title (found in the Greenhouse model), which combines the duties of a CNA, housekeeper, and cook.

In other industries, efforts to transform work have also engaged frontline workers, and in some instances this has occurred under the auspices of a union representing the frontline workers as a group. Several major U.S. unions in the steel, auto, textile, telecommunications, transportation and other industries realized that competitive and economic forces necessitated new ways of working with management to preserve jobs and the financial health of their employers [23].[§] In response to these forces, some unions and management have formed partnerships to “add value” and achieve “mutual gains” in the form of better quality control, self-management by frontline workers, more secure jobs, investment in workers’ skills, improved products and services, and a range of improvements in work and human resource practices[12-14].

There have been relatively few high profile cases of labor-management cooperation around such goals, however. The partnership between the United Auto Workers and General Motors at the Saturn Plant (mid 1980s) was one success story [30], as is a long-term partnership between Southwest Airlines and five local unions representing its employees [15]. More recently, Kaiser Permanente and the 26 AFL-CIO unions representing its employees have developed ways to achieve mutual gains for both the growing organization and its workers [see materials at 21] [especially Eaton et al., 11]. The Kaiser case study identifies a number of instances where the mutual commitment of workers and managers has resulted in substantial improvements in quality and efficiency.

[§] Rubinstein and Kochan’s insights apply here; in 2001 they stated, “Management needed greater flexibility, more cooperation and involvement from the workforce, and higher quality and productivity. Unions needed a new strategy for organizing workers (and especially needed to neutralize employer opposition to organizing), a new role and source of power, and access to the levels of management at which the key strategic decisions influencing worker welfare were being made. Moreover, workers were calling for a greater say in the decisions affecting their jobs and work environment and at the same time demanding more assurances of job security from their unions and employers”[30].

Approximately 60% of New York State nursing homes are unionized. Nationally, nursing assistants in 15.4% of facilities are members of unions. In some states, such as Iowa, direct care staff associations have been formed to support their interests. We recognize that traditional labor-management relationships most likely prevail in many of these nursing homes. However, we are optimistic that the QCC model described in this case study can significantly impact both union and non-unions facilities across the country. It is possible for union and long-term care industry leaders to move beyond issues of wages and benefits and together imagine new models of care.

B. The Labor Management Partnership or Quality Care Committee Initiative

This study examines whether and how a mutual gains approach between management and organized labor in the New York City region has the potential to transform nursing homes toward the PCC model of care. The New York City labor-management initiative to create PCC in existing nursing homes is perhaps the most ambitious in the nation. In 2002, in pursuit of the vision that the future of the nursing home industry lies in high quality residential facilities that are more “like home,” leaders of 1199SEIU (a union representing thousands of health care workers in New York State) and the Continuing Care Leadership Coalition (a trade association with a membership of over 100 nonprofit nursing homes that is a part of the Greater New York Hospital Association, GNYHA) came together to form a partnership called the Quality Care Committee (QCC) to pursue PCC. Staff from the 1199SEIU Training and Employment Funds were charged with providing consultation and support to the Union-Management Steering Committee that leads the QCC. The Training and Employment Funds is a multi-faceted organization, funded through collective bargaining, which provides a wide range of education, skills and support services to union members and health care organizations.**

These activities have resulted in PCC initiatives in over 40 nursing homes over a five-year period. The QCC has held numerous conferences and events, sent workers to national conferences and site visits to PCC homes in other regions, and provided off-site and on-site training of interdisciplinary teams. The latest collective bargaining agreement, ratified in January 2007, includes language to encourage pilot projects to expand PCC through new job descriptions and more flexible work rules.

Overall, the labor-management partnership model integrates three important learning approaches. The first is teaching and learning about the broader context of long-term care or “macro” learning. This approach brings together all levels of staff (frontline workers,

** It is beyond the scope of this project to describe in detail the genesis of the partnership between the labor union, 1199SEIU, and the provider organization, the Continuing Care Leadership Coalition (CCLC). Briefly, for over 20 years 1199SEIU and the Greater New York Hospital Association have collaborated on issues of mutual interest (e.g. funding, training programs, legislative initiatives) with considerable success. In 2003, the CCLC was created as an affiliate of the GNYHA to focus on issues of continuing (in contrast to acute) care. The QCC Steering Committee is comprised of leadership from the Nursing Home Division of 1199SEIU and members of the CCLC board of directors.

nurses, managers, union representatives, etc.) to learn about and engage in discussions on overarching issues affecting long-term care (including financing, city and state policy discussions, national changes in relevant legislation, etc.). The second is intensive, off-unit trainings that include interdisciplinary teams of frontline workers, professionals, and managers and builds both skills and integrated approaches to providing care. Third is the day-to-day on-the-job implementation of new knowledge, roles and relationships promoting PCC and integrating the team-building that emerges from the first two approaches. From a policy and practice point of view, the homes in this case study are important because they are creating PCC in large, existing nursing homes, and because labor is collaborating with management to lead and support the changes.

II. Methods

We used a case study of the Labor-Management Partnership for Person-Centered Care to document the initial conditions for this partnership, how the partnership evolved, and experiences during the first two years of activity, focusing on the perceived strengths and barriers of this labor-management approach. Standard case study methods [37] and methods drawn from Participatory Action Research [6, 20, 35] were adapted to the problem under study.

The project was a collaboration among the grantee (the Training and Employment Funds, TEF) and its research team subcontractor (Brandeis-Boston College nursing home workforce study team). The case study combined a review of records and archival data, interviews of key actors in the development of the labor-management partnership model and field research at two contrasting nursing home sites. At these sites, we systematically gathered information from management, union leaders, supervisors, and frontline caregivers, to determine the range and depth of adoption of the labor-management approach at the nursing home level.

The research effort was highly collaborative, with co-PIs from the TEF and the research team, and intensive collaboration between the research team and a Research Advisory Committee (RAC). The RAC consisted of ten union and management leaders who all had experience with PCC, and who had knowledge of the nursing homes active in the QCC. The RAC met several times to help delineate research questions, consider methods and approaches, advise on study site selection, recommend potential interview participants and questions, and interpret findings.

The first study "finding" to report is the revision and refinement of our initial study questions based on participatory action research dialogue with the RAC. Three broad study questions resulted:

- How does the Labor-Management Partnership work?
- What are the Labor-Management Partnership's essential elements of achieving PCC - in labor-management partnership, in management, in clinical areas, in frontline work, and in relationships with residents and families?

- What's "on the other side?" How can PCC be sustained, expanded, and replicated through evolving labor-management partnerships; through more efficient and effective approaches to organization, management and clinical care; and in the face of changing economic and political realities?

With assistance from the TEF, the study team assembled and reviewed records concerning labor-management partnership activities and characteristics of participating nursing homes and their workers. Our objective in collecting and reviewing these materials was to describe the distribution of key nursing home variables that might affect incorporation of PCC culture and practices, supporting our understanding of variation in effects. Example documents include records of partnership deliberations, announcements and newsletters, and the budgets, plans, materials and participant lists for training sessions. These records were quite extensive for some homes (e.g., including trainers' notes on what was discussed in sessions) but for others were limited to the number of participants per year by training topic. Also, these were union records and did not always accurately reflect the number of management participants.

As part of our effort to select case study sites and to place the sites in context, all nursing homes participating in the QCC effort were asked to respond to a questionnaire concerning their progress toward person-centered care [16, 25]. Only a small number of homes returned responses, and the staging tool, designed for the typical nursing home, gave mixed and conflicting assessments for these large urban homes. In the end, the results of this effort were not used in selecting nursing homes for the case study phase.

Members of the study team also attended two city-wide conferences, at one of which we led a plenary workshop that asked participating homes to list their current PCC activities and to report on what promotes PCC and what tends to block progress. They reported that many things were working well, e.g., communication, increased roles for residents and families, and working committees and teams. Factors reported to be key to success included commitment of nursing home leadership (including board involvement), management follow through, and management respect for staff. Things that still were not working at some homes included communication, teamwork, and commitment. Barriers mentioned by homes included resistance to change, fear of failure, loss of control, and long-standing work habits. Other common barriers were lack of resources, burdensome regulations, and staff shortages and turnover.

Following gathering and consideration of background information, we met with RAC members and reviewed what we had learned about PCC activities. We asked them, based on their knowledge of homes in the initiative, to recommend potential study sites based on seven criteria:

- Active PCC committee(s) with staff from both management and labor.
- Involved in PCC activities for at least 2 years.
- Have moved beyond preliminary efforts; focused on sustaining PCC.

- Open to outside researchers coming into the nursing home; comfortable talking about challenges.
- On-site leaders (management and union) knowledgeable about PCC activities; staff who can facilitate site visit.
- Available documents, meeting notes, survey results, other internal records to supplement data.
- No cumbersome IRB process.

Using these criteria, the RAC members were each asked to write down three candidate study homes. The votes were tallied, the rankings were discussed, and a list of ten nursing homes resulted. For each home we obtained a management and union informant to provide more detail about the PCC activities and the labor-management relationships in the homes. Union informants included both delegates, i.e., a frontline worker analogous to a shop steward, and organizers, i.e., a union employee responsible for organizing and contract issues in several homes. We conducted telephone interviews with the informants using an open-ended interview guide. Interviews lasted between 30 and 90 minutes.

Due to availability of these informants, we were able to conduct both union and management interviews with only 8 of the 10 nursing homes. The union delegates were particularly difficult to interview, since they usually had to be contacted at home during non-work hours. Although it is difficult to make definitive decisions based on two informants, the interviews corroborated the RAC's judgment that these homes were actively involved in the QCC's PCC initiative. They also echoed some of the challenges reported in the earlier plenary meetings. To one degree or another, both labor and management informants at all nursing homes reported that their homes:

- Had some interest and activities related to PCC prior to the QCC initiative in 2003.
- Engaged in QCC city-wide events as well as training sessions around particular issues.
- Used the QCC resources to change the process and content of labor-management communications, communications on the units, and the participation of FLWs in PCC.
- Faced barriers related to willingness/readiness of workers and managers to change attitudes and behaviors and to adopt the PCC ethic.
- Faced barriers in resources (for staffing, physical plant changes, continued training).

There was variation among the informants at the eight homes, however, in terms of how far along they said they were in implementing PCC, in whether the implementation was moving forward or seemed stalled, and whether a constructive and collaborative labor-management dialogue was occurring. Again, it is important to emphasize that individual informants bring their own views and experiences, which may differ from others involved in the process, particularly in large and complex nursing homes, where each unit and department can have its own culture and personalities. Overall, here is how the homes compared on two key selection criteria, implementation of PCC and active labor-management cooperation on PCC:

- The reported breadth and depth of implementation of PCC varied from substantial and dynamic in three homes (1, 2, 3), to modest and moving in three homes (4, 5, 6), to modest and stalled in one home (7). Progress was difficult to determine in one home due to conflicts between the management and union interviews (8).
- The degree to which labor and management were engaged in a new and constructive dialogue ranged from three homes with active and constructive talking about issues, barriers, progress, etc. (1, 2, 3); three homes in which management and labor agreed that they seemed to be having problems in this area (4, 5, 7); and two homes in which management and labor differed about how well the dialogue was going (6, 8).

Based on these results we selected numbers one and two from the sample (called NH1 and NH2 hereinafter). Nursing home number two was chosen over nursing home number three to provide diversity in size and ownership; nursing homes two and three are both exceptionally large, and nursing home three was owned by the same corporate entity as nursing home one. In summary, we chose the two homes that we thought would display the most advanced approaches and implementation outcomes based on information gleaned from archival data and the key informant interviews.

We next contacted the two target nursing homes to confirm their willingness to participate, to obtain management and labor contacts, and to negotiate site visit dates and approaches. Within each nursing home, the unit or "community" that was most advanced in PCC practices was selected for intensive case study. Within the study unit, we attempted to interview all staff from the day shift (approximately 7AM-3PM) and a smaller sample of staff from the evening shift (approximately 3PM-11PM). Respondents included community coordinators, nurses, CNAs, dietary workers, housekeepers, recreation therapists, dieticians, and social workers. At the nursing home level we interviewed all senior managers and department heads, including the CEO, CFO, DON, and HR director. We also interviewed the union organizer (a full-time union position managing union issues in the nursing home) and union delegates (workers in different occupations in the bargaining unit working full-time for the nursing home who are elected by their peers). All told, we interviewed 37 individuals in NH1 (27 frontline workers, 9 managers, and the organizer) and 34 in NH2 (22 frontline workers, 11 managers, and the organizer). Records of interviews were from extensive notes that were transcribed after the site visits. We also conducted observations at both nursing homes.

Data were analyzed and interpreted using a content analysis approach, coding emerging themes in all the data sources, triangulating the field notes and archival data and summarizing major findings.

III. Findings

A. How does the Labor-Management Partnership work?

There are three components of the Labor-Management Partnership model:

1. Macro-level learning and team building. As frequently as three times per year, the QCC convenes city-wide, day-long conferences to engage all participating nursing homes in awareness and learning about accomplishments, issues, and new initiatives of the QCC. By encouraging labor and management in participating homes to send frontline workers, union representatives, professionals, and managers, the QCC's macro-learning model tries to ensure that the information shared and the discussions that follow build teams that bring the learning back to individual nursing homes. The tenor of these conferences is a mix of specific information, policy discussions, and pep rally. There are speeches of encouragement and support from CEOs and union leaders, showcases of successful projects presented by teams of frontline workers, professionals, and managers from individual nursing homes, presentations from outside experts, and break-out groups that provide skills enhancement (e.g. improved communications, conflict management)

2. Intensive educational trainings on staff-chosen substantive topics. Since 2001, with funds provided by New York State, through its Health Care Reform Act program, the TEF has organized on-site training programs in over 100 nursing homes. Different models have been developed (3, 5, 6 or 8 days) but all contain four elements: 1) unit-based, on-site training, 2) interdisciplinary and inter-shift staff participation, 3) training provided by an outside expert/consultant, and 4) content chosen by the individual nursing home's Training and Education Committee. Workers are fully compensated for participating in training, as part of their jobs; and participating nursing homes are compensated for hiring "backfill" substitutes for the workers in training. The sessions have the character of day-long, off-unit retreats even though they are held at the nursing home sites for the convenience of participants. The training days are staggered over two to three months so that the teams can return to their units on the workdays following each session to test approaches, discuss them with their learning group at the next session, and so on. Between 2002 and 2005, 6,744 frontline workers, professionals, and managers from 24 QCC nursing homes participated in these trainings.

3. Day-to-day transformation of the labor-management dialogue, the organization of work, and work roles: The third component of the model involves implementing learning and role changes on the job, every day. The approach includes encouraging frontline workers to take initiative, voice their opinions and insights about care issues, try out new skills or change routines, and assume leadership roles. Essentially this component of the model is built on treating frontline workers as critical actors in care provision and encouraging their ongoing advancement. This component is multi-faceted and activities include "community meetings" in which all staff have the opportunity to voice their

opinions and insights, one-on-one support from a designated PCC coordinator and work-site mentors, and formation of and participation in labor-management committees concerned with specific aspects of care and work organization.

Due to resource and time limitations, we could not carry out an in-depth assessment of how all three of these LMP components are working. We were able to get a flavor of the first component by attending two city-wide conferences, but we were not able to attend any of the intensive trainings from the second component. Instead, our inquiry focused primarily on the third component, as reported and observed in our site visits.

Overviews of PCC in the two study homes ("models" of PCC)

Nursing Home 1

The first study nursing home is one of several nursing homes owned by a religiously-based health care system. It has 350 beds and is located on the edge of New York City in a relatively well-off area. The census is 62% Medicaid, 18% private pay, 16% Medicare, and the rest managed care. Prior to being acquired by the system in the early 1990s, it was a privately held for-profit catering to a more affluent clientele. The nursing home has its own board, which has been very supportive of PCC, but the home is also responsible to the larger corporate board on some issues.

The administrator reported that the nursing home has been interested in PCC for a number of years. They started with a pilot community (the study unit), and about 1.5 years before our visit, they divided the entire nursing home into seven communities. A large part of the community initiative is to renovate space for dining, which was completed on the study unit at a cost of \$500,000. NH1 sent 55 staff to training in 2003 (customer service), 14 in 2004 (customer service), and none in 2005, for a total of 69. These numbers (maintained by the union) do not reflect management participation.

At the time of the visit, management was conducting focus groups with management staff (community coordinators, head nurses, recreation staff, dieticians) to evaluate where they were in developing PCC practices in the nursing home. The administrator said the message was, "We are moving too fast." They were planning to conduct similar focus groups with direct care staff in a few weeks.

Social workers and therapeutic recreation staff were non-union in NH1, but a vote was coming up soon after our visit on whether they would join.

Nursing Home 2

The second study site is a large (about 700 beds) stand-alone nursing home that has seen a great deal of change in its neighborhood since its founding late in the 19th Century. In the last 30 to 40 years they have tried to make more community connections through collaborations. Besides the nursing home, they have senior apartments, medical adult day care, a childcare center, a home care program, naturally occurring retirement community programs (NORCs), and a community resource center.

The nursing home sent a small group to the first QCC conference in 2003. They came back enthusiastic and created a collage that hung in the cafeteria. They did not really start to involve the frontline staff until the trainings expanded in 2004. They sent 26 staff to training in 2003 (topics included T and E committee, foreign language), 444 in 2004 (customer service, clinical pain management), and 117 in 2005 (palliative care, gerontology), for a total of 587. Social workers are members of the union at NH2.

The PCC neighborhood consists of two 34-bed units in the same high rise, but separated by several floors. We visited the part of the neighborhood that was more advanced, in part since they had renovated the lounge (at a cost of \$200,000) to accommodate dining.

Summary of similarities and differences

Both homes reported that they had a history of patient-centeredness that preceded the Labor-Management Partnership initiative, as well as an interest in PCC. To initiate PCC, both study homes formed pilot communities led by community coordinators, moved dining to the units, and instituted classic PCC practices on the front line (e.g., teamwork, expanded jobs, "just do it" ethic, accommodating resident preferences in schedules and food, etc.) To start and reinforce initiatives, both extensively drew on the QCC's training modules, as well as other approaches. Both recognized the need to shift decisions in line departments (nursing, dining, activities, housekeeping, and social work) to the units, while creating a more streamlined administrative oversight of more traditional departmental functions. Both negotiated and discussed labor-management and contractual issues in a labor-management committee and other groups at the nursing home level, and in the communities via delegates. Both had a mix of supportive and less supportive delegates, and the organizers covering both homes were more in the traditional mold. Both were farther along on the day than the evening shift.

The major difference between the two homes was in the degree of letting go of management control and trusting the process on the community level. Further, the legacy of labor-management conflict seems to be stronger at NH1.

B. Essential elements of change and how they worked in the study homes

1. Joint management-union committees, visions, and resources

Managers, workers, and union delegates and organizers drew on QCC momentum, vision, and training programs to create new types of labor-management discussions and approaches to organizing work. Although the legacy of labor-management conflict did not go away, the committees and discussions were a way to handle them and move forward together on PCC initiatives.

Labor-management partnership training

It is difficult to over-emphasize the importance of participation in training on the implementation of PCC in the two nursing homes. Both frontline workers and managers were impressed:

People were worried at first – thinking, "Oh boy, it's going to be harder," but then the training programs people explained it to us and they realized it's good and it's easier than before. The training is the key. It's the key to it. They really helped a lot.... I'd tell someone starting it (PCC), "Just continue. Go to the training, try it. Keep with it and you'll see it's worth it. At first it seems hard and you don't want to do it, then it catches on and gets much easier and it's worth it." (A CNA on the evening shift)

The QCC helped because they are like the connection. They validate what we are doing. Like for the union and the union staff I think that's really important.... The union really embraces this also. And the QCC is like the vehicle to bring us together so that we are all on the same page. I don't think that we would have gotten anywhere near what we have done if that wasn't the case. I think they have really been like the middle man, you know, bringing everyone together. (A manager from NH1)

I will say 1199 has been wonderful in supporting opportunities in getting people away from their work so they can learn and experience new things. That is the biggest help in terms of doing this together with labor. (A manager from NH2)

When people go to the conferences, they get lots of information, etc., and then bring that back to their own nursing home, which essentially spreads the word and increases the hype.... "One of the things they did at the QCC conference that really mattered to CNAs (was) they flipped the organizational chart so that residents were on top, then CNAs, and then at the bottom was management.... as a support system for the people who care the most and know the most about the residents.... When they brought this chart in and showed it, there was crazy applause. It was really a big deal." (A CNA delegate at NH2)

Joint committees to handle initiatives and conflicts

At NH1 the labor-management committee meets once a month. The director of human resources sets the agenda. Attendance includes the administrator, the community coordinators, the director of food and nutrition, the director of nursing, the union organizer, and several delegates. After what one manager called "a rocky start," they changed the membership, including having the Administrator join, and the union brought in a facilitator who helped.

Respondents pointed to the following example showing the committee working well. When the union raised a question about how CNAs and food service staff were being treated, the committee decided to develop a code of conduct. Discussions broadened the code beyond the immediate issue to include tone of voice used by front-line workers and supervisors in speaking to each other and to residents and families, talking in public versus private, saying hello, answering the phone when it is next to you, responding to a call button whoever you are. A recreation therapist on the labor-management committee described how they created a video on the code:

We put together a video ... to show comically the right way to treat residents etc. (phone etiquette, behavior, etc)... Then we did it (showed it) to everyone at an in-service.... The committee decided that our project for the year was customer service – helping residents, families, etc. So that’s why we made the video.... Our goal is to get workers on board with PCC and really be in tune with residents, their families and the people who donate money to us. So hiring we talked about – you need to have the right personality: friendly, approachable, happy people, we can train them to do anything.

The video is now shown in new employee orientation.

The going is not always smooth. Managers in both homes had a variety of complaints about the union, e.g., attendance, power struggles, and lack of full commitment to PCC. But a top manager in NH2 was optimistic, saying that they tried to invite "more difficult workers and union delegates and win them over." He put the challenges in this area to two functions: the big Labor-Management and the day-to-day in the workplace." The question is, "Is the second informed by the first? Maybe a little." He saw the union as both a challenge and an ally - a challenge in that they needed to negotiate, but an ally in that "the union brings resources, and 1199 is not the typical union. It's enlightened much of the time. It sees the value (of PCC) to the health care worker." He described how the union helped develop and support an approach to absenteeism and lateness: "We're working together for better solutions, but there is a distance to go.... But there are also local supervisors and HR managers who have a long way to go too. I'm not so sure we're any better at it than the union is."

Knowledge of the Labor-Management Partnership seemed to fade as we moved down the occupational line to frontline workers, although workers did have a general sense that the union supported PCC. This CNA's understanding was typical: "Before culture change happened, we had training for the culture change. I think the union sponsors it." Like many others, she was not really sure, but almost all workers we asked did know that there was joint union/management support for PCC. A CNA from NH2 reported that management and frontline staff worked together more since PCC.

'Management puts more interest to us – especially when we ask for something. They (management) respect us more now. They respect our decision when we talk to them. We know the residents more than anyone else. They listen to us now – when we suggest things. About things for residents: Care, food, room furniture arrangements, etc. – whatever it is. So whatever I see I want to change in the room. I don't do it without permission – but now I can go and talk to them – the supervisors and they will listen and respect my suggestions. When we have floaters – nurses - I know the tricks – some of the residents won't take their meds but I know them, I know how to get them to do it. So now the nurses will listen to us – in a situation like that. Before (PCC) they wouldn't have.'

A union organizer for NH1 related how she worked to create this safe space:

The major benefit (from the Labor-Management Partnership is the) the membership on a whole... has a forum which is promoted and protected by my top leadership and management top leadership. It's protected where they can voice their opinion and their concerns and know that there is a body there that care about our relationship. So if I have a concern, my concern will be looked at because there is a relationship in process that people really take seriously and people are willing to fight to protect.

This organizer (an LPN) explained that the safe space also allowed non-union community coordinators to approach her individually about PCC:

And they themselves (coordinators) will speak to me from time to time, and that's a managerial position by the way - it's a non-bargaining position.... Through culture change and our committees they are able to share with me what their concerns are and I am able to hear that. When if there was no culture change, that aspect of the discomfort their job role, I wouldn't know. I would just only know what the discomfort is from labor point of view. Now we are able to openly share what our discomfort, our affairs, our joys our achievements are. We are able to openly share that now.

In summary, it is difficult to say if discussions like those that led to the video could happen without a union representing workers. But the union did seem to create a safe space for labor-management discussions, a space where workers had voice and could act, and a window into workers' concerns.

2. Management support for PCC: Reorganization and devolution of decisions to the community level

Although management and the union collaborated in joint committees in the homes, all acknowledged that at the level of the nursing home, it is management's responsibility to initiate, shape, and maintain PCC. There were several essential elements, including creating the community coordinator role, giving some autonomy to the communities, flattening the management structure, setting an example by pitching in, and moving food service to the floor.

Giving autonomy to the pilot communities and community coordinators

Both homes were finding that the role of the community coordinator was central to the success of their neighborhoods, and both were still working out the scope of the coordinators' jobs and the skills needed. Coordinators had to learn regulations on environment, food service, etc., while also figuring out how to create and manage the community. When asked what the coordinator did, one replied, "Everything! (I'm a) "mini-administrator (of) nurses, aides, housekeepers, dieticians, recreation therapy - everyone reports to us. The coordinator is the administrator of the unit."

The challenges of ceding control to community coordinators were openly acknowledged in NH1, where the administrative structure was still straddling both worlds. The model was to give more control to the community coordinators and to turn former department

heads into consultants in their areas of expertise, e.g., social work, recreational therapy, housekeeping, food services. One community coordinator reported, "This has been and continues to be an extremely difficult switch." First the housekeepers and food service workers were under the community coordinator, and then the latter went back to food service. "So these director/consultants call department meetings without telling the community coordinator, ... and it's a big fight." Also, scheduling was all still centralized under nursing, housekeeping, dietary, etc. We heard of conflicts along the same lines in NH2, but the tide seemed to be more firmly shifted to giving control to the coordinators.

Top administrators and department heads understood the need to cede decisions and control to the communities/neighborhoods, but their dilemma was that they were still responsible for their "silos." They could not afford to lose all control. The two homes were in different places on this issue, but both acknowledged problems giving up control of institutional decision-making.

A top administrator in NH1 said that the coordinators did not trust department heads to make decisions, and the feeling was mutual: "I get scared to let go.... In my heart I haven't changed... In my heart I think they haven't either." A director related how she had recommended a performance improvement plan, and the coordinators pushed back, saying, "You're giving us things to do - let us do them." She agreed that the coordinators needed to be able to make mistakes and that she "should just be there to make sure there are no catastrophes."

The reluctance to let go could also be relatively trivial, although symbolically important. For example, one of the model units in NH1 apparently had made the decision not to have a Christmas tree, until an administrator came by and said, 'Where's the Christmas tree?' The unit felt compelled to hustle to get one. Another administrator gave the example of a corporate-level decision not to provide soda on the units. This was in conflict with resident-centered care, which says that the residents can decide, and they decided they wanted soda. So NH1 let the community make a special order, but the community coordinator had to keep the soda in her office and track it being handed out.

Less was heard about these kinds of struggles in NH2. An example of giving more autonomy was self-scheduling, which was said to be especially important for CNAs and nurses. The prior policy was that central scheduling would look across the nursing home for needs, and if a floor was short, the scheduler would pull people from the PCC unit to fill in. This has been stopped, and nurses and CNAs are no longer pulled from the PCC floor.

The managers in NH2 also "talked the talk" of recognizing what expanded responsibilities for workers meant. In the words of one senior administrator: "If the housekeeper sits down to have coffee with a resident, you can't have a supervisor come in and say, 'that corner's not clean.' ... We can't [just] give lip service to this."

Restructuring (streamlining/flattening) management

To free up resources for staffing the new communities, and also to devolve decisions and responsibility to them, it was the consensus of respondents that homes needed to "flatten" or streamline administration by cutting positions and re-defining administrative responsibilities. One manager put it as "Flatten out your organization.... not as many managers, administrators, directors.... Bring management out to the floor closer to care delivery itself." He went on that each community is different, so approaches may differ and gave the example that the housekeeper might run the staff meeting in one.

But flattening was challenging. As described above, NH1 eliminated its housekeeping and food service departments and turned the directors of these departments into "consultants" for their respective areas. This proved to be a difficult switch, including struggles over whether frontline workers in these departments reported to the community coordinators or their respective consultants, over who could call meetings, and over who controlled scheduling.

Setting an example by pitching in

One way that managers sold PCC to staff in both homes was by saying that everyone would pitch in to help frontline workers. In the early days of forming communities, managers were in evidence pitching in and in getting to know workers and residents better. When this participation declined, some cited it as evidence of over-selling the benefits of PCC. The complaints were common at NH1: "They're telling us to get on board and now they've jumped off the train." One of the community coordinators pointed out that this led to problems with the union:

This is what union people are complaining about. Union people were told that everyone will help you – you will get a lot of help. But they don't get this help. The layers were added to the top, not to the direct care, not on the floor, where they are needed. And this breeds resentment on the part of the union staff.

Continuing examples of pitching in were more common in NH2, e.g., an administrator who brought Buddhist spiritual exercises to staff and residents in his spare time. But an administrator pointed to the challenge of getting middle management involved, in part since they had not been to the training as often as the line staff.

Our biggest challenge is to engage the department heads and the middle managers because we haven't had the training for the middle staff... we haven't had the funding to do the training for this group like we have for the line staff. And we have a big middle... I want to use the word lighten up, but really that's what they need to do. Stop having a knee jerk reaction and when they see things changing, engage – ask- before they start making accusations. I'd really like to do the lead by example initiative... that if the line staff, who has not been through the training, sees a supervisor or whatnot engaging in non traditional ways, that the behavior will patterned and move throughout the institution.

Move food to the floor

Moving the serving of food to the floor appeared to have multiple, positive impacts on PCC at both case study homes. The move was a major change that involved use of and renovation of space, as well as managers and workers from multiple departments. A social worker in NH2 related a meeting of kitchen staff, who were wondering what would happen when steam trays moved to all floors and more food workers were interacting with residents. She said they were 'looking forward to having the resident contact, but it will be different, scary, confusing – an enormous change. The change will involve everyone. Food is huge around here.' A nurse from NH2 described how moving the food advanced PCC:

'We used to use trays that came from downstairs, and if someone didn't want what was on the tray we'd have to call down and wait for them to send (a substitute) up. So now we have choices on the floor – fruit, cereal, eggs, etc., on the floor. It's much better for us. They get up when they want and then eat breakfast in bed or at the table in the dining room.'

Resources - day shift/evening shift differences

Respondents were clear that material investment was necessary for creating PCC. This came out clearly in the funds for training (see above), but also in appropriate physical space, and in adequate staffing of the PCC unit, particularly on the evening shift.

The need for renovated space was seen as important but not as essential as changed staffing levels and processes. A senior administrator in NH2 admonished:

Make sure that you understand what it means programmatically in terms of peoples' lives, and try to entertain opportunities without having to wait for physical changes. It's a big error to wait for physical changes. You can live and work together in a different way even if the environment continues.

He said that this is true even though shared rooms for residents did not represent optimum autonomy and dignity.

It was difficult to sell the expanded jobs and helping out if it meant helping do someone else's job without getting something back on your job. This came across most clearly in contrasts between the day and evening shifts and apparent staffing up on the former and not the latter. For example a nurse in NH1 pointed out that in the daytime there was additional supervision from the new community coordinator position, but at night there was very little supervision. "They have to focus on the night shift - it needs to spread." A CNA working days in NH1 liked the flexibility of PCC, but she received negative feedback when she left unmade beds for the evening shift: "So when the 3pm shift comes in it should be ok, but really it's not like that. They get mad."

These three evening CNAs at NH1 were not happy. Said one, "Yes, we have more say because now we have meetings where we can give our ideas and let them know what can be done and we try to work with each other.... You talk but nothing changes. We get

promises." Said another, "There's no staffing. Give us more pay." And the third: "I haven't seen any changes. We work more."

In summary, respondents in both homes recognized that management supported PCC, and that support was key to success, even if things didn't always work perfectly. According to this social worker at NH2, clear management support was linked to success.

'It's because it came from the top that it will or even can work. If it came from CNAs, nurses, social workers, etc, it would never work. It works because it's a top-down initiative – it comes from high up. Because upper management makes it clear that they are committed to culture change, it frees up staff to be creative – to think outside the box.'

3. Union support of PCC

The third ingredient that seemed essential to creating PCC was support from the union. Person-centered care was introduced into the study homes in the context of the existing union contract, union representatives, union members, and history of labor-management relationships in the study homes. Parallel to management, the union appeared to do a lot to support PCC, but it also had some trouble letting go of traditional ways of operating. Essential elements of making the union a support rather than a hindrance to PCC included several factors.

Turning around a legacy of conflict

Given their roles and traditional relationship, the union and management were used to conflict. While they were working together in the QCC, there was still this legacy of conflict to overcome. From the interviews it appeared that there was more of this tension among delegates and organizers, rather than tension generated from worker-level resistance to job changes. Nevertheless, as will be seen below, there were still frontline workers in both nursing homes who were not buying into the PCC initiative, and they were apparently letting the union know about it. This put the union organizers and delegates who supported the PCC initiatives in a difficult position of appearing to side with management over workers.

A NH1 manager who attended the labor-management committee referred to this tension in his comment about working with the union:

"It's (hesitates) OK.... It's hard to get away from labor management conflict.... back to old school.... I keep thinking, 'this is not big stuff, so can't we get positive?' ... Is it that the organizer feels he has to assert himself in front of the members?"

An organizer who worked at NH1 as well as a larger home from the same system (NH3) gave her view of the difficulty of jumping into change. She contrasted how the union in the larger home was older, larger, stronger, and more established and therefore could approach PCC from a position of strength and participation:

And the level of participation of the membership in effecting the change, it is not as great in NH1 as it is in the (sister NH). The level of membership participation in NH1 is basically, what I am hearing is from them is, "management say and we do." In (the sister NH) they are more mature union and more union oriented and their contract has been in existence much longer, and... it's not as challenging for them to give up any part of their collective bargaining agreement than NH1.

Two other organizers we interviewed also referred to dynamics that pulled the union back into the protective mode. When we asked one who worked with NH1 why workers seemed so happy working there, he did not acknowledge the positive but rather said that complaints were the same as everywhere, and there were also new ones related to PCC. He said that when CNAs had to start cleaning tables, they were very unhappy and complained that this was not their job. He said workers complained, "I wouldn't have gotten CNA training if I knew I was going to be cleaning tables," and that to these workers, PCC looked like more work – doing more with less. He said he heard angry members saying, "The union is selling us out."

An organizer in NH2 had supportive things to say about the PCC changes, but he agreed that workers often said that PCC is more work for the same pay, and also that the delegates were not too happy with the new agreement. They wanted more specifics about the expectations regarding PCC. If PCC works, he felt that workers should have more say in assignments and schedules. Although we heard these types of complaints from a few workers, they were much the exception rather than the rule. One explanation for the organizers' stories of dissatisfaction rather than the satisfaction we heard from workers may be that organizers and delegates are put in the position of hearing complaints. They are also vulnerable to the accusation that they are "selling out" to management by cooperating to expand jobs and allow experimentation outside the contract.

But we do not want to imply that this cautious, defensive stand was the only view expressed by organizers and delegates. The first organizer quoted above also articulated how the union supported PCC and how it helped frontline workers to buy in:

.... Because we got it (PCC experimentation) written as part of our bargaining agreement. I see it as a very vital tool in problem solving and it has given our members a greater awareness of their responsibility as workers in an institution. Not just "I am a worker," but "I have an interest in this, I am a part of this, I am owning this, if it fails it means I fail." Sometimes they don't feel like that is, but then there are other times when they do feel like, "yes, my needs are met and I have a voice."

Flexibility in job descriptions

Notwithstanding struggles, the union was not letting the contract stand in the way of altering job descriptions in ways that supported PCC. Organizers explained that sometimes descriptions were changed in writing and sometimes just allowed to happen. In either case, the extent of working out of role seemed to be left to individual workers who were working it out with their coworkers and supervisors on the units. Managers

related similar stories of flexibility on the parts of workers and the union. The HR director (NH1) said that after the home re-did job descriptions, they met with the union, and they "tweaked them a little." The extra wording was to "help work together with the community." He said that when the environmental people went to the units, there was no forcing them to help. He just said, "You're part of the community, and if you want to help you can." There was no change in their job descriptions.

One of the organizers explained the ripple effects on job descriptions of a successful initiative of moving dining to the unit, followed by giving residents a choice of when to get up. Again there is the issue of bringing workers along:

Then they brought in this wake-to-change where the residents say when they wake up and when they go to bed. The challenge is how do we get enough staff to facilitate the needs, that kind of free flowing needs of the residents. So we are still really at the crossroads with how do we adequately staff these units to meet the needs.... With all the best of intentions I think we are going really, really fast and we kind of need to slow down a little bit because I think on some level we end up with a lot of our members being very frustrated because they are very lost in the process, too. Because now we are at the point where job descriptions are getting in the middle, the contract is intertwining - now seniority is a big issue. It's a matter of us dealing with the collective bargaining agreement versus our best intentions.... I don't think we have given them enough time to do that. I myself being in the middle of the process, I am understanding of it. But I am not so sure that all the people I represent have all the same thoughts and ideas. One or two or three people because I can still hear them saying, "I tell you its more with less, I tell you its more with less." And I just feel like that is the rope I see as fraying at the end. Even though we have such great things and systems in place, we need to perfect these systems and keep them before we move along. The train is moving faster than we are ready for.

Backing workers in PCC

Closer to the front line, the union delegates sometimes supported PCC, and sometimes they did not. On the one hand, a CNA (NH2) reported, "the delegate is there when we want. There's always a delegate there." She related the example of meeting about adding Saturday and Sunday to the days food is served on the floor. She had related that those were the worst days on the floor; that the residents were unhappy with the food; and that food, medications, and hygiene were related. They are the key things and they go together. These are three things that need to be coordinated, since some medications cannot be taken without food. She said that the delegate said she would help: "She did and it changed." In other interviews, the delegate on the PCC unit in NH2, a dining service worker, was cited as a leader in the PCC process. An administrator said, "She's vocal and has stepped out of her role." "Humans are not a tray ticket" is a slogan. She also led the cooking group on the unit, which included taking residents shopping.

On the other hand, there were counter examples. A head nurse in NH2 said that they had excellent relationships with the delegates, but there were still PCC-related grievances.

For example, when the dirty laundry was not getting to the laundry on time, and the clean laundry was not getting up in time, they had CNAs spend time in the laundry and laundry workers spend time on the unit in order to understand each other's jobs. There was a grievance filed immediately. It wasn't from the staff involved, but rather from the delegate.

Union members' knowledge that the union supported PCC

Rank and file union members generally did not seem to know the details of the Labor-Management Partnership, particularly at the city level, but they did know that the union supported PCC. A nurse at NH2, a member of the union, said she and her colleagues "go to lots of trainings" and conferences set up by the union. They made her rethink the boundaries of each person's duties. She also said that the union "gives us teeth," so not only is it nice that they have opinions but they have some force. A CNA at NH1 cited weekly meetings with the delegates that "keep us up to speed." Also, "Delegates mediate between CNAs, etc., and management.... They go between us both."

But as suggested above, the feeling of being supported was not unanimous. Here is a CNA working evenings at NH1:

The union and management are friends – (smirking) very good friends. I think they shouldn't be such good friends. They are supposed to be protecting me – not speaking for management. And if you speak for management you are not protecting me. The union is not helping me in any way. A lot of people feel the union delegate gives them the run around nowadays and don't really protect us.

Maintaining traditional protections

The union delegates and organizers maintained their solid vigilance concerning the traditional rights protected by the contract. These include scheduling issues, rights to jobs, and representation for grievances brought under the contract.

Scheduling

Choices about assignments, weekly schedules, and vacation timing are typically allocated by seniority across the employee group, but when control is devolved to the neighborhood or unit level, there is pressure to constrain individual worker choice to stay within these more limited boundaries. Scheduling at the unit or neighborhood level furthers the PCC principle of assigning groups of workers to groups of residents, which fosters better worker relationships with and knowledge of residents but limits the unit's flexibility to "float" workers in or out to meet workers' schedule desires.

With respect to vacation, the human resources director at NH1 said that some things had not changed: "The older workers know that clause [with respect to choice of vacation according to seniority] very well." Another supervisor told us, "There is talk of managing vacation time by community or village versus overall seniority in nursing home. Working this out is difficult because time off is so important - some people have second jobs."

In one case, the principle of maintaining the attachment of workers to the community gave way to seniority and other rules. Some senior nurses wanted to move to part time without losing their permanent assignments to a particular community. The DON asked all the nurses to decide as a group whether this would be acceptable, and the nurses overwhelmingly chose to remain with the traditional rules: "no - if you cut, you float."

Management commented at NH2:

One of the difficulties we have encountered with this first community: vacation by contract is based on seniority within the house... so what can happen is that I might have 3-4 members be on the vacation at the same time, because the vacation is planned to the larger house. So how are we going to do that if we are going to have staff self schedule within their block? That's a major union issue. So, how [can we] roll that out differently.

The contract that says vacation is by seniority, but Unit 4 is trying self-scheduling. "If a CNA says, "I want February," I have to do it according to seniority in the facility."

Rights to jobs

Seniority is also the traditional principle for job upgrading, but PCC is seen as demanding new skills and talents, and the most senior job candidate may not be selected for a new position in the flattened organization.

On the other side, when jobs are lost seniority protects the longest-serving workers. These nursing homes were not downsizing overall, but were closing down the tray line in the dietary department, for example, and shifting workers to the floors. Among the QCC homes, several were downsizing, and union and management leaders alike were aware of homes in the New York City area that have recently downsized or closed.

Many facilities are downsizing and having layoffs. Not this facility. But in a few months the laundry is closing. But there will be no layoffs - all 35 workers will have the option to go to dietary or housekeeping or training for CNA. They keep house seniority (in case of a layoff or a bump) but start at the bottom in their new department.

It will be difficult when the tray line is abolished and the jobs are shifted. This is likely to happen in three or four months. Q: how will be people be placed? Seniority chooses? A: I'd like to be able to assign by fit, level of energy, but I fear it will be seniority.

Grievances

The union organizers remained committed to traditional union functions, including supporting workers who bring grievances under the contract and connecting workers to the benefits they were entitled to, like childcare, training, health and dental insurance. Grievances seem to be brought at about the same rate, but about different issues or in a different manner from previously.

If a worker is given a directive by supervisors [that she feels is not within her job definition] - just do it and grieve it later. Don't just say no, it's not my job – [if she were to say that,] then the worker is suspended, told to clock out. Instead, go through grievance procedure. Third step hearing, hear both sides.

For example, a year ago there were a lot of workers tardy or AWOL. They agreed that the union would work with the identified workers about why they were not there when they should be. They learned that some people came all the way from Brooklyn and had to drop off a child first. So they pushed back their start time by a half hour. The union did this by meeting one on one with the workers.

For example, there's a suspension and a third-step grievance, and the organizer has to say something on behalf of the member. But it's changed in subtle ways from the past in that if there is a good management case, the organizer will not fight. It's more like, management puts out the case, and the organizer says, "Do you understand what HR just said?" Management will also call the union if they suspect a drug problem and ask the union to get the worker into 1199's drug counseling.

An example was given of a situation that likely would have led to a grievance being filed previously: A male resident was often “out of control, hitting, cursing, threw glass of water across the room. Rather than filing a grievance, the staff put a petition together, [saying] we can't take this.” The staff “worked out a rotation to spread *him* around,” and implemented it through the monthly labor-management committee.

4. Frontline workers' support for PCC

The fourth essential feature of creating PCC in the two study homes was the reaction of the frontline workforce to PCC concepts and practices. The overwhelming majority of paraprofessional frontline workers - including CNAs, nurses, housekeepers, and food service workers - seemed to whole-heartedly embrace PCC, and their embraces seemed to reinforce and solidify change. Social workers, recreational therapists, and dieticians were more tentative in their embrace, for reasons described below. There were some differences among frontline workers in perceived gains and losses, but generally they reported gains, including most importantly the chance to better serve residents and to enjoy their jobs more. As illustrated in the sections below, the status of frontline workers as "essential ingredients" is illustrated in their willingness to "pitch in," to find their voice and contribute their ideas, to collaborate with one another, and in how they reacted to the expansion of their jobs.

"Pitching in"

One piece of the PCC ethic that frontline workers cited over and over was the need to get by the "it's not my job" attitude and embrace the "just do it" or "pitch in" attitude. Most found that they got back just as much or more than they gave in the form of help from other workers and positive reinforcement from residents.

For example, a housekeeper in NH1 reported that his day started with taking residents to breakfast and helping with feeding, and that "then my job begins." He said he was not required to do the extra work but rather volunteered to help with transporting, eating, and recreation. He also took residents to the garden, played cards with them, and more; and he said he was "paid back" when others helped clean up.

A housekeeper in NH2, when asked how he balanced his regular job and the time working with the residents said that he told his supervisor (the housekeeping director) that every Thursday he would spend 30 minutes with the residents: "The supervisor knows it's part of my job to work with residents. If they need help, I need to stop my work and help the resident first." When asked whether there were some things he should not help with, he replied, "Anything I do I feel better to do it."

A CNA delegate in NH2 sees workers stepping out and supports it:

A lot of natural leaders who set examples and took the lead, this helped people to understand - hey, it's ok to care. It's ok to become emotionally involved with the people who you take care of. See - it's all about no separation, no longer a them and us... residents and workers. We are them and they have been us. Sometime this will be you - that's when you realize how important this is. It's much bigger than all of us individually.

A nurse coordinator from NH2 reported that pitching in changed her job, as well as the jobs of others:

Everything changed for me. I used to stay on the phone, pay attention to supplies, do appointments.... (Now, instead of calling a CNA), I go myself. (So now) I know patients better.... Every call bell is your call bell.... I would say that 90% of CNAs like it better. (Supervisors, even security will) jump right in.... They used to walk right by the lights...I worked at another place and it was 'dog eat dog.' Here we help each other out.

But there are CNA exceptions, most markedly on the evening shift. Here's a female CNA from NH1:

We need more togetherness.... Some of the workers get very upset if you ask them to do something. If they're not friendly with you, they don't help you. Culture change hasn't changed that. The resident is supposed to be everyone's resident, but they don't do it.... So, if I go on break for 30 or 40 minutes and one of my residents has to be toileted, she has to wait until I get back to go to the bathroom. That's not working together! That's not culture change! This happens every day. It just happened tonight. (Q: Do the nurses help?) (She laughs.) The nurses don't pitch in or anything. They don't help you do nothing.

The workers who were having the most difficult time embracing the "just do it" ethic were recreation therapists and (reportedly) social workers. We only interviewed one social worker in the two homes, but they were said to have the same challenges to their identity and status as we found in some recreation workers. Two administrators at NH2

reported that "there was push back" from social workers and the union (social workers are in the union there) when they asked social workers to take training in basic competencies, including feeding. Some were said to complain, "Now she wants us to go upstairs and feed."

The call to pitch in came along with an effort in both homes to devolve the traditional social work and therapeutic recreation departments, which meant less contact with their professional peers and an end to reporting to a department director in their area. An administrator in NH1 said, "Some are traumatized. For some [others] it's a plus. [But the first group,] ...they felt like they lost their mother." The workers in disciplines where department-head functions had been reassigned were said to wonder where to go if the community coordinator had a different professional background, for example when a nurse reported to a community coordinator trained as a social worker, or the recreational therapist reported to a nurse community coordinator rather than to a recreation therapy department head as in former days. Additionally, she said that "the biggest complaint is that chipping in cuts into their professional time." A recreational therapist in NH2 seemed to sum up several of these thoughts. She said that her colleagues:

are scared and confused, because when you go to training and say, 'what will I do?' they don't know how to explain it.... (One therapist colleague) got pulled to be a community director and had to take the CNA course. They worry - 'Will I have to do CNA work?' ... The administration needs to be more prepared in in-services.... There's not enough education about what it will be.... Now my office is on the second floor [i.e. on the pilot unit]. I heard I will be on the floor. If a resident doesn't want to do an activity, will I be cleaning or doing CNA work? ... Will the job be just the community or also the whole facility like now? It's not fun - for staff or residents - to be just on three units.

But this experience was not the only one for recreation therapists. One from NH1 said she was ready to quit before PCC. She said she had not felt listened to, but now she could come up with her own activities. She did a photo journal. She said she wanted to "touch passive residents with touch, smell." The coordinator encouraged these ideas. Here is another recreational therapist from NH1:

Part of (PCC) was getting rid of middle management – that brought about us doing some of the admin work ourselves. So we design our own programs, print schedules. It's a work in progress.... We don't have a department head any longer. So now the community coordinator oversees everything as a whole – so she's now my supervisor. I think that's a great concept. She's right there on the floor – able to really be involved. As TR (Therapeutic Recreation), we have always been involved in the care planning meetings.

Voice

Informants consistently reported that the PCC initiative had created an atmosphere and settings where frontline workers could speak out and contribute ideas. It also gave them

freedom to innovate on their jobs. They also generally thought their ideas were listened to, even if they were not always acted on.

For example, when a housekeeper in NH1 brought an idea to her community coordinator, she felt listened to: "I thought residents could benefit from going out more. They listened and started allowing more outings." A CNA in NH1 was happier coming to work because he felt heard: "I hardly call in sick – only 2 times in the last years because I feel happy coming to work. If you have a problem, you can feel free to go to your charge nurse, your community coordinator, the DON or even the administration, and they'll listen. Other places are not like that."

A community coordinator reported that staff on her unit were more comfortable going after what they needed - "not needing a middle man to do it." She gave the example of a housekeeper who asked her environmental services supervisor for a consistent replacement when she was out. Once when it didn't happen, she complained. The coordinator said that PCC is about the fact that she asked and got what she wanted and could complain when it did not happen.

A dining services worker with experience on the PCC unit also felt free to speak out. He had recommended to his supervisor that another dining worker get training before moving to a new PCC unit: "He did cleaning before going up there. He never learned puree or mechanical chop. He didn't know what's a chopped vegetable." He told the supervisor there that they should have sent him or the other PCC unit dining veteran to do the training.

Another level of voice came from participating in the city-level conferences. A manager at NH2 described how frontline workers were respected as leaders in these conferences:

In 2005 we had the opportunity to do a presentation on what we call our career track for some of our CNAs to become unit coordinators. (They were) very excited about doing the presentation. (This was) the first time you have line staff presenting to a larger group. Normally the unit director or the leader would provide this information. I think the modeling provided by QCC has been really helpful.

But this nurse from NH2 was not alone among supervisors in pointing out that frontline workers also asked for things for themselves. She said, "CNAs have a lot more voice," and she described that they will make suggestions and ask for help. But "it's not always a good thing...they are asking for more..." (e.g., improved ratios, work conditions, etc.) But speaking out is not all bad. There was always poor communication between shifts, and "Now we have more." Overall, CNAs "will come and tell what's going on...so I learn more about the residents"... but they "have more complaints too."

One way frontline workers had a voice in how things were done was in regular meetings on the PCC unit. A CNA in NH2 said both residents and workers were included: "I heard that PCC is going to all of the home.... I guess that when they have meetings, they ask the residents how they like it." She said that the first step is to bring food on the

floors. The next in the PCC unit is more family activities with the residents. When asked how that gets planned, she responded, "We talk... There's time after lunch. Or on lunch breaks what they want us to do." She said they also talk to the floor coordinator.

The security of being able to give ideas and ask for changes, even with superiors, was reflected in being able to make choices about one's own job. For example, a non-union food service worker in NH2 reported, "I have independence to do it my way. I like it that way. (I have freedom) to try things out - no one watching over my shoulder." A CNA in NH1 reported that she had "my own personal routine." She said she had residents who slept late according to their individual preferences. Culture change "was the biggest deal. (We're) in charge of our destiny forever more." We heard this from professional staff, too, e.g., a dietician in NH1: "I can just do whatever I need to. Want to do. It's easier now for me to do things as need be. I'm less restricted."

Working together

As can be seen in the informants' comments related to pitching in and voice, work on the PCC units came to be characterized by more productive working relationships between frontline workers and managers. Frontline workers were encouraged to think about their work with residents and about how the unit operated - and to talk about it. This led to opportunities to create and test new ways to collaborate and coordinate their care.

For example, a CNA at NH2 reported that at the start of the day she went through the residents one by one, especially those who had particular issues, e.g., if medication changed, if they had fallen, etc. She said that the nurse always said to her, "Whatever it is, you can get me right away. Whatever I am doing, I'm not too busy to go and see." It is clear that this was a very big deal.

Another CNA at NH2 reported how the CNAs collaborated to switch patient assignments. In contrast to other units, "Here we sit down with the other CNAs and decide who gets who." She gave the example of an aggressive Spanish-speaking patient, whom she traded with another aide who spoke Spanish. They told the nurse and she was OK with it. "We have a very diverse culture here. It's nice. It's New York City."

Here is a female CNA from NH2 who described an openness in relationships. She said they "try to work as a team. Understand each other." If there is a problem, in other nursing homes, some people just fight. It's better "to encourage people to work as a team and to understand each other. ...If there is a problem here, I can look in the face and say 'what happened to you?' because I know your face."

A CNA delegate in NH2 talked about how frontline workers supported each other when they encountered difficulties:

(There is) resistance to change. From staff. On both sides. ... We have a lot of people on board now, but there's still some resistance. Support groups been helpful in working thru those problems. Trainings. Peers talking to peers about different things.

Dining was another area where frontline workers reported collaborating. A recreation therapist in NH2 said that the difference between the PCC unit and the rest of the NH was that "we know what the residents want." The staff work together. For example, a resident got an extraction and did not want the food. The dietician was not around so the other staff went to the community director and asked if they could go to a local Spanish restaurant and get soup with noodles. She said OK and the resident said OK and they bought the soup, and the resident ate it all. You are "more likely to see that here."

A consulting psychologist in NH2 said that one of her goals in the nursing home was to get residents to be more assertive to get their needs met. For example, on a regular unit a woman was separated from her table partner, who was giving her food (the woman was obese and on a limited diet). She worked with the staff and the resident to get her back with her friend. She contrasted this to the PCC unit: "It wouldn't happen on this unit. They'd understand the social connections between the residents earlier and work it out."

A dining service worker in NH2 gave an example of how he worked through a resident's needs and preferences with colleagues:

The nurse or a CNA will talk about a meal or a resident, and I'll confirm with the dietician.... The menu says a mechanical chop, but the resident says, no. I'll talk to the dietician, and she talks to the resident, and she says, try her on regular.

A female housekeeper in NH2 described how she collaborated when asked if she had a chance for voice. She described an issue to the monthly unit meeting. Her question was, "If I'm not here, why can't someone else clean the microwave? Or clear out old food from the refrigerator?" (Question: What were the results?) "One thing about this team: If you ask, they'll listen and do it. Without teamwork, forget it."

Expanded jobs

The frontline workers were essentially unanimous that PCC was more work, but they mostly reported that it was more enjoyable and fulfilling work. Housekeepers experienced the biggest expansions, and they were the most consistently positive and remarkably caring. Here is a male housekeeper from NH2:

When I come in I say Hi to the residents. "How are you doing?" I help them feel better.... What do you want to eat? If you need food, just call me. (He goes room to room.) I want people to feel like this is a home. (Question: Can you give any advice?) You have to be loving to them. If you have compassion and loving, you can do (PCC). Sometimes residents are hard to reach. You need love, compassion, and patience. Some residents are hard. They say, 'I don't want it.' Without patience you leave it alone. With patience you go over the options. Patience - and love them. They left their home and they came here. It's not easy, but with those you can work through it.

Here is a male CNA from NH1:

Culture change changed my job a whole lot. I began in '93 – then it was you work by yourself, if you ask for help you don't get response. Now everyone helps – now with culture change – nurses, community coordinator - now they help us to make our job easy for the benefit of the residents. They help with care of residents. So, culture change has made my job better, makes me feel like I want to continue working here.

CNAs gave both positive and mixed reviews of job expansions, the latter more common on the evening shift. Here are contrasting CNAs on evenings:

The culture change – we get more things done and the flow is better. It's much easier now to me. It's easier. Things flow.... We (CNAs) didn't want culture change when it initially started. We thought it would be much harder but now we see it's better – it's not harder.

Culture change is more work, it's much more work.... Now we have to set up the dining room and help puree the food or whatever they need, so that's more work. That's adding to our job duties. We have to get it ready for each and every resident.

This dietician from NH1 said that all staff on the PCC unit were very involved with the residents, and it paid dividends in promoting teamwork:

I help toilet the residents, etc. I help when and where needed – I don't mind at all. I think people see each other as peers now. (There's) not a big hierarchy among staff on our unit. ... I trust the CNAs implicitly. Anything they tell me is valued ... and I let them know that ... and they know it. I think that's why our floor works so good. I need to rely on CNAs' observations of the residents' behaviors, eating, etc., and they are excellent at communicating that to me. I always listen to whatever they tell me about residents.... They are integral to how I do my job. And I trust them and their judgments. We have a great staff here.

A manager at NH2 discussed the challenges for vanguard workers - challenges that came from both management and co-workers:

On the model unit, by selection or luck, the staff from environmental services and dining services are wonderful and have just taken initiative on that unit that would not normally happen on another unit. For example, on the weekend a CNA floated in and the environmental services worker knew that the resident was very particular in their needs and wants and so she spoke to the resident first and then the CNA assigned to her and switched with another CNA. Now this would not happen on any other unit. First of all the awareness that this was going to be a tough day for the resident and the staff, and to take the initiative and not have gone to the nurse... so that kind of behavior, and that's what I call a self-directed response to the needs of the resident.

5. Residents' and families' contributions to PCC

The concept of person-centered care makes little sense if the persons in question - the residents - cannot or do not express their preferences. Thus resident and family participation are the fifth essential ingredient to PCC. Although we did not interview residents, and thus we cannot let them speak for themselves, they did not sound like or look like passive players in PCC. Rather, through interviews with staff and managers, we saw evidence of dynamic communities forming with individual preferences expressed, understood, and attended to. Among staff, the idea of choice for residents was universally valued and associated with PCC and with a better place to work, even when it was also a source of additional work. Respondents even reported tension around residents' asking for too much - either something that was too much work or not appropriate for the resident.

The choices that were most discussed by staff - when to get up, when to take a bath, and what to eat - seem so basic to dignity and individual autonomy that it is easy to overlook that they are often not honored in nursing homes in the U.S. This CNA from NH2 contrasted bathing in the PCC unit with bathing in the rest of the home as the absence of "the tug of war": "It was hard - the tug of war. Residents were difficult about not wanting a bath." In the rest of the nursing home, there were aide/resident disagreements, whereas in the PCC unit, "I like what I see in the change for residents and CNAs.... All departments pitch in.... Residents get what they like.... There's no 'tug of war' that we had in the old days." (Now we can) "accommodate what they like." For example, the night shift does two showers.

Offering residents choices led to more demands, and frontline workers had to figure out how to respond. For example, a food services worker in NH2 explained that PCC "is based on residents' needs, not our needs.... It's actually more demanding on staff.... You know if the resident is alert, they demand a lot, and they are ALWAYS right.... They ask for everything...three deserts, always demanding more." In her opinion, residents needed to have "more explained to them about" PCC and "not just that this means they get everything they want," which is the message that she thought some workers and residents had received.

A social worker in NH2 explained that residents on the PCC unit were aware that they were the model unit, and they had developed higher expectations of care. There were more amenities on the unit, and staff (CNAs) were bothered early on because residents expected more, expected the staff to do more for them. This was difficult for many of the CNAs who'd been working with these same residents. Residents were now so demanding and quite entitled, saying in the words of this respondent, "You're supposed to do this for me, because it's the PCC floor." The social worker said that this was a big snag to work through, but that it was no longer such a big problem since this was what was being promoted: more rights for the residents. Staff should feel good that the residents are more aggressively demanding and knowing that there can be change.

One of the new skill sets that frontline workers needed to hone was how to work with families. CNAs reported working directly with families about care issues, e.g.,

suggesting clothing with fasteners in the back for a resident now being bathed with a Hoyer lift. Some said that families explicitly asked to work with the CNA rather than going through the nurse. Even housekeepers developed relationships with families, e.g., a housekeeper from NH2 who said that families were sometimes on the phone when he picked it up. "I say, 'I'll get the nurse,' and they say, 'no I want to talk to you.' ... One resident said to me, 'Why do you take charge and help with the team? I can't believe you're leading.'" He said he couldn't believe the resident was watching and would say this, but that she went on...."go back to school." He said it was clear that she was really concerned for him.

Workers on the unit also had to learn to mediate between the differing preferences of residents and families. For example, a clinical administrator in NH1 reported that families, like staff, are subject to "institutional creep," e.g., the family comes in and says, "Why is mom not up by 9? They don't necessarily accept 'that's her preference.'"

Families and residents who felt their preferences were honored were reported to reinforce staff commitment to PCC and to help bolster staff morale. Again, housekeepers stood out in their enthusiasm:

I learned that teamwork made the job faster. Then you're in a better mood. The residents are more happy too. They're looking to you to make them happy.... (I sometimes hear from families), 'I'm glad you're here and doing a good job. The place is clean.' (NH2)

This housekeeper from NH1 contrasted PCC with the time before PCC, when there was no touching residents, and he could "not even talk with residents." He went to the PCC classes and got permission to help with food, coffee, feeding, and assisting with moving. "Now they relate to us – we talk more, some recognition, smiling – look into eyes.... I feel that they know me.... I benefit – I make someone's day."

Finally, we also heard reports of residents' participating in more public ways to shape PCC. The dietician in NH2 reported that on Fridays, the dietary aide ran a cooking program with residents. Two or more took part. They cooked soup and lamb chops. She said that the aide planned it on her lunch hour and break, and she shopped for the food herself. The community coordinator in NH1 reported that there were community meetings once a month. Of 34 residents, maybe one or two families typically attended. Issues raised by residents included wanting a washer-dryer on the floor (which was accommodated). The residents also formed a welcoming committee of residents. They also suggested programs, some of which cost extra money. They included an art show of the spouse of a resident, a trip to Broadway, bowling, and bringing in exotic animals.

6. Summary of essential elements of changing to PCC

Having site visited just two nursing homes, we cannot make any universal claims about the "essential" elements of transforming nursing homes to PCC. We cannot even claim to have the final word about transformations in New York City homes that have been participating in the Labor-Management Partnership process. We can only talk about the

process at the two study homes in the period of our visits. In these nursing homes we saw five elements in evidence.

First, change was tackled jointly by management and the union in an explicit and open manner. At the city level the joint effort was embodied in the QCC and the extensive training activities and resources it made available to individual nursing homes. Both of the study homes participated in the city-wide effort, and at the nursing home level they had a labor-management committee to oversee the changes, as well as smaller committees of managers and workers to handle specific issues at the nursing home and unit level. These committees did not always function smoothly or to the satisfaction of both sides, and there was experimentation in composition. But there were also examples of good process and substantive success to which participants could point. In short, the committees were evidence that the two sides were in this together and needed to work together.

Second, it was generally acknowledged that management was responsible for planning and implementing how PCC would happen. Management had to carve "communities" out of the larger nursing home. They had to define the community coordinator's role and support it by giving autonomy to the community. Doing so brought management face-to-face with what seemed to be the most difficult challenge: revamping the old management structures and roles. Especially in NH1, it was difficult for top managers and department heads to cede authority and responsibility to the communities, and this seemed to sap efficiency and effectiveness.

Two initiatives were used by management in both homes to try to create communities and flatten management: setting an example by pitching in, and moving food to the floor. When managers pitched in, it was noticed by frontline workers, and when they stopped, it was noticed, too. A considerable amount of goodwill appeared to be available at a relatively low cost. Moving the serving of food to the floor was a major initiative in both homes, as it required both physical renovations and changes in staffing, job descriptions, and operations in multiple departments. In these two homes it became the centerpiece of changes in how frontline workers related to one another and how workers related to residents. Moving the dining initiative to additional units/communities was the next management initiative on the agenda of both study homes.

Third, union support for management's PCC initiatives was crucial to moving forward. The union, as personified by the organizers and delegates in the study homes, had to figure out how to maintain its role as protector of workers' interests, even as it was transitioning into a stance of partnership rather than confrontation with management. The central issues revolved around expanding job descriptions for union (and other) workers, which was clearly a practice that could be stopped by invoking the contract. The way that both homes seemed to get around this at the nursing home level was to let individual workers decide for themselves if they wanted to take on expanded roles. When the great majority did so, the issue generally took care of itself. Workers were aware that the union supported PCC efforts, and this seemed to make for a safer space for experimentation. The space was safer yet, since the rest of the structure of union protections of workers - job security, benefits, and seniority protections - remained in

place. In the meantime, at the city level, during the time of our study, the union and management reopened the contract to explicitly allow PCC homes to experiment with expanded job descriptions.

The fourth essential element was the way that frontline workers responded to the space that management and the union created for developing PCC. The response was positive, strong, and nearly unanimous. Workers bought into the concept of PCC ("it's all about the resident" was heard again and again); they embraced job expansion to help out when and where they could rather than staying within their roles ("just do it" was the mantra); and they collaborated across job titles and hierarchy in the interest of improving care. The community framework also gave frontline workers a chance to voice their opinions and to take initiative as leaders, and they appreciated the opportunities and the respect that came with this.

The final element that we saw was the role that residents and families played in PCC. Although we heard this only second-hand through the staff, the role seemed to be real and important. Residents of nursing homes are either physically or cognitively debilitated (or both), but they have preferences and can express them. The PCC initiatives opened the space to hear and try to honor those preferences. It seemed to be fulfilling for staff to be able to respond, and residents were said to appreciate the effort. Residents, staff, and families appeared happy to defuse the "tug of war" over bathing and getting out of bed, to have dining be more homelike, and to have residents have personal and caring relationships with a broader range of staff.

IV. What's "on the other side"?

The third question that the RAC asked the research to address was "What's on the other side?" That is, how do management, the union, and the two working together, make PCC a lasting reality rather than sets of pilots? One of the administrators framed the question as follows. He wondered to what degree was change realistic in a labor-management partnership, i.e. is this a "marriage" or an "affair" (at both senior and frontline levels) and how can it be made the former? He said he had "no illusions about being finished with this." The question was "where's the tipping point?" How can management and the union and the operations in the two homes go past the point of no return rather than turning back? The answers we heard - both directly to this question when it was posed, and from analysis of other responses that speak to this point - are several fold.

First, respondents said that it was difficult to maintain one or two pilot units when the rest of the nursing home had not been changed. At some point the decision needs to be made to go nursing home-wide or not. An administrator in NH2 pointed out that there are ripple effects from making more widespread changes: "When do you clean, use the elevator, do rehab, TR (therapeutic recreation)... We need to get to a mindset where it's not a complete free-for-all, but we need to be able to accommodate preferences.... when to get up, move, do things. The patterns will vary by unit.... We'll need to set up changes in hours on and off."

Second, to do this, there need to be models to roll out from the pilot neighborhoods into new neighborhoods. For both nursing homes, dining seemed to be a core component of the rollout. The community director in NH2 explained how this was being piloted on a floor without a kitchen. First, all the dining staff went through PCC/customer service training. They also did observing on the pilot unit. She said she hoped that a future agenda will include developing core competencies nursing home-wide. Besides the dining model, both nursing homes had other components to roll out. An idea in NH2 was that all new hires would get a chance to interact with residents and staff on the floor before they were hired. Another is to expand the "It's your call" initiative that said everyone should answer call bells, know how the system works, and know the right response. Similarly, the video that was developed in NH1 was being used to train all new hires.

Third, to successfully expand model units and practices, sufficient training resources (time off with backfill) are needed. In the words of an administrator at NH2: "One hour of training with 50 or 60 workers is not enough. Other issues come up." Another described how they worked to expand the dining host initiative to a new unit with only mixed success. It was discussed at labor-management meetings; 80% of the dining staff participated in steam table training, and "the dining staff are eager to get out." But they discovered that they had not put enough time into staff and resident relationships, e.g., how does the dining host get to know the CNAs? When they put the food on the unit, the CNAs "backed off." The dining host said, 'where's the help you promised?'

An organizer from NH1 put the resources issue more generally:

What would really hinder and still is hindering us from getting there is adequate staffing or maybe how we utilize the staffing resources.... Our members really like the fact that they can interact with the patient and they have a say so in how care is given, and the patients have a feedback and a say so in how their care is being done. What I think is really hindering is staffing, the resources to actually make it happen. Enough people to actually do the work.

The possibility of losing the training resources that the Labor-Management Partnership had marshaled with the help of the state was front and center right after the election of a new Governor in New York. Said one senior executive at NH2:

The new Governor talks about transforming nursing homes and finding alternatives to institutional care, but I don't think he understands it. This isn't like making instant coffee... How do I reach my 2007 objectives with cuts in the rates? ... The relatively simple and cheap renovations (on the PCC unit) cost \$200,000, and we have 18 units. (Question: What could go wrong?) The money dries up. The union could lose religion or at the operational level there could be a disconnect.... And management - will management buy in?

A fourth issue is control of staff schedules, which respondents generally called "self-scheduling," i.e., scheduling staff at the unit level rather than the nursing home level. Neither of the homes had solved this challenge, although NH2 seemed farther along. A

nurse coordinator at NH2 related the progress they had made, but also the remaining agenda: "We need more self-scheduling...we do a lot more independent scheduling...especially for the holidays we work out ourselves.... (But for vacations) downstairs takes over."

An organizer at NH1 contrasted the current staffing model with the unit-based future:

So in the NH1 we have in the union about give or take about 400 members within the entire bargaining unit, nurses, dietary workers, CNAs, housekeeping workers, nurses. Nurses are the biggest portion of the bargaining unit. I'd say about 250 of that 400 is just nurses and the rest are split up. So you'd see all those 250 people reporting to one person, who is like nursing director, their supervisor. Now you do have 4, 6 or 8 nursing attendants who belong to one community and then are just reporting to one person. So it's like breaking down the pool from like the bigger group to a smaller group. So whatever issue - personal or job-related issue - it gets dealt with in a little more personal way because it's smaller. So instead of waiting in line behind 200 or 300 people to speak to one person, you know have to wait for 2 or 3 people and you are able to speak to your coordinator who will have the, supposedly, have the autonomy to address the issue. So for me that is a plus.

A fifth issue is to make PCC more consistent across shifts. The human resources director from NH1 said that the 3-11 shift was a problem since there were only two nurse supervisors and a charge nurse on every floor. Usually the LPN was in the union and did not take on a lot besides administering medications. They "are not happy campers on evenings." There are "feuds (and) nights are tight," in part since these are second jobs for many workers. The Coordinator comes in sometimes, but perhaps not enough to get them to bridge their schedules routinely.

A sixth issue is to avoid and combat "backsliding." Management informants at NH1 referred to it as "institutional creep," whereby staff revert to old practices. A manager at NH1 gave the example of a resident who vomited (just once), and the nurse called the doctor, who ordered an abdominal x-ray. The focus changed from sitting with the resident, holding hands, and giving her some ginger ale, to getting the x-ray. The manager blamed both the nurse and the doctor for slipping back to the medical model. He wondered whether they could establish a practice of doing a "sentinel event" analysis on this kind of thing, i.e., violation of the community model. Workers experienced backsliding, too. An LPN in NH1 felt that PCC sounded nice, but she said it was short-lived. At first, the activities staff came in and poured coffee for other staff, but this did not happen any more - "not even a glass of water." She observed that the kitchen did not have the help they had when they started PCC.

A union organizer from NH1 suggested that a way to combat backsliding was to consolidate gains:

I just think that we are at a crossroads at the moment. We are really in a puzzle at the moment. And we really kind of need to stop and look at all that we have accomplished. Try instead of keep moving on, I think it would be better if we

stopped along the way and perfected some of the things that we have implemented. Because, what I see is that we are twining a rope and I think the rope is coming loose, it's loosening at the end. You know you start at one end and you didn't secure that end properly and you have the best rope in the middle but the end is coming loose.

Finally, numerous respondents cautioned that there is no cookie-cutter approach to developing and replicating PCC, even within a single nursing home. A training director told us, "You have to grow your own." Since staff and resident personalities and capabilities vary by unit, each community will take a slightly different path. Nursing homes will need to accommodate this reality within their overall approach.

V. Conclusion: Relevance and Study Limitations

As academic researchers we come away from this study humbled by the efforts of the managers, union staff, professionals, and frontline workers we encountered in the two study homes and in the broader city-wide effort. The managers and labor leaders in the QCC, and the managers and workers in the study homes are clearly on a mission, and it is a difficult one. We are hesitant to draw conclusions about their achievements and shortfalls from our brief study of two homes.

On the one hand, from a wholly objective, cost-benefit perspective, it would be tempting to be pessimistic: If NH1 and NH2 are the best examples among the 40 participating nursing homes of implementing PCC, this is a small and not very promising return for the money. After several years trying, neither home has successfully transformed itself into a PCC nursing home, and each faces years of hard work ahead. From our interviews with representatives of the other six candidate nursing homes for the case studies, only one is as advanced as these two. We assume the other 30 homes are even less far along.

On the other hand, no one said it would be easy to transform large, existing nursing homes. In the words of one of the CEOs, "This is not like making instant coffee." The management, union, professional, and frontline participants have made changes that they like and that they value - in their nursing homes, in their working relationships, and in how they treat residents. They have learned a great deal, and they have a model for sharing their learning with one another. It is not a cheap model, but it is difficult to see how one could do this on the cheap and succeed.

If the transformations do not succeed, it will not be because frontline workers do not embrace or understand PCC. On the contrary, they appear to thrive on it in terms of the substantive contributions they make to care and practices, and in terms of the recognition and dignity their expanded roles bring them. Frontline workers who choose this career - particularly CNAs - have the personalities and the values that help them stay on even in traditional, alienating nursing homes, because they love caring for vulnerable residents. When their caring side is empowered to do better, they simply beam with pride.

The 1995 SEIU and Continuing Care Leadership Coalition face more difficult challenges because more people and larger institutions are involved, including the staff and boards

of participating homes, state regulators and legislators, and the larger union leadership. The union and the Coalition have invested a great deal in the QCC initiative, and they have convinced others to support them. In addition to continuing the current city-wide and nursing home-specific training and education efforts, their plan for the future is to find ways to support PCC practices in the negotiation of the next contract.

The latest collective bargaining agreement, ratified in January 2007, started this process by opening the contract to accommodating PCC through experimentation with new job descriptions and more flexible work rules. In May the QCC held a series of meetings with teams from the 17 nursing homes in the League of Voluntary Nursing Homes to promote "interest-based problem solving" as a way to approach labor-management discussions, particularly around PCC initiatives. The May meetings also introduced a process for participating nursing homes to propose new PCC pilot programs, which explicitly incorporate interest-based problem solving, and which also model PCC-based approaches for the next contract. These pilots will be funded in the summer of 2007 and carried out and evaluated by the end of 2008.

In summary, learning from the QCC's initiatives in PCC will continue to evolve and emerge in coming years. The learning will be important not only in New York City, but also nationally. SEIU is developing partnerships with employers, advocacy groups and other stakeholders in several other states with the goal of improving quality care, funding and training for nursing homes. In New Jersey and Pennsylvania, the union is working with two large nursing home corporations, Genesis and Beverly Enterprises. The recommendations and lessons learned through a case study of the New York City experience will significantly affect the work that is occurring in other areas of the country.

Labor-management partnerships in the long-term care field have the potential to achieve enduring mutual gains for all stakeholders. In particular, the process of organizational innovation toward person-centered care must rely on input from frontline workers to improve resident care processes. Labor-management partnership can potentially support full inclusion of frontline workers in the transformation toward person-centered care. The other groups that stand to benefit from a greater understanding of the value that unions can add to the organizational change process are leaders/managers of long-term care nursing homes throughout the country, as well as other union leaders. In addition, nursing home providers, residents and their advocates, policy makers and regulators are eager to learn more about the outcomes of nursing home organizational transformation toward person-centered care, and about the most effective ways to foster this process.

References Cited

1. Baker, B., *Old Age in a New Age: The Promise of Transformative Nursing Homes*. 2007, Nashville TN: Vanderbilt University Press.
2. Bishop, C.E., D.B. Weinberg, J.H. Gittel, W. Leutz, A. Dossa, S. Pfefferle, and R. Zincavage (2007). Nursing Assistants' Job Commitment: Effect of Nursing Home Organizational Factors and Impact on Resident Well-being. Working Paper, The Heller School, Brandeis University. February 2007.
3. Boan, D., "Changing culture in the home health setting: strategies for success". *Home Health Nurse*, 2006. 24(10): p. 662-9; quiz 670-1.
4. Bradley, E.H., T. Webster, D. Baker, M. Schlesinger, S.K. Inouye, M.C. Barth, K.L. Lapane, et al. (2004). Translating Research Into Practice: Speeding the Adoption of Innovative Health Care Programs. The Commonwealth Fund. July 2004.
5. Centers for Medicare and Medicaid Services (2004). Proposed Summary of Draft 8th Statement of Work. Quality Improvement Group.
6. Dodson, L. and L. Schmalzbauer (2005). Participatory Methods in Poverty Research. Boston College Department of Sociology. Unpublished Manuscript.
7. Dodson, L. and R.M. Zincavage, "'It's like a family': Caring labor, exploitation and race in nursing homes". *Gender & Society*, 2008. Forthcoming.
8. Eaton, S., *What a Difference Management Makes! Nursing Staff Turnover Variation Within a Single Labor Market*, in *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes Phase II Final Report*. 2001, Centers for Medicare and Medicaid Services: Baltimore.
9. Eaton, S.C. (1997). Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs. Harrisburg, PA. Keystone Research Center. High Road Industry Series #1. April 1997.
10. Eaton, S.C., "Beyond 'unloving care': linking human resource management and patient care quality in nursing homes". *International Journal of Human Resource Management*, 2000. 11(3): p. 591-616.
11. Eaton, S.C., T.A. Kochan and R.B. McKersie (2003). The Kaiser Permanente Labor Management Partnership: The First Five Years. Cambridge. Institute for Work and Employment Relations, Massachusetts Institute for Technology. <http://mitsloan.mit.edu/iwer/n-kaiserpermanente.php>.
12. Frost, A.C., *Variation in Labor-Management Cooperation over the Redesign of Work: Impacts on Work Organization and Outcomes*, in *Advances in industrial and labor relations*, D. Lewin, B. Kaufman, and D. Sockell, Editors. 1998, JAI Press: Stamford, Conn. and London. p. 89-117.
13. Frost, A.C., "Explaining Variation in Workplace Restructuring: The Role of Local Union Capabilities." *Industrial and Labor Relations Review*, 2000. 53(4): p.559-78.

14. Frost, A.C., "Reconceptualizing Local Union Responses to Workplace Restructuring in North America". *British Journal of Industrial Relations*, 2001. 39(4): p. 539-64.
15. Gittell, J.H., A. Von Nordenflycht and T.A. Kochan, Mutual Gains Or Zero Sum? Labor Relations And Firm Performance In The Airline Industry., in *Industrial & Labor Relations Review*. 2004, Cornell University. p. 163-180.
<http://search.epnet.com/login.aspx?direct=true&AuthType=cookie,ip,url,uid&db=buh&an=11731622>.
16. Grant, L.A. and L. Norton. *A Stage Model of Culture Change in Nursing Facilities*. in *Symposium: Culture Change II: Theory and Practice, Vision and Reality, The 56th Annual Scientific Meeting of the Gerontological Society of America*. 2003. San Diego. <http://www.myinnerview.com/ccstagingtool.php>, select Read research paper.
17. He, W., M. Sengupta, V.A. Velkoff and Kimberly A. DeBarros (2005). 65+ in the United States: 2005. U.S. Census Bureau. Current Population Reports P23-209. www.census.gov/prod/2006pubs/p23-209.pdf.
18. Health Resources and Services Administration (2004). Nursing Aides, Home Health Aides, and Related Health Care Occupations --National and Local Workforce Shortages and Associated Data Needs. National Center for Health Workforce Analyses, Bureau of Health Professions, Health Resources and Services Administration. February 2004.
<ftp://ftp.hrsa.gov/bhpr/nationalcenter/RNandHomeAides.pdf>.
19. Hecker, D.E., "Occupational Employment Projections to 2014". *Monthly Labor Review*, 2005. 128(11): p. 70.
20. Heron, J. and P. Reason, *The practice of co-operative inquiry: Research "with" rather than "on" people*, in *Handbook of action research*, P. Reason and H. Bradbury, Editors. 2001, Sage: London.
21. Institute for Work and Employment Relations. [accessed 2007 September 28, 2007]. Available from: <http://mitsloan.mit.edu/iwer/n-kaiserpermanente.php>.
22. Kane, R.A., T.Y. Lum, L.J. Cutler, H.B. Degenholtz and T.C. Yu, "Resident outcomes in small-house nursing homes: a longitudinal evaluation of the initial green house program". *J Am Geriatr Soc*, 2007. 55(6): p. 832-9.
23. Kochan, T.A., H.C. Katz and R.B. McKersie, *The transformation of American industrial relations*. 1986, New York: Basic Books.
24. Misorski, S., "Pioneering Culture Change". *Nursing Homes: Long Term Care Management*, 2003. 52(10): p. 24.
25. My Innerview. *Culture Change Staging Tool*. 2007 [accessed May 2006]. Available from: <http://www.myinnerview.com/ccstagingtool.php>.
26. National Center for Health Statistics. *National Nursing Home Survey 2004 SAS file public use*. 2007 [accessed 2007 July 23]. Available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NNHS/nrhs04/SAS_Data.

27. National Center for Health Statistics. *National Nursing Assistant Survey 2004 ASKE File Public Use*. 2007 [accessed 2007 July 23, 2007]. Available from: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NNAS/2004/publicuse.
28. Pagan, J., "LEAP toward culture change. This unique program focuses on respect and rewards". *Contemp Longterm Care*, 2002. 25(10): p. 36-40.
29. Rader, J. and J. Semradek, "Organizational Culture and Bathing Practice: Ending the Battle in One Facility." *Journal of Social Work in Long-Term Care*, 2003. 2(3/4): p. 269-283.
30. Rubinstein, S.A. and T.A. Kochan, *Learning from Saturn: Possibilities for corporate governance and employee relations*. 2001, Ithaca and London: Cornell University Press, ILR Press.
31. Stone, R.I., S.C. Reinhard, B. Bowers, D. Zimmerman, C.D. Phillips, C. Hawes, J.A. Fielding, et al. (2002). Evaluation of the Wellspring Model for Improving Nursing Home Quality (Technical Report).
32. Stone, R.I., "Selecting a Model or Choosing Your Own Culture." *Journal of Social Work in Long-Term Care*, 2003. 2(3/4): p. 411-422.
33. U.S. Bureau of Labor Statistics. *Occupational Projections and Training Data, 2006-07 Edition, V-1. Employment and output by industry, 1994, 2004, and projected 2014*. 2007 [accessed September 28, 2007]. Available from: <http://www.bls.gov/emp/optd/home.htm>.
34. U.S. General Accounting Office (2001). Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern (17-MAY-01, GAO-01-750T).
35. Viswanathan, M. and A. Ammerman (2005). Community-Based Participatory Research: Assessing the Evidence. Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment Number 99 AHRQ Publication 04-E022-1. <http://www.ahrq.gov/clinic/epcsums/cbprsum.htm>.
36. Weiner, A.S. and J. Ronch, eds. *Culture Change in Long-Term Care*. 2003, Haworth Social Work Practice Press: New York.
37. Yin, R.K., *Case Study Research: Design and Methods*. Third Edition ed. Applied Social Research Methods. 2002: Sage Publications.