The Qualitative Report

Volume 17 | Number 41 | Article 1

10-8-2012

A Preliminary Qualitative Evaluation of the Virginia Gold Quality Improvement Program

Gerald A. Craver
Virginia Department of Medical Assistance Services, rdt1134@gmail.com

Amy K. Burkett
Virginia Department of Medical Assistance Services, amy.burkett@dmas.virginia.gov

Follow this and additional works at: https://nsuworks.nova.edu/tqr

Part of the Quantitative, Qualitative, Comparative, and Historical Methodologies Commons, and the Social Statistics Commons

Recommended APA Citation
Craver, G. A., & Burkett, A. K. (2012). A Preliminary Qualitative Evaluation of the Virginia Gold Quality Improvement Program . *The Qualitative Report*, *17*(41), 1-26. Retrieved from https://nsuworks.nova.edu/tqr/vol17/iss41/1

This Article is brought to you for free and open access by the The Qualitative Report at NSUWorks. It has been accepted for inclusion in The Qualitative Report by an authorized administrator of NSUWorks. For more information, please contact nsuworks@nova.edu.

A Preliminary Qualitative Evaluation of the Virginia Gold Quality Improvement Program

Abstract

Certified nursing assistants (CNAs) perform an important role in the long-term care system because they provide the majority of paid care to nursing facility residents. Unfortunately, annual CNA turnover often exceeds 100 percent nationally. Many factors account for this, including stressful working conditions, low pay, and limited benefits. The end result of high turnover is compromised continuity of care for residents, which often leads to poor quality and substandard care. In an effort to improve quality of care and staffing, the Virginia Department of Medical Assistance Services in 2009 implemented a pilot program, known as the Virginia Gold Quality Improvement Program, which provided funding to five nursing facilities to develop projects that improved working conditions for CNAs. This study presents the results of an evaluation performed on the program toward the end of its first year using 10 CNA and resident focus groups. Eight themes emerged from the focus groups, suggesting that both quality of care and working conditions improved in the pilot facilities after the program was implemented. However, these findings are preliminary and additional research is needed to more fully understand how the program influenced conditions in the pilot facilities.

Keywords

Medicaid, Nursing Facility, Quality of Care, Quality Improvement, Certified Nursing Assistants, Supportive Work Environments, Civil Money Penalty Funds

Creative Commons License

This work is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 4.0 License.

The Qualitative Report 2012 Volume 17, Article 81, 1-26
http://www.nova.edu/ssss/QR/QR17/craver.pdf

A Preliminary Qualitative Evaluation of the Virginia Gold Quality Improvement Program

Gerald A. Craver and Amy K. Burkett
Virginia Department of Medical Assistance Services, Richmond, VA, USA

Certified nursing assistants (CNAs) perform an important role in the long-term care system because they provide the majority of paid care to nursing facility residents. Unfortunately, annual CNA turnover often exceeds 100 percent nationally. Many factors account for this, including stressful working conditions, low pay, and limited benefits. The end result of high turnover is compromised continuity of care for residents, which often leads to poor quality and substandard care. In an effort to improve quality of care and staffing, the Virginia Department of Medical Assistance Services in 2009 implemented a pilot program, known as the Virginia Gold Quality Improvement Program, which provided funding to five nursing facilities to develop projects that improved working conditions for CNAs. This study presents the results of an evaluation performed on the program toward the end of its first year using 10 CNA and resident focus groups. Eight themes emerged from the focus groups, suggesting that both quality of care and working conditions improved in the pilot facilities after the program was implemented. However, these findings are preliminary and additional research is needed to more fully understand how the program influenced conditions in the pilot facilities.
Keywords: Medicaid, Nursing Facility, Quality of Care, Quality Improvement, Certified Nursing Assistants, Supportive Work Environments, Civil Money Penalty Funds

In the United States, nursing facilities are an important source of long-term care for seniors and individuals with disabilities (Wiener, Freiman, & Brown, 2007). Because these individuals often require staff assistance to complete many activities of daily living (e.g., bathing, dressing, toileting, eating, and grooming), appropriate quality of care is highly dependent on the care provided by certified nursing assistants (CNAs). Thus, nursing facility quality of care is largely influenced by CNA job performance (Burgio, Fisher, Fairchild, Scilley, & Hardin, 2004).

Nationally, interest in improving nursing facility quality of care extends back several decades. In the 1970s and early 1980s, a series of investigations revealed that many nursing facility residents were neglected or even abused (Walshe, 2001). In response, the federal government enacted the Nursing Home Reform Act (NHRA) in 1987 to reform the regulation of nursing facilities. This legislation contained several staffing components due to evidence indicating that quality of care depended largely on the availability of qualified staff (Burgio et al., 2004; Castle, 2008; Zhang & Grabowski, 2004). While subsequent research suggests that the NHRA staffing requirements generated some improvements (Zhang & Grabowski, 2004), nursing facility quality of care and staffing still continue to be public policy concerns, mostly due to the fact that annual staff turnover is exceptionally high (Mukamel, Spector, Limcango, Wang, Feng,

& Mor, 2009; Temple, Dobbs, & Andel, 2010; Wiener, Freiman, & Brown, 2007). Annual turnover typically ranges between 55 and 75 percent for registered and licensed nurses, while often exceeding 100 percent for CNAs (Mukamel et al., 2009).[1]

High CNA turnover is problematic because these workers provide the majority of paid direct care (e.g., measuring vital signs and assisting with activities of daily living) to nursing facility residents (Riggs & Rantz, 2001; Zeller & Lamb, 2011). CNA turnover is expensive because it costs nursing facilities roughly $2,500 to replace each CNA who resigns (Bishop, Weinberg, Leutz, Dossa, Pfefferle, & Zincavage, 2008). It is also costly for the remaining staff due to their increased workloads. While these costs are important, the most serious costs related to high CNA turnover are borne by nursing facility residents in the form of poor health outcomes because turnover disrupts their continuity of care and contributes to psychological distress (Castle & Engberg, 2005; Temple et al., 2010).

Prior research suggests that the CNA workforce is vulnerable because it is comprised mostly of women who are low-income, single-parents, and work multiple jobs to support their families. This vulnerability is compounded by the workforce's racial and ethnic diversity that contributes to working conditions where the potential for miscommunication and conflict among CNAs, other staff, and residents is high (Dill, Morgan, & Konrad, 2010; Ryoshu, 2011; Stone & Dawson, 2008). Due to their role as frontline caregivers, considerable research has been done to identify factors associated with CNA turnover. Examples include lack of training and promotion opportunities, low pay, emotionally and physically demanding work, job stress, poor supervision, understaffing, lack of respect, and lack of health insurance and other benefits (Howes, 2008; Kemper, Brannon, Barry, Stott, & Heier, 2008; Rosen, Stiehl, Mittal, & Leana, 2011).

A number of policy interventions have been implemented to reduce CNA turnover; however, evidence on their effectiveness is lacking because most were not rigorously evaluated (Dill et al., 2010; General Accounting Office, 2001; Lehning & Austin, 2010; Mukamel et al., 2009; Tsoukalas, Rudder, Mollet, Shineman, Lee, & Harrington, 2006). The fact that quality of care and staffing continue to be policy concerns suggest that they are complex phenomena not easily addressed through these interventions (Mukamel et al., 2009). Nevertheless, a pressing need exists to develop interventions that address these issues and to rigorously evaluate their effectiveness. Because the demand for CNAs is projected to increase along with an aging population (Stone & Dawson, 2008), failure to identify solutions to these issues could have serious consequences for the nation as growing numbers of Americans turn to nursing facilities for long-term care support.

An Overview of the *Virginia Gold* Quality Improvement Program

The *Virginia Gold* Quality Improvement Program is an example of one such policy intervention that was developed to improve nursing facility quality of care. The *Virginia Gold* Program was implemented on September 1, 2009, by the Virginia Department of Medical Assistance Services (i.e., Virginia Medicaid). Because the

[1] Annual CNA turnover will exceed 100 percent if CNAs and their replacements work in nursing facilities less than one year.

program was only authorized to operate as a two-year pilot, it expired on August 31, 2011. The *Virginia Gold* Program was funded entirely using civil money penalty (CMP) funds, which are fines collected from nursing facilities that fail to meet federal quality of care standards.[2] The overall goal of the program was to improve and expand the quality of care provided to nursing facility residents in Virginia by providing nursing facilities with grant funding to retain CNAs through the development of supportive work environments (Department of Medicaid Assistance Services [DMAS], 2007, 2009, 2010; Hickey, 2009).

To implement the program, Virginia Medicaid solicited applications from licensed, Medicare/Medicaid-certified nursing facilities through a request for applications (RFA) in April 2009 (DMAS, 2009). Twenty-eight nursing facilities (out of approximately 278 facilities in Virginia) responded by submitting applications indicating how they would use CMP funds to improve CNA retention. After reviewing the applications, five nursing facilities (two non-profit and three for-profit facilities) were selected by a stakeholder advisory committee to participate in the program (Table 1). Each nursing facility was awarded up to $50,000 in grant funding to develop a quality improvement project, which included certain activities that could be tailored to meet its specific needs. Examples of these activities included new staff orientation, recognition and rewards, peer mentoring, and in-service training. To facilitate this process, the nursing facilities received technical assistance on developing and implementing their quality improvement projects from the Virginia Health Quality Center (VHQC), which is a federally designated quality improvement organization. As part of the *Virginia Gold* Program, the nursing facilities had to agree to report on their success in implementing their quality improvement projects and to participate in an evaluation (DMAS, 2010). Additional information on the nursing facilities' quality improvement projects is provided in Appendix A.[3]

Purpose

The purpose of this study was to conduct a preliminary evaluation on the *Virginia Gold* Quality Improvement Program using a qualitative design that allowed for an in-depth understanding of the program's processes and outcomes from the perspectives of its main beneficiaries – the CNAs and nursing facility residents (Patton, 2002).

---

[2] Because the federal government is the dominate payer of long-term care services in the nation, it established quality of care standards for nursing facilities that participate in the Medicare and Medicaid Programs. The standards require facilities to ensure that residents receive care that meets their individual needs, assistance with activities of daily living, and appropriate nutrition and medical services. The standards also require facilities to have adequate staff available and to control infectious diseases. States are responsible for inspecting nursing facilities annually to ensure that they comply with all quality of care standards. Facilities with a high number of deficiencies may receive a variety of punishments including CMP fines up to $10,000 a day, state oversight, or termination.

[3] This study was adapted from an evaluation that the authors performed on the *Virginia Gold* Program for Virginia Medicaid. The evaluation is available online at: http://dmasva.dmas.virginia.gov/Content_atchs/ltc/vagold-rpt2.pdf. Material from the evaluation was revised for this study. Information on the specific quality improvement projects developed by the nursing facilities is also available online at: http://dmasva.dmas.virginia.gov/Content_pgs/ltc-vagold.aspx.

Table 1. Descriptive Characteristics of the *Virginia Gold* Nursing Facilities

Nursing Facility	Number of Beds	Percent Medicaid Residents	CNA Staffing Level (% of total staff)*	Annual CNA Turnover*	Ownership Type
Autumn Care of Portsmouth, Virginia	108 beds	75%	46 (37%)	75%	For-Profit
Birmingham Green/Northern Virginia Health Center Commission of Manassas, Virginia	180 beds	90%	67 (22%)	78%	Non-Profit
Dogwood Village of Orange County, Virginia	164 beds	54%	83 (35%)	63%	Non-Profit
Francis Marion Manor of Marion, Virginia	109 beds	67%	42 (60%)	65%	For-Profit
Trinity Mission Health and Rehabilitation Center of Charlottesville, Virginia	180 beds	70%	99 (45%)	54%	For-Profit

*Reflects status at time of *Virginia Gold* application (Spring, 2009).
Source: DMAS, 2010.

The study provides information on the effectiveness of the *Virginia Gold* Program during its first year of operation, which was from September 1, 2009 to August 31, 2010.

Role of the Evaluators

Gerald Craver (Ph.D.) is a Senior Research Analyst in the Policy and Research Division at Virginia Medicaid. Dr. Craver was responsible for designing the evaluation, collecting, analyzing, and interpreting data, and preparing the evaluation study. Amy Burkett (B.S.W.) is a Program Analyst in the Long-Term Care Division at Virginia Medicaid. Ms. Burkett coordinated and monitored the *Virginia Gold* Program for the

agency, and was responsible for assisting with data collection, analysis, and interpretation of the focus group findings.

Theoretical Framework for the *Virginia Gold* Quality Improvement Program

Program theory seeks to understand the effects of programs by identifying the implicit or explicit set of assumptions (i.e., professional logic or beliefs) that underlie the programs' intended actions (Weiss, 1997; 1998). Weiss (1998) defines program theory as, "…an explanation of the causal links that tie program inputs to expected program outputs, or as Bickman (1987) has put it, 'a plausible and sensible model of how a program is supposed to work (p. 5)'" (p. 55). Weiss further defines program theory as, "…the mechanisms that mediate between the delivery (and receipt) of the program and the outcomes of interest. The operative mechanism of change isn't the program activities per se but the response the activities generate" [p. 57].[4] A program's underlying assumptions do not have to be based on formal (or grand) social science theory, nor does it have to be correct or even uniformly accepted. Instead, the assumptions must simply reflect the logic upon which the program was developed to improve life for a specific group of people by changing one or more outcomes (Weiss, 1998). Using this definition as a guide, we determined that *Virginia Gold*'s theory was based on two assumptions: (a) CNAs employed in nursing facilities with less supportive work environments may not consistently provide good care to residents[5], and (b) quality of care can be improved by providing nursing facilities with funding to develop supportive work environments for CNAs. *Virginia Gold*'s theory is supported by research indicating that nursing facility work environments can influence resident health outcomes (Bishop et al., 2008; Rantz et al., 2004; Stone & Dawson, 2008; Tempkin-Greener, Zhen, Cai, Zhao, & Mukamel, 2010).

Figure 1 illustrates the logic model developed for the *Virginia Gold* Program. Logic models depict the underlying theory (or assumptions) that program architects have about why particular programs will work (Remler & Van Ryzin, 2011). The model indicates the path that *Virginia Gold* follows to improve nursing facility quality of care. It shows the program's main inputs (funding and pilot facilities), activities (nursing facility quality improvement projects and technical support), and outputs (supportive work environments, workforce stability, and quality of care). Key to the program's success is the implementation of quality improvement projects that contain certain components (e.g., peer mentoring, new staff orientation, coaching supervision, rewards and recognition, staff training, and worker empowerment) that are associated with supportive work environments and the response the activities generate among CNAs (Barry, Brannon, & Mor, 2005; Bishop et al., 2008; Kemper et al., 2008; Koren, 2010). The inputs, activities, and outputs depicted in the model are intended to set in motion a causal sequence of outcomes. The short-term outcomes of the *Virginia Gold* Program are improved CNA job satisfaction and professional competency. These outcomes lead to

---

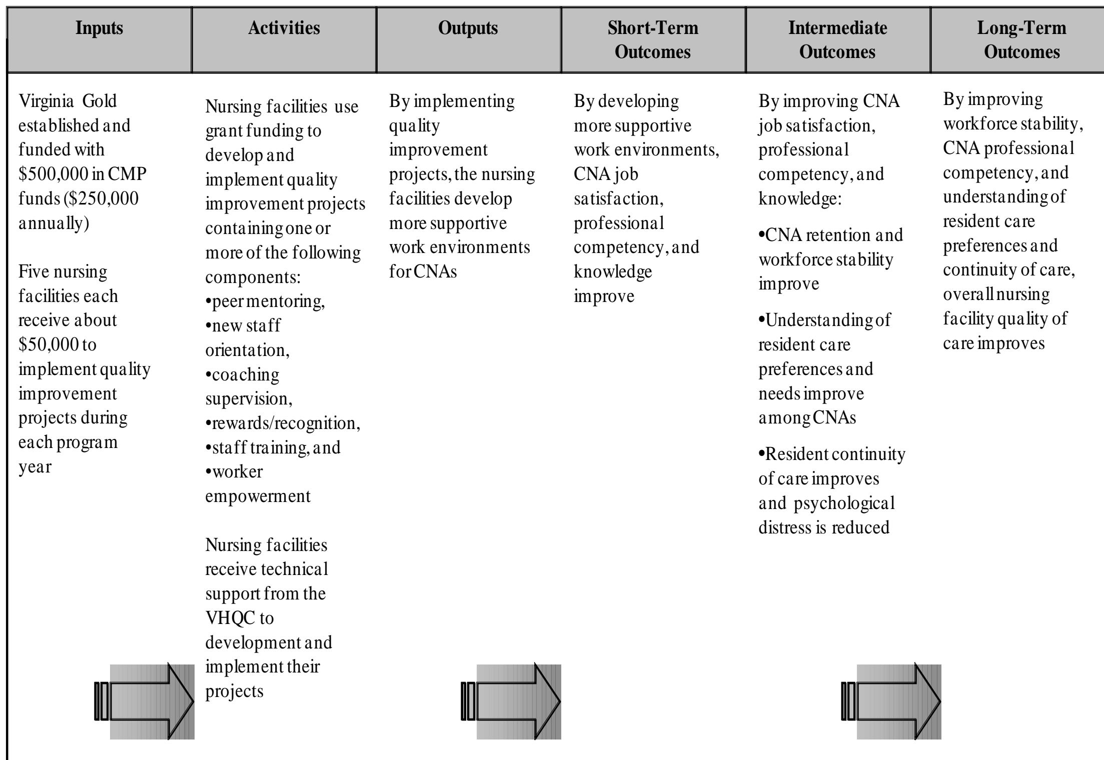
[4] While the concept of program theory has developed substantially since Weiss' work was published, her work is still considered to be highly relevant (Rogers, 2007).

[5] For example, work environments where CNAs are not treated with respect by their supervisors, their work is not valued because it is perceived as unskilled, and CNAs do not receive appropriate support to perform their jobs.

the intermediate outcomes of improved CNA retention and workforce stability, improved CNA knowledge of resident care preferences, and improved resident continuity of care and reduced psychological distress that, in turn, lead to the program's long-term outcome of improved nursing facility quality of care.

The logic model provided a structure for conceptualizing, planning, and implementing the evaluation presented in this study. Using the model as a guide, two overall study questions were developed: (a) What changed for CNAs and residents as a result of their facilities' participation in *Virginia Gold* and (b) Has *Virginia Gold* made a difference in the lives of CNAs and residents, and if so, how? The first question sought to identify important changes that occurred in the work environments and quality of care at the facilities during the program's first year, while the second question sought to determine if the program produced meaningful experiences for staff and residents. Addressing these questions allowed for an examination of the program over time from the perspectives of both the CNAs and nursing facility residents.

Figure 1. Virginia Gold Quality Improvement Program Logic Model



Inputs	Activities	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Virginia Gold established and funded with $500,000 in CMP funds ($250,000 annually) Five nursing facilities each receive about $50,000 to implement quality improvement projects during each program year	Nursing facilities use grant funding to develop and implement quality improvement projects containing one or more of the following components: •peer mentoring, •new staff orientation, •coaching supervision, •rewards/recognition, •staff training, and •worker empowerment Nursing facilities receive technical support from the VHQC to development and implement their projects	By implementing quality improvement projects, the nursing facilities develop more supportive work environments for CNAs	By developing more supportive work environments, CNA job satisfaction, professional competency, and knowledge improve	By improving CNA job satisfaction, professional competency, and knowledge: •CNA retention and workforce stability improve •Understanding of resident care preferences and needs improve among CNAs •Resident continuity of care improves and psychological distress is reduced	By improving workforce stability, CNA professional competency, and understanding of resident care preferences and continuity of care, overall nursing facility quality of care improves

Methodology

The *Virginia Gold* Program was evaluated using a qualitative design based on ten participatory focus group interviews with CNAs and residents conducted across the five pilot nursing facilities. Two focus groups were conducted at each facility; one group consisted of CNAs, while the other consisted of residents. Prior to data collection, management staff at Virginia Medicaid reviewed the evaluation questions and design and

determined that they were appropriate for meeting agency requirements. The subsections that follow provide detailed information on the procedures used to conduct the focus group interviews, the CNAs and residents who participated in the focus groups, and the methods used to analyze data obtained during the interviews.

Design

Focus groups are moderator-led interviews conducted with small groups of individuals (e.g., generally four to twelve) to examine their views on particular topics (Hollander, 2004; Patton, 2002). We used focus groups as the data collection method for two reasons: (a) they are widely used in both evaluation and policy research (Duffy, 1993; Patton, 2002; Remler & Van Ryzin, 2011) and (b) they are appropriate for collecting information on participant perspectives regarding change during or after planned interventions (Fitzpatrick, Sanders, & Worthen, 2004; Flores & Alonso, 1995).

The focus groups for this study were conducted during April and May 2010. Dr. Craver served as the focus group moderator, while Ms. Burkett prepared notes that documented the outcomes of the interviews. The focus groups were conducted in locations selected for maximum privacy, such as conference rooms and administrative offices. The CNAs and residents received no incentive for participation and all participants signed consent/confidentiality agreements, which was the only permission needed for this study. The focus groups were audio recorded and lasted approximately 45 minutes.

Participants

We used purposeful sampling to select focus group participants in order to gain an in-depth understanding of the program from the perspectives of the CNAs and residents. We accomplished this by providing management staff at the pilot facilities with criteria to select individuals for both the CNA and resident focus groups (Duffy, 1993; Remler & Van Ryzin, 2011).[6,7] As a result, our sample consisted of individuals who were familiar with both *Virginia Gold* and the inner workings of their respective nursing facilities.

The number of CNAs per focus group ranged from four to nine (a total of 32 CNAs participated), while the number of residents per focus group ranged between five and six (a total of 27 residents participated). Most focus group participants were female (78% of the CNAs and 59% of the residents were female). The average work experience of the CNAs at their respective facilities ranged between 3.8 and 24.4 years, while the average length of stay of the residents ranged between 1.0 and 5.2 years. Eight CNAs (25%) worked as peer mentors and were directly involved with implementing the *Virginia Gold* Program at their facilities. Based on the composition of the participant

---

[6] Random sampling was not used for two reasons: (a) we did not have direct access to the CNAs and nursing facility residents and (b) it may have resulted in the selection of individuals who were unfamiliar with the Virginia Gold Program.

[7] For example, we requested that the focus groups consist of both male and female participants who were knowledgeable about the program and had been at their respective facilities since at least the summer of 2009.

pool, we concluded that the focus groups were sufficient to meet the objectives of the evaluation.

Focus Group Interview Questions

To collect data for our study, we asked general questions to elicit participants' thoughts regarding the events and activities that they deemed important. Conducting the focus groups in such a manner contributed to the richness of the interview data (Patton, 2002). The CNAs and residents were each asked five questions (Table 2). For both groups, the first question served as an "ice breaker" to get participants talking about *Virginia Gold*, while the remaining questions were used to collect information related to the study. We developed our questions in conjunction with Virginia Medicaid staff to ensure that they met agency information requirements. After each focus group interview, we compared field notes and discussed group dynamics and findings.

Table 2. Virginia Gold Focus Group Interview Questions

I. Certified Nursing Assistant Focus Group Interview Questions

1. What do you know about *Virginia Gold*?
2. What were your impressions of the work environment at this facility before *Virginia Gold* was implemented?
3. What are your impressions of the facility's current work environment?
4. What staff retention event that happened during the past year has made the biggest impression on you and why?
5. How do you think your facility's participation in *Virginia Gold* has influenced staff retention?

II. Nursing Facility Resident Focus Group Interview Questions

1. What do you know about *Virginia Gold*?
2. What was the care like that you received from staff last summer?
3. Does anything seem different about your care now?
4. In what way has your life changed because of the care you receive from staff at this facility?
5. Overall, how do you think *Virginia Gold* has influenced the care that staff provides to residents?

Source: DMAS, 2011.

Data Analysis

The focus group recordings were transcribed verbatim by a professional transcriber, which resulted in 413 transcript pages (227 pages from the CNA recordings and 186 pages from the resident recordings). Using basic content analysis, we examined the transcripts independently and collectively using an iterative process to identify important words, phrases, and concepts that corresponded to the interview questions. After reaching consensus, we grouped the codes produced through this process into meaningful themes that captured the essence of the participants' experiences (Patton, 2002; Bogdan & Biklen, 2007). For example, we identified and coded important data that pertained to the question about nursing facility work environments prior to the implementation of the *Virginia Gold* Program. These coded segments were then grouped into themes that represented particular patterns present in the data. For instance, the theme "Poor Communication and Lack of Teamwork" (i.e., lack of communication among CNAs and other nursing facility staff that resulted in staff not working together) emerged from statements such as, "We didn't have much communication back then" or "A year ago…I [didn't] want to spend another moment here passing on information [to other CNAs]," that described how participants experienced the nursing facility work environments prior to *Virginia Gold*. Examples of statements that supported the eight themes that emerged from the data analysis and their definitions are presented in Table 2. The final step in the analysis involved identifying relevant quotes that illustrated each theme. Because *Virginia Gold* primarily sought to develop supportive work environments for CNAs, themes that emerged from the CNA focus groups were used to evaluate the program, while findings from the resident focus groups were used to support CNA themes where appropriate.

Validity of the Focus Group Findings

We used five strategies to ensure the validity of the focus group findings: (a) the use of mechanically recorded data, (b) two researchers (e.g., we established consensus by independently reviewing transcript codes and themes), (c) participant member checking (e.g., we summarized themes that emerged during the interviews and asked participants to verify their accuracy), (d) a peer reviewer (e.g., a neutral peer who challenged the accuracy of the interview themes), and (e) a draft of the evaluation was provided to nursing facility staff for review and comment (McMillan & Schumacher, 2010).[8]

[8] The nursing facility staff reviewed a draft of the original evaluation report prepared for Virginia Medicaid. The findings presented in this study are comparable to the findings presented in the original evaluation report.

Table 2. Examples of Text Segments, Themes, and Theme Definitions

Text Segments	**Themes**	**Theme Definition**
"We didn't have much communication back then." "A year ago…I [didn't] want to spend another moment passing on information [to CNAs]."	Poor Communication and Lack of Teamwork	Lack of communication among CNAs, other staff, and residents prior to *Virginia Gold* that resulted in staff not working together to accomplish common objectives.
"[Peer mentors] are a big help [because new CNAs] can learn more. "[New CNAs] get the same story from the mentors…they know exactly what to do…"	Peer Mentoring and Consistency	Peer mentoring created a supportive work environment for new CNAs through dissemination of consistent information about assignments, duties, and responsibilities
"[Virginia Gold] improved everybody's awareness [and] communication. " "Everyone works as a team [now]. I think Virginia Gold enhanced [that]."	Enhanced Communication and Improved Teamwork	More effective communication among CNAs, other staff, and residents allowing them to work as a team to accomplish common objectives
"We have been asked for our advice on [improving] our work environment." "…CNAs will sit on the interview [panels and] ask [applicants] questions…"	Empowerment	CNAs were involved in decision making activities related to the facility's work environment and resident care
"We [learned] about team work." "The training was very, very useful."	In-Service Training	Education was provided to CNAs to increase professional knowledge, skills and interpersonal abilities
"Just ask [other CNAs] if they have the…benefits that we have." "They started employee of the month [for CNAs]."	Recognition and Benefits	CNAs received monetary and/or non-monetary benefits, rewards, and recognition.
"[Virginia Gold] makes you want to stay on the job." "It makes you happy…you	Staff Retention	Supportive work environment emerged that promoted CNA retention

don't want to leave."		
"We started the bedside plan of care...to involve residents in their own care." *"CNAs are more willing to help [residents now]."*	Improved Resident Care	Residents received care that was appropriate and timely

Results

Based on our analysis, eight major themes emerged as key factors related to the nursing facility work environments before and after the *Virginia Gold* Quality Improvement Program was implemented. The themes provide qualitative evidence on the program's effectiveness from the perspectives of the focus group participants. Detailed information on the themes is provided in the sections below.

Poor Communication and Lack of Teamwork

We began the focus group discussions by asking participants to describe the nursing facility work environments prior to *Virginia Gold*. One theme emerged around this discussion: Poor Communication and Lack of Teamwork. Participants across all facilities indicated that poor communication and lack of teamwork existed among CNAs, other staff, and residents prior to the program. One CNA mentioned that, "…communication…[was]…always a big issue" while another said, "…lack of communication among everybody…played a very important part [in the environment]." Poor communication affected the ability of staff to work together. One CNA reported that, "If we had a new CNA come in, and she didn't know anybody…you wouldn't introduce yourself, you wouldn't say, well do you need any help?" Similar comments from other CNAs included, "The communication [was] not there between the CNAs and nurses" and "We [didn't] get very much feedback from our nurses when we…[came] on the floor."

Several participants described how CNAs did not work together to accomplish common objectives or share pertinent information about residents before *Virginia Gold* started. One CNA said, "We were here as individuals. We did our jobs, got our paychecks, and went home," while another said, "There used to be [an attitude] like, the resident in room 23 needs something, but the CNA has [rooms] 16 to 21, so she was like, well that's not my resident." The lack of teamwork contributed to CNA turnover and low job satisfaction. "We used to lose a lot of CNAs. The new ones sometimes would leave by the next week or by the next pay period, simply because they wouldn't get any help from staff," reported one CNA. Finally, another CNA described the work environment at her facility prior to *Virginia Gold* as "very hectic" and "overwhelming" due to understaffing, which she said affected "…the residents' morale…because they didn't get the care they deserved."

Several comments were received from residents that supported this theme. According to one resident, CNAs were unhappy and would not help residents who were

not directly under their care before *Virginia Gold* started. Another resident said CNAs did not respond quickly when residents called for assistance nor would they talk to residents to find out what was wrong when responding to their calls. In fact, this resident reported that, "CNAs would come in, work two or three weeks, and they're gone. You know, and it [was] like they [didn't] care the way you needed something done. They just wanted out of the room."

Peer Mentoring and Consistency

Peer Mentoring and Consistency emerged as a theme during the discussion of the nursing facility work environments after *Virginia Gold* started. This theme reflects beneficial changes that participants reported occurring at the nursing facilities during the first year of the program. For example, CNA participants said peer mentoring was beneficial because it placed experienced CNAs in positions to help new CNAs adjust to their jobs through individualized training and consistent information about duties and responsibilities. Before *Virginia Gold*, mentoring was an ad hoc process performed (if at all) by any available CNA, which contributed to low morale among new CNAs because they did not always receive appropriate training or consistent information about their jobs. Comments from one CNA supporting this theme included:

> I started when [new CNAs] were still floating around to different staff, and you were really concerned with the next day, who am I going to get stuck with? Are they going to show me the ropes right or are they going to show me their bad habits?

After *Virginia Gold* was implemented, the nursing facilities moved to address these issues by hiring experienced CNAs as peer mentors to facilitate training and information exchange during the orientation process. The new peer mentoring process offered CNAs career advancement opportunities, pay increases, and responsibilities in staff training and patient care. Many participants reported that the new mentoring process was effective. According to one CNA, "Now that we have this mentorship, it has brought everybody together, and we've learned to know each other, we've learned to help each other." One peer mentor succinctly summarized this theme by stating, "[We] try to get [new CNAs] comfortable…to acclimate to our facility, the way we like to have things done…we nurture them along …until we are sure they're okay."

Enhanced Communication and Improved Teamwork

Enhanced Communication and Improved Teamwork emerged as a theme from participant comments about how communication and teamwork improved after Virginia Gold started. The CNAs attributed these improvements to the fact that program funds were used to provide current staff with communication and teamwork training, and new staff with enhanced peer mentoring services. Comments from CNAs illustrating this theme included, "Communication is a lot better from back then [before *Virginia Gold*]" and "We have more interest in how to communicate, how to get along and how to deal

with people's tempers, attitudes, and feelings." One CNA provided a good overview of how his nursing facility improved communication:

> We have a [new] system…where at shift change, we walk around so staff know exactly what's going on with each resident. The group that's leaving gets with the group that's coming in and [they] walk the hallways [and] check on residents…Also, we want [residents] to be part of their care, [so we] keep them informed about what we're doing.

Concerning improved teamwork, one CNA reported that before Virginia Gold, CNAs did not help each other care for residents; however, this changed after the program started because of the emphasis placed on good communication and teamwork skills. Another CNA said, "I enjoy coming to work [now], everybody works as a team…I think Virginia Gold has…kind of enhanced the overall quality." Other CNAs indicated that the training instilled staff camaraderie. "The coworkers…[have become] a big family. We can have dinner together, we can party together…We actually interact outside this building," remarked one CNA. According to the CNAs, the end result of this process was that staff stayed longer at the facilities. Decreasing CNA turnover is important because it can improve quality of care by allowing staff to spend more time learning the residents' needs and preferences (Wiener, Squillace, Anderson, & Khatutsky, 2009). As one CNA mentioned, "We've got [more staff] and everybody is happy, the patients are happy and everybody is a team." Another said that after Virginia Gold started:

> I just feel like we're all family…everybody is a team…and I think that makes you want to come to work…If the CNAs are happy and all of us get along and you're recognized for your work, it makes you want to produce more and that makes you want to go above and beyond.

Comments from several residents supported the Enhanced Communication and Improved Teamwork theme. For instance, one resident said that since Virginia Gold started, the CNAs were more willing to help residents, while another said the CNAs seemed happier with their jobs, were eager to work, and were more focused on meeting resident care needs. Another resident reported that:

> There's teamwork [now]. Like I used to have one person try to put me to bed in the hoyer lift. Now I've got at least two, and I don't have to request it no more. It's just automatically two…and you used to not ever see that. All you would see was one [CNA] fussing about how the other ones wouldn't help them. And you don't see that no more…It's the same staff…so that shows something is working.

Empowerment

The Empowerment theme came from CNA comments about how they began to receive more decision-making authority after Virginia Gold started. Research suggests that CNAs often lack empowerment because they feel undervalued by their employers

and stigmatized by low wages, difficult working conditions, and lack of job advancement opportunities (Dill et al., 2010; Lehning & Austin, 2010). As one CNA said, "Before Virginia Gold, you were just a CNA, you didn't have any input or anything [and] you didn't care as much." Empowerment is important because empowered workers are more confident in their abilities, have control over their work, and feel that they have an impact on organizational outcomes (Kostiwa & Meeks, 2009). After Virginia Gold started, the CNAs became more involved in activities as part of their facilities' quality improvement projects. Other comments from CNAs that support this theme included, "Now we go to [resident] care plan meetings," "We [were] asked for our advice on different things that can improve our work environment," "We participate in interviews and give [applicants] a perspective of what [the facility] is like," and "CNAs sit in on interviews and ask questions…we'll ask things we know would happen [to see] how [applicants] would handle the situation…[to find out if] they're going to be a good person to work here."

In-Service Training

In-Service Training emerged as a theme from discussions about meaningful experiences during Virginia Gold's first year. The pilot facilities used program funding to provide staff with training on various topics including resident care, communication, teamwork, personality and self awareness, and cultural competency. The CNAs reported that the trainings were particularly meaningful because they learned new skills and about how their behaviors influenced relations with peers and residents. One CNA said that the training on diseases, such as dementia, was "…very, very useful [because] it helped us know more about how residents act and how we should act toward them." Another participant said the training was beneficial because it provided CNAs with instruction on teamwork building and ethics. This CNA described the training as, "…helping us [learn] team building skills…to help us work better with one another…[to] come up with better solutions than always holding grudges and being mad." Finally, one CNA reported that:

> The training was fine…because we were learning how to be team players. The instructor was having us learn how to [resolve conflicts] by talking…He was telling us how to get along with each other, and that's the most important thing, how to get along instead of trying to stab each other in the back.

Because CNAs are racially and ethnically diverse, the cultural competency training conducted at one nursing facility is particularly noteworthy because 32 languages are spoken by staff and residents at this facility. Having such diversity in this facility increases the potential for conflict due to miscommunication. However, training can alleviate this by helping staff understand cultural differences. As one CNA reported:

> We have people from all over. When I talk to someone, I like to look them in the eye and I like them to look me back in the eye, but in other countries, they…find that as rude. Well, when I first came here, I'm like, why are they constantly looking at the floor, why aren't they looking at me? I thought they were rude. But then we had the diversity training and

> it helped me understand that we are from different places. They were not being rude and I think that's helped a lot.

Recognition and Benefits

CNAs often receive little recognition or employment benefits for the work they perform (Dill et al., 2010; Kemper et al., 2008). Recognition and Benefits emerged as a theme because the CNAs reported that the nursing facilities used *Virginia Gold* funds to develop monetary and/or non-monetary benefits, rewards, and recognition incentives for CNAs as part of their quality improvement projects. Examples of these incentives included employee of the month awards, performance bonuses, and meals. Because CNAs work under stressful conditions, the lack of appropriate incentives can lead to low job satisfaction and poor quality of care. As one CNA mentioned, "If you're recognized for your work, it makes you want to produce more and the happier we are, the happier the residents are." The CNAs appreciated the incentives offered to them as part of the program. "When I get recognized, I'm feeling good because somebody appreciates me," reported one CNA.

While recognition is important, one pilot facility used program funding to provide CNAs with health insurance benefits (in addition to the private insurance that the facility already provided) through a local community health center. Health insurance is an important retention strategy because CNAs often lack this benefit (Eaton, 2000; Stone & Dawson, 2008; Squillace, et al., 2009; Temple et al., 2010). According to one CNA at this facility:

> As far as the insurance goes, I mean, with our salary, we really don't make that much money…but when you think about what we would have to pay [for our health insurance package], $55 every pay period, that's over $100 a month you have to pay, then you still have to pay the deductible and the copay and pay to get your medicine, on [our] salary, you… can't afford it. No matter how you look at it, you really can't afford it. Especially when you have serious health problems like me, and you constantly have to go to the doctor, you constantly have to have medicine because you take it every day, but without pay raises for the CNAs or a better health package, [the insurance benefit] is the best thing that could have been done for us.

Staff Retention

Staff Retention developed as a theme from the discussion about how the program influenced the nursing facility work environments. This theme suggests that *Virginia Gold*'s emphasis on developing supportive work environments improved staff retention. As one CNA mentioned, "…having the extra training and the mentors…makes people feel…not as uneasy about working here, it makes them feel like they can do it. [The facility] also rewards people for doing well, so people want to stay." Comments from other CNAs included, "[*Virginia Gold*] makes you want to stay on the job," "I think [Virginia Gold] has helped us retain, getting people in and keeping them here," "I think this year has been the best year as far as keeping CNAs," and "…with the grant money,

the facility is able to show people more appreciation…it's the little things that say thank you…[that] keeps people here longer." In addition, one CNA working at the facility that provided the health insurance benefit reported, "The turnover rate is not that great. I guess [CNAs] understand that this is about the best thing going with the insurance."

Improved Resident Care

Finally, comments from several CNAs suggested that quality of care improved after *Virginia Gold* started due to its emphasis on enhanced work environments. As one CNA reported, participating in *Virginia Gold*, "…actually makes it better for the residents because if the [CNAs] are happy, then we just pass it on to them." Another CNA said quality of care at her facility was better since *Virginia Gold* started because CNAs could spend more time caring for the residents:

> I [have] time to actually take care of some of my female patients better. I [have] time to put makeup on, you know, brush their hair, take time with their curls, and that means a lot, both to me and them, because women like to feel pretty, and I like to…be able to take time with our patients to make them look good. That makes them feel good.

The CNAs indicated that they began to feel more responsibility for residents after *Virginia Gold*: "…it's like now everybody knows that all the residents in the building is each of our residents, instead of before, it was like that's not my resident" and "…when you walk through [the front doors], all of the residents belong to you. You know, they are all [our] responsibilities." Comments from two CNAs are particularly noteworthy because after *Virginia Gold* started, they began visiting residents on their off days: "Some of us when we're off, we come [here] to be with the residents…we sit with the residents, we have games, we have fun" and "A lot of the residents ask me to bring [my children]…so on my day off, I'll bring them here and the residents like it."

Many residents indicated that they received good care from the nursing facility staff before and after *Virginia Gold*. However, some reported that the quality of care improved after the program started. For example, one resident said the CNAs seemed to be spending more time getting to know residents so they could provide better care, while another said residents could now simply notify peer mentors if the CNAs provided substandard care instead of having to contact multiple staff as they did prior to the program. Another said CNAs were, "…willing to talk to you now. Instead of just flying in your room and flying back out. They even call you by your first name, which is important." Comments from other residents indicated that the CNAs were more responsive to resident care needs. For instance, one resident reported that, "[The CNAs] are listening [to the residents], and they are reacting quicker than what they used to, and [it's] a lot better," while another said, "If you put your [call] light on and [the CNAs] see that light, they're there right on the spot almost. You don't have to wait for a long time." Another mentioned that, "[The CNAs are] responsive when you ask them something, and they treat you right when you shower and everything." Finally, one resident stated that, "It's not even about the care. It's about the camaraderie…we've become a family in the nursing home."

Discussion

This preliminary study sought to evaluate the *Virginia Gold* Quality Improvement Program by collecting in-depth information from CNAs and residents at the five pilot facilities. It was performed to provide policymakers and other stakeholders with information on the program's effectiveness. The subsections that follow contain findings related to the study questions and the policy implications of the evaluation.

Study Question Findings

The *Virginia Gold* Program was implemented to improve quality of care and CNA retention in Virginia by providing nursing facilities with grant funding to develop more supportive work environments. Because *Virginia Gold* sought to create change through various environmental enhancements, the first study question asked, "What changed for CNAs and residents as a result of their facilities' participation in *Virginia Gold*?" Our analysis found that prior to *Virginia Gold*, the nursing facility work environments were characterized by poor communication and lack of teamwork among CNAs and other staff that interfered with their ability to care for residents. However, after *Virginia Gold* started, three processes developed that improved the work environments: peer mentoring and the dissemination of consistent information, enhanced communication and improved teamwork, and worker empowerment. The second study question asked, "Has *Virginia Gold* made a difference in the lives of CNAs and residents, and if so, how?" Based on our results, meaningful experiences were produced in two areas: in-service training and recognition and benefits. Collectively, these processes are important because they offer CNAs career advancement opportunities, improved job quality, and credibility within their organizations, while demonstrating that nursing facility management staff views them as valuable employees (Kostiwa & Meeks, 2009; Temple et al., 2010). This information suggests that *Virginia Gold* is performing as intended because these processes are characteristics of supportive work environments (Hayunga, 2007; McDonald & Kahn, 2007; Koren, 2010).

While improved CNA retention and resident quality of care are the intermediate and long-term outcomes of *Virginia Gold*, information obtained from participants during the focus groups suggests that the program influenced these outcomes. However, two caveats accompany this finding. First, we were unable to corroborate participants' perceptions that quality of care actually improved because clinical quality of care measures (e.g., frequency rates of pressure ulcers, restraint use, and catheterization) were not examined during the study. Second, we attempted to corroborate participants' views about improved staff retention by analyzing CNA retention data; however, our analysis revealed that only two of the five facilities experienced improved retention rates during the program's first year, while retention rates for the other three facilities remained about the same (DMAS, 2010). This result may be due to the fact that developing a comprehensive CNA retention program that addresses many of the factors associated with this issue is a long-term process that requires time and effort.

Policy Implications

Appropriate investments are vital to addressing many of the issues that affect the CNA workforce. These issues are complex and occur at both the policy and practice levels. While nursing facilities are able to address practice-level issues, they are not always able to influence policy-level issues. For example, government reimbursement policies that affect provider compensation, benefits, certification, and training requirements are usually beyond the control of most nursing facilities. In order for workforce investments to be successful, they must include both policy- and practice-level components (Stone, 2007).

Virginia Gold was designed to improve the quality of care provided to nursing facility residents through the retention of qualified CNAs using policy- and practice-level components. Virginia Medicaid implemented the program using civil money penalty CMP) funds and required the pilot facilities to develop quality improvement projects detailing how these funds would be used to develop more supportive work environments specific to the unique needs of their staff and residents. The nursing facilities were to include certain elements in their improvement projects and to submit financial and quarterly progress reports to Virginia Medicaid for review. In addition, the nursing facilities were to participate in an evaluation to assess the program’s effectiveness. While preliminary, this study suggests that including both policy- and practice-level components in the program allowed it to exert some influence on staff retention and quality of care at the pilot facilities through relatively simple changes in the work environments, including some at no cost. Based on this study, *Virginia Gold* may represent an effective model for improving CNA retention and nursing facility quality of care.

The study results also suggest that using CMP grant funds to finance nursing facility quality improvement projects may be a cost-effective strategy for improving quality of care and staff retention. For example, Virginia Medicaid awarded $250,000 in CMP funds to the pilot facilities for project implementation during the first year of the program. However, each facility completed the first year under budget because it only cost them $136,469 to implement their projects (DMAS, 2010). This demonstrates that the pilot facilities were able to successfully implement various quality improvements at a lower cost than initially estimated. While some states have used CMP funds to pay for nursing facility quality improvement projects, they have typically only allocated the funds to short-term projects lasting less than one year. This is problematic because projects that are implemented over time may actually have a better chance of improving nursing facility quality of care rather than short-term projects. Because states can use CMP funds to pay for projects that directly benefit nursing facility residents, these funds may represent a possible source for financing long-term quality improvement projects (Tsoukalas et al., 2006). However, certain policy issues exist that must be addressed before CMP funds can be used to pay for these projects. Examples include developing formal review procedures to ensure that CMP funds are not used to finance projects and activities for which nursing facilities are already responsible for providing under state or federal regulations (Centers for Medicare and Medicaid Services, memorandum, March 11, 2011), and for providing nursing facilities with financial incentives to continue the

projects after grant funding ends (DMAS, 2011). The findings and implications of the evaluation are summarized in Table 3.

Table 3. Findings and Implications of the Preliminary Evaluation of the *Virginia Gold* Program

1. The *Virginia Gold* Program was implemented to improve quality of care and CNA retention in nursing facilities in Virginia by providing facilities with grant funding to develop supportive work environments.

    - Prior to *Virginia Gold*, facility work environments were characterized by poor communication and lack of teamwork; however, after the program started, three processes developed that improved the work environments: peer mentoring and the dissemination of consistent information, enhanced communication and improved teamwork, and worker empowerment.

    - Meaningful experiences for CNAs developed in two areas after the program started: in-service training and recognition and benefits. These processes offer CNAs career advancement opportunities, improved job quality, and credibility within their organizations, while demonstrating that management staff view them as valuable employees.

2. The *Virginia Gold* Program may represent an effective model for improving CNA retention and resident quality of care.

    - Virginia Medicaid implemented the program using CMP funds and required the pilot facilities to develop quality improvement projects detailing how these funds would be used to improve work environments for CNAs.

    - The pilot facilities were required to include certain elements in their quality improvement programs, submit financial and quarterly progress reports to Virginia Medicaid for review, and participate in an evaluation.

    - The pilot facilities received $250,000 in CMP grant funds during the first year of the program; however, it only cost them $136,469 to implement the program.

Limitations and Future Research

As with all evaluation research, this study has certain limitations that should be considered when interpreting the results. First, the study does not represent a definitive evaluation of *Virginia Gold* because it is only based on the perceptions of a limited number of CNAs and residents from each facility. As a result, it provides insights into activities that occurred at the nursing facilities during the program's first year using information obtained from these participants; however, their views may not represent the views of other CNAs and residents at the facilities. Second, the information collected

from the participants may be biased because they were selected by nursing facility management staff. While we provided management staff with criteria for selecting the participants and informed them that the study was not focused on determining the performance of their specific facilities, some managers may still have selected individuals who they believed would portray the program positively. Third, the information collected from the participants may also be biased because they were asked to discuss events that happened in the past. Their ability to discuss these events accurately may be affected by the passage of time and their current beliefs. Fourth, the study did not account for differences between the nursing facilities or control for other quality improvement initiatives that may have been implemented prior to *Virginia Gold*. While we informed the participants that we were only interested in discussing *Virginia Gold*-related events, it is possible that some may have described events not related to the program. If this occurred, then an additional bias may be present. Fifth, the study may be subject to facilitator bias if our comments influenced the participants' responses during the focus group interviews.

Because this study presents the results of a preliminary qualitative evaluation of the *Virginia Gold* Program, several areas exist for additional research. Quantitative data, such as clinical quality of care, CNA retention, or certain organizational change measures, could be examined over time to determine how they were affected by the program's implementation. Future research could also involve different qualitative methods, such as observations or in-depth interviews of CNAs, other staff, and residents, to collect detailed information on their interactions and behaviors when working or socializing together or on their perceptions of how the facility work environments and quality of care changed during the program. Finally, comparable quantitative and qualitative data could be collected from both the pilot facilities and comparison sites to gain insights into how quality of care and CNA retention faired at nursing facilities that were not exposed to the program. Collectively, these analyses would provide a triangulated approach to obtaining richer data that could better highlight changes that *Virginia Gold* introduced into the pilot facilities. While we initially considered using some of these methods and data sources in our study, we were unable to due to time and resource constraints.

Conclusion

This study suggests that the *Virginia Gold* Program improved the quality of care provided to nursing facility residents through the retention of CNAs. Prior to *Virginia Gold*, the ability of CNAs and other staff to care for residents in the pilot facilities was hampered due to poor communication and lack of teamwork. However, peer mentoring and the dissemination of consistent information, enhanced communication and teamwork among staff, and worker empowerment emerged after *Virginia Gold* started, all of which helped improve the nursing facility work environments. The study also found that the program improved job quality for CNAs through in-service training and recognition and benefits. Finally, the study suggests that these processes may have influenced CNA retention and quality of care in the pilot facilities. However, the study is only preliminary and additional research is needed to more fully understand the program's impact on nursing facility work environments, CNA retention, and resident quality of care.

References

Barry, T., Brannon, D., & Mor, V. (2005). Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *The Gerontologist*, *45*(3), 309–317.

Bishop, C. E., Weinberg, D. B., Leutz, W., Dossa, A., Pfefferle, S. G., & Zincavage, R. M. (2008). Nursing assistants' job commitment: Effect of nursing home organizational factors and impact on resident well-being. *The Gerontologist*, *48*(Special Issue 1), 36-45.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to the theories and methods*. Boston, MA: Pearson.

Burgio, L. D., Fisher, S. E., Fairchild, J. K., Scilley, K., & Hardin, J. M. (2004). Quality of care in the nursing home: Effects of staff assignment and work shift. *The Gerontologist*, *44*(3), 368–377.

Castle, N. G. (2008). Nursing home caregiver staffing levels and quality of care: A literature review. *Journal of Applied Gerontology*, *27*(4), 375–405.

Castle, N. G., & Engberg, J. (2005). Staff turnover and quality of care in nursing facility. *Medical Care*, *43*(6), 616–626.

Centers for Medicare and Medicaid Services. (2011). *Relationship Between Civil Money Penalty Funds Paid by Nursing Homes and the Money Follows the Person Demonstration.* Retrieved from http://www.cms.gov/Medicare/Provider-Enrollment-and-certification/SurveyCertificationGenInfo/downloads/SCLetter11_12.pdf

Department of Medical Assistance Services. (2007). *Development of a nursing facility quality improvement program using civil money penalty funds*, *October 1, 2007*, *State of Virginia.* Richmond, VA: Author.

Department of Medical Assistance Services. (2009). *Request for applications for Virginia Gold: Creating supportive work places and reducing staff turnover in nursing facilities (RFA 2009-01), April 15, 2009*, *State of Virginia.* Richmond, VA: Author.

Department of Medical Assistance Services. (2010). *Interim report of Virginia Gold Program: September 1, 2009 through August 31, 2010*, *State of Virginia.* Richmond, VA: Author.

Department of Medical Assistance Services. (2011). *A review of the Virginia Gold Quality Improvement Program: Interim review*, *State of Virginia.* Richmond, VA: Author.

Dill, J. S., Morgan, J. C., & Konrad, T. R. (2010). Strengthening the care long-term care workforce: The influence of the WIN A STEP UP workforce intervention on the turnover of direct care workers. *Journal of Applied Gerontology*, *29*(2), 196–214.

Duffy, B. P. (1993). Focus groups: An important research technique for internal evaluation units. *Evaluation Practice*, *12*(2), 133–139.

Eaton, S. C. (2000). Beyond 'unloving care': Linking human resource management and patient care quality in nursing facility. *International Journal of Human Resource Management*, *11*(3), 591-616.

Fitzpatrick, J. L., Sanders, J. R., & Worthen, B. R. (2004). *Program evaluation: Alternative approaches and practical guidelines* (3rd ed.). Boston, MA: Pearson.

Flores, J. G., & Alonso, C. G. (1995). Using focus groups in educational research: Exploring teachers' perspectives on educational change. *Evaluation Review*, *19*(1), 84-101.

General Accounting Office. (2001). *Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern* (GAO-01-750T). Retrieved from http://www.gao.gov/new.items/d01750t.pdf

Hayunga, M. (2007). *Training that really works*. Retrieved from http://www.ncnova.org/upload/doc/fa_feat_trainingthatreallyworks_v6n2.pdf

Hickey, G. (2009). *Governor Kaine announces program to enhance the quality of care in nursing facilities*. Retrieved from http://www.governor.virinia.gov/MediaRelations/NewsReleases/viewRelease.cfm?id=1055

Hollander, J. A. (2004). The social contexts of focus groups. *Journal of Contemporary Ethnography*, *33*(5), 602-637.

Howes, C. (2008). Love, money, or flexibility: What motivates people to work in consumer-directed home care? *The Gerontologist*, *48*(Special Issue 1), 46-59.

Kemper, P., Brannon, D., Barry, T., Stott, A., & Heier, B. (2008). Implementation of the better jobs better care demonstration: Lessons for long-term care workforce initiatives. *The Gerontologist*, *48*(Special Issue 1), 26–35.

Kemper, P., Heier, B., Barry, T., Brannon, D., Angelelli, J., Vasey, J., & Anderson-Knott, M. (2008). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist*, *48*(Special Issue 1), 17–25.

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, *29*(2), 1–6.

Kostiwa, I. M., & Meeks, S. (2009). The relation between psychological empowerment, service quality, and job satisfaction among certified nursing assistants. *Clinical Gerontologist*, *32*, 276–292.

Lehning, A. J., & Austin, M. J. (2010). Long-term care in the United States: Policy themes and promising practices. *Journal of Gerontological Social Work*, *53*, 43–63.

McDonald, I., & Kahn, K. (2007). *Respectful relations: The heart of better jobs better care*. Retrieved from http://www.ncnova.org/upload/doc/fa_feat_respectfulrelationshipsheartofbjbc_v6n2.pdf

McMillan, J. H., & Schumacher, S. (2010). *Research in education: Evidence-based inquiry* (7th ed.). Boston, MA: Pearson.

Mukamel, D. B., Spector, W. D., Limcango, R., Wang, Y., Feng, Z., & Mor, V. (2009). The costs of turnover in nursing facility. *Medical Care*, *42*, 1039–1045.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Rantz, M. J., Hicks, L., Grando, V., Petroski, G. F., Madsen, R. W., Mehr, D. R., . . . Mass, M. (2004). Nursing home quality, cost, staffing, and staff mix. *The Gerontologist*, *44*(1), 24–38.

Remler, D. K., & Van Ryzin, G. G. (2011). *Research methods in practice: Strategies for description and causation*. Thousand Oaks, CA: Sage.

Riggs, C. J., & Rantz, M. J. (2001). A model of staff support to improve retention in long-term care. *Nursing Administration Quarterly*, *25*(2), 43–54.

Rogers, P. J. (2007). Theory-based evaluation: Reflections ten years on. *New Directions for Evaluation*, 63–67. DOI: 10.1002/ev.225

Rosen, J., Stiehl, E. M., Mittal, V., & Leana, C. R. (2011). Stayers, leavers, and switchers among certified nursing assistants in nursing homes: A longitudinal investigation of turnover intent, staff retention, and turnover. *The Gerontologist*, *51*(5), 597-609. doi: 10.1093/geront/gnr025

Ryoshu, N. (2011). Experiences of racism by female minority and immigrant nursing assistants. *Journal of Women and Social Work*, *26*(1), 59–71.

Squillace, M. R., Remsburg, R. E., Harris-Kojetin, L. D., Bercovitz, A., Rosenoff, E., & Han, B. (2009). The national nursing assistant survey: Improving the evidence base for policy initiatives to strengthen the certified nursing assistant workforce. *The Gerontologist*, *49*(2), 185–197.

Stone, R. (2007). *Better jobs better care: The public policy journey*. Retrieved from http://www.ncnova.org/upload/doc/fa_feat_bjbcpublicpolicyjourney_v6n2.pdf

Stone, R. I., & Dawson, S. L. (2008). The origins of better jobs better care. *The Gerontologist*, *48*(Special Issue 1), 5–13.

Temple, A., Dobbs, D., & Andel, R. (2010). The association between organizational characteristics and benefits offered to nursing assistants: Results from the national nursing home survey. *Health Care Management Review*, *35*(4), 324–332.

Tempkin-Greener, H., Zheng, N. T., Cai, S., Zhao, H., & Mukamel, D. B. (2010). Nursing home environment and organizational performance: Association with deficiency citations. *Medical Care*, *48*(4), 357–364.

Tsoukalas, T., Rudder, C., Mollet, R. J., Shineman, M., Lee, H. Y., & Harrington, C. (2006). The collection and use of funds from civil money penalties and fines from nursing facility. *The Gerontologist*, *46*(6), 759–771.

Walshe, K. (2001). Regulating U.S. nursing homes: Are we learning from experience? *Health Affairs*, *20*(6), 128–144.

Weiss, C. H. (1997). Theory-based evaluation: Past, present, and future. *New Directions for Evaluation*, 68–81. Doi: 10.1002/ev.225

Weiss, C. H. (1998). *Evaluation* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Wiener, J. M., Freiman, M. P., & Brown, D. (2007). *Nursing home care quality: Twenty years after the Omnibus Budget Reconciliation Act of 1987*. Retrieved from http://www.kff.org/medicare/7717.cfm

Wiener, J. M., Squillace, M. R., Anderson, W. L., & Khatutsky, G. (2009). Why do they stay? Job tenure among certified nursing assistants in nursing facility. *The Gerontologist*, *49*(2), 198–210.

Zeller, J. M., & Lamb, K. (2011). Mindfulness meditation to improve care quality and quality of life in long-term care settings. *Geriatric Nursing*, *32*(2), 114–118.

Zhang, X., & Grabowski, D. C. (2004). Nursing home staffing and quality under the nursing home reform act. *The Gerontologist, 44*(1), 13–23.

Appendix A

Virginia Gold Nursing Facility Quality Improvement Project Activities

---

1. Autumn Care of Portsmouth, Virginia

    A. Medical Benefits: Health insurance arranged through a local community health center that offers physician office visits and prescriptions at a lower cost.

    B. Employee Assistance: Telephone counseling provided in areas not limited to domestic abuse, alcohol and drug dependencies, mental health, grief, legal, financial, housing, child care, work place, and career planning.

    C. Peer Mentoring: Mentoring provided by experienced CNAs to support newly hired staff.

    D. Employee Reward and Recognition Activities: CNAs are rewarded through activities such as monthly appreciation days and "on the spot" recognition for CNAs observed going beyond their duties to support other staff and residents.

    E. Enhanced Training and Development Opportunities for CNAs: Training provided to staff to address problem solving, critical thinking, understanding different personalities, enhancing skills learned, and developing better working relationships.

2. Birmingham Green/Northern Virginia Health Center Commission of Manassas, Virginia

    A. Enhanced Training: Training provided to CNAs to enhance their professional skills.

    B. Preceptor Program: Mentoring provided by experienced CNAs to support newly hired staff through hands-on training.

    C. Cultural Diversity Training: Training provided to CNAs to foster communication and team building skills.

    D. Employee Wellness: Promoting wellness, stress management, exercise, and healthier living activities for CNAs.

    E. Staff Awards and Recognition: CNAs are recognized for years of service completed at the facility, employee of the month, and the Above and Beyond the Call of Duty Award.

3. Dogwood Village of Orange County, Virginia

   A. Train the Trainer: Supervisory staff received training through a local community college on topics such as communication, active listening, self-awareness, problem solving, and building effective working relationships.

   B. Peer Mentoring: Mentoring provided by experienced CNAs to support both newly hired staff through hands-on training and experienced staff through performance improvements.

   C. CNA Screening and Interviewing: CNAs are involved in the screening, interviewing, and hiring process to improve the facility's CNA workforce.

4. Francis Marion Manor of Marion, Virginia

   A. Best Excellence Shining Through (BEST) CNA Advancement: The BEST program motivates CNAs through multi-level incentive awards for professionalism and clinical bedside patient care.

   B. Go for the Gold: Multi-faceted quality improvement project designed to improve working conditions for CNAs through orientation and training, communication, and recognition and reward activities.

   C. Visits to Five Star Nursing Facilities: Staff performed site visits at several five star nursing facilities to identify examples of culture change and performance improvement activities that could be implemented at Francis Marion.

5. Trinity Mission Health and Rehabilitation Center of Charlottesville, Virginia

   A. CNA Retention Team: A retention team initiated improvement in training, interviewing, and recognition activities identified as priorities by staff based on the results of a CNA satisfaction survey.

   B. Interview Roundtable: A staff roundtable was developed to improve the screening, interviewing, and training process for new CNAs. The roundtable also conducted exit interviews with staff to identify reasons for leaving and to discuss options for increasing staff satisfaction.

   C. Enhanced CNA Staff Training: CNAs were provided with periodic training to enhance their professional skills.

   D. CNA Participation in Team Care Plan Meetings: CNAs participate in resident care plan meetings.

   E. Peer Mentoring: Mentoring by experienced CNAs to support newly hired staff through hands-on training and counseling.

F. Awards and Recognition: A number of initiatives were established to recognize CNAs including a CNA of the month award and a best new CNA award that recognizes new CNAs after the first 90 days of employment.

G. Consistent Assignment: CNAs are consistently assigned to the same residents to improve continuity of care through relationship building.

Source: Department of Medical Assistance Services, 2010.

Author Note

Gerald A. Craver is a Senior Research Analyst in the Policy and Research Division at the Virginia Department Medical Assistance Services. He received his Ph.D. in educational research and evaluation from Virginia Commonwealth University and has conducted program evaluation studies for the Commonwealth of Virginia since 1999. All correspondence regarding this study should be directed to: Gerald A. Craver, Policy and Research Division, Virginia Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219; Telephone: 1-804-786-1754; Fax: 1-804-786-1680; E-mail: gerald.craver@dmas.virginia.gov.

Amy K. Burkett is a Program Analyst in the Long-Term Care Division at the Virginia Department of Medical Assistance Services. She received a Bachelor's of Social Work Degree from Radford University and has 24 years of professional experience in the areas of nursing facility health care compliance and physical rehabilitation programs within the Commonwealth of Virginia. Email: amy.burkett@dmas.virginia.gov.

The findings and conclusions in this study represent only the authors' opinions and do not necessarily represent the views of the Virginia Department of Medical Assistance Services (DMAS). While staff members at DMAS reviewed the report, their review in no way represents an endorsement of the content, analysis, or findings of the study.

Copyright 2012: Gerald A. Craver, Amy K. Burkett, and Nova Southeastern University

Article Citation

Craver, G. A., & Burkett, A. K. (2012). A preliminary qualitative evaluation of the Virginia gold quality improvement program. *The Qualitative Report*, *17*(Art. 81), 1-26. Retrieved from http://www.nova.edu/ssss/QR/QR17/craver.pdf