Extended Care Career Ladder Initiative (ECCLI) Qualitative Evaluation Project

Final Report

Prepared for
Commonwealth Corporation

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List of Abbreviations

ABE: Adult Basic Education
ADL: Activity of Daily Living
CMS: Centers for Medicare and Medicaid Services
CNA: Certified Nursing Assistant
CommCorp: Commonwealth Corporation
DON: Director of Nursing
ECCLI: Extended Care Career Ladders Initiative
ESOL: English for Speakers of Other Languages
GNAS: Geriatric Nurse Assistant Specialist
GED: General Education Development
HHA: Home Health Aide
IFAS: Institute for the Future of Aging Services
LEP: Limited English Proficient
LPN: Licensed Practical Nurse
OASIS: Outcome and Assessment Information Set
PHI: Paraprofessional Healthcare Institute
REB: Regional Employment Board
RN: Registered Nurse
UMB: University of Massachusetts at Boston
UTI: Urinary Tract Infection
WIB: Workforce Investment Board

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Executive Summary

Introduction

Low retention, high turnover and vacancies pose significant challenges among frontline jobs in the long-term care (LTC) field. These negative trends can affect the quality of care for LTC clients and residents. There is increasing evidence of the link between a quality workforce and quality outcomes, in the form of good resident/client care.

The Extended Care Career Ladder Initiative (ECCLI) is part of the Massachusetts Nursing Home Quality Initiative enacted in 2000. ECCLI is a competitive, multiple-round grant program available to Massachusetts nursing homes and home health agencies to support development of career ladders and other training initiatives for the LTC frontline workforce. ECCLI's primary goal is to enhance the quality and outcomes of resident/client care while simultaneously addressing the dual problems of recruiting and retaining a skilled direct care workforce.

This final report is the culmination of an 18-month qualitative evaluation of implementation and outcomes of the ECCLI program, conducted by the Institute for the Future of Aging Services and the Gerontology Institute at the University of Massachusetts Boston for the Commonwealth Corporation, which administers ECCLI.

The primary goal of this evaluation was to identify and document changes in organizational culture, leadership, work and care processes and human resource practices. It also investigates the extent to which these changes may be attributed to ECCLI and their influence in improving various workforce and resident/client outcomes.

Methodology

The conceptual areas addressed in this evaluation stem from the larger hypothesis that higher quality jobs, job skills and work environments for frontline caregivers will result in better patient care and quality of life. The questions asked were grouped into five major topic areas: external environment, implementation of training programs, changes in structure/practice, outcomes and sustainability.

The qualitative evaluation focused on eight nursing homes and three home health agencies that reflected different intensities (one or more funding cycles) and timing (initial or recent cycles) within the ECCLI initiative. The evaluation is strengthened by the triangulation of data sources from a variety of stakeholder groups within the grantee organizations. Members of the research team conducted full-day site visits at each organization and a subsequent visit at the eight organizations with ongoing funding six to nine months after the initial visit. The site visits included focus groups with direct care staff and supervisors, interviews with residents/clients and family members and observations of meals and activities. Two management telephone interviews were conducted for each organization: one targeted program implementation and contextual issues; the other focused on the impact of ECCLI from the management perspective. In total, researchers completed 102 interviews, 40 focus groups and 19 site visits.

Raw data for each organization were organized by conceptual areas and themes and then used to create individual case studies. The case studies were then used to synthesize findings across organizations.

Characteristics of ECCLI Sites

All nursing homes were moderate in size, ranging from 90 beds to 140 beds. Six were part of multi-site chains, and two were stand-alone facilities. Three were for-profit, while five were nonprofit. The three home health agencies were all nonprofit but varied in number and type of clients served. The organizations reflect variation in geography: location within Massachusetts and urban/suburban/rural communities.

Program Implementation

Career ladders. As mandated by ECCLI, all 11 organizations created career ladders for certified nursing assistants (CNAs) and home health aides (HHAs). Some organizations also created ladders for other entry-level staff, such as dietary or housekeeping employees. Typically the approach to career ladders involved creating incremental steps with associated modest wage increases. Career ladder steps focused training on both clinical skills (e.g. nutrition, skin assessment, transferring) and soft skills (e.g. communication, mentoring, leadership). Some organizations developed a bridge to nursing component that prepared employees to enter a college-level nursing program. Because grant recipients had the freedom to design career ladders to meet their particular needs, structure, training content and rewards varied from organization to organization. The majority of organizations relied on partner organizations (community colleges, Regional Employment Boards, Workforce Investment Boards) to provide training in order to access expertise appropriate to their goals. Many partnered with other LTC organizations for joint training activities. These partnerships expanded the training capacity beyond what each organization could have provided on its own and allowed employees to experience a connection to the larger long-term care community.

Other initiatives. In addition to career ladders, ECCLI funded other training and educational opportunities that reached a wider audience of employees. Frontline workers were trained in communication skills, conflict management and teamwork. Supervisors were taught basic supervision and capacity building in order to incorporate new CNA/HHA skills into work practices. ESOL and ABE classes provided many employees with educational opportunities to improve their language skills or to prepare for college-level classes. Mentor training was often part of a career ladder in nursing homes and part of soft skills training for home health aides. Three nursing homes sent management staff members to Eden Alternative training, with two actively following up to implement some Eden principles as part of their culture change initiatives. Permanent resident assignments and training on person-centered care were among the initiatives introduced to foster culture change practices.

Implementation challenges. Organizations experienced various challenges to implementing ECCLI programs and activities. In resolving these challenges, the organizations learned a great deal about how to best implement or modify their ECCLI initiatives to yield the greatest success. Three key challenges that emerged were under-estimated need for ABE and ESOL, staff coverage during training and translating training into practice.

Until initiating ECCLI, many organizations did not realize the depth to which their frontline employees were in need of basic and remedial education, especially for employees whose primary language was not English. Organizations often expanded their ABE and ESOL training, which became the foundation for more advanced training activities.

Nearly all organizations experienced difficulty providing adequate coverage for resident/client care when employees were attending ECCLI training classes. The logistics of juggling workers' schedules was extremely challenging, particularly for home health agencies. Unlike nursing homes, home health agency workers are in the field, and there is no equivalent to an on-floor employee who can assist in providing staff coverage while others are in training. To address these challenges, some organizations chose to offer longer training sessions off-site, which were less disruptive to workers' schedules, increased staff motivation and focus and facilitated arranging staff coverage.

There were sometimes challenges in translating training into practice. For example, some supervisors felt threatened by the changing roles of advanced CNAs and thus discouraged them from taking on new responsibilities traditionally done by nurses. One nursing home reached a point where its organizational structure could not support or utilize the senior level skills of all its ECCLI-trained CNAs, and supporting the higher salaries of senior aides began to strain the organization's already tight budget.

ECCLI Program Outcomes
The programs implemented allowed organizations to begin to realize their broadly stated goals of providing workforce development opportunities for frontline caregivers and improving the quality of care to residents and clients. Career ladders and soft skills training programs provided the basis for better career opportunities for employees. The impact of ECCLI seemed to be experienced largely as a result of the breadth of training opportunities offered for all employees, tailored to the needs of the organizations. Outcomes observed across most if not all organizations were improvements in communication, clinical skills, teamwork, respect and self confidence, wages, retention and recruitment, organizational culture and practice change and resident/client quality of care and quality of life.

Improved communication. Improved communication was the most far-reaching outcome of ECCLI. It was reported in all organizations and directly affected all levels of personnel, clients/residents and family members, as well as indirectly affecting operations and quality of care. Improvements in communication among staff resulted in part from improved English comprehension and fluency among frontline non-native English

speaking staff members who took ESOL classes. Staff at all levels commented on the positive effects of improved English proficiency, and those whose English improved reported feeling more self-confident. The impact of language training is reflected in this CNA's comment, *"English classes helped a lot. Before I was afraid to talk … I always talked to clients, but in meetings, I was afraid to talk. Now I am not afraid anymore."*

Frontline staff also attributed improved communication to soft skills training. At most nursing homes, there were improvements in the sharing and communication of resident information, particularly across shifts. Interdepartmental problem-solving meetings also became more effective due to improvements in staff communication skills. As one nurse supervisor said:

> *Communication has improved a lot. I think CNAs don't feel so much like—"You're the nurse and we can't contribute anything." They feel like—"I know there's something wrong," and they'll come to us more readily with that. And I think we are more receptive because we know they know more. I think that communication and their [CNAs'] knowledge have changed. Now there is more mutual respect between the CNAs and nurses.*

Improved communication between frontline staff and their supervisors was less consistent. Many supervisors reported that, as a result of ESOL and communication training, CNAs/HHAs were better able to communicate about residents'/clients' conditions and seemed more confident and comfortable approaching supervisors when problems arose or when they had concerns over the care of a resident. However, some CNAs expressed mixed opinions about communication with their supervisors. Improved supervisor-supervisee communication was most apparent at organizations with interdepartmental communication training or where supervisors received training on how to communicate effectively with subordinates.

Clinical skills. ECCLI clinical training for direct care staff resulted in increased staff understanding of the complex needs of some residents/clients and greater competence in providing targeted care. Increased clinical knowledge contributed to the willingness and ability of frontline workers to contribute to resident care planning. In addition, staff at all levels reported that increased clinical skills resulted in better and more timely care of residents/clients.

Despite the increase in clinical skills among frontline staff, there were differences among organizations with regard to whether frontline staff could use these skills and transfer training into practice. One home health agency reported difficulty matching HHAs with clinical training on particular conditions or procedures with clients who had matching needs. At one nursing home, nurse supervisors were uncomfortable with CNAs doing tasks traditionally done by nurses and thought CNAs should become nurses before being given such responsibilities. However, at another nursing home, some nurse supervisors reported that, as a result of frontline staff's improved clinical skills, their own jobs had been made easier.

Teamwork. The frequency and quality of teamwork improved at both nursing homes and home health agencies. For some organizations, this was intentional, for example, assigning interdepartmental teams to units or neighborhoods. For other organizations, teamwork improved due to increased understanding of the importance and interdependence of roles within the organization, improved communication and flattening of the workforce hierarchy. Overall, organizations described employees as "bonding," "feeling closer" or more "like a family" as a result of ECCLI activities.

Respect and self-confidence. An important outcome of ECCLI training was increased self-esteem and self-confidence among frontline staff, accompanied by increased recognition, respect and trust of frontline staff on the part of supervisors and management. Across nearly all organizations, staff at all levels, as well as family members, commented that frontline staff exhibited greater self-respect and empowerment. As self-confidence increased, frontline staff more often approached supervisors to discuss resident/client issues, offered information and suggestions during care planning meetings and initiated conversations with residents/clients and family members. In addition, nursing home supervisors generally felt greater respect for their CNAs when they provided insightful contributions at care planning meetings or reported important resident observations. An administrator said:

> I think that nurses today understand that their time with the patient/resident is extremely limited, and they need to depend on this member [CNA] of their team to implement the plan of care and evaluate the effectiveness of the care plan on a daily basis. They now see this in their and their patient's own best interests to embrace this level of staff as an equal member of the care team.

At the one nursing home where nurse supervisors voiced lack of trust of trained CNAs' capabilities, CNAs did not see benefits to training, and supervisors did not trust advanced CNAs to handle functions they were trained to do. On closer examination of this outlier organization, it became apparent that supervisors had not participated in management or leadership classes. This suggests that supervisory training may be a critical component of capacity building that enables nurse supervisors to view CNAs who have increased clinical skills and communication competency in a new light.

Impact of increased wages. All organizations linked completion of one or more career ladder steps or learning modules with a modest hourly wage increase. Some CNAs thought the wage increase was not adequate compensation for the responsibility and extra work associated with the career step. However, the sense from frontline workers at most organizations was that increased wages were appreciated but the greater benefits to ECCLI training were improved communication, clinical skills and being valued and respected for their contribution to the residents/clients and to the organization.

Retention and recruitment. Of the eight organizations for which recruitment and retention information was available, three did not have a problem with retention, three showed notable improvement in retention and two had modest, uneven results. At most organizations, the large majority of staff was stable with a small portion of staff turning

over several times within a year. Administrators reported reduced turnover among staff who participated in ECCLI classes, suggesting the importance of enrolling newly hired employees in training.

Employees at both nursing homes and home health agencies viewed the opportunity for training-linked wage increases as an incentive for people to seek work at their organizations. Several organizations indicated they needed to do less formal recruiting because employees act as ambassadors for the organization. Decreased need for recruitment resulted in lower advertising costs, less time spent at job fairs and fewer hiring and orienting expenses. However, for most participating organizations, the cost savings associated with decreased need for recruitment and reduced staff turnover are too recent for administrators to verify.

Resident/client quality of care and quality of life. Family members, nursing home residents and home health agency clients almost all reported excellent care. While it is difficult to link quality of care directly to ECCLI training initiatives, some interviewees noted recent changes in CNA/HHA language proficiency and clinical skills, as well as increased resident/client autonomy and inclusion in care decisions. In addition, some residents/clients and family members who were able to compare their experiences in the present care environment with other care environments were more satisfied with their current situations.

Several nursing homes were adopting culture change concepts, using ECCLI funds for training to promote person-centered care. These organizations have implemented permanent staffing assignments to encourage greater familiarity between residents and care staff. They also embrace and encourage resident choice and decision-making and are incorporating a variety of home-like elements (e.g., pets, plants and intergenerational activities with children).

Sustainability and Long-Term Impact
With few exceptions, most of the organizations planned to retain ECCLI programs, some through continued ECCLI funding but most through ongoing commitment to the goals and objectives of the ECCLI initiative. At least three organizations that no longer received funding had incorporated the CNA career ladders and associated salary increases into their operating budgets. In addition, most organizations were continuing to offer some training in areas such as soft skills and ESOL with a variety of resources. Some provided training "in-house," drawing from internal expertise and train-the-trainer strategies. Collaborations with educational partners result in sustained targeted educational offerings, while collaborations with other LTC organizations encourage cost efficiencies.

The most lasting element of the ECCLI program is the mission of the program itself. Although not all organizations continued ECCLI activities as they were first implemented, what they had done with ECCLI funding had empowered them to continue to engage in other efforts to support the careers and professional and educational development of their frontline staff. Further, several organizations were moving forward

in the implementation or continued development of person-centered care principles and culture-change, demonstrating commitment to the ECCLI goal of improving both staff and resident/client quality of life.

Conclusions

The evaluation highlighted elements integral to successful implementation of the ECCLI initiative and its components, particularly career ladders for the direct care LTC workforce. These include:

- Career ladders help establish a "culture of learning" and generate enthusiasm for education.
- ESOL and ABE are crucial to successful LTC workforce development.
- A commitment to improved communication is key to any workforce development initiative.
- The opportunity for education and career advancement improves frontline workers' feelings of self-confidence and respect and leads to improvements in the quality of resident/client care.
- Increased wages and elevated titles are important to improve workplace quality, but not sufficient without mechanisms for frontline workers who achieve higher titles and wages to use their skills.
- Supervisory training is essential to the success of workforce development initiatives.
- Career ladder and other workforce development initiatives are unlikely to succeed without the support of upper and middle management.
- The most successful career ladder and training programs are those that incorporate an initial needs assessment and are well thought out and thoroughly planned from the outset.
- Working with experienced training providers is instrumental to an organization's ability to reach specific targeted goals of workforce development initiatives.
- Offering career ladders and training opportunities can make an organization more attractive to potential new employees.
- Culture change requires corporate commitment and/or the vision and energy of an administration that is committed to person-centered care.
- Providing workforce development training presents different challenges for home health agencies than for nursing homes.
- Data about the specifics of training initiatives and the number of employees trained are important to evaluating the success of workforce development initiatives such as ECCLI.

Chapter 1: Introduction

Low retention, high turnover and vacancies pose significant challenges among frontline jobs in the long-term care (LTC) field. These negative trends can affect the quality of care for LTC clients and residents. There is increasing evidence[1] of the link between a quality workforce and quality outcomes, in the form of good resident/client care.

In 2000, the Massachusetts state legislature enacted a major Nursing Home Quality Initiative. Its primary purpose is to improve LTC patient care quality and outcomes. Of the various components that make up this initiative, one is the Extended Care Career Ladder Initiative (ECCLI). The Massachusetts Nursing Home Quality Initiative (including ECCLI) was one of the first state-initiated efforts in the United States to address the issue of frontline workforce quality improvement in LTC.

The ECCLI program issues competitive, multi-year grants to Massachusetts nursing homes and home health agencies (and their partners) to create "career ladders" and other training initiatives for the frontline workforce. These trainings increase the skills of the direct care workers and promote positive workplace practices (such as salary increases and more job responsibilities) to support and develop them further. ECCLI funds also help support management and supervisory training, which is key to helping direct care workers translate their newly acquired skills into practice. ECCLI activities are implemented with the ultimate goal of enhancing patient care quality and outcomes, as well as addressing the dual problems of recruiting and retaining a skilled direct care workforce.

At the time of this study, the ECCLI initiative had gone through approximately seven rounds of funding and several rounds of supplemental funding. During the normal funding rounds, organizations were invited to submit grant proposals in response to a Request for Proposals. Each funding round had slightly different parameters and guidelines. Rounds I-IV were open to both nursing homes and home health agencies. Rounds V and VI were targeted specifically to nursing homes, while Round VII was directed at home health agencies. Supplemental funding was offered only after the conclusion of a particular round and only to the sites that participated in that round. Sites had to apply for the supplemental funding, which was usually used to complete the activities they had begun with the normal round funding. With the exception of Round III, at least one organization in this evaluation participated in each of Rounds I through VII.

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[1] Stone, R.I., Dawson, S.L. and Harahan, M.F. 2004. "Why Workforce Development Should be Part of the Long-Term Quality Debate." *Alzheimer's Care Quarterly*, 5(1): 52-59.
Lipson, D.J. 2005. *Linking Payment to Long-Term Care Quality: Can Direct Staffing Measures Build the Foundation?* Report published by the Better Jobs Better Care National Program Office, Washington, DC.

This final report is the culmination of an 18-month qualitative evaluation of outcomes of the ECCLI program, conducted by the Institute for the Future of Aging Services (IFAS) and the Gerontology Institute at the University of Massachusetts Boston (GI-UMB) for the Commonwealth Corporation (CommCorp). The primary goal of this evaluation project was to identify and document changes in organizational culture, leadership, work and care processes and human resource practices. It also investigates the extent to which these changes may be attributed to ECCLI and their influence in improving various outcomes.

The purpose of conducting a qualitative evaluation is to better understand a phenomenon (or in this case, an initiative) by capturing and communicating the participants' "stories." Understanding these stories is useful in that they illuminate the processes and outcomes of the particular initiative. However, while this type of evaluation can add a level of detail and depth that statistical findings cannot, qualitative methods also have limits. Specifically, making conclusions about cause and effect are limited by the type of measurements utilized (e.g. interviews, participant observation, etc.). With these strengths and weaknesses in mind, this evaluation still provides a unique opportunity to use nursing homes and home health care agencies as natural laboratories to assess whether the diversity of interventions that ECCLI helped to create have produced workplace changes, and the extent to which such changes affect care outcomes.

Chapter 2: Methodology

An expanded methodology section can be found in *Appendix A*, with additional in-depth details and information.

2.1   Theoretical Framework & Evaluation Topic Areas

The conceptual areas addressed in this evaluation were guided by the work of the late Susan Eaton[2], as well as previous studies conducted by members of the IFAS/GI-UMB research team. Essentially, they stem from the larger hypothesis that higher-quality jobs, job skills and work environments for frontline caregivers will result in better patient care and quality of life. The questions asked were grouped into five major topic areas: contextual, implementation of the interventions, changes in structure/practice, outcomes and sustainability.

2.2   Data Collection Planning & Preparation

Obtaining the perspectives of a variety of stakeholders within the ECCLI grantee organizations helped researchers to develop a more complete picture of implementation experiences and their outcomes. This qualitative evaluation was strengthened by a triangulation of data sources at each organization, including:

1. Participant observation and informal discussion.
2. Formal one-on-one interviews (both in-person and on the telephone).
3. Focus groups.
4. Document review (when possible).

Stakeholder groups that were asked to participate in formal interviews or focus groups included: clients/residents, family members, frontline staff, frontline supervisors and management. To conduct the formal interviews and focus groups, 10 different question protocols were generated. Each contained questions tailored to one of the targeted stakeholder groups

First, researchers addressed the clients/residents, family members, frontline staff and frontline supervisors. Two protocol versions were created for each: one to be used in home health agencies and the other in nursing homes. Second, for management, two different question protocols were created: #1 focusing on ECCLI implementation (typically used to interview the ECCLI coordinator) and #2 focusing on overall organizational questions (typically used to interview the CEO or administrator).

2.3   Site Selection

As specified by CommCorp, the sample for the qualitative evaluation consisted of 11 organizations, each assigned to a "component" based on what ECCLI funding they had received. Organizations in "Component A" were funded in ECCLI Rounds I through IV, completed their projects and are no longer receiving funding. Those in "Component B"

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

were new projects that received funding in Rounds V and VII. Finally, those in "Component C" have continued to receive funding in multiple rounds (Rounds I through VII). The 11 organizations were divided among the components as such: three nursing homes in Component A, three nursing homes and one home health agency in Component B and two nursing homes and two home health agencies in Component C.

Before selecting organizations for each component, researchers developed a list of candidate ECCLI organizations based on CommCorp documents. Once these organizations were listed, several exclusions were applied. Final decisions about these exclusions were made in consultation with CommCorp.

2.4   Site Recruitment

Once the sites were identified for inclusion in the study, letters were sent to the nursing home administrators and top management personnel at the home health agencies informing them of their selection for the study and encouraging their participation.

Several of the selected organizations across all components (A, B, and C) chose not to participate in the study for a variety of reasons, such as recent management changes or time constraints. Replacement organizations were identified. As we anticipated, the A sites, which were no longer receiving ECCLI funding, were less willing to participate. However, with extended time and additional efforts, researchers were able to secure three A sites that met the criteria.

Stipends were offered both to individual participants and to the nursing homes and the home health agencies. A visit coordinator was identified in each ECCLI site who worked with the research team to arrange the site visit and telephone interviews.

2.5   Data Collection

Researchers visited Component A sites only once during this evaluation and visited B and C sites twice (two different data collection time points). Thus, researchers accomplished a total of 19 site visits. In general, two researchers from GI-UMB (and on four of the site visits, IFAS) conducted a site visit. On these visits, researchers conducted participant observation, interviews with clients/residents and family members and focus groups with frontline staff and frontline supervisors. Management interviews were conducted via telephone after a site visit was completed.

Each site visit included two focus groups. One focus group targeted frontline caregiving staff, predominantly certified nursing assistants (CNAs) or home health aides (HHAs), although nursing homes also included dietary, housekeeping, maintenance and clerical staff in some groups. The other focus group included frontline supervisors, usually licensed practical nurses (LPNs) and registered nurses (RNs), but also included food service, maintenance and housekeeping managers and activity directors at some nursing home sites. Individual in-person interviews with approximately two residents/clients and two family members per site also occurred, though occasionally only one of each of these could be conducted. Two management interviews were conducted via telephone with upper-level personnel after each site visit. One management interview targeted

implementation and contextual issues, and the other focused on the impact of ECCLI from the management perspective. The site visit teams also spent time observing activities or meals and walked around the organizations collecting personal observations both on their own and with members of the management staff conducting tours. In total, researchers completed 102 interviews, 40 focus groups and 19 site visits.

2.6 Analysis
All analysis and report writing was guided by the five key conceptual areas: external environment, implementation of the interventions, changes in structure/practice, outcomes and sustainability. First, raw data were organized based on conceptual areas and themes and then used to create individual case studies, one for each site in the evaluation. The case studies were then used to synthesize findings across the sites and create this final report. Executive summaries of the case studies can be found in *Appendix B*. The full case studies are available from CommCorp.

Chapter 3: Overall Characteristics of Study Sites

3.1 General Characteristics

As described in Chapter 2, three of the 11 selected ECCLI sites were home health agencies, while the other eight were nursing homes. Of the 11 Component A, B and C sites, three were for-profit and eight were nonprofit[3]. The three for-profits were all nursing homes. As dictated by our methodological design, all nursing homes were moderate in size, ranging from 90 to 140 beds. Six of these nursing homes were part of multi-site chain and the other two were stand-alone facilities. The home health agencies also varied in size and served differing numbers of clients (Table 3.1).

Table 3.1   Characteristics of Study Sites

Organization Type	ECCLI Funding Rounds	Ownership
Component A		
1. Nursing Home	Round I: 11/00 – 07/03	For-profit
2. Nursing Home	Round II: 03/01 – 06/02	Nonprofit
3. Nursing Home	Round I: 11/00 – 06/02	For-profit
Component B		
4. Nursing Home	Round V: 04/04 – 06/06	Nonprofit
5. Nursing Home	Round V: 04/04 – 06/06	Nonprofit
6. Nursing Home	Round V: 04/04 – 06/06	For-profit
7. Home Health Agency	Round VII: 04/04 – 06/06	Nonprofit
Component C		
8. Nursing Home	Round I: 11/00 – 06/02 Round VI: 04/04 – 06/06	Nonprofit
9. Nursing Home	Round I: 11/00 – 06/02 Round VI: 04/04 – 06/06	Nonprofit
10. Home Health Agency	Round IV: 11/02 – 12/03 Round VII: 04/04 – 06/06	Nonprofit
11. Home Health Agency	Round IV: 11/02 – 12/03 Round VII: 04/04 – 06/06	Nonprofit

3.2 Resident/Client Quality Indicators

The Centers for Medicare and Medicaid Services (CMS) maintains a Web site that reports how individual facilities rate on quality indicators/measures. This data is collected periodically from nursing homes and home health agencies.

Nursing home data in this report come from four sources: the Minimum Data Set (MDS), the Online Survey, Certification and Reporting (OSCAR) database and the Massachusetts Nursing Home Report Card. CMS maintains MDS data and enters them into a national

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[3] A key part of our selection process was guided by which organizations the ECCLI project director assessed were doing more in workforce development than others. Our site selection focused on choosing organizations that had accomplished more in developing their workforce rather than selecting organizations that varied in their organizational or residential outcomes. The rationale was to see what could the organizations judged "more successful" achieve and what were their experiences. By adding this criterion, only six organizations were designated by the CommCorp project director as having done significantly more in workforce than others. Among these six organizations, four are non-profit and two are for-profit. As a result, we ended up with more non-profit organizations than for-profit organizations in the study.

database known as the MDS Repository. CMS posts MDS online data quarterly. Data from the last three state surveys are available in the OSCAR database, also posted on the CMS Web site. Lastly, Massachusetts prepares a "nursing home report card" based on the last three state health department surveys and compiles a facility score.

Home health agency data discussed below are collected from the Outcome and Assessment Information Set (OASIS), similar to the MDS and made available and updated quarterly on the CMS Web site. These data represent a rolling 12 months of information collected from home health agencies. There is no Massachusetts "nursing home report card" equivalent for home health agencies.

3.2.1 Nursing home quality measures

Overall, nursing homes participating in the ECCLI funding rounds receive better than average to high marks on quality measures and during state health department surveys. Detailed information regarding scores is located in Tables 3.2 and 3.3.

As a group, the nursing homes in this evaluation scored at or above the state average on 13 of the 15 quality indicators reported by CMS in January 2007. While there was variation in which indicators the participants had higher scores on, four of the indicators had seven of the eight participating nursing homes scoring better than average. These included: percentage of long-stay residents with moderate to severe pain, long-stay residents who stay in a bed or chair most of the time, long-stay residents with urinary tract infections (UTIs) and long-stay residents who lose too much weight. Additionally, six of the eight homes scored better than state average on another four indicators: percent of residents needing more help with activities of daily living (ADLs), high-risk residents with pressure sores, long-stay residents physically restrained and long-stay residents who have or have had a catheter inserted and left in their bladder. There was one quality measure where only one home scored better than the state average: percent of long-stay residents who lose control of their bowels or bladder.

Along with higher scores than the state averages on quality indicators, with one exception these homes also had fewer deficiencies cited during annual state health department surveys. Six out of eight homes achieved better than state averages on their last three surveys (2004-2006) and one home on two out of the last three surveys (2004-2006). One received higher than average *deficiencies* on all three state surveys. Lastly, on the Massachusetts nursing home report card measure, a measure that combines the number of state health department deficiencies with the scope and severity of those deficiencies for the last three surveys, six of the eight homes in the study scored higher than the state average in 2006.

The two nursing homes focused on culture change as a goal scored particularly well on quality measures with one scoring better than state average on 12 of the 15 measures and the other on 13 of the 15 measures. Both experienced higher deficiencies on state surveys than other homes on at least one survey in the last three, which may speak to the difficulties of introducing culture change practices and how state surveyors view these changed practices during annual visits.

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Table 3.2 MDS Quality Indicators for Nursing Homes* (January 2007)

Quality Indicators	MA Avg.	1	2	3	4	5	6	7	8
Needs more ADL assistance	16%	13%	4%	19%	12%	7%	28%	5%	1%
Long-stay resident: w/ moderate or severe pain	3	2	0	0	3	5	4	1	3
High risk resident: w/ pressure sores	12	5	12	7	5	9	16	23	4
Low-risk resident: w/ pressure sores	2	n/a	2	2	6	n/a	4	n/a	0
Long stay: physically restrained	5	6	0	0	3	7	1	0	5
Long-stay: anxious or depressed	15	17	5	8	8	21	24	11	11
Low-risk, long-stay: w/ incontinence	59	70	64	77	73	64	49	n/a	65
Long-stay: w/ catheter	5	5	4	6	2	2	2	47	5
Long-stay: in bed/ chair most of the time	2	0	1	0	2	1	0	4	2
Long-stay: ability to move in room is worse	15	26	5	14	12	22	20	6	14
Long-stay: w/ UTI	10	9	7	10	5	10	3	17	7
Long-stay: losing too much weight	7	5	8	6	5	6	5	3	4
Short-stay resident: w/ delirium	2	7	0	9	2	2	2	n/a	2
Short-stay: w/ moderate or severe pain	20	23	13	6	51	17	26	n/a	14
Short-stay: w/ pressure sores	17	21	15	17	13	10	9	n/a	18

*Shading indicates performance better than the MA state average.

Table 3.3 Massachusetts Nursing Home Report Card (2006) and State Survey Nursing Home Data (2004-2006)

	MA Average	1	2	3	4	5	6	7	8
MA Report Card 2006	**123**	131	128	131	129	130	116	128	115
Deficiencies 2006	**6**	1	2	2	5	1	9	6	0
Deficiencies 2005	**6**	2	5	1	2	2	11	0	10
Deficiencies 2004	**6**	3	1	0	2	0	7	0	5

*Shading indicates performance better than the MA state average.

3.2.2 *Home health agency quality measures*

Home health agencies showed mixed results on quality measures reported from data collected on OASIS reports in January 2007. One agency scored better than average on eight out of 10 quality measures, one on three out of 10 measures, and one did not score better than average on any measure. This agency had been participating in ECCLI funding rounds since 2001, as did the agency that fared the best. The third agency began ECCLI participation in 2004. For detailed information on scores, see Table 3.4.

Table 3.4 OASIS Quality Measures—Home Health Agencies* (January 2007)

Quality Measures	MA Average	1	2	3
Who walk or move around better	**41%**	32%	17%	48%
Better at getting in and out or bed	**51**	56	24	62
With less pain when moving	**64**	57	45	66
Whose bladder control improves	**51**	53	31	57
Who get better at bathing	**62**	56	44	66
Better at taking oral meds	**43**	37	21	48
Short of breath less often	**60**	64	41	58
Stay home after home health ends	**65**	58	61	68
Needing hospital admission	**32**	38	39	29
Needing urgent unplanned medical care	**23**	26	32	25

*Shading indicates performance better than the MA state average

3.3   External Environment

During the management interviews, respondents (e.g., administrators, assistant administrators, DONs, ECCLI coordinators, etc.) were asked to describe the extent of changes in their external environment since starting ECCLI. Respondents were probed to describe any changes in regulations, the survey and certification process, state or federal legislation, Medicaid/Medicare reimbursement or other market factors that might affect the grantees. Despite probing, the interviewees generated few responses.

Among the substantive responses, two key themes emerged, mentioned by multiple organizations. Home health agencies described Medicare/Medicaid reimbursement challenges, either not being paid adequately or having reimbursement levels cut. Several other organizations noted that Massachusetts legislators tried to cut ECCLI funding over the course of several years. According to one organization, this resulted in delays in receiving ECCLI grant funds, which made it difficult for the organization to keep the ECCLI program running.

During the period covered by ECCLI, Massachusetts has been through a recession (December, 2000 – March, 2003) and a very slow recovery. It is one of a few states that have not yet recovered their total employment levels prior to the recession in 2001.[4]

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[4] Massachusetts Budget and Policy Center. "The State of Working Massachusetts 2006." September, 2006. http://www.massbudget.org/State_of_Working_Massachusetts_2006.pdf.

Unemployment was significantly higher in 2006, with a statewide annual unemployment rate of 5%, compared to an unemployment rate of 3.7% in 2001 and a peak rate of 5.8% in 2003.[5] As a result during the period 2002 through 2004, employment opportunities were limited for workers and only since 2005 has employment been increasing.

Vacancies in critical positions such as RN and CNA continue to be high. According to the most recent Massachusetts Job Vacancy Survey, nearly one fifth of the 4,581 RN vacancies and more than 3/5[ths] of the 1,994 CNA vacancies occur in the nursing care industry.[6] Filling the RN positions is more difficult in nursing homes and home health agencies as nurses in these two industries earn 18% and 14% less, respectively, than the median wage for nurses in Massachusetts, $65,040. Nursing aides in these two industries, on the other hand, do earn roughly the median wage of $26,010.[7]

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[5] United States Department of Labor. Bureau of Labor Statistics. Local Area Unemployment Statistics (LAUS). http://www.bls.gov/lau/home.htm.
[6] Foley, Cathy. E-mail to the Author. April 25th, 2007.
[7] Massachusetts Department of Workforce Development. Division of Career Services. Occupational Industry Crosswalk. May, 2005.

Chapter 4: Implemented Programs

CommCorp offered organizations applying for ECCLI grants flexibility in designing programs as long as they met some general requirements such as creating career ladders for CNAs/HHAs and paying trainees for at least 50 percent of their time spent in training. As a result, grant recipients implemented programs that varied to meet specific organizational needs. This chapter describes the programs that organizations implemented and partnerships they formed.

4.1 Implemented Programs

Implemented programs generally followed the plans that organizations presented to CommCorp in their original proposals. Given that the grant allowed for flexibility, during the initial planning time, organizations sometimes received input from other staff members or training partners that caused them to alter their plans to better meet their stated goals. For the purposes of this report, programs are categorized as either career ladder training or other initiatives. Career ladder training programs targeted a specific group of employees (generally CNAs and HHAs) and included salary increases once program criteria were met. Other initiatives reached employees at all levels throughout the organization to meet a specific organizational need and did not involve salary increases. Training was offered during work time, with the grant requiring the organization to pay employees for at least 50 percent of their time spent in training. This made classes accessible to many employees who would not have otherwise been able to attend career development or personal development classes.

The 11 sites involved with this evaluation received ECCLI funding for different lengths of time, allowing those with longer funding periods to implement more programs than those only receiving single-round funding or those whose funding began more recently in 2005. Those in later rounds benefited from lessons learned in earlier rounds. Thus, later round participants offered more basic education and career counseling programs. Both individual organizational need and lessons learned in early rounds drove the content and structure of programs offered in later rounds.

4.1.1 CNA/HHA career ladders

One grant requirement was the creation of career ladders for CNAs/HHAs. All 11 participants studied created these ladders within the CNA/HHA ranks, and some also created ladders for other entry-level staff, such as dietary or housekeeping employees. Many also created opportunities for CNAs or HHAs to prepare to become nurses with a "bridge to nursing" program. Typically, steps within CNA/HHA career ladders provided employees with a salary increase once the training for that level was completed. The bridge to nursing component prepared the employee to enter a college-level nursing program and did not involve a salary increase, as the financial reward would eventually be realized when the employee became a nurse. Because grant recipients had the freedom to design career ladders to meet their particular needs, structure and rewards varied from organization to organization. Table 4.1 provides details for each organization's system of training and rewards.

Table 4.1 Career Ladders

Organization	Career ladder steps[8]	Increase per hour per step	Maximum CNA/HHA increase per hour	Hours of training to earn increase
Component A				
Nursing home	2	$0.50 per hr per step	$1.00 per hr	48 hrs /40 hrs
Nursing home	2	3% per hr per step	Approx. $1.00 per hr	42 hrs/42 hrs
Nursing home	1	$1.25 per hr	$1.25 per hr	100 hours
Component B				
Nursing home	3	$0.25 per hr /$0.75 per hr/ $50 training-time bonus for mentoring	$1.00 per hr	30-40 hrs/30-40 hrs/ 20 hrs
Nursing home	1	3% increase per hr	Approx. $0.40-$0.50 per hr	80 hrs
Nursing home	2	$0.40 per hr/ $0.60 per hr	$1.00 per hr	32 hrs/40 hrs
Home health agency	1	$1.00 per hr	$1.00 per hr	120 hrs
Component C				
Nursing home	3	$1.00 per hr $0.50 per hr/ no increase	$1.50 per hr	24 hrs/16 hrs/ 22 hrs
Nursing home	2	$0.30 per hr/$0.30 per hr + training-time bonus/$0.25 per training hr	$0.60 per hr	16 hrs/24 hrs
Home health agency	1	$0.50 per hr	$0.50 per hr	Approx 60 hrs
Home health agency	3	$0.25 per hr/$0.25 per hr/$0.25 per hr	$0.75 per hr	40 hrs/20 hrs/ 15 hrs

<u>Nursing home career ladder structure</u>
The most common career ladder approach involved the creation of a number of ladder steps aimed at developing skills incrementally and rewarding employees for their achievements at each step. Six of the eight nursing homes had at least two steps beyond entry level for CNAs with incremental salary increases generally ranging from $0.25 to $0.50 per hour for each step reached with maximum increases ranging from $1.00-$1.50 per hour at the top ladder step. The other two nursing homes offered a single step, such as Senior CNA, above entry level, providing salary increases all at once instead of incrementally. One nursing home offered a three percent per hour increase and the other $1.25 per hour. There also was variation in how much training time was required of each person in order to achieve the maximum salary increase available. Required training times ranged from 40 to 120 hours, with most sites requiring between 80 and 100 hours.

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[8] Indicates number of steps available beyond entry-level CNA or HHA.

Home health agency career ladder structure
Multiple-step career ladders were less common among home health agencies than nursing homes. Although two home health agencies initially introduced career ladders following a two-step model (beyond entry-level), both quickly changed to a one-step model to better meet their needs. These agencies continued to train HHAs in advanced clinical skills without developing a hierarchy of aides. Advanced training earned these aides a salary increase with job titles and responsibilities remaining essentially the same. One agency offered a $0.50 per hour increase after 60 hours of training and the other a $1.00 per hour increase after 120 hours.

The third home health agency maintained a three-step approach because it provided basic homemaker services in addition to home health care. Employees advanced from homemaker to personal care homemaker to home health aide with additional training and earned an additional $0.25 per hour at each step.

Training within career ladders
Partners most often provided training, although some organizations chose to provide training "in-house." One of the healthcare organizations within the partnership usually taught the clinical skills classes, while a career development organization or consulting groups typically taught soft skills classes. Bridge-to-nursing classes usually were available through the local community college.

There were many similarities and some differences in the types of topics covered in career ladder training. Most organizations included both clinical and soft skills training within the career ladder steps. A few focused simply on improving clinical skills within the ladders and offered soft skills training as separate training initiatives available to all employees whether or not they were participants in career ladder training. Table 4.2 describes the clinical skill topics most frequently covered, and Table 4.3 lists soft skill topics.

Table 4.2 Common Career Ladder Clinical Skills Topics

Organization	A1	A2	A3	B1	B2	B3	B4	C1	C2	C3	C4
Restorative care	✓	✓	✓	✓	✓		✓	✓	✓		✓
Complex physical needs e.g. orthopedic, respiratory, infection control, pain management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complex behavioral needs e.g. anxiety, mood disorders, mental illnesses	✓	✓	✓		✓	✓					
Dementia care	✓	✓	✓	✓	✓	✓	✓		✓		✓
Death and dying			✓		✓	✓	✓		✓		

One program included training in nutrition, another in skin assessment and care and another in transferring techniques and oral hygiene. Some topics were included as a result

of an initial needs assessment that the facility performed to better understand where to focus its attention. Others were standard courses provided by the Benjamin Healthcare Center training program, whose material CommCorp made available to the organizations.

Table 4.3 Common Career Ladder Soft Skills Topics

Organization	A1	A2	A3	B1	B2	B3	B4	C1	C2	C3	C4
Teamwork	✓	✓							✓		
Conflict management		✓	✓			✓					
Mentoring		✓	✓	✓		✓		✓	✓		
Communication		✓	✓	✓		✓	✓	✓	✓		
Leadership	✓		✓			✓		✓	✓		
Stress management		✓				✓					

Soft skills topics most often covered were communication skills, mentoring and leadership skills. The exact content of these modules varied, with some sites developing a career ladder step around mentoring skills.

Mentor training often was part of soft skills training provided in nursing home career ladders, with two nursing homes specifically designating a step to be a Mentor CNA. One in particular believed that a strong mentoring program was the key to solving turnover of newly hired CNAs. This nursing home developed both Mentor CNAs and Senior Mentors as part of its career ladder. Soft skills within career ladders focused almost exclusively on some type of leadership or group dynamics, such as conflict management, teamwork and communication skills, preparing highly trained CNAs to accept leadership positions within the organization as senior level CNAs or as unit or neighborhood coordinators.

Home health agencies as a whole offered more advanced clinical skills training and fewer soft skills classes within career ladder training, although they did offer these skills in separate training initiatives not related to salary increases. Advanced clinical skills seemed to be more important for aides to succeed in serving clients with increasingly complex healthcare needs.

Some participants offered specialty tracks within advanced positions. For example a senior level aide could pursue special training as a dementia care specialist, a rehab specialist or a resident life specialist. These different tracks provided individuals the opportunity to focus training in areas that were of particular interest to them and gave the facility a designated set of "experts" in certain areas.

Other frontline worker advancement opportunities
Several nursing homes offered other frontline workers opportunities to advance their careers. One created a chef apprenticeship program for dietary workers to become dietary managers, even if these employees needed to leave the facility for personal advancement. One nursing home successfully introduced ladders for environmental staff by offering training in resident relations, work-related fitness and safety. This home also provided dietary workers with classes in cooking math, knife safety, resident-centered dining and supervisory training. Employees successfully completing these training tracks received a

$0.30 per hour salary increase. This effort reflected the true spirit of ECCLI-funded workforce development focus of enabling low-wage workers to progress to better jobs. Another nursing home planned to offer career ladders for housekeepers and dietary workers but conceded that not enough thought was put into development of such programs and abandoned the idea.

Two nursing homes offered CNA I initial certification training for employees in other departments such as housekeeping, maintenance or dietary services to become CNAs. While employees did not receive a salary increase for simply completing the training, they did realize increases when hired into CNA positions within the facilities.

4.1.2   Other initiatives implemented

In addition to career ladders, participating organizations offered a variety of training programs, such as communication classes or computer skills and educational opportunities such as English for Speakers of Other Languages (ESOL) or basic math and career counseling or case management to all levels of employees. Training classes generally reached a larger number of employees and were much shorter in duration than career ladder training. Most training classes focused on a certain topic, such as communication skills, in about a three-hour workshop. Classes were intended to improve specific skills or introduce new concepts, such as person-centered care, to the entire organization. Education topics could last several months. Career counseling was offered as needed; some organizations offered this resource only to employees participating in the career ladder while others offered career counseling to a wider audience of employees.

Topics that different organizations offered often were similar; however, sometimes motivation for including a certain topic varied. For example, many participants offered cultural diversity or cultural awareness training. Some programs were aimed at helping direct care workers gain a better understanding of the clients they served; others were intended for supervisors and direct care workers to better understand each other. Classes titled "communication skills" were sometimes focused on improving an individual's writing skills and style of communication, while others had broader goals such as improving group-level communication among departments, among different levels of employees or between "difficult" residents and staff members.

Topics offered were sometimes similar to soft skill topics offered within career ladders, but they reached a much wider audience. They were meant as skill enhancement opportunities and did not involve salary increases for participants. In some cases, all levels of employees—from frontline workers to managers—participated in the same training class, for example, on communication skills. In other cases, separate classes were held for each group, sometimes on similar topics such as cultural diversity.

Basic/soft skills training
All participants offered some level of soft skills training classes and most offered these to both frontline workers and supervisory and/or management staff. Some offered topics that were seen as strictly work-related, such as peer mentoring or customer service while

most workshops included topics that were applicable to work and non-work related situations, such as communications and conflict management.

The most commonly offered soft skills training classes, other than ESOL and Adult Basic Education (ABE) described below, were communication skills, conflict resolution and problem solving for direct care workers and capacity-building or coaching and mentoring subordinates for supervisors. Other topics covered by just a few sites included teamwork, time management, stress management, customer service, building relationships, computer skills and basic life skills.

ESOL and ABE
Nine of the 11 study participants offered ESOL classes for their employees. Of the two not offering these classes, one had mostly native-English speaking employees, and the other only received round one funding and may not have had time to implement this type of training. Many sites offered multiple ESOL classes, either to offer employees a chance to continue improving their language proficiency by offering an advanced level of ESOL, or to offer more employees the opportunity to take basic ESOL. Beginning ESOL was most often offered to dietary or housekeeping staff members with little English speaking ability. At one nursing home, it was important that continuing classes be called "advanced" in order to avoid the perception that employees needed the classes because they didn't learn well enough the first time. Employees generally were not embarrassed to enroll, and peers and supervisors supported their training efforts.

ABE consisted of basic math, reading and writing skills. Many frontline workers without high school diplomas took advantage of these classes in order to prepare for general educational development (GED) exams. Since employees were paid for at least half of their time spent in training, this seemed to be a signal to the trainees that education was important, and there was no stigma attached to admitting personal deficiencies with these skills. One CNA reported that her family had been encouraging her to apply to nursing school. She had never admitted to not having a GED before and just brushed off their suggestions. This work-related training allowed her to earn her GED and begin to prepare to take college-level nursing classes.

Advanced levels of ABE were offered in many cases as a bridge-to-nursing program. These classes also offered math, reading and writing and did so at a level that would prepare frontline workers with strong technical skills to take nursing program entrance exams.

Career counseling and case management
Career counseling efforts varied considerably, in some places being offered at the beginning of ECCLI funding and at others being offered continuously throughout funding. Partner organizations offered counseling at first, but some organizations later decided to offer these services through in-house supervisors or human resources staff.

When in-house staff offered career planning, it was often done in conjunction with performance appraisals. Two nursing homes hired a partner to work with employees to

develop career plans and used in-house supervisors to support employees to implement those plans.

This support, sometimes called case management, involved helping employees break down barriers to learning, such as childcare or transportation issues or other influences outside of work that would prevent them from pursuing their goals. The employer usually offered these services through an Employee Assistance Program (EAP). One nursing home that promoted case management services found that this could really make a difference. One employee described the difference between education with support services and traditional tuition reimbursement programs this way:

> *We have always had tuition reimbursement, but I could never figure out how to take classes and take care of my family. Now, I can go [to classes] partly on work time, and they helped me find after-school care for my kids that I could afford. Now they are helping me apply for financial aide for the nursing program.*

Management and supervisory training
Management skills and capacity building were offered at many locations for managers and supervisors. This training helped these leaders to understand how CNA roles were changing and how to help CNAs incorporate new skills into everyday practice. Engaging nurse supervisors in understanding new roles for direct-care workers seemed to be essential to their acceptance of ECCLI training programs.

Another type of supervisor training offered was supervisory training for direct care workers, providing them with skills necessary to grow into leadership positions. This training helped these CNAs begin to take on leadership positions within their organizations such as supervising other staff members, participating in interviewing and hiring decisions or leading a unit or neighborhood as the person in charge of day-to-day issues.

Mentoring
While nursing home participants typically included mentor training as part of career ladder steps, home health agencies trained workers as mentors outside of these ladders. One agency was beginning to introduce a mentor program and included training for supervisors on how to incorporate direct care worker training into work practice.

Culture change training and initiatives
Three nursing homes actively engaged in training in order to introduce culture change concepts. Two sent employees to Eden Alternative[9] training and planned to implement some or all of the Eden concepts into their facilities; a third had done this prior to ECCLI funding. One of these introduced classes in person-centered care in an attempt to begin the journey into culture change. They changed scheduling patterns from rotating resident

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[9] The Eden Alternative is a culture change model the mission of which is to improve the well-being of elders and those who care for them by modifying the communities in which they live and work. The model seeks to eliminate loneliness, helplessness and boredom by changing the physical and social environment of care facilities for the aged.

assignments to permanent assignments in an attempt to promote more familiarity between residents and staff members providing care. The second nursing home planning to introduce Eden Alternative principles in its organization chose not to apply for subsequent ECCLI funding after Round II and reported that their strategic plan was taking a different direction.

The third nursing home with Eden-trained managers had been receiving ECCLI funding since the beginning and had begun the discussion about culture change prior to ECCLI. This site organized units into neighborhoods and trained senior CNAs to be neighborhood coordinators handling scheduling and personnel-related tasks for their units, as well as becoming the point person for resident and family issues. Residents and family members were encouraged to work in partnership with staff members in choosing which activities would be offered, and the facility incorporated many home-like features, including introducing plants and animals and bringing school children in to work on school projects with residents through an intergenerational program. In addition, staff members were taught that death and dying were a natural part of life. Residents designed a mourning quilt used when a fellow resident died and encouraged other residents to write memories of that resident in a specially displayed book. ECCLI participation helped this facility to implement their culture change ideas by allowing them to train staff, residents and families on what their culture change vision entailed.

4.1.3   Partnerships
Organizations in the study formed partnerships with other healthcare organizations, community colleges, career centers, Workforce Investment Boards, Regional Employment Boards, consultants and other for-profit and not-for-profit community organizations to help them implement ECCLI-funded projects.

Community colleges
All study participants partnered with at least one community college for curriculum development, training and/or career counseling services. For the most part, community college partners worked closely with the healthcare organizations to tailor services provided to their particular needs rather than requiring them to only participate in already scheduled college activities. For example, soft skills training programs in communication or cultural diversity focused specifically on those issues within the healthcare environment. Pre-college classes were organized for aspiring LPNs. Nursing classes were sometimes added to accommodate participants' employees. ESOL classes evolved to provide training in both basic English and more advanced classes depending on the needs of the group.

These colleges also offered career counseling services for employees, helped with college applications and financial aid applications and generally helped to break down the college mystique for some people who had been out of school for a long time or for those who never thought they could go to college. Participants who were able to take classes in a college setting, whether the classes were pre-college or college level, expressed a sense of pride in going to college. Once they gained confidence that they could successfully participate, that confidence carried over into their jobs and into their desire to continue

pursing educational goals. One nursing home recognizing the value in having employees succeed hired tutors to help some struggling participants catch up to others in pre-college math and English classes. Another provided transportation to the training site by contracting with a transportation provider and paying for this service for its employees. Some managers reported that having employees take classes off-site assured that employees would not be distracted by work events.

Overall, most community colleges partnerships have grown stronger over the course of the ECCLI funding rounds and seem to reliable, responsive and provide quality teaching and support services for ECCLI partners.

Other training partners
Private workforce development firms and consultants provided training in some cases on specialized topics such as mentor training, cultural diversity and culture change practices. Most reports of these types of partnerships reflected positive relationships and quality training. Managers appreciated the expertise of these partners with training on such topics as conflict management, supervisory skills or computer skills. Sometimes training was provided by another healthcare organization within the partnership. One home health agency provided the clinical training for CNAs and HHAs from the various healthcare partners. Another used its corporate regional staff to train on management and supervisory skills and to introduce person-centered care principles. In both cases, ECCLI support provided the opportunity for these participants to train many more people than they would have been able to accomplish alone.

Partnerships with other healthcare organizations worked well when training needs were similar and when their geographical proximity facilitated coordination of training classes. Two organizations that partnered during several rounds described the relationship as very positive, as their training needs were similar, geographical locations close and ability to coordinate training plans worked well. Those in more urban locations reported successful relationships that allowed them to offer more training classes, both clinical and soft skills than they would have be able to do on their own.

Workforce Investment Boards and Regional Employment Boards
Partnerships were established with workforce investment boards (WIBs) and regional employment boards (REBs). WIBs were not mentioned often when managers were asked to describe organizational partners. When prompted, however, they did describe these organizations as consultants, particularly in the beginning stages of the project. WIBs often were able to link participants with expert training partners or other community-oriented services to help support employees. For example, one WIB helped to connect a nursing home with a fuel assistance program for its employees. Two organizations worked with REBs that offered career counseling services to their employees.

Partnerships seemed to evolve with changing needs and grant requirements. For example, as nursing homes and home health care agencies become more experienced in working with ECCLI, they began to take over their own training in career ladder skills or career counseling. Partnerships then developed to allow them to pursue bridge-to-nursing

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programs or LPN training. One nursing home joined with a local consortium of healthcare providers outside of the ECCLI program in order to establish a nursing program for existing healthcare employees. Nursing programs had developed waiting lists, exacerbating the existing nursing shortage. This nursing home guaranteed payment for two employees to attend the nursing program, as did other area employers, and convinced the college to run a program for them. Another nursing home administrator became an advisory member to a center providing career ladder programs to western Massachusetts's healthcare providers. While not directly funded by ECCLI, these partnerships developed as a result of the nursing homes' participation in ECCLI.

Overall, the consensus among participant organizations was that despite some logistical challenges and conflicting goals, developing partnerships allowed them to broaden the training they offered and that their partners' expertise in a particular area provided a more professional and quality training experience for their employees. Employees benefited by participating with peers from other organizations and broadening their outlook, whether it was learning other ways of doing things from "competitors" or commiserating about sharing similar challenges. Without these partners, it would have been more difficult to reach the goals they established for ECCLI participation.

4.2   Summary
The ECCLI grant required participating nursing homes and home health agencies to establish CNA/HHA career ladders and allowed for flexibility in content and structure of the career ladders. Ladders established reflected this flexibility with training requirements for salary increases varying from 40 to 120 hours and increases ranging from $0.50 per hour to $1.50 per hour upon successful completion of the training. Most nursing homes offered classes in both soft skills and clinical skills while home health agencies concentrated career ladder training on clinical skills.

In addition to career ladders, ECCLI funded other training and educational opportunities that reached a wider cross section of employees. Frontline workers were trained in communication skills, conflict management and teamwork. Supervisors learned basic supervision and capacity building to incorporate new CNA/HHA skills into work practices. ESOL and ABE classes provided many employees with educational opportunities to improve their language skills or prepare for college-level classes. Mentor training often was part of a career ladder in nursing homes and of soft skills training for home health aides. Three nursing homes sent management staff to Eden Alternative training, with two actively following up to implement some Eden principles as part of their culture change initiatives. Permanent resident assignments and training on person-centered care were among the initiatives introduced to foster culture change practices.

ECCLI participants formed partnerships with a number of community organizations, including community colleges, WIBs and private workforce development organizations in order to access expertise appropriate for achieving their goals. These partnerships expanded the training capacity beyond what each organization could have provided on its own and allowed employees to experience a connection to the larger long-term care community.

Chapter 5: Implementation Challenges and Lessons Learned

Throughout the duration of their ECCLI funding, the participating organizations experienced and/or continue to experience various challenges and barriers to the implementation of ECCLI programs and activities. These challenges, presented by domain, are discussed throughout this chapter. Although some of these challenges were relatively easily addressed, there are still several with which organizations continue to struggle. However, as a result of their encounters with these challenges, organizations have learned a great deal about how to best implement or modify their ECCLI initiatives to yield the greatest success.

5.1   CommCorp Requirements

Two A site organizations reported challenges with the CommCorp's requirements pertaining to ECCLI. Both these organizations stated that the CommCorp reporting requirements were very time consuming and the paperwork burdensome to complete. One facility stated that the nature of the paperwork had even kept it from applying for additional ECCLI funding. This same facility experienced challenges in meeting the competing requirements of CommCorp and the union while also facing difficulties in working with the union to agree on training partners for ECCLI activities.

5.2   Industry Climate

Some organizations reported challenges due to a general lack of Massachusetts state support for what the organizations were trying to do through ECCLI. One home health agency also noted being challenged by a tight state budget that resulted in a continual fight to preserve ECCLI funding. One nursing home noted that one of its greatest challenges was finding quality workers and competing with other LTC organizations for these workers within a tough employment market (low regional unemployment). The nature of the employment market, low wages and a general lack of respect—both within and outside the LTC industry—for direct care workers left the facility challenged by a low retention rate. Other external challenges organizations noted included payment reimbursement issues and the evidencing of improvement as required by CMS.

5.3   Coordination of ECCLI Activities

Challenges arose for some organizations because of the way in which they chose to coordinate their ECCLI activities. Two nursing homes chose to have an internal employee coordinate ECCLI program activities. These organizations found it was difficult for such an employee to focus on her regular job while at the same time coordinating ECCLI activities and training schedules. Both nursing homes realized that hiring someone whose specific job was to coordinate ECCLI activities would have been more beneficial. One of the homes did, in fact, eventually utilize an individual employed by their employment resource partner to coordinate ECCLI and found this to be extremely successful. A third nursing home also attempted to manage the ECCLI project as well as provide all training without external support or assistance. However, this proved to be too taxing for existing staff to do well. This organization was no longer receiving funding; however, the administrator conceded that if additional funding were available, she would contract with training partners.

5.4 ECCLI Program Logistics

Some organizations faced challenges with the implementation of particular ECCLI programs. For example, one home health agency experienced difficulty implementing its peer mentoring program. Management attributed this difficulty to the fact that the program was incorporated before participants had completed career ladder training and, thus, before they were prepared to assume a mentoring role. The agency found the mentoring program to be more successful after its first round of ECCLI funding during which staff participated in mentor training.

Two nursing homes experienced low levels of interest in career counseling among direct care workers. Both facilities noted they initially had no system in place to support or encourage the use of the career counseling options. For example, one of the nursing homes experienced little management support for finding staff coverage for employees who wanted to attend career counseling appointments. However, in one of its later funding rounds, this same facility developed a consistent approach to career counseling that streamlined the scheduling of appointments to accommodate employees and, thus, resulted in a more successful career counseling program.

Other organizations also encountered challenges with their career counseling programs. For example, at least one nursing home found that supervisors were reluctant to release employees from work for counseling activities. In addition, in some cases there was conflict regarding whether career planning should be initiated from the employee or employer. Finally, some organizations found that some employees only would take advantage of career counseling if it was provided by people outside the organization. These employees were more comfortable talking with outside professionals and limiting work relationships to everyday work issues.

5.5 Basic Education Needs of Frontline Staff

Several organizations were challenged by their employees' lack of basic education and training. Until they began ECCLI activities, these organizations had not realized the depth to which their frontline employees were in need of basic and remedial education. This was especially true of employees whose primary language was not English. One home health agency recognized that many of its frontline staff had, in fact, been effectively hiding their educational deficiencies. In response to the educational need, this agency, as well as other organizations, worked to expand ABE and ESOL training and make training in these areas a building block for many other training activities.

5.6 Staff Coverage

Perhaps the greatest challenge that the majority of organizations faced was difficulty in providing adequate coverage for resident/client care when employees were attending ECCLI training classes. Organizations found the logistics of juggling workers' schedules to be extremely challenging. One home health agency noted that it was doubly hard for organizations of its nature to cover staff members in training. Unlike the nursing home setting, home health agencies' direct care workers are in the field, and there is no equivalent to an on-floor employee who can assist in providing staff coverage while

others are in training. In addition, agency employees often travel to many different work sites in one day, which can further challenge the need to cover staff in training. Another agency noted that it was not able to recruit enough participants for its program and noted that this may have been due to staff coverage issues. The agency's management believed its workforce may have been more readily engaged in shorter trainings, as well as trainings that required less juggling of work schedules in order to maintain client caseload. A third agency, because of an inability to cover staff in training, required its HHAs to carry the same workload and see the same number of clients each day when they were engaged in ECCLI training. As a result, HHAs often were overwhelmed, which may have negatively impacted their personal interest and investment in the ECCLI program.

To address the challenges with staff coverage, one nursing home offered ECCLI training over four eight-hour days rather than once a week for 10 weeks as originally planned. The four-day training format was much easier to schedule and also allowed the facility to offer training in an off-site classroom, giving employees the chance to get away from the workplace and focus on the training. Another nursing home also learned that scheduling training for full-day sessions was easier on all concerned than scheduling more frequent half-day or shorter sessions. In addition, staffing units was easier when trying to fill full-day shifts, and employees seemed more motivated to attend and retain more from these full-day sessions. One home health agency also made changes in its training schedule. Realizing it was difficult to pull management as a group away from work, the agency decided to conduct a leadership retreat weekend rather than hold training within the context of regular work hours as originally planned.

5.7   Staff's Personal Circumstances and Responsibilities

Several organizations noted that personal circumstances (e.g. lack of transportation) or family responsibilities (e.g. child care) made it difficult for some employees to participate in ECCLI training, especially when this training took place outside regular work hours. As a result, supervisors and managers were challenged in developing a training schedule that would accommodate all employees' needs and personal responsibilities. Some organizations offered direct assistance with employees' needs. For example, one nursing home responded to employees' struggles with transportation to the training site by contracting with a transportation provider and paying for this service for its employees. In addition, the case management programs that some organizations offered assisted employees indirectly by helping them develop their own effective strategies for balancing their work and personal responsibilities. Yet, for some employees, personal responsibilities and life events took precedence, and they chose not to participate in the training.

5.8   Frontline Staff Perceptions of and Attitudes Toward ECCLI

Some organizations faced challenges related to the frontline staff's perceptions of and attitudes toward career ladders and training. For example, some aides at one nursing home were disappointed to learn that the career ladder program did not immediately result in admittance to nursing school. These aides had expected training to be more focused on biology and other science courses that would help them earn an LPN degree.

It was not clear whether the organization had failed to thoroughly explain the ECCLI program to its employees or whether employees had simply misunderstood what the end result of their training would be.

At another nursing home, supervisors and management discussed the need not to alienate employees who were already strong performers in their jobs and were not interested in the classes and training offered through ECCLI. At yet another nursing home, management recognized that education was not always the right path for every employee. With this recognition, the nursing home made efforts to ensure that those employees who were good workers and team members felt valued, even if they did not participate in the ECCLI training. Efforts also were made at this nursing home to help employees overcome any feelings of inadequacy that may have been due to a lack of basic education.

Finally, one nursing home found it was important that continuing classes (i.e. classes that built upon material learned in an early course) be called "advanced." Providing courses with this "advanced" title helped to avoid creating the perception among employees that they needed the classes because they didn't learn well enough the first time. Employees generally were not embarrassed to enroll in "advanced" courses, and peers and supervisors supported their training efforts.

5.9   Supervisor Perceptions of and Attitudes Toward ECCLI

Some nursing homes found that not all supervisors wanted to work within a system in which the traditional roles of the CNA were changing. Some supervisors felt threatened by advanced trained CNAs and feared their own jobs might be eliminated. In two cases, CNAs reported that nurses prevented them from using their newly acquired clinical skills, such as taking vital signs or assisting in wound care. Some nurses believed they were more highly skilled in these areas and, therefore, they should perform these tasks, not aides.

Some supervisors also felt excluded from career advancement opportunities and resented the amount of attention and training given to frontline workers. To address this problem, one nursing home instituted a career ladder step for LPNs that included advanced skills training. The home also was considering offering an RN preparatory program.

One nursing home reported being challenged not only by supervisors' perceptions and attitudes but by those of management, as well. The facility found it difficult to convince management of the value of having more highly skilled CNAs. The home even experienced some turnover in leadership over the issues of developing a better-trained workforce.

5.10   Translating Training into Practice

Some organizations faced the challenge of finding a way in which employees' newly acquired skills could be used. One nursing home reached a point where its organizational structure could not support or utilize the senior level skills of all the CNAs trained through ECCLI. In addition, supporting the higher salaries of the senior aides began to

strain the organization's already tight budget. As a result, some employees had completed all the training necessary to advance through the career ladder but had not received associated pay raises because the nursing home was unable to utilize their skills. Similarly, the home had difficulty in sustaining a distinction between their entry-level CNAs and those CNAs trained through the career ladder to be mentors. Because of low turnover rates at the nursing home, there were few new CNAs to mentor and, as a result, the skills of those trained as mentors were seldom needed or utilized.

Other organizations, particularly those that had offered advanced clinical training, found it difficult to match employees with newly acquired skills with the appropriate set of residents or clients so they could apply these skills. At least two organizations recognized the difficulty of turning learning into practice and either designated or planned to hire someone who could focus on turning advanced training into everyday practice. However, despite this strategy, difficulties remained due to the aforementioned resistance on the part of supervisors. Without supervisor support for the use of their subordinates' new skills, it was difficult for organizations to effectively translate training into practice.

Finally, some nursing homes faced similar training-to-practice challenges when they attempted to establish career ladders for non-CNA frontline workers, such as dietary aides and housekeepers. Although these nursing homes had good intentions in setting up such career ladders, they soon realized there was little need for advanced skills within the dietary and housekeeping departments. Generally, dietary and housekeeping mangers were already in place and the additional employees with advanced skills were not necessary and, in some cases, could not be supported by the organization's infrastructure. Thus, although some employees were trained in advanced dietary and housekeeping skills, these skills generally were not put into practice. For this reason, one nursing home chose to abandon the idea of career ladders for dietary and housekeeping staff and, instead, focused on training dietary and housekeeping staff interested in becoming CNAs.

5.11   Partnerships

Overall, organizations had positive experiences with their external partners and faced fewer challenges with them than within their own organizations. Those partnership challenges that were encountered were, for the most part, organization-specific and cannot be generalized across all organizations. For example, one nursing home encountered difficulty in working with its WIB because the WIB experienced some turnover, and new WIB employees had difficulty incorporating ECCLI responsibilities into its new positions. Another organization found its WIB to be "not very helpful' because the WIB wanted to direct training efforts on its own, with little input from the organization. Another nursing home found its transportation vendor to be unreliable and had to find an alternate vendor. A fourth nursing home found the computer training organization with which it partnered to be of poor quality and its partner adult education program to be too small to serve the facility's needs. As a result, the facility had to establish new partnerships to better meet its computer training and adult education needs.

Community colleges

Two organizations—one nursing home and one home health agency—experienced the shared challenge of partnership difficulties with community colleges. The nursing home had partnered with a community college to provide college credit computer courses for its employees. However, the college underwent a change in administration that resulted in an inability of the nursing home to continue its alliance with the college. The home health agency attempted to partner with two community colleges but found both attempts to be unsuccessful. The first community college was "not on board" with what the agency was attempting to accomplish. The second college initially helped the agency to implement a bridge-to-nursing program that would aid CNAs in their pursuit to become LPNs. However, the college later decided not to pursue an RN to MSN program rather than an LPN program. As a result, the agency dropped its partnership with the community college.

Other LTC organizations
Some organizations reported that working with other nursing homes or home health agencies was difficult. One nursing home's difficulties stemmed from problems in establishing trust and difficulties in coordinating schedules with other organizations, as well as their lack of clear goals and objectives. The nursing home did, however, eventually establish a successful partnership with another LTC facility, which resulted in additional capacities and expertise for the nursing home. Additional problems included difficulty in working out training times convenient to all parties and differences in geographic location that made it difficult for organizations to share training classes.

5.12   Summary
Although organizations experienced challenges due to CommCorp requirements, the external environment and their partnerships, the majority of challenges were intra-organizational in nature. Key among these were the unanticipated need for staff ABE and ESOL, difficulties in providing staff coverage during training, supervisor attitudes toward ECCLI and the translation of training into practice. These are challenges that were nearly universal among all organizations and, as such, challenges which may be faced by other ECCLI-funded organizations now and in the future. By addressing these potential challenges in the early stages of ECCLI implementation, an organization is likely to see more positive outcomes of its ECCLI activities and training programs.

Chapter 6: Program Outcomes

The programs that organizations implemented allowed them to begin to realize their broadly stated goals of providing workforce development opportunities for frontline caregivers and improving the quality of care to residents and clients. Career ladders and soft skills training programs provided the basis for better career opportunities for employees. How ECCLI-funded programs helped organizations reach their specific goals can best be understood by examining the changes that occurred since these programs were initiated. We acknowledge the limitations of qualitative methods in determining program outcomes. Data for this evaluation study come primarily from the reflections and perceptions of limited representatives of different stakeholder groups. There was no attempt to measure quantifiable changes in workforce or client/resident outcomes. (Results of an earlier study investigating the effects of ECCLI on quality of care outcomes were published previously.[10]) Improved workforce retention and turnover rates referenced in this evaluation were volunteered by administrators, not based on official reports. However, qualitative interview data, by explaining how programs were implemented as well as perceptions of the impact of those programs on staff and clients, offer compelling indicators of program outcomes, especially when reported perceptions are similar across different types of respondents (levels of staff, clients and family members).

The impact of ECCLI seemed to be experienced most as a result of the breadth of training opportunities offered for all employees, tailored to the needs of the organization. An important strength of the ECCLI program is that it encouraged organizations to customize their educational and career offerings in support of their vision. For example, where language training was needed and provided, employees and residents benefited from improved communication; when residents and clients with more complex health needs were being served, training tailored to address those needs contributed to feelings of satisfaction with care. The initial time organizations spent assessing needs and developing plans to meet those needs seemed instrumental in being able to impact resident care. The ability to offer ABE and pre-college classes seemed to impact career advancement opportunities for those interested in advancing. Basic career ladder training programs helped to improve skills and salaries for those frontline workers participating in the training opportunities—its overall impact seemed to be that a "culture of learning" developed that motivated many frontline workers to seek educational opportunities.

In this section, the following outcomes will be discussed: improvement in communication, clinical skills, teamwork, respect and self-confidence, wages and benefits, retention and recruitment, organizational culture and practice change and resident/client quality of care and quality of life. Researchers recognize that organizational improvements derive from many sources. However, we try to indicate results directly and indirectly attributable to the ECCLI program.

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[10] Jones, R.N., Morris, J., Singh, N., & Uvin, J. (August, 2006). "Improving quality of care: A closer look." *Research and Evaluation Brief, Volume 4 Issue 2*. Boston, MA: Commonwealth Corporation.

6.1   Improved Communication

Improved communication was perhaps the most far-reaching outcome of ECCLI funding because it was reported in all organizations studied and because it directly affected all levels of personnel, clients/residents and family members, as well as indirectly affecting operations and quality of care. However, improvements in communication were not even across the 11 sites. Moreover, not all sites faced the same challenges with regards to communication. Organizations where frontline staff members were predominantly non-native English speakers discovered early in their ECCLI journey the enormity of the communication challenges such workers face. Not only did frontline staff need to improve English proficiency and learn effective communication styles, but all staff needed cultural diversity training to improve communication with each other.

Three types of ECCLI-funded training were aimed explicitly at improving communication: ESOL classes for non-native English speakers, soft skills training on how to communicate effectively and leadership/management training. In some organizations, soft skills training was offered only to frontline workers, while in several organizations, communication classes were interdepartmental with staff at all levels and from all departments participating in mixed classes. As is discussed later, interdepartmental training appeared to be the most effective approach to improving communication within the organization.

The home health agencies and over half of the nursing homes described notable improvements in English comprehension and fluency among frontline staff who participated in ESOL classes. Demand for ESOL classes was high, and many organizations offered additional and higher-level classes. While ESOL may have been offered initially to ready workers for clinical training, the training experience made evident the extent of communication barriers for some workers, even if they were able to conceal their limited English. Staff at all levels commented on the effect of improved English proficiency. Frontline staff (dietary, housekeeping, maintenance, as well as CNAs and HHAs) reported feeling more self-confident with increased self-esteem. One HHA remarked:

> *English classes helped a lot. Before I was afraid to talk; after classes I am not afraid anymore. I always talked to clients, but in meetings I was afraid to talk. Now I am not afraid anymore.*

Supervisors and management also commented on the impact of improved English proficiency of workers' confidence and self-esteem. A home health agency supervisor reported on an HHA:

> *I have seen a great change. There was one worker [who] became very chatty once she took an ESL class. She used to be embarrassed to speak English. Now, she will have little conversations that she would not have before. This is a big change. I work out in the field and see them out there. It has built up self-esteem, pride in what they're doing.*

Further, managers frequently commented that upgrading English proficiency resulted in overall improved staff communication throughout the organizations.

According to several administrators, cultural diversity training also helped supervisors, management and native English speaking frontline staff to understand the challenges experienced by limited English proficient (LEP) staff. Cultural diversity training increased the level of respect for LEP workers. One home health agency provided customer service training that helped LEP staff understand American values of responsibility and accountability. For some LEP staff, increased English proficiency was a sufficient goal: they could better communicate with residents/clients and with their supervisors. For others, increased English competence gave them the self-confidence to take other career ladder classes.

Communication was a key component of soft skills training provided to frontline staff in all organizations and to supervisors in some. Communication also was covered in management and leadership training at most organizations. Some organizations provided interdepartmental soft skills training and even some clinical training, in which staff from all departments and at all levels of the organization participated in classes together. It appeared that this approach was most effective because, not only did participants learn about communication methods, interdepartmental classes "leveled the playing field" and served to break down hierarchical barriers within the organizations.

Frontline staff in all of the nursing homes and one of the home health care agencies reported improved communication with co-workers as a result of ECCLI training. For example, one CNA reported learning to "think before they judge people." Frontline staff at many nursing homes also reported that the ECCLI training helped them communicate better with residents. As one CNA said:

> *The communication classes I took for CNA II training taught me how to talk with angry family members and residents. Now I know when to answer a family member and when to refer them to the nurse. I also know how to talk to residents when they are sad.*

In most of the nursing homes, frontline staff also reported improved communication with upper management. Many spoke of an "open door policy" where staff felt welcomed and comfortable speaking with an administrator or director of nursing about work-related or personal concerns. Most reported that they "felt listened to" and acknowledged, even though several staff noted that their suggestions were not always adopted.

In examining communication among frontline staff and supervisors, researchers found that most supervisors reported improved communication with their CNAs. Many supervisors reported that, as a result of ESOL and communications training, CNAs and HHAs were better able to communicate about residents'/clients' conditions and that frontline staff have become more confident and comfortable approaching supervisors when problems arose or when they had concerns over the care of a resident. A nurse

supervisor provided her perceptions on changed communication between nurses and CNAs:

> *Communication has improved a lot. I think CNAs don't feel so much like— "You're the nurse and we can't contribute anything." They feel like—"I know there's something wrong," and they'll come to us more readily with that. And I think we are more receptive because we know they know more. So I think that communication and their [CNAs'] knowledge have changed. Now there is more mutual respect between the CNAs and nurses.*

Home health aides reported generally improved communication with supervisors. At one home health agency, aides were confident their supervisors really listened and responded to resident concerns they reported and that supervisors maintained open lines of communication as to how the situation was being handled. Aides believed the positive communication they had with supervisors enabled everyone to provide better care to clients. At another home health agency, aides reported feeling more comfortable speaking up at staff meetings because of improved English proficiency.

At nursing homes, however, some CNAs expressed mixed opinions about communication with their superiors, and many did not report improvement as a result of ECCLI even if communication was described as "good." At one nursing home, CNAs learned how to communicate better with their peers, but noticed no improvement in supervisor-subordinate communication. At other nursing homes, CNAs mentioned that communication with some nurses was better than with others or that communication was better on certain shifts or units than on others. Examining this more closely, it appeared that improved supervisor-supervisee communication was most apparent at organizations with interdepartmental communication training together or where supervisors received training on how to communicate effectively with subordinates in leadership training classes. Moreover, even at organizations where supervisory training was provided, not all supervisors may have been able to participate in the training.

At one nursing home where employees from different departments as well as different levels (frontline workers, supervisors and managers) took communications classes together, there was consensus that communication improved considerably as a result of the ECCLI classes. The experience resulted in greater understanding of others' perspectives and work experiences leading to improved communication among staff at all levels. As one frontline worker said:

> *You get a better understanding of what other people's jobs are like. And you have a little more respect for them for what they do. Besides the respect, you have a better understanding of where they are coming from when they [say] certain things.*

At another nursing home that provided training to prepare supervisors for changes associated with career ladders, CNAs also spoke positively about communication with supervisors:

We can go to the supervisors any time to talk about things. They take your opinions seriously. They treat you like an equal … This has changed as a result of an ECCLI communication class.

Some organizations reported on specific areas of improved communication, such as interdepartmental problem solving and communication about residents. Staff spoke about interdepartmental problem-solving meetings at a number of organizations. In some organizations, including frontline staff in these meetings was a change, while at other organizations the change was in the effectiveness of the meetings because of improved communication.

One nursing home introduced a communication technique called "learning circles" to solve problems by bringing involved parties together to discuss an issue. Each person has an opportunity to express his/her perception of the issue before the group works on a solution. Another nursing home adopted interdepartmental in-services to work out miscommunications or other problems. For example, the issue of resident complaints about staff speaking Spanish in the dining room was resolved by using structured problem solving within a group that included staff from different departments, Participants were able to understand the issue from staff and resident perspectives and resolved the issue by getting residents involved in conversations.

Another important area of communication is how resident information is shared between shifts. Some nursing homes reported improvements in the quality of between-shift communication. For example, at a nursing home where CNAs received communication training with a focus on resident-centered care, a supervisor reported substantive change. Prior to ECCLI training, CNAs usually told each other that everything was fine, while now they pass on specific information about residents. Inter-shift communication also was improved when incoming and outgoing staff overlapped by at least 15 minutes or where staff schedules were staggered. Two nursing homes introduced care cards that CNAs maintain daily to document resident care and changes in resident status. These also resulted in improved communication of resident information between shifts.

6.2   Increased Clinical Skills

ECCLI funding provided for a great deal of training, mostly for frontline staff, but also for supervisors and upper management. CommCorp records indicate wide variation in the number of employees who participated in trainings, as well as how many trainings employees completed. Through these trainings, CNAs and HHAs especially, had opportunities to gain clinical knowledge (through lectures and field experiences), as well as improve methods of communicating with clients, peers and supervisors. Not only did frontline staff receive wage increases and advanced titles, many also became more engaged in the nursing care they provided because they understood the importance of their work, from a clinical perspective. As one CNA reported:

We've taken them all—CNA II, CNA III, Mentor, Alzheimer's. It just gives you knowledge of what to do with the residents. Why you're doing for the residents.

It gave me the understanding WHY I'm doing the range of motion. In one course, they talked about meds and side effects. Back then, all we'd think about is, "Why do we have to learn about meds?" Now we understand the reaction of meds. If we see certain side effects, we know to rush to the nurse and tell them.

The benefits of clinical training were not limited to CNA/HHAs. At a nursing home that offered career ladder classes for other frontline staff, dietary staff members were taught about death and dying, which helped dietary aides realize that their job is more than just bringing the food to the residents—that they also can help by empathizing with residents. This helped the dietary aides understand that care is not just about nursing. They reported that they now feel they are more an important part of the organization.

There was some unevenness with respect to whether frontline staff could use newly acquired skills. At one nursing home, nurse supervisors were uncomfortable with CNAs doing tasks traditionally done only by nurses; they thought CNAs should attend college and become LPNs if they were to be given such responsibilities. At a home health agency, management reported difficulty helping HHAs integrate new skills into their actual work. For example, it proved to be difficult to match HHAs with training on particular conditions or procedures with clients who had matching needs. Moreover, the organization has not yet worked out how to incorporate HHAs' newly acquired supervisory skills into the team.

One nursing home was more successful at integrating trained CNAs. Supervisors reported that the organization does a good job of rewarding people and acknowledging their achievements. When CNAs receive training on any topic, management makes sure that all the supervisors are aware that the CNA has been trained so supervisors can support the CNA in putting this newly acquired knowledge into practice.

Some nurse supervisors reported that, as a result of improved communication and clinical skills of CNAs with ECCLI training, their own jobs were made easier. Advanced aides learned to take resident vital signs, thereby freeing nurses to focus on other clinical or supervisory activities. As well, CNAs spoke of being able to contribute more because of their clinical knowledge. One CNA reported, *"Because of the classes, I can help nurses more than before with dressings, taking temperatures and other things. I feel good about learning."*

Especially in more recent ECCLI funding rounds, nursing homes and even home health agencies began to develop bridge-to-nursing capabilities. This typically involved college preparedness for CNAs and HHAs who aspired to be nurses. Some organizations went further and supported employees to go through an LPN program. A few organizations funded the aides, while others supported them with getting scholarships, gave them release time or allowed them to reduce their hours. We heard reports of several LPN graduates and many more who were attending LPN programs full or part-time. As an example, one CNA reported that her family had been encouraging her to apply to nursing school. She had never admitted to not having a GED before and initially, just brushed off

their suggestions. The ECCLI training allowed her to earn her GED equivalency and to prepare to take college-level nursing classes.

Administrators reported a number of benefits to helping frontline staff become LPNs. One nursing home had as its primary ECCLI goal to "grow their own nurses." This organization believed nurses who had worked for many years at the nursing home and knew how it operated would contribute more upon graduation than nurses hired from the outside. Typically, the employees had to agree to return to the organization for a minimum of two years upon graduation. For home health agencies, where there is less need for nurses, administrators know they are likely to lose the employees once they graduate, but they are committed to improving the quality of the LTC workforce.

A bridge-to-nursing program also could serve as an incentive to attract motivated applicants who have ambitions to move up a nursing career ladder but who need financial and case management support to do so. In organizations that supported LPN students, there was great pride in this program as well as in the LPN students/graduates, many of whom had begun working at the organization with only a GED.

6.3   Improved Teamwork

Another aspect of work life frequently mentioned, especially by frontline staff but also supervisors and management, was the quality of teamwork within the organizations. Some described employees as "bonding," "feeling closer" or "like a family," while others spoke of how well people work together with co-workers. This was true of home health agencies, as well as nursing homes.

A number of ECCLI-supported initiatives contributed to greater teamwork within organizations. Soft skills and leadership training helped shift employees' focus from their individual work to the group goal of resident-centered care. A number of CNAs spoke of sharing the workload to help each other rather than exclusively focusing on "my work." For example, one CNA reported that when a resident has a need, CNAs would respond, even if the resident was not their assignment. A CNA at different nursing home reported that if she asks for help, everyone is ready to help. Another nursing home uses a partner system so that when one CNA needs assistance (as with transferring residents), she calls her partner. Mentors also orient new CNAs to act as part of a team. As one mentor stated:

> *I like the teamwork. We train the new CNAs to help each other. They used to just pick up the habits of the person they were assigned to work with. Now, we train them the way we want them to work with us. You show them that no matter whose light it is, you go and help everybody. We will then always have that teamwork from now on.*

Several organizations spoke of interdepartmental cross-training, whereby, in conjunction with career ladder training, frontline staff from one department would shadow staff from another department for 20 hours or more. For example, housekeepers shadowed CNAs, or CNAs spent time in dietary, activities or therapy departments. This helped staff understand how all nursing home services contribute to quality resident care and had the

additional benefit of improving communication and sense of teamwork. As a result, staff from one department might help with tasks associated officially to another department. For example, a former housekeeper (now a CNA through the career ladder program) reported, *"We talk with other departments and help each other. Like when I was a housekeeper, whatever they needed, I would help them with—like getting them supplies."*

Collaborative interdepartmental training, where staff of all levels participated in trainings together, also contributed to a sense of teamwork by breaking down barriers associated with job title, as did structured inter-departmental problem-solving mechanisms (such as the learning circles previously described). At one nursing home, a supervisor mentioned that she would not ask the people she manages to do things she would not do herself. Everyone is expected to pitch in. This sentiment was reported similarly by a supervisor at another nursing home where CNAs recognized and appreciated that supervisors will help with daily tasks.

6.4   Increased Respect and Self-Confidence
An important outcome of ECCLI training was increased self-esteem, self-confidence and competence on the part of frontline staff, accompanied by increased recognition, respect and trust on the part of supervisors and management of their frontline workers.

A theme featured strongly across all organizations was that frontline workers projected greater self-esteem after participating in ECCLI classes. Across nearly all of the organizations, supervisory, administrative, some direct care staff and even some family members commented that frontline staff demonstrated increased self-respect, self confidence and even empowerment. Upper management and supervisors often remarked that this change was a consequence of ECCLI classes and training, and many frontline staff did as well. As frontline workers improved in English fluency and effective communication, achieved career ladder steps and learned new clinical skills, they became more self-confident. They viewed themselves and were perceived by others as more competent. As self-confidence increased, frontline staff increasingly approached supervisors to discuss resident/client issues, offered information and suggestions during care planning meetings and initiated conversations with residents/clients and family members. With better understanding of resident/client medical or dementia issues, CNAs seemed to be more engaged and proactive in how they provided resident care.

The following reflect supervisors' and managers' perceptions of the changes among frontline employees:

> *Improved communication … has resulted in increased self-esteem for the frontline staff, which in turn, positively affects quality of staff interactions and resident care.*

> *CNAs seem more confident, feel comfortable participating in care planning discussions, and are better able to communicate with abusive or depressed residents.*

ECCLI training resulted in staff members having more self-respect as they gained an appreciation of how important their roles were to the nursing home residents, family members and supervisory staff. By participating in peer leadership training and having the opportunity to interact with peers from other [LTC] facilities, they began to appreciate their own role from a broader societal perspective.

Along with improvements in communication and clinical skills, upper management and supervisors often spoke about their increased respect for and trust in their frontline workers. Supervisors felt greater respect for their CNAs when they provided insightful contributions at care plan meetings or reported important resident observations. A manager spoke of the importance of acknowledging CNAs when they demonstrated newly acquired skills. With their career ladder training, CNAs were increasingly encouraged to problem solve around client care. Supervisors at one nursing home reported that more problems were resolved among CNAs or between CNAs and their supervisors without the need to involve upper management. The following quote exemplifies the impact of increased staff self-efficacy:

Education through ECCLI has led to more CNA empowerment, leading them to have more self-respect and to be more respected by others. They are involved in more decisions; they have more input into resident care and feel more valued by everyone, other staff, residents and family members. This boost in confidence has allowed them to focus their attention on the residents and to structure work processes for the benefit of the residents.

At one nursing home, however, there appeared to be a lack of trust and respect among nurse supervisors and CNAs. CNAs did not trust that training would result in benefits to them; they anticipated they would be expected to take on more responsibilities than the pay increase warranted. Moreover, nurse supervisors did not trust advanced CNAs to handle functions they were trained to do, such as taking vital signs or changing dressings. One supervisor seemed to capture the prevailing opinion:

There are certain things an aide has to do; there are certain things nurses have to do. I know they are trying to create this in between thing [advanced CNA], but it just doesn't work. It has nothing to do with ECCLI—that's just being a CNA. Either you go to school to become a nurse and your whole role changes, but between CNA I, CNA II and II, there's not a difference.

Upon closer examination of this nursing home, which differed markedly from the others evaluated, it appeared that supervisors had not participated in management or leadership classes. Such classes may be a critical component of capacity building that enables supervisors to view CNAs with increased clinical skills and communication competency in a new light. At another nursing home, upper management spent a great deal of time with supervisory management employees to get them to recognize the value of education for frontline staff. As a result, managers became more willing to make accommodations to release staff to take classes. Managers came to recognize the benefits they and their

department received when staff was more educated and had a greater sense of empowerment. Thus, it would seem that self-efficacy and respect may be at least as important—if not more important—than wage increases for frontline workers' quality of work life.

Management and supervisors in home health agencies also observed increased HHA self-confidence and increased respect for and trust in frontline staff. Supervisors at one agency reported that, as a result of ECCLI classes, aides seemed more confident in their communication and were more likely to approach a supervisor with questions and concerns. A manager at another agency reported, *"There is noticeably increased respect for frontline caregivers by the office and management staff."* Moreover, this increased respect has led to internal discussions about tangibly elevating the frontline worker position, by making them equal members of care teams.

> *I think that nurses today understand that their time with the patient/resident is extremely limited and they need to depend on this member of their team to implement the plan of care and evaluate the effectiveness of the care plan on a daily basis. They now see this in their and their patient's own best interests to embrace this level of staff as an equal member of the care team.*

Frontline staff at both nursing homes and home health agencies often echoed supervisor and management comments by reporting the extent to which they perceived that administrators and supervisors respected and trusted them. CNAs at one nursing home reported feeling respected by supervisors and management and that what they had to say was considered valuable (for example, at care plan meetings). HHAs at one agency were confident their supervisors would really listen and respond to the concerns they might present and would maintain an open line of communication with them as to how a situation was being handled. A CNA commented:

> *I am very satisfied especially with how we are treated by nurse supervisors. They communicate, listen, take the time and respect what we say. Even if they don't agree, if we suggest something, they listen very respectfully and carefully.*

Residents/clients and family members generally reported positively about staff. Most said it had been that way since they started receiving care, but there was some evidence that family members and residents had increased respect for frontline staff. Specifically, some mentioned improved communication with frontline staff. And a few family members recounted times when the CNA or HHA had detected a change in their family member that warranted a change in treatment. They believed that, because aides have more opportunity to follow residents/clients closely, these changes might have gone untreated for a while if aides had not bee able to detect and report the change.

6.5   Impact of Increased Wages and Benefits
Organizations receiving ECCLI funds were mandated to create a career ladder for frontline workers accompanied by a wage increase. All organizations in this evaluation linked completion of one or more learning modules with an hourly wage increase. These

ranged from very small increases ($0.25 or $0.30 per hour) to larger increases ($1 or $1.25 per hour), usually depending on the number of hours of training required. Healthcare and personal benefits were not linked to ECCLI career ladders with the exception of one home health agency where ECCLI-trained HHAs committed to more hours or packaged hours, so they would qualify for benefits that were only available to full-time employees.

In as much as training and wage increases were intended to be linked to increasing steps in a career ladder, most organizations attached titles to career steps that designated higher status (e.g., CNA I, II, III; Advanced CNA, etc.). One nursing home linked only one training module with a title (geriatric nurse assistant) and wage increase. A home health agency had not yet determined a title to accompany completion of a training because they wanted a title (and associated job role) that reflected the more responsible position this training warranted. For a few organizations that spelled out actual career steps, it was not clear what impact the new title had on employee roles or responsibilities, despite the apparent increase in clinical knowledge and soft skills.

While few frontline staff complained about the small wage increases, most did not express much enthusiasm about them. "*What impact has the $0.25? You can't buy a cup of coffee.*" Some thought the wage increments associated with ECCLI training and career steps had supplanted raises they previously received. (It is likely that business economic circumstances impacted routine cost-of-living raises during the time period.) Some CNAs thought the wage increase was not enough compensation for the responsibility and extra work associated with the career step. At most organizations, staff were pleased to get a wage increase but also seemed to enjoy the training and to feel proud of their accomplishments apart from the wage increase. "*Most people don't do it for the $0.25, but for the new skills.*"

At one nursing home, frontline staff expressed satisfaction with their wages and benefits, which were generous even without ECCLI-related increases. In fact, two CNAs returned the focus group incentive ($10) to the nursing home to benefit residents.

Some administrators believed the wage increase was meaningful and an incentive to complete career ladder training. At one home health agency, ECCLI-trained HHAs received a wage increase (amounting to about $1,000 per year) on top of a 3-4 percent cost-of-living raise and increased health benefits (not related to ECCLI but occurring at the same time). The administrator believed this made the earnings package better than the industry average. At another home health agency that had experienced wage freezes for several years (for business economic reasons), supervisors thought the $1 per hour pay increase associated with completing ECCLI training was a significant motivator to get employees to enroll in the program.

Most frontline staff spoke positively about the opportunity for training, whether ESOL, ABE, soft skills and clinical training or classes preparing them for an LPN program. Some viewed the career ladder training as a meaningful step toward career advancement. Staff acknowledged the benefit of being able to receive training and education on paid

work release time. Many reported that they would not be able to take ESOL or basic education classes on their own time because of competing work and family obligations.

Many employees were initially reluctant to take ECCLI classes, especially immigrants and older workers who had not attended school in a long time. However, once persuaded to attend, most were able to continue and complete the training. Thus, another benefit of the training opportunities was to move frontline workers past the hurdle of thinking they could not succeed in academic programs. As discussed previously, ECCLI training resulted in increased self-esteem and self-confidence. For some, completing ECCLI training gave them the self-confidence to continue their education. And in organizations that provided support for college preparatory classes or LPN programs, a number of frontline workers were enrolled, and some had completed LPN programs.

It is important to understand the extent to which modest wage increases associated with completing training is effective in actually impacting perceptions of frontline jobs in nursing homes or home health agencies. It appeared that the most critical component of improved job perception is frontline workers' perception that they are respected and trusted, that their role in resident care is valued. Offering educational opportunities, especially at no cost and on paid work time, and acknowledging achievement of training modules with wage increases, even though small, send a message to frontline workers that they are appreciated and valued. One supervisor reported:

> *The wage increase is the carrot to get CNAs to training, but it really makes a difference. They feel part of the whole organization; they feel that their opinion counts. They have become very vocal about changes they see in residents.*

On top of this, it is also important that middle management support career advancement opportunities of the staff they supervise by encouraging them to take classes (even if it is inconvenient to find floor coverage while staff are in class), allowing trained CNAs and HHAs to use the clinical skills they have learned and to demonstrate respect toward frontline staff, including them as equally important team members. In one nursing home, supervisors repeatedly reported that CNAs should not be permitted to do tasks they associated with an LPN degree, despite the training. CNAs at this organization were distrustful that the career ladder training was a way to get them to take on more responsibilities with the same case load and did not think the wage increase was adequate compensation. While the supervisors had brief training at the beginning of ECCLI, unlike the other organizations, they did not have training on how to integrate more highly trained CNAs into the nursing team.

6.6   Improved Staff Retention and Recruitment

The majority of organizations had as an explicit goal for ECCLI to reduce staff turnover. Typically, these organizations had a strong corps of long-term dedicated employees, but a smaller percentage of employees turned over several times during a year. Such high turnover is disruptive to staff and residents; involves hiring "agency staff" to fill in, which is expensive and breaks up continuity of care; and increases the time and expense

associated with recruitment, hiring and training new staff. Of the nine organizations from which we had information, three did not have a problem with retention, three showed notable improvement in retention and two had modest, uneven results.

The following represent modest reductions in turnover. One nursing home reported a 20 percent improvement in retention rate for CNAs with a year or more of service, but even after ECCLI, still had difficulty retaining newly hired CNAs. A manager expressed concern that CNAs were coming out of certification training not prepared for the job. They left after a brief time working as CNAs when they realized that CNA work is difficult and salaries are better at retail stores or fast-food restaurants. A home health agency reported reduced turnover (by at least 20 percent), but that it was creeping up again. However, employees who had participated in ECCLI classes experienced the least turnover.

The following represent more substantial declines in staff turnover. One home health agency reported that turnover rate went from 30-50 percent to five percent after ECCLI, with residual turnover due to personal reasons (e.g., relocation), not job dissatisfaction. The administrator at one nursing home believed ECCLI had a strong impact on staff retention: *"I think ECCLI was a huge success for us. We had a huge problem with retention—now we've had one CNA leave in the past two years."* However, the administrator also noted changes in the economic climate that may contribute increased retention. Since their involvement with ECCLI, there had been a *"flood of CNAs on the market."* The administrator thought CNAs were staying with good employers because the jobs aren't as easy to find.

One nursing home saw a decline in annual turnover rates of over 50 percent and a 50 percent decrease in new employees over the five years it participated in ECCLI. Another nursing home saw a reduction in CNA turnover from 87 percent to 25 percent (among the 30 percent who had been turning over several times a year). The administrator attributed this to involving experienced CNAs in hiring new CNAs, training mentors on how to orient and train new CNAs and including CNAs in planning resident care. Some long-term CNAs at this nursing home saw the need for further improvement in staff turnover and believed new employees came to the organization to get the free training, then went to other LTC organizations where they could earn more money.

At least two nursing homes involved CNAs in the hiring process. The rationale was that CNAs are most aware of what it takes to be a good CNA and whether a recruit will fit into the organization's structure. One nursing home also included residents and family members on the hiring team since they would best detect how well the hire might relate to residents and interact with family members. If new hires are a good fit for the organizational environment and demonstrate a commitment to nursing care rather than simply getting a job, they are more likely to stay.

While many nursing homes and home health agencies have CNA/HHA mentors, most were doing this without specialized training. Some organizations provided training for mentors, specifically aimed at teaching them *how* to orient and train new recruits.

Organizations typically linked mentor bonuses to a recruit remaining at the organization for a given periods of time (e.g., $100 for six weeks, another $100 for three months). We heard from some mentors and administrators that if mentors learned formally how to train new CNAs and were recognized with monetary incentives, there was a better chance of new recruits remaining at the organization.

Obviously, if staff turnover rates are down, there is less need to recruit more staff, which also reduces recruitment costs. Several organizations indicated they needed to do less formal recruiting because employees act as ambassadors by telling friends and acquaintances what a good place the organization was to work.

One nursing home administrator reported that recruitment costs have decreased. Advertising costs have gone down because the word has gotten out in the area that the nursing home is "the place to work" and provides quality healthcare. When nursing home representatives go to job fairs to recruit, they primarily focus on food service employees (where there is considerable competition with fast-food restaurants that pay more for less strenuous work); the other positions are not as hard to fill anymore. The administrator reported that *"staff recruits for us,"* and the agency staff the nursing home uses also refer people to them.

Employees at both nursing homes and home health agencies viewed the opportunity for training-linked wage increase as an incentive for people to come work at their organizations. "*New people jump on it [the training opportunity]. They are looking for the $0.25*."

Reduced turnover results in lower employee costs (fewer call-outs, less overtime pay, fewer "temp" workers and lower agency fees). Decreased need for recruitment results in lower advertising costs, less time spent at job fairs and fewer hiring and orienting expenses. Researchers did not hear directly how those cost savings translated into improved services for residents/clients. However, one nursing home increased its CNA/resident staffing ratio since participating in ECCLI, which gave CNAs additional time to provide more personalized and better quality care. For most participating organizations, the cost savings associated with reduced staff turnover and recruitment are too recent for administrators to even verify. However, it would seem that this could be a source of funds to support continuation of career ladder training and associated wage increases.

6.7 Organizational Culture and Practice Change

While culture change was not a requirement for ECCLI participants, CommCorp was interested in examining the extent to which this was incorporated in participating nursing homes and home health agencies and the role ECCLI funding played. Several organizations mentioned culture change as an objective within their ECCLI proposals. However, for most of these organizations, culture change activities were very modest, and other activities took priority.

One nursing home that embarked on a full-scale culture change effort simultaneous with ECCLI participation used ECCLI funding to provide management training in the Eden Alternative and LEAP[11], a national leadership training program aimed at recruiting, developing, empowering and retaining quality LTC staff. Using a train-the-trainer model, they extended LEAP training for all levels of staff. This nursing home organized residents into "neighborhoods" headed by neighborhood coordinators (experienced CNAs with specialized advanced training) who have responsibility for day-to-day operation of their neighborhoods. Each neighborhood has an interdepartmental work team that includes housekeeping, nursing and maintenance. In keeping with the culture change philosophy of person-centered care, residents and family members are partners in planning policies, environmental changes and activities, and resident decision making is encouraged.

Another nursing home had focused on culture change for nearly a decade prior to ECCLI. It also has interdepartmental teams assigned to units that are responsible for personnel issues (work schedules, dealing with call-outs and interviewing prospective employees). An administrator believed that ECCLI-funded training enabled the nursing home to implement culture change practices much more quickly, by training CNAs and supervisors on practice changes and involving staff members and residents in how to implement new practices, such as permanent (rather than rotating) resident assignments.

Other nursing homes (and an assisted living facility connected with a home health agency) have initiated some culture change elements, although most of these are independent of ECCLI. One nursing home that has not received ECCLI funding for several years began to prepare for and incorporate elements of culture change when participating in ECCLI. A supervisor thought the nursing home's culture change efforts could be attributed to ECCLI-funded culture change seminars. A group problem-solving method—learning circles—reflected culture change but was not initiated with ECCLI funds. Moreover, the research team saw little evidence of culture change except for one unit that had instituted primary assignments and some resident-friendly environmental features. Another nursing home identified culture change as an ECCLI goal, and a group of managers had attended Eden Alternative training, but management reported they did not have the time to implement culture change. Still another nursing home seemed very "person-centered," with innovative home-like elements in the facility and special programs for staff. It also had plans for a new building that would operate under culture change philosophy, but all this was independent of ECCLI.

A number of organizations have moved (or are in the process of moving) from rotating to permanent assignments whereby frontline staff in nursing homes are assigned to particular residents and particular units or neighborhoods. Permanent assignment is considered an important element of resident-centered culture change. The two nursing homes that have instituted permanent assignments throughout the facilities (both are culture change organizations) commented on the benefits of this approach. Permanent

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[11] LEAP is a nationally recognized program that stands for Learn, Empower, Achieve, Produce. LEAP is a comprehensive LTC workforce initiative aimed at recruiting, developing, empowering and retaining quality LTC staff, with residents as the center of the workforce initiative.

assignments to particular units and residents allowed CNAs to know residents and their family members on a more personal level and to recognize more readily changes in resident behavior. It also encouraged resident decision making because they know residents' capacity to make informed decisions and whether particular resident choices are safe. One nursing home had instituted primary assignments on one unit. CNAs liked the change since they could get to know residents and also other CNAs better, but were skeptical if it would work with difficult residents or residents with intense care needs. A fourth nursing home was in the process of transitioning from rotating to primary assignments. The administrator anticipated a challenge with this change because CNAs preferred rotating assignments. They were developing training for frontline and supervisory staff that addressed the benefits of primary assignments and planned to introduce the change slowly, one unit at a time. Staff at other nursing homes commented that they liked rotating assignments because it provided variety and they did not get permanently "stuck with difficult residents," though, typically, they rotate within a floor or unit, not throughout the facility.

Along with acknowledging the importance of frontline workers because of their daily contact with residents/clients, most organizations reported that CNAs/HHAs with advanced training are more involved in resident/client care planning. In some organizations, this was deliberate and formalized; frontline staff members who achieved top career levels (such as CNA/HHA III, GNAS, NC or Mentor) were explicitly expected to contribute to care planning.

In one culture change nursing home, an outside consultant recommended that CNAs should be involved in all aspects of planning for resident care. This was implemented, and employees reported feeling more respected as a result. In the other culture change nursing home, advanced CNAs (neighborhood coordinators) are expected to take a lead role in care planning meetings, and all CNAs provide input. According to CNAs, care plans are done as a team; everyone is involved. Nurse supervisors acknowledged that *"changes in resident status should be picked up by the CNAs caring for the resident because they know them best. After CNA input, everybody gets involved."*

In other organizations, this happened informally—when management realized that frontline staff were better able to communicate and had gained clinical knowledge such that they could recognize changes in important residents' health status. At a home health agency, HHAs input into resident care planning evolved gradually. According to a supervisor, as HHAs' communication skills improved, aides "*are more open to reporting things. Now we are able to turn around and react to things the clients need better. Their input is incorporated more, and overall, the quality of care to the client is improved because of this.*" At a nursing home funded early in ECCLI, frontline staff felt very involved in decisions around resident care and supervisors reported that CNAs are included in bi-weekly interdisciplinary meetings where care plans are discussed and modified. At some organizations, however, CNAs/HAAs still have no direct involvement in resident care planning meetings.

At some organizations, especially those with advanced CNA titles that signify a greater role as well as level compared with other CNAs, advanced CNAs have greater responsibility than is usually afforded CNAs. For example, at one nursing home, nurse coordinators are permitted and expected to read client "in-service sheets" that report changes in resident status and background info. At two other nursing homes, advanced CNAs (CNA III or GNAS) who have advanced clinical training viewed their roles differently. In one organization, CNA IIIs are trained and expected to take resident vital signs. Managers reported that CNA IIIs are trusted with greater responsibility for residents, for example, taking blood pressure and pulse or providing range of motion exercises. At the other nursing home, GNASs have been given responsibility for certain tasks that nurses used to handle, such as documenting residents' weights and designing plans for intervention in the case of weight gain or loss.

At one nursing home, the GNAS (advanced CNA) role provides back-up help for nurses on clinical, as well as personnel issues.

> *They [GNASs] have a lot of responsibility and provide a buffer for nurses so CNAs don't always bring their problems directly to supervisory staff; they sometimes bounce things off GNASs first. Supervisors feel that this process gives CNAs more autonomy because they have a choice of coming directly to the supervisor or resolving issues among CNA/GNASs. They feel like they have that control, and they certainly do.*

CNA IIIs at another organization took on the responsibility of monitoring documentation and training other nursing assistants.

Frontline staff members at many organizations reported having greater flexibility in their job assignments. This allows them to adapt their responsibilities to meet residents' needs and requests: for example, catering to residents' preferences (for when to get up or get dressed) or "doing a resident's hair and nails" during slack time.

Employees also often mentioned increased focus on problem solving, a skill that was part of soft skills career ladder training. As frontline staff learned more clinical and communication skills and gained self-confidence, they were encouraged to work out scheduling and caregiving challenges without involving management. Supervisors often reported on increased problem-solving capabilities of frontline staff.

6.8   Resident/Client and Family Perceptions of Quality

It is difficult to establish a connection between resident/client/family opinions of service and ECCLI initiatives. Most were not aware of ECCLI initiatives, although some were aware of staff members taking classes. Overall, residents/clients and family members interviewed were satisfied with care and services provided. Some were able to compare their experience in the present environment with other care environments and were more satisfied with their current situations.

6.8.1   Nursing home interviews

Some residents and clients did notice that changes had occurred in the recent past, most notably an increase in English language ability among direct care workers. Both residents and family members from a number of nursing homes commented that workers seemed to be more engaged in conversation with residents, especially dietary, housekeeping and maintenance employees with limited English-speaking ability.

A second noticeable change was that CNAs had better clinical skills. Some family members remarked that workers are better able to notice symptoms of an impending problem and take swift action. Others noticed that workers were better able to deal with difficult behavioral issues and *"know just what to say to get [Mom] to respond."* Supervisors at some locations also remarked that the direct care workers' greater clinical knowledge made their jobs easier and improved care to the residents.

Many residents and family members also commented on the fact that residents had more autonomy and were more involved in decision making both pertaining to their own care and to facility issues and policies. This was true of several nursing homes, regardless of whether they had mentioned culture change as a goal. As one resident commented: *"…they encourage me to do things for myself; I have choices. They want me to be happy; they are like my sisters."* In some other sites, however, residents and family members both complained about their lack of involvement in personal decisions, such as time to get up, choices for food, activities and care routines. Most residents and family members seemed to comment on personal choice, whether it was good or needed improvement, indicating how important having some choice seems to be for residents and family members. One resident complained that staff members don't listen to residents and simply go about their self-created routine.

Family members and residents also almost unanimously spoke about positive relationships between residents and direct care workers, which improved their quality of life. In one instance, staff members and residents ate lunch together in order to get to know one another better on a personal level. In others, residents talked about how well trained the direct care workers were or how great it was that they could do little things for them like style their hair or polish their nails.

Several residents and family members remarked that improvements were needed in staffing levels: *"They are always short-staffed"* and *"My mother never wants to ask for something because the aides always seem so overworked."*

Although language ability seemed to improve substantially in many places, there was still room for improvement. Some family members and residents mentioned that staff members often spoke to each other in their native language in front of the resident. This bothered some residents because they thought staff members were speaking about them, while others seemed unconcerned because they trusted the aides to be working in their best interests; they understood that communication was simply easier in one's native language.

Quality in a culture change environment

One nursing home engaged in culture change activities for several years stood out in terms of how quality of life was viewed. Residents felt they had more choices and freedoms than before. Staff members attributed this to permanent assignments to residents, which allowed them to involve residents more in decisions about their care and their daily routines. They were able to get to know residents' preferences, health conditions and limitations and strengths in order to better plan care delivery and daily activities.

One family member commented that now when her mother gets a new roommate, she is told about it in advance and prepared for a new arrival rather than just having someone show up in the room.

This nursing home makes it a point to involve family members in the residents' lives to the extent that they are willing and able to be involved. They sometimes help to provide care and participate in meals and activities. These actions help to improve both the residents' quality of life and the family members' comfort level with having a relative living in a nursing home.

Another nursing home not yet heavily involved in culture change activities also makes it a point to involve families in day-to-day life at the facility. Families have an attractive café available for them to visit casually with residents and are encouraged to provide input by participating in active family councils. Family members interviewed in this case praised the facility for making it easy for them to be involved.

6.8.2 *Home health agency interviews*
Clients and family members interviewed were all very satisfied with the quality of services provided and with the quality of life these services allowed them or their loved one to maintain. Given a high level of satisfaction, these clients consistently reported that they had "always been happy with the care" and could not discern any change as a result of training. Understanding what clients are satisfied with helps paint a picture of what quality means to them.

Two clients noted that their interactions and relationships with the aides helped them to remain social and engaged, which in turn had positive effects on their mental and emotional health. One family member expressed these same thoughts about her family member's relationship with the aides.

Others talked about autonomy in relation to care. One family member described what it means to her mother this way:

> *Her goal is to say at home and their care makes all the difference in the world. They come for an hour. They come when they say; they are lovely. We know the rules; they know the rules. It is lovely. She gets to make the choice of what is done when.*

One client stated she thought the training had given aides more confidence in their work because they had been given the tools to provide better care.

Staff members themselves reported that ECCLI had an impact on clients' quality of life because of HHAs increased knowledge. Some examples of changes as a result of ECCLI are understood best from the words of HHAs:

> *[ECCLI classes] opened my eyes to the residents' perspective. How would I like to be treated? Now, I don't rush them along.*

> *I learned about Alzheimer's behavior and now understand why they act the way they do and how to treat them. I understand them [clients] better. I got to know them as people now, not just clients.*

> *Learning about grief and loss helps me deal better with the residents.*

Overall, quality of life in study sites seemed to be characterized by mutual respect. Residents/clients and direct care workers, supervisors and direct care workers, staff members and families, all showed mutual respect for one another, impacting positively on perceptions of quality of care and quality of life.

While it is difficult to draw any conclusions regarding ECCLI's impact on quality indicators, it is worth noting that ECCLI funding provided organizations with unique training opportunities, allowing them to address issues pertaining to their resident/client populations. Having more direct care workers trained in advanced clinical skills can result in more trained eyes understanding how to better manage pain, recognize symptoms of urinary tract infections or discover why someone may not have an appetite and be able to address the underlying problem more quickly

6.9   Summary
ECCLI training, tailored to the needs of individual organizations, resulted in improved language and communication skills. This was beneficial at all levels: from direct outcomes—increased conversations between frontline staff and clients/residents, better understanding among frontline staff and between frontline staff and residents, family members and supervisory staff—and secondary outcomes—increased input by frontline staff regarding clients/residents status and care and increased self-confidence and sense of competence among frontline staff. ECCLI clinical training resulted in increased staff understanding of the complex needs of some residents/clients and greater competence in providing targeted care, especially among direct care staff. There was at least perception that increased clinical skills resulted in better and more timely care of residents/clients. Clinical knowledge also contributed to the willingness and ability of frontline workers to contribute to resident care planning.

As reported, teamwork improved at many of the nursing homes. For some organizations, this was intentional—e.g., assigning interdepartmental teams to units or neighborhoods. For other organizations, teamwork improved because of the increased understanding of

the importance and interdependence of roles within the organization, improved communication and flattening of the workforce hierarchy. Organizations that engaged in interdepartmental/interdisciplinary diversity (and other) training commented on its beneficial impact on teamwork.

All organizations implemented career ladders that included permanent wage increases. Most direct care staff appreciated the increased wages associated with completing ECCLI-funded career step training. However, the sense from the site visits, especially from frontline worker focus groups, was that increased wages were nice but the greater benefits to ECCLI training were improved communication, clinical skills and sense of being valued and respected for their contribution to the residents/clients and to the organizations. Many administrators reported that staff retention had improved, with fewer call-outs and need for agency staff. Some reported reduced recruitment costs.

A few nursing homes embraced culture change and were at different stages in implementing person-centered practices. Most organizations reported some organizational changes—from implementing permanent assignments, increasing flexibility (e.g., self-managed teams) and flattening the staff hierarchy (mostly by improving lines of communication and giving greater responsibility to advanced CNA/HHAs).

Family members, nursing home residents and home health agency clients almost exclusively characterized care provided by their respective organizations to be good. While it is difficult to connect good care directly with ECCLI training initiatives, some interviewees noted recent changes in CNA/HHA language proficiency, clinical skills and resident/client autonomy and inclusion in care decisions. Staff members with permanent resident assignments believed that knowing their residents better allowed them to include the residents more in decisions about care.

Chapter 7: Sustainability and Long-Term Impacts

Sustainability and creating long-term impacts are the eventual goals of many types of initiatives. ECCLI is no different in this respect; funds are given to grantees with the hope that the programs and activities initiated will continue post-funding. Also, as expected, it is hoped that positive long-term impacts from the initiation of a program such as ECCLI will be realized and maintained. Though sustainability and long-term impacts were not the primary focus of this qualitative evaluation, they are certainly a further indicator of how the realized outcomes of this initiative may translate over time.

All three A sites ceased receiving ECCLI funding two to four years prior to researchers' site visits. Two of the B and C sites ceased receiving funding approximately six to seven months prior to the second site visits. However, two of the B and C sites had only just completed their ECCLI funding period, and the remaining four B and C sites were still receiving funding at the time of the second site visits. Thus, post-ECCLI sustainability can be thoughtfully examined only through consideration of the A sites. In the case of the B and C sites, sustainability is best considered through examination of the continuity and sustainability of programs across multiple ECCLI funding rounds. Yet, all sites' success in sustaining ECCLI programs provides insight into long-term impacts.

7.1   Long-Term Sustainability: A Sites

As mentioned above, sustainability is best examined through the experiences and findings on the A sites included in this evaluation. Because their funding had stopped over two years prior to this evaluation, there is truly an opportunity to examine what activities could and should be continued once a site's obligations to the ECCLI grant ended.

The three A sites that participated in this research study took different approaches to sustaining ECCLI-implemented activities. One continued its ECCLI activities by tailoring the trainings more to their specific organizational needs and absorbed the cost into their operation budget. The other two, though continuing to focus on workforce development activities, did not continue what they had specifically implemented with the ECCLI monies but did engage in other initiatives that were aimed at promoting direct care workers. Perhaps the greatest impact seen in long-term sustainability was in the way that engaging in ECCLI encouraged sites to continue to work on assessing and developing their frontline workforce.

The first site mentioned did indeed incorporate the CNA career ladder into its operating budget (as staff development) once ECCLI funding had ended. One way it was able to do so was by using its own employees as trainers, with employees from various departments providing education about their areas of expertise to employees in different departments. As management explained:

> *Most department heads train in their own area. For example, resident rights is done by Social Services. The DNS [Director of Nursing Services] and one of the ADNS' [Assistant Director of Nursing Services] do pieces of leadership and quality indicators and quality care, and talk about the survey process.*

This site also continued to foster staff development by joining a consortium that was implementing an LPN program. According to the administrator, when ECCLI funding ceased, they immediately entered into the LPN program. During that time period, they ceased the activities that were funded through their ECCLI grant. They have since reinstituted what they started and are simultaneously maintain their participation in the LPN program. However, it should be noted that the LPN program is supported through ECCLI funds received by another organization as the lead grantee.

The other two A sites in this evaluation had sustained ECCLI-promoted employees at their new level, but had not offered additional training for CNA career ladder positions. In one site, it was primarily due to low turnover rates of CNAs. As the Human Resources Director commented, *"Since we haven't lost any of our aides, there isn't really anyone new who needs the training."* The facility indicated it would consider reinstating the career ladder training should the need arise. As an alternative to continuing ECCLI-initiated activities, this site formed a separate consortium with other nursing facilities and a community college to develop and send employees to a propriety LPN program. This was apparently quite successful, and 16 students from the eight partners were in their final clinical at the time of this evaluation.

The final A site had used ECCLI funds to expand an existing training program (developed by its home corporation) through which CNAs could become GNASs. Though they are also no longer specifically maintaining their ECCLI activities, it continues to train GNASs, albeit only when there is sufficient demand. However, it also indicated it was hoping to revamp the GNAS training to emphasize leadership and mentoring skills such that the facility could implement increased responsibilities for GNASs. In addition, interdisciplinary workshops and training were being offered, although not within the context of a career ladder.

Overall, in the two to four years since ECCLI funding had ended, A sites had maintained promoted employees at the higher levels they had achieved through ECCLI. However, in most cases, ongoing training appeared to be somewhat minimal, often occurring only on an as-needed basis. Perhaps the greatest impact in terms of sustainability was in the mission of the ECCLI program. Though the sites did not continue ECCLI activities exactly as they had initially, what they had done with their ECCLI funding had empowered and encouraged them to continue to engage in other efforts to support the careers and professional development of their frontline staff.

7.2   Short-Term Sustainability: B and C Sites

Most all B and C sites were maintaining— either post-ECCLI or in subsequent funding rounds—the career ladders developed through ECCLI. At least two nursing homes whose funding had just ended had absorbed all ECCLI-related salary increases into its budget. One nursing home that had ceased receiving funding six months prior was working on creating new titles for those employees who had reached the level of CNA II or CNA III. This same facility was studying whether it was ECCLI or another approach to promoting CNAs that would result in the best outcomes, have the greatest sustainability and would be the easiest to incorporate into the facility's daily routine. Most organizations, even

those no longer receiving funding, were continuing to offer at least some training in areas such as soft skills, ESOL and computer skills. In addition, two nursing homes were continuing in their efforts to train CNAs to become nurses. Several organizations, including some whose funding was ongoing, had internalized at least some training efforts by using their own staff or volunteer staff to train other employees. However, some organizations maintained partnerships with other organizations in order to allow training efforts to continue. For example, at least one nursing home whose funding had ended was supporting continued soft-skills training and other ECCLI courses by partnering with another ECCLI-funded organization. Other organizations that were still receiving ECCLI funding were considering how to maintain and/or restructure their existing partnerships in order to allow for greater success in sustaining ECCLI activities once funding had ended. Finally, several organizations also were working to implement or maintain resident-centered care practices that were initiated and/or enhanced through ECCLI activities.

7.3   Long-Term Impacts

Long-term impacts of the ECCLI initiative are somewhat difficult to address given that time had allowed only the three A sites the opportunity to demonstrate long-term effects. However, one A site in particular demonstrated how ECCLI affected its employees, even three years after funding had ended. Some frontline staff at this site, having recognized through ECCLI the value of education, had continued ESOL training on their own. In addition, many CNAs and GNASs wished that other frontline staff, including kitchen and housekeeping staff, could have the opportunity to participate in ESOL classes. They believed such classes for these staff would further improve communication within the organization. Supervisory staff, seeing the impacts of ECCLI on CNAs and GNASs, wished for educational opportunities for *all* frontline staff. In addition, supervisors hoped to see more training in communication and culture change, as well as more career counseling. Thus, although this A site was no longer receiving ECCLI funding and did not have the funding to support many of the desired initiatives of which staff spoke, the attitudes of the staff—both frontline and supervisory—reveal a greater understanding of the value of education. This understanding demonstrates a positive long-term effect of the activities and programs the site implemented through ECCLI.

In addition, to what this A site had done, many B and C sites were moving forward in their implementation or continued development of person-centered care principles and culture-change. These efforts demonstrate organizations' continued commitment to the ECCLI goal of improving both staff and resident/client quality of life. If these efforts prove successful, culture change and the adoption of person-centered care principles will emerge as a very positive and enduring long-term impact of the ECCLI initiative.

In summary, although this evaluation did not include an in-depth study of the long-term impacts of ECCLI, the demonstrated sustainability of the ECCLI programs and activities is a promising sign of the impacts the ECCLI initiative may have over the long-term. With few exceptions, most ECCLI programs were being sustained, some through continued ECCLI funding but most through ongoing commitment to the goals and objectives of the ECCLI initiative. This commitment arose out of the realization of the

beneficial outcomes of workforce development activities. By sustaining such programs and activities, the organizations are likely to extend these beneficial outcomes over the long-term, resulting in an overall positive impact of the ECCLI initiative.

Chapter 8: Conclusions & Recommendations

We present in this chapter our conclusions and related recommendations regarding the elements integral to successful implementation of the ECCLI initiative and its components, most specifically career ladders for the direct care LTC workforce. Our conclusions, however, cannot be considered definitive given the inherent limitations of qualitative evaluations such as this. Nonetheless, the conclusions and recommendations provide valuable insight into successful implementation of LTC workforce development initiatives and bear significance for the LTC field as a whole.

Conclusion 1

The opportunity for education and career advancement improves frontline workers' feelings of self-confidence and respect and leads to improvements in the quality of resident/client care. In many cases, the mere offering of educational opportunities to frontline workers made these workers feel as though they and the work they did were more respected by their organization. In fact, this greater sense of respect and self-esteem was often as meaningful, if not more meaningful, to frontline staff as any wage increases they received through participation in career ladder training. Further, as a result of these feelings, frontline workers were more likely to offer information and suggestions during care planning meetings, to approach their supervisors to discuss resident/client issues and to initiate conversations with residents/clients and their family members. Management and supervisors noted that this increased engagement on the part of frontline workers had a positive impact on the quality of care provided to residents/clients.

Recommendation
- All levels of staff should acknowledge frontline workers' accomplishments and new skills and the value of their work.
- Frontline workers should become more involved in the care planning process.

Conclusion 2

Offering career ladders and training opportunities can make an organization more attractive to potential new employees. Many organizations found that, through word of mouth, several potential employees learned of their career ladder and other education programs and were drawn to the organization. Some organizations came to use their positive ECCLI outcomes as a recruitment tool.

Recommendation
- If positive ECCLI outcomes are realized, organizations should make a conscious effort to discuss how these outcomes might be used in their efforts to recruit new employees.

Conclusion 3

Career ladders help establish a "culture of learning" and generate enthusiasm for education. Success in completing an initial training program often fueled a desire to engage in further education and training. However, there was a risk of alienating

employees who were already strong performers but who did not wish to participate in the career ladder training.

Recommendations
- Organizations should promote among staff the benefits of education and training.
- Organizations implementing career ladder and training initiatives should recognize that education is not always the right path or personal preference of every employee.
- Organizations should make every effort to ensure that employees who choose not to participate in training are not looked down upon or criticized by co-workers, supervisors or management.

Conclusion 4

The most successful career ladder and training programs are those that incorporate an initial needs assessment and are well thought out and thoroughly planned from the outset. Many organizations experienced challenges in later stages of the ECCLI implementation process because they had not thoroughly discussed how trained employees' new skills would be used or how particular training initiatives would unfold. In addition, nearly all organizations struggled with how they would provide staff coverage for employees who were in training.

Recommendations
- All aspects of training initiatives should be thoroughly thought out before implementation so that poor organizational planning does not lead to the failure or elimination of otherwise promising programs.
- An initial needs assessment should be conducted and should: 1) examine the English language and ABE abilities and needs of frontline staff and 2) estimate the number of positions at each career ladder step that the organization can feasibly support.
- Organizations should develop a plan or system through which they will cover for the duties of staff who are in training and, in so doing, provide uninterrupted, quality care to residents/clients.

Conclusion 5

Career ladder and other workforce development initiatives are unlikely to succeed without the support of upper and middle management. For example, without creating new roles and responsibilities to be assumed by newly trained career ladder employees, these employees are unable to utilize their skills. Consequently, few if any of the potential, positive outcomes—namely improved quality of the work environment and improved quality of care—associated with use of these career-ladder skills will be realized.

Recommendation
- Organizations should ensure they have management buy-in and support before undertaking any workforce development initiative such as ECCLI.

Conclusion 6

Working with experienced training providers is instrumental to an organization's ability to reach specific targeted goals of workforce development initiatives. Training providers such as community colleges and WIBs provided resources and expertise that organizations were lacking but that were needed for successful implementation of certain educational and skills training programs. Partnerships with other LTC organizations were not as successful often due to unaligned program goals of partner organizations and/or logistical problems resulting from the geographic distance between organizations.

Recommendations
- When undertaking workforce development initiatives, organizations should seriously consider establishing partnerships with local education and training organizations so as to take advantage of the resources and expertise they provide.
- If partnerships of LTC organizations are to be formed, all partners should be in close geographic proximity and should have well-aligned training goals.

Conclusion 7

Culture change requires corporate commitment and/or the vision and energy of an administration that is committed to person-centered care. Culture change is not an inevitable consequence of participation in ECCLI. ECCLI funds, however, can provide critical funding and support to facilitate the culture change journey. Further, culture change involves receptivity to organizational change and the slow process of initiating all levels of staff (and residents/families).

Recommendation
- Before organizational culture and practice change initiatives are implemented, organizations should assess their organizations' overall state of readiness and capacity to implement such initiatives. Some elements of readiness to be assessed include: management support for and commitment to quality improvement, worker-supervisor relationships, sensitivity to cultural and language differences among staff and communication and teamwork within the organization.
- Organizational culture change may be best achieved by introducing elements gradually or within one unit at a time.

Conclusion 8

Providing workforce development training presents different challenges for home health agencies than for nursing homes. While home health staff may be permitted to attend trainings on work time, this is often difficult to arrange because of the decentralized nature of work through home health agencies. Home health staff customarily works with the same clients. Thus, regardless of their participation in training, the staff must still provide services to their clients. As a result, training must often be done on unpaid time. A different, more flexible training model may be needed for home health agencies.

Recommendation
- Home health agencies may need to develop customized training models specific to the work schedules of their HHAs. This might be offering all-day trainings,

rather than shorter sessions, or perhaps providing staff a stipend to attend trainings if they cannot find coverage for clients.

Conclusion 9
ESOL and ABE are crucial to successful LTC workforce development. Several organizations did not recognize, until ECCLI, how great the need was for this type of training among their frontline staff. Many frontline employees had, in fact, been effectively hiding their deficits in these areas. Organizations came to realize that without first laying a strong foundation in English language fluency and basic education, more advanced trainings of any nature and any career ladder initiative would be significantly hindered, if not poised for failure. Training in ESOL also had benefits for communication within the organization.

Recommendation
- As part of any workforce development initiative, courses in ESOL should be offered to all employees whose primary language is not English and ABE offered to all employees.
- ESOL and ABE should be successfully mastered by employees either prior to or as part of advanced career ladder training programs.

Conclusion 10
A commitment to improved communication is key to any workforce development initiative. Training in ESOL was one avenue through which organizations demonstrated this commitment. Organizations also offered specific courses in communication skills. At some organizations, these courses were offered interdepartmentally which promoted greater levels of understanding and respect among all levels of staff. By making these commitments to improving communication, organizations saw improvements in the quality of the work environment and greater job satisfaction, particularly among frontline staff.

Recommendation
- Communication skills training, particularly inter-departmental communication training, should be included as part of any workforce development initiative.

Conclusion 11
Increased wages and elevated titles are important to improve workplace quality, but not sufficient without mechanisms for frontline workers who achieve higher titles and wages to use their skills. Some organizations faced situations in which they were unable to use the newly acquired skills of their frontline staff. Reasons for this included inability of the organizational structure to support all those trained, as well as a lack of focus on translating training into practice. In essence, frontline workers at some organizations were receiving training but, without the opportunity for skill utilization, the training did not contribute in a meaningful way to the career advancement of these employees.

Recommendations

- Career ladder steps should have meaningful titles that translate into greater responsibility, autonomy and opportunities to use skills.
- Supervisors should play an active role in helping frontline staff translate their newly acquired skills into practice.

Conclusion 12
Supervisory training is essential to the success of workforce development initiatives. The consequences of not offering such training can be seen in one organization that offered neither supervisory nor capacity-building training. This organization experienced significant tension and distrust between frontline staff and supervisors. Supervisory training is essential not only to supervisors' acceptance of the ECCLI program but to establishing an environment of trust and respect which, as discussed above, can have significant impact on resident/client quality of care.

Recommendations
- Organizations should educate supervisors about the changing role of the CNA/HHA and other frontline workers.
- Supervisors should be provided training in how to help their subordinates incorporate newly acquired skills into their daily work practices.

Conclusion 13
Data about the specifics of training initiatives and the number of employees trained are important to evaluating the success of workforce development initiatives such as ECCLI. We found that many organizations were not collecting data or had very spotty data about the specific content of their training programs, as well as about the numbers of employees who were trained. Yet these data are important for benchmarking purposes and for evaluation—particularly external evaluation—of implemented programs.

Recommendations
- ECCLI organizations should improve data collection so that all organizations are collecting data or documenting information pertaining to their training and career ladder curricula, as well as the numbers and staff positions of those being trained.
- Data collection should be uniform across all organizations and made easily accessible for evaluation and benchmarking purposes.

APPENDICES

Appendix A: Methodology

Theoretical Framework & Evaluation Topic Areas

The conceptual areas addressed in this evaluation were guided by the work of the late Susan Eaton[12], as well as previous studies conducted by members of the research team. Essentially, they stem from the larger hypothesis that higher-quality jobs, job skills and work environments for frontline caregivers will result in better patient care and quality of life. The questions asked were grouped into five major topic areas: contextual, implementation of the interventions, changes in structure/practice, outcomes and sustainability.

Contextual questions. To place the site case studies and this final report within the larger economic, political and social context, we asked about generic contextual issues that should affect all nursing homes and home health care agencies in our study. This includes things such as: 1) regulatory changes that have hindered or enhanced ECCLI activities, 2) changes that have occurred in the survey/certification and public reporting process over the study period, 3) changes in Medicaid and Medicare requirements, benefits and reimbursement, 4) the role of the QIO nursing home and home health care quality initiatives and 5) the effects of other statewide activities (e.g. statewide culture change activities) that may affect the behavior of the organizations in our case studies.

Implementation of career ladders (ECCLI) and other workplace initiatives. The implementation of ECCLI was not a primary focus of the data collection; this evaluation covers perceived changes and outcomes. However, ECCLI's implementation is part of the evaluation in as much as the purpose was not only to document changes, but also to understand why certain changes took place in some organizations. We asked about whether and how well initiatives have actually been implemented and the nature and scope of each of the initiatives undertaken with ECCLI funding or other sources.

Structural/practice changes. We expected to see evidence of a number of structural and practice changes as a result of ECCLI support and other activities in which the ECCLI organizations were engaged. Thus, changes in leadership/management style, work practices and human resource practices were investigated.

Questions related to leadership/management style included: 1) shifts in organizational structure (e.g. flattening of the hierarchy, shifts from units to neighborhoods/ households), 2) changes in staff roles at all levels and 3) changes in the relationships and communication patterns between supervisors and employees.

Questions related to changes in work practices included: 1) work assignment—flexibility and autonomy of workers, as well as the extent of their case load, 2) how jobs have been reorganized/redesigned (e.g. self-scheduling, self-managed work teams), 3) how and to what degree frontline caregivers and other staff have become empowered (e.g. increase in decision-making authority, direct involvement in assessment, care planning and

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

continuous quality improvement), 4) changes in the level and quality of communication/interaction between peers, between staff and residents/clients and between staff and families and 5) job satisfaction.

Questions related to <u>changes in human resource practices</u> included the availability and use of educational and training opportunities for frontline staff and increases in wages and other benefits.

Perceptions of outcomes. Within the context of this qualitative research effort, we examined different stakeholders' (i.e. residents/clients, family, frontline staff, frontline supervisor, management) *perceptions* of the extent to which there have been positive (or negative) outcomes related to quality of care/quality of life for residents/clients, job satisfaction for staff and organizational performance/costs.

Questions related to <u>quality of care</u> included resident/client, family and staff perceptions of changes in health and functional status. Questions related to <u>quality of life</u> included changes in resident/client and family satisfaction over the course of the study period and changes in resident/client feelings of autonomy and self-direction. Questions related to <u>quality of work life</u> included questions to staff and management about perceived changes in job satisfaction, changes in feelings of empowerment, peer-to-peer, worker-supervisor and worker-client relationships, and the extent to which one would recommend working in the particular nursing home/home health care agency to anyone else. Questions related to <u>organizational performance and costs</u> included perceived changes in turnover and retention.

For each of the changes and outcomes identified above, we attempted to assess to what degree each could be <u>attributed to the ECCLI program</u> and/or to some other interventions that were occurring simultaneously.

Sustainability. We asked about organizations' experiences with the program, including problems and challenges in using the resources and opportunities for sustaining interventions with continued support. We also asked about organizations' plans for continuing the activities once ECCLI support is terminated.

Data Collection Planning & Preparation
Obtaining the perspectives of a variety of stakeholders within the ECCLI grantee organizations helped the researchers to develop a more complete picture of implementation experiences and their outcomes. This qualitative evaluation was strengthened by a triangulation of data sources at each organization, including participant observation and informal discussion, formal one-on-one interviews (both in-person and on the telephone) and focus groups.

Stakeholder groups that were asked to participate in formal interviews or focus groups included <u>clients/residents</u>, <u>family members</u>, <u>frontline staff</u>, <u>frontline supervisors</u> and <u>management</u>.

Protocol development. To conduct the formal interviews and focus groups, 10 different question protocols were generated. Each contained questions tailored to the stakeholder group with whom researchers would be using them.

First, researchers addressed the clients/residents, family members, frontline staff and frontline supervisors. Two protocol versions were created for each—one to be used in home health agencies and the other in nursing homes. Second, for management, two different question protocols were created: #1 one focusing on ECCLI implementation (typically used to interview the ECCLI coordinator) and #2 on overall organizational questions (typically used to interview the CEO or administrator). These two protocols were utilized in both nursing homes and home health agencies. However, for the second round of data collection, the #2 protocol was revised to include new questions. For example, some of these questions asked management to talk about what they planned in their original grant proposal versus what they actually implemented. Thus, the list of all protocols developed included:

1. Home Health Agency *Client Interview* Protocol
2. Nursing Home *Resident Interview* Protocol
3. Home Health Agency *Family Member Interview* Protocol
4. Nursing Home *Family Member Interview* Protocol
5. Home Health Agency *Frontline Staff Focus Group* Protocol
6. Nursing Home *Frontline Staff Focus Group* Protocol
7. Home Health Agency *Frontline Supervisor Focus Group* Protocol
8. Nursing Home *Frontline Supervisor Focus Group* Protocol
9. *Management* Protocol #1 (Organizational Structure, Work Processes, HR Practices)
10. *Management* Protocol #2 (Implementation & Context)

To develop the questions in these protocols, a two-step process was utilized. First, for each of the five major evaluation topic areas described earlier, more detailed issues were discussed and these were assigned to target groups judged to be most appropriate to address them. Researchers generally made sure that each issue was assigned to more than one target group (to enable comparison of views among types of stakeholders) and also made certain that no group had too many topics to cover during an interview or focus group. Second, using the topic-area assignments, questions were drafted, reviewed by CommCorp and members of the ECCLI Advisory board, and revised based on these reviews.

Site Selection
Components. As specified by CommCorp, the sample for the qualitative evaluation consisted of 11 organizations, each assigned to a "component" based on what ECCLI funding they had received. Organizations in "Component A" were funded in ECCLI Rounds I through IV, completed their projects and are no longer receiving funding. Those in "Component B" were new projects that received funding in Rounds V and VII. Finally, those in "Component C" have continued to receive funding in multiple rounds. Our 11 organizations were divided among the components as such: three nursing homes in

Component A, three nursing homes and one home health agency in Component B and two nursing homes and two home health agencies in Component C.

Since Component A sites had ended their ECCLI participation and had been without funding for at least three years, the evaluation of this component provided a unique opportunity to examine the long-term effects of the program and the potential for sustainability. Component C organizations have continually received ECCLI funding over a five-year period. Given the level of external investment, these organizations have the greatest potential to achieve changes in organizational structure and behavior and work and human resource practice to affect better resident/client, staff and cost outcomes.

Selection criteria. Before selecting organizations for each component, researchers developed a list of candidate ECCLI organizations based on CommCorp documents. Once these organizations were listed, several exclusions were applied. Final decisions about these exclusions were made in consultation with CommCorp.

1. The sample of nursing homes was limited to medium-sized organizations (50 to 150 beds) to control for the potential of size to either hinder or enhance the implementation and success of the ECCLI interventions.
2. The list of candidate organizations for sampling included only those that served as the lead agency for the ECCLI grant because they should have the most knowledge among collaborating organizations about ECCLI.
3. ECCLI lead organizations were excluded from consideration if they also participated in the Better Jobs Better Care national workforce initiative to avoid confounding ECCLI and BJBC workplace interventions and to minimize additional burden on these sites.
4. Organizations that received ECCLI special project funds as of October 2005 (when the sample was finalized) were excluded because these awards were not competitive or subject to the same evaluation criteria as the Component A, B and C grants.
5. For Component A, lead organizations that were not nursing homes were excluded.
6. For Components B and C, lead organizations that were neither nursing homes nor home health agencies (e.g. corporate headquarters, hospitals, unions) were excluded.
7. Any Component A, B or C lead organizations that dropped out of ECCLI were excluded.

For each candidate site, we obtained information on location within Massachusetts and funding rounds. For each nursing home, we also obtained number of beds, ownership (for-profit or nonprofit, whether part of a multi-site organization and number of health deficiencies).

The CommCorp project manager for ECCLI reviewed the initial list of possible sites and made recommendations for sample selection based on her experience regarding which organizations were more involved in workforce activities. Based on their recommendations, we drew a purposive sample of 11 organizations from among the

nursing homes and home health care agencies that have received ECCLI funding since 2000. The final sample was selected by mutual agreement between CommCorp and the evaluation team in consultation with the ECCLI statewide advisory board. More detail on selected characteristics of the recruited sites can be found in Chapter 3.

Site Recruitment
Once the sites were identified for inclusion in the study, letters were sent to the nursing home administrators and top management personnel at the home health agencies informing them of their selection for the study and encouraging their participation. Two letters went out initially, one from CommCorp and one from the IFAS/GI-UMB research team. One designated research team member then phoned these executives to answer any questions regarding the study and to set up the site visits.

Several of the selected organizations across all components (A, B and C) did not want to participate in the study for a variety of reasons, such as recent management changes or time constraints. Replacement organizations were identified. As we anticipated, the A sites, which were no longer receiving ECCLI funding, were less willing to participate. Therefore, members of the ECCLI advisory board became involved in making phone calls and writing letters to urge their participation. By the December 2005 deadline for completing the first round of site visits, only one A site had agreed to participate. CommCorp staff, ECCLI advisory board members and a member of the GI-UMB research team initiated numerous telephone calls aimed at procuring commitment from A sites. With this effort, two additional A sites agreed to participate.

To both entice the organizations to participate in the study and to defray some of their labor costs associated with our stipulation that, whenever possible, staff members participate in focus groups during their normal work hours, stipends were offered both to individual participants and to the nursing homes and home health agencies. For example, each focus group participant in a nursing home received $10, as did resident and family member interview participants. The nursing home then received $15 for each focus group participant. In the home health agencies, focus group participants received $25 each because extra travel was required for them to participate. The agency received $100 for recruiting participants and setting up the site visit.

An ECCLI coordinator was identified in each ECCLI site who worked with the research team to arrange the site visit and telephone interviews. This involved several phone calls. Because the ECCLI site coordinators had many responsibilities to juggle, site visits usually took at least two to three weeks to set up. As a result, each site visit was actually scheduled for approximately a month from the initial phone call.

Data Collection
As mentioned earlier, Component A sites were only visited once during this evaluation, and B and C sites were visited twice (two different data collection time points). Thus, a total of 19 site visits were conducted. On these site visits, researchers conducted participant observation, interviews with clients/residents and family members and focus

groups with frontline staff and frontline supervisors. Management interviews were conducted via telephone after a site visit was completed.

There were a total of seven researchers, five from GI-UMB and two from IFAS, who conducted the site visits in various combinations. In general, each site visit team consisted of two people: either two from GI-UMB or one person from GI-UMB and one IFAS team member (IFAS team members joined in on four site visits). Site visits took approximately one full day. In nursing homes, all the focus groups, interviews and observation could take place on-site, whereas home health agency visits involved driving to multiple locations to conduct client interviews. Table A.1 gives an overview of the data collection activities conducted for this evaluation.

Table A.1 Overview of Data Collection Activities

Setting/Activity	Time One Data Collection	Time Two Data Collection
Nursing Homes	*8 nursing homes*	*5 nursing homes*
Site Visits	8	5
Frontline staff focus groups (@1/site)	9	5
Frontline supervisor focus groups (@1/site)	9	5
Resident interviews (@2/site)	15	9
Family member interviews (@2/site)	15	7
Management telephone interviews (@2/site)	15	10
Home Health Care Agencies	*3 agencies*	*3 agencies*
Site Visits	3	3
Frontline staff focus groups (@1/site)	3	3
Frontline supervisor focus groups (@1/site)	3	3
Client interviews (@2/site)	6	5
Family member interviews (@2/site)	3	5
Management telephone interviews (@2/site)	6	6
Total interviews	102	
Total focus groups	40	
Total site visits	19	

Each site visit included two focus groups. One focus group targeted frontline caregiving staff, predominantly CNAs or home health aides, although nursing homes also included dietary, housekeeping and clerical staff in some groups. The other focus group included frontline supervisors, usually LPNs and RNs, but also included food service managers, maintenance and housekeeping managers and activity directors at some nursing home sites. Some sites also included upper management personnel, such as the director of nursing (DON), in the frontline supervisor group. These groups ranged in size from five to 12 participants. Focus groups were tape recorded.

Individual in-person interviews were conducted with approximately two residents/clients and two family members per site, though occasionally only one of each of these could be conducted. Some of the family member interviews were done over the telephone. Interviewers took notes during these non-recorded interviews.

Generally, two management interviews were conducted via telephone with upper-level personnel after each site visit. One interview targeted implementation and contextual issues, and the other focused on ECCLI impact from the management perspective.

The site visit teams also spent time observing activities or meals and walked around the organizations collecting personal observations both on their own and with members of the management staff conducting tours. Requests to shadow CNAs were rejected due to concerns about privacy issues. At one facility, for example, the administrator conducted a tour upon the site visit team's arrival and throughout the course of the day, one researcher toured the facility alone, while the other researcher observed an activity with residents involved in a discussion about current events.

Analysis
The evaluation team developed the findings in this report using a deliberate, inductive process. All analysis and report writing were guided by the five key conceptual areas: external environment, implementation of the interventions, changes in structure/practice, outcomes and sustainability. First, raw data were organized, then analyzed and used to create individual case studies, one for each site in the evaluation. These case studies are available from CommCorp. Second, the case studies were then used to synthesize findings across the sites and create this final report.

Organization of collected data for analysis. For each in-person and telephone interview, interviewers typed up electronic notes reflecting the conversation or transcribed what the interviewees had stated. For each focus group, the session was recorded and the note taker took notes to reflect key findings and quotes or transcribed the conversation directly. Researchers also recorded their observations and impressions from the visit. Finally, at the end of each respective site visit, the team brainstormed to develop a list of about five main themes they took away from that site.

Case studies. Eleven site-level case studies were generated, informed by the raw data collected (e.g. interviews, focus group transcripts, participant observation notes, secondary documents from sites, etc.). These case studies synthesized a set of findings for each individual site and were organized by each of five key areas mentioned above. Case study writing was divided up evenly by the analysis team (consisting of four primary researchers). For each site case study, researchers reviewed the following data collection documents:

 – Client/resident interviews
 – Family member interviews
 – Management interviews #1 & #2
 – Note taker notes and/or frontline staff focus group transcripts
 – Note taker notes and/or frontline supervisor focus group transcripts
 – Researchers' impressions from participant observation
 – "Top five" themes document
 – Secondary data documents and information obtained from CommCorp and respective sites

Final report. The analysis team then developed an outline for the final report and assigned the writing for each section one to specific team member. The final report writing was informed by the case studies that had been created. Analysis team members reviewed the appropriate materials across all 11 case studies to write their respective sections. For example, the researcher writing the sustainability section of the interim report reviewed the sustainability sections of each of the 11 case studies and developed common and divergent themes from across these. Once the report sections were written and assembled, the analysis team reviewed the report and revised sections based on each others' comments.

Appendix B: Site Case Study Executive Summaries

As part of the evaluation process, we developed case studies for each of the eight nursing homes and three home health agencies. The final report draws primarily from these in-depth case studies. The executive summaries for the 11 case studies are included in this Appendix. Case studies A1, A2 and A3 represent the three nursing homes that participated in early ECCLI rounds, but have not been receiving ECCLI funds for several years. Case studies B1, B2 and B3 represent nursing homes that recently began receiving funds, while case study B4 represents a home health agency that began receiving ECCLI funds only recently. Case studies C1 and C2 represent nursing homes that have been receiving ECCLI funds for two or more rounds along with supplemental funds; case studies C3 and C4 are home health agencies that also received ECCLI funds for multiple rounds.

A1 Case Study Executive Summary
A1 is a modest-sized, for-profit skilled nursing facility and rehabilitation center located on the North Shore of Massachusetts. In past years, it focused on providing care primarily for long-term residents; however, its focus changed more recently to short-term patients since it expanded its rehabilitation program. Although it still has Alzheimer's and LTC units, these individuals and the short-term rehab patients are now all kept on separate wings of the facility, and there has been an increase in rehab patients. A1 first applied for Round I ECCLI funding in 2000 and was subsequently involved in one round of supplemental funding.

A1 management decided to use the ECCLI grant funds to create a sustainable career ladder program for all staff members. Workforce development has been an important value for A1 for some time, although it has struggled with maintaining the training momentum in the face of competing priorities. ECCLI funds succeeded in allowing more certified nursing assistants (CNAs) to move successfully up the career ladder. In addition, supervisory training included sessions on how to support CNAs in their new and expanded roles. This has made the difference in sustaining the advanced CNA training because newly acquired skills have developed into new roles and responsibilities for CNA IIs and CNA IIIs. CNA IIs handle more advanced clinical tasks and are participating more in providing care and in contributing to care plan decisions. CNA IIIs have taken on leadership roles on the units. They ensure that all CNA documentation is complete and timely, in addition to mentoring new CNAs. A1 stayed focused on improving the quality of care through improving the skills of the direct care workforce. Building clinical skills, team building and leadership skills for CNAs and developing the capacity of supervisors to support CNAs enabled A1 to sustain its career ladder program, one of its primary goals.

The chef apprenticeship program for dietary staff was less successful. The original goal was to train four dietary employees to become chefs, but A1 was able to train and promote only one employee. A1 found the motivation to advance was different among dietary staff, even people it thought could advance were not interested. Having promoted

one person, however, it now has a process for developing dietary candidates interested in career advancement in the future.

A1's strategy of focusing on workforce development has resulted in a significant improvement in staff retention and improved communication among all employees. Management has been able to develop a climate of trust that has allowed them to introduce change (i.e. strategy shift to more rehab patients) without losing staff in the process.

Overall, A1 entered into ECCLI funding with specific, tangible goals. It looked at this as a chance to "develop" its workforce. Although it could have had more far-reaching objectives, it chose not to and was ultimately successful with its stated goal. The ECCLI program certainly helped it get its career ladder off the ground and truly incorporate positive changes to its workforce.

A2 Case Study Executive Summary
A2 is a nonprofit skilled nursing facility located in metro-west Boston serving more than 120 residents. It belongs to a large, faith-based health system serving both long-term and short-term residents for more than 30 years. While known for quality care, A2 had been experiencing frequent turnover of CNAs in recent years and hoped to reverse that trend, in part, through participation in the ECCLI grant. A2 received ECCLI funding in Round II from March 2001 through June 2002 and again in a supplemental funding round from December 2002 through August 2003.

A2 created career ladders by introducing facility-based initial CNA certification training (CNA I) and two new CNA positions. CNA IIs were trained as restorative aides whose job involved helping residents with moderate impairments achieve their maximum level of functioning. CNA IIIs were trained in advanced clinical skills to assist those residents with higher levels of functional impairment and in leadership skills to assist both nurses and newer CNAs. CNA IIIs fill mentorship roles and take on more responsibility for residents' care.

In addition to establishing career ladders, A2 trained all of its employees in cultural diversity and teamwork. Supervisors were trained in leadership skills and in the Eden Alternative philosophy. Dietary, housekeeping and nursing staff participated in cultural diversity workshops and in ESOL classes where appropriate.

These efforts led supervisors to report having a greater respect for CNAs and improved communication throughout the organization. Residents and family members reported high satisfaction with care at A2, and the facility scores well in public health department surveys compared with the state average. While the supervisors attributed improvements to ECCLI training, family and residents reported to be satisfied with care and communication with staff all along.

CNAs reported to have better peer relationships but overall felt "cheated" after ECCLI training, as they did not view their very modest pay increases to be reflective of their

increased knowledge, skills and responsibilities. While there was a three percent pay increase associated with each CNA level (II and III), CNAs seemed unable to separate these increases from normal yearly raises, and therefore believed they were just being given more responsibility without compensation.

Efforts at A2 to implement elements of the Eden Alternative culture change model had been well-intentioned, but management reported they did not have the time required to become an Eden-certified facility. As a result, A2 fell short of its goal of implementing the Eden Alternative philosophy.

A2 achieved modest success by reducing turnover of existing CNAs and providing extensive interdisciplinary staff training in a variety of topics, along with specialized training for CNAs, supervisory staff and non-nursing frontline staff. A2 made progress in elevating the roles and appreciation for nursing assistants, although the CNAs who participated in the focus group did not acknowledge this. A2 is committed to maintaining the CNA levels, including providing training to future CNAs as needed. It also partnered with other area nursing homes and a community college to develop an LPN training program, from which two A2 CNAs recently graduated.

In spite of some reports of improved communication and respect for CNAs, there seemed to be an overall tone of strained relationships and uneven communication throughout the facility. The level of trust often required to achieve and sustain change seemed absent at this site.

A3 Case Study Executive Summary
A3 is a middle-sized skilled nursing facility located in a suburban community north of Boston. It is a Medicare/Medicaid-certified nursing home and part of a large national for-profit corporation providing long-term care and rehabilitative services. It employs approximately 70 full- and part-time entry-level staff, and 70 percent of the frontline staff has English as a second language.

A3 participated in Round I of ECCLI from November 2000 until June 2002. The parent corporation already had established a career ladder program in which A3 CNAs participated. Because career ladders were already in place, the programs it proposed to implement through ECCLI focused on providing career counseling and planning for every employee and increasing the number of career ladder participants. Individual case management was proposed to identify and address potential barriers to success such as childcare, transportation or housing issues and to help employees gain access to college classes though on-site college preparation classes provided by instructors from a local community college. A3 also proposed training managers and supervisors in how to support their subordinates interested in career advancement. A3 anticipated that ECCLI-funded activities would create an environment where employees could feel comfortable taking the initiative to participate in training activities.

Twelve CNAs were trained and promoted to Geriatric Nurse Assistant Specialist (GNAS) positions through ECCLI-funded programs. In addition to GNAS training, A3 provided

LPN preparation classes, ESOL classes and supervisory skills training for interested employees at any level in the organization. A3 provided career counseling to a limited number of employees who expressed interest in advancing their careers. However, widespread career planning for all employees did not take place as anticipated.

According to A3 supervisors, improved communication in both language skills and communication techniques was the most far-reaching result of ECCLI training. Frontline staff members increased their self-esteem, which, in turn, positively affected quality of staff interactions and resident care. Training all levels of staff together facilitated improved facility-wide communication. When staff at all levels had an opportunity to interact in classroom settings, they developed a greater appreciation for one another.

GNASs have increased responsibilities in handling some clinical issues and personnel matters. Given that A3 had a higher number of GNAS employees than other facilities, the company asked them to participate in a new corporate initiative involving culture change. Although ECCLI funding had ended, A3 seemed more ready to take on this new initiative than other corporation facilities. On one floor, CNAs received primary resident assignments. Both residents and CNAs on this floor reported this as a positive. CNAs on other floors were more reluctant to accept primary assignments because they appreciate serving a variety of residents.

The parent corporation recently revamped the GNAS training program because, according to the administrator, they felt management was not using the existing GNASs in leadership or mentoring roles as originally planned. A3 is now offering a refresher class for existing GNASs in order to allow A3 to change the GNAS role more effectively.

The past training focus seemed to have a lasting impact as reported by frontline staff and supervisors. Staff members at all levels are more committed and feel freer to take the initiative. Housekeepers feel comfortable interacting with residents and attempt to assist, for example, *"getting a resident a sweater when she is cold rather than asking a CNA to do this."* Other changes included an easier approach to handling last-minute resident food requests by using technology (headsets) that facilitates communication from the unit to the kitchen.

Even though ECCLI funding ended some time ago for A3, staff members held strong opinions about the importance of good communication. They also reported feelings of respect and empowerment attributed to ECCLI-funded classes. ECCLI funds helped to jump-start the education process for A3 employees. Supervisors attributed the increase in well-trained GNASs to the ECCLI grant, which has made their jobs easier. ECCLI also gave some people an opportunity to pursue further education and go on to LPN school. Since there was already an established career ladder, ECCLI allowed many more employees to take advantage of that training by offering more slots and by providing other educational/life supports necessary for employees to have the opportunity to attend classes. A3 continues to offer interdisciplinary workshops and trainings, though not currently associated with career ladders.

B1 Case Study Executive Summary

B1 is a middle-sized, nonprofit nursing home situated in a close-knit rural community. This home is part of a small chain in which most residents rely on Medicaid as their primary payment source. Staffing is relatively stable, with the current administrator in place for more than 10 years and a high percentage of long-term employees. One area of staffing needing improvement was retention of newly hired CNAs.

B1 received ECCLI funds in Round V and established CNA career ladders focused on improving clinical skills and creating strong mentors in an attempt to improve retention among newly hired nursing assistants. B1's career ladder offered training for three positions—CNA IIs, CNA mentors and senior mentors. CNA IIs received an additional $0.25 per hour after completing 10 workshops and CNA mentors earned an extra $0.75 per hour upon completion of an additional series of workshops. Senior mentors received $50 for each employee successfully trained. In addition, B1 offered training in math, writing and computer skills for those interested in taking college-level nursing classes. Managers and supervisors were trained on how to support mentors in their new roles. B1 received supplemental funding that supported training on person-centered care principles.

Sixty employees enrolled in classes of various kinds. Thirty-two CNAs have been promoted as a result of completing a series of classes, and 13 more are in the process of taking classes that can lead to promotion. Twelve employees attend nursing classes on work time and are working toward earning a nursing degree.

ECCLI-funded training classes have helped to strengthen already strong communication patterns. Communication is very open with staff members at all levels feeling comfortable interacting with one another. ECCLI training classes reportedly have helped CNAs to speak up with more confidence and share information more thoroughly between shifts. Communication may be further improved by sharing reasons for decisions made with all staff members, particularly when they have been part of the decision-making process.

B1 has been focused on culture change for almost 10 years. The senior management staff had been trained in the Eden Alternative and began to adopt ideas from the training that they thought would benefit their employees and residents. Once ECCLI began to fund training, B1 was able to implement culture change practices much more quickly. They were able to train CNAs and supervisors on what practices would change and involve staff members and residents in how to implement new practices. For example, work assignments changed from rotating assigned residents each week to permanent resident assignments. This change has allowed the nursing assistants to know the residents on a more personal level and has impacted their input in the care planning. Nursing assistants also are involved in interviewing prospective nursing assistants and provide input in the hiring process. In addition, staff members encourage residents to make decisions for themselves and to do as much for themselves as realistically possible.

B1 has reduced turnover of nursing assistants from 87 percent to 25 percent. Prior to ECCLI, B1 had a stable core staff of nursing assistants, but about 30 percent turned over

several times a year. According to the CNAs, newly hired CNAs still turn over frequently and often leave because wages are not competitive and because schedules often change without notice.

Management and most CNAs believe mentoring has helped to improve retention. ECCLI contributed to this by training CNAs on how to mentor others and CNAs now train new staff members to not only understand what needs to be done, but also embrace the idea of resident-centered care. CNA mentors also emphasize the importance of teamwork at B1 to new employees and help them understand how to fit into a team-oriented culture.

Some CNAs enjoyed learning new skills offered through ECCLI but were disappointed with the $0.25 increase they received on the first step of the career ladder. Others were simply happy to have the chance to learn and were not concerned about the money involved. The positive work environment proved to be incentive enough to remain working at B1.

Family members and residents appreciate how easy it is to talk with the staff members, how accessible they are, how attentive they are and how much respect they show to the residents. They make it a point to involve family members who are interested in being involved in discussions regarding resident care, in planning activities and in providing choices for meals.

This nursing home will continue to move forward with implementing resident-centered care practices supported by supplemental ECCLI funding. It also has developed strong partnerships with area healthcare organizations and community colleges to continue training CNAs to become nurses. The home will strive to continue to pay tuition for two new LPN candidates every two years. It also plans to continue training CNAs on clinical skills and computer skills using its own staff. There are no current plans to train additional aides to be mentors, as they are working effectively with the mentors now in place.

Given its rural location, B1 was not able to partner with other healthcare organizations for ECCLI training. It did forge strong partnerships with a community college, a consulting firm and a career center to provide career counseling and training for CNAs, managers and supervisors. B1 staff will teach skills training and computer classes in the future, while the community college will continue to provide bridge-to-nursing and consultants will provide person-centered care workshops.

B1 has benefited in several ways through its ECCLI participation. It created career ladders for CNAs, offered education for other employees pursuing GEDs and still others interested in becoming nurses. It strengthened communication and teamwork and introduced new work units centered on improving staff-to-resident relationships.

B2 Case Study Executive Summary
B2 is a modest-sized, nonprofit nursing home in an urban community. Frontline staff members come from diverse backgrounds, and the majority speak English as a second

language with Haitian Creole and Spanish being their primary first languages. B2 has a history of scoring well on state health department surveys and works with a higher than average staffing ratio. Turnover is not considered a problem. With the possible exception of the dietary department, staffing has been very stable.

B2 received ECCLI funding as the lead organization of a consortium in Round V and as a partner in Rounds VI and VII. B2 offered three approaches to training: one career ladder step for CNAs featuring advanced clinical training; one for other entry-level workers offering ESOL and soft skills; and one for supervisory staff with communication skills, teamwork and relationship building. CNAs completing the advanced clinical training received a three percent salary increase. B2 hoped this training would open career opportunities for staff by providing dietary and housekeeping staff members a chance to become CNAs and offering a bridge-to-nursing program for current CNAs. B2 also sought to improve the quality of care to residents by having a more educated workforce, with a better command of the English language.

Twenty-one of the 24 CNAs signing up for advanced clinical training classes completed the training and received a salary increase. About 25 employees benefited from ESOL classes, and many more were trained in other soft skills such as cultural diversity, teamwork and communications. Supervisors were taught how to support the CNAs by helping them to incorporate their new skills into their jobs.

A variety of innovations, both for staff members and residents, exemplify management's philosophy regarding caring for its people. B2 has a store for its employees where they can "purchase" everyday groceries and household items from points earned while working. Employees with five years or more of service are treated to an all-expense paid vacation. A free European Spa offers massages, manicures, pedicures and facials to each resident about once every six weeks.

Between the first and second site visits, B2 received a grant from the Robert Wood Johnson Foundation (RWJF) to implement plans to build a Green House, a new nursing home prototype built on Eden Alternative culture change principles[13]. B2 began introducing those principles to employees in its current building and managers felt that ECCLI training for supervisors opened the door that allowed them to introduce new concepts more easily.

Overall, ECCLI training resulted in B2 direct care staff members having more self-respect as they gained an appreciation of how important their roles were to the nursing home residents, family members and supervisory staff. By participating in peer leadership training and having the opportunity to interact with peers from other facilities,

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[13] The Green House model creates a small intentional community for a group of elders and staff by altering facility size, interior design, staffing patterns and methods of delivering skilled professional services. Its primary purpose is to serve as a place where elders can receive assistance and support with activities of daily living and clinical care, without the assistance and care becoming the focus of their existence. The Green House is intended to de-institutionalize long-term care by eliminating large nursing facilities and creating smaller, more home-like social settings. (www.edenalt.com)

they began to appreciate their own role from a broader societal perspective. All levels of staff describe the work environment as one of "mutual respect" and "like a family." Turnover at B2 is very low; when people leave, they often come back once they realize what they gave up.

B2 seemed to be different from other nursing homes prior to ECCLI given its innovative programs, low turnover and good communication patterns. Its organizational structure is relatively flat, and staff members easily communicate at different levels within the organization. Frontline staff members are given flexibility and encouraged to make decisions. Residents are encouraged to remain as independent as possible. *"There is a culture of respect for autonomy in our organization,"* according to one supervisor. There have been no formal changes to date in organizational structure related to ECCLI, although plans are being made for changes when the new building is completed. However, since ECCLI training, staff members are more appreciative of each other and are more proactive and involved in interactive problem solving.

The frontline staff members did not necessarily view ECCLI training as providing career ladders or career advancement within CNA ranks. Training did result in a modest pay raise, and they benefited from increased knowledge, but they had the impression that they would be able to become nurses through the training and may have benefited from ongoing career counseling. B2 provided career counseling in conjunction with an initial needs assessment; however, there seemed to be no mechanism for ongoing career counseling.

Family members and residents seemed pleased with the care given at B2 and some could see modest positive changes in CNA interactions as a result of ECCLI. They were often quick to say that staff members were already well-trained, and the classes seemed to help develop communication skills and increase resident interactions and improve relationships.

B2 plans to offer ECCLI classes again to staff by partnering with other ECCLI-funded organizations. The bridge-to-nursing program continues through 2007 in partnership with a home health agency. Although no additional CNA training classes aside from the bridge-to-nursing are currently planned, B2 does not rule out that possibility for the future. Currently, its energy is focused on preparing all community members, staff, residents and family members for changes associated with building a new nursing home focused on person-centered care principles. This is being done outside of ECCLI through a RWJF grant.

B3 Case Study Executive Summary
B3 is a modest-sized nursing home located in a small city that is part of a large for-profit healthcare company. B3 has undergone several management changes during the ECCLI project, turning over the administrator and several key nurse manager positions. B3 had nine deficiencies in its last state survey, which is higher than average. Staffing levels are below average by about 13 minutes per resident per day.

B3 received ECCLI funding in Round V (for about 18 months) to create career ladders for its employees. According to B3's proposal, it wanted to create a culture where employees' professional development, skills and competencies are valued, recognized and compensated. Management believed that establishing career ladders would improve retention and would pave the way to introduce a culture change initiative focused on person-centered care.

B3 developed CNA II training classes focused on enhancing basic skills and soft skills and CNA III training classes focused on advanced clinical and technical skills. Completion of CNA II training resulted in an increase in pay of $0.40 per hour. CNA IIIs earned an additional $0.60 per hour. B3 also provided ABE classes, ESOL classes and a bridge-to-nursing program. Partnering with a consultant, it developed a facility needs assessment and individual skill assessment in order to better target training to meet specific individual needs.

ECCLI played a role in reducing turnover by 20 percent at B3. Retaining newly hired CNAs was still a problem, however. Training also helped to bridge communication gaps, particularly as its non-native English speakers were able to improve language and writing skills in ESOL classes. Communication between departments improved because employees spent time in other departments and gained an understanding of how departments could work together toward meeting residents' needs. Aides also were more confident and felt comfortable participating in care planning discussions as a result of training. Communication between CNAs and supervisors seemed strained as supervisors were reluctant to allow CNAs to practice new skills, such as taking vital signs and admitting new residents. Progress seemed to be made between site visits but appeared to still need improvement.

One significant issue within B3 seemed to be a lack of trust and respect among staff members. Many CNAs did not trust that the training process would yield positive results for them. Some believed they would be expected to take on more responsibility than the increase in pay was worth. Supervisors did not trust the CNAs to handle functions they had been trained to do, such as taking vital signs and changing dressings. One possible reason for this may be that nurse supervisors received some management skills training at the very beginning of ECCLI training, but it did not include information on how CNAs' roles could change as a result of their ECCLI training.

While the overall atmosphere seemed to be changing, change is coming slowly. Despite advanced training, there seems to be a general feeling among supervisors that this is not the right approach. They were not against CNAs advancing their careers, but felt they should go to school to become nurses and there should be no "in between." One person saw a clear distinction between a CNA role and a nurse's role. This person seemed to influence the other supervisors against expanding the roles and duties of CNAs even to allow them to include the skills they had recently learned, such as taking vital signs and changing dressings. According to management, CNA IIs and IIIs have new job descriptions; supervisors report they did not have time to "implement" these new job descriptions.

Residents interviewed noticed a difference in how CNAs approached care issues and appreciated being given a choice in when to go to meals, take a shower and when to get up. CNAs seem to understand and respect residents' right to choose. While it is difficult to relate this change directly to ECCLI training, this change appeared to coincide with the timing of ECCLI training classes.

Overall, two family members interviewed were happy with the facility despite reporting care-related issues. They felt the care was good overall and activities were plentiful and interesting. They said that *"it did not feel like an institution."*

B3 plans to sustain career ladders as it feels this has helped to elevate the respect for the CNA position. It is working on creating new titles for CNA IIs and IIIs and wants to develop consistency throughout the company. This will allow CNAs to transfer within the company and maintain their position more easily.

B3 successfully implemented career ladders and offered opportunities for its CNAs to advance. Not providing training for nurse supervisors seemed to be key to limiting the success at B3 in incorporating new CNA skills into work practices. While CNAs benefiting from career ladder advancement appreciated the opportunities afforded them, other CNAs and supervisors lacked trust that the overall process of how career ladder training was offered and implemented worked to reward higher-performing employees. ESOL classes helped to bridge some communication gaps among staff members and residents, and the adult basic education proved successful in elevating confidence in some staff members intending to pursue nursing careers. B3 seemed committed to sustaining education initiatives with support from its parent company and would benefit by further developing supervisor training and teamwork and trust between supervisors and frontline workers.

B4 Case Study Executive Summary
B4 is an independent, nonprofit, Medicare/Medicaid-certified healthcare agency that provides home healthcare, hospice care and adult day health services. B4 serves a large number of suburban communities. Nearly a third of its workforce is HHAs who, collectively, provide 800 hours of home health services each week to a large number of clients living at home or in assisted living. B4 received ECCLI funding in Round VII, as well as supplemental funding.

B4 used ECCLI funds to provide HHAs with what was termed Level I training. This training consisted of instruction in basic skills, ABE, ESOL and cultural awareness/customer service. Level I training served to prepare HHAs to undertake a career ladder training unit that, during the initial round of funding, consisted of three specialty modules: dementia/Alzheimer's disease, end-of-life and rehabilitative and/or chronic care. During the supplemental funding round, the career ladder training unit's three modules addressed the topics of dementia/Alzheimer's disease, hospice and improving client care outcomes in home care. HHA career ladder participants received 50 percent coverage for their time spent not only in career ladder training but all other HHA

training components offered through ECCLI. HHAs who completed the career ladder training received an increased pay rate of $1.00 per hour.

ECCLI activities also included cultural awareness/customer service training and soft skills training for all staff. In addition, all supervisors and managers received leadership training. B4 also developed a mentoring program in which experienced aides mentored new employees. Interviewing skills training also was implemented with ECCLI funds. Supervisors who had direct responsibility for hiring new employees took part in this training that helped to improve a variety of interviewing skills. Finally, B4 engaged in capacity building in the areas of mentor training, career counseling/case management and cultural awareness/customer service training.

Overall, both direct care workers and supervisory/management staff perceived communication to be very good at B4. HHAs felt comfortable speaking with their supervisor about client needs or issues that arose. In addition, the aides were confident their supervisors would really listen and respond to their concerns. Aides believed the positive communication they had with supervisors enabled everyone to provide better care to the agency's clients. Supervisors also noted good, continuous communication with their aides. They reported that, since ECCLI, aides seemed more confident in their communication and were more likely to approach a supervisor with questions and concerns. In addition, management noted that, as a result of ECCLI, training supervisors had a much better understanding of how to improve the quality of communication within the agency.

Although overall communication was good, supervisors and managers both cited language and cultural differences as a barrier to even better communication. Efforts were made to improve aides' communication skills, as well as other employees' handling of aides' communication deficiencies. ESOL training also proved helpful in improving communication. As aides' proficiency with English increased, they became more confident in their communication abilities.

Management, supervisors and direct care workers all spoke very positively of the work environment at B4. The environment was described as family-like. Aides believed supervisors truly cared about them and were very supportive of them in their work. All levels of staff spoke of a very strong sense of teamwork and mutual respect within the agency. Aides felt respected as professionals and as a member of a team. As a result of ECCLI activities, aides also developed greater confidence in their own abilities and began taking more initiative in their work.

No information on turnover rate at B4 was provided. However, management noted that retention was not a major problem at the agency. At the time of the follow-up site visit, 90 percent of employees who had completed the career ladder training were still employed at the agency. Three aides who completed the training had gone on to apply to nursing school.

There was a lack of consensus around whether new job responsibilities and titles were granted upon completion of the ECCLI career ladder training. This discrepancy seemed to exist primarily between the beliefs and perceptions of frontline workers and supervisors and those of management. It appears that if there were changes in work roles, they were relatively subtle and not clearly communicated to the aides. What most all levels of staff did agree upon was that ECCLI training had given aides new skills which, in turn, strengthened not only their capabilities but also their confidence to do their work.

All clients and family members interviewed stated they were very satisfied with the care received at B4. Clients and family members felt aides were very responsive to their needs and requests and treated them with great respect. In addition, both clients and family members believed the services received through B4 helped to maintain the clients' health and independence and improve their quality of life.

The biggest challenge B4 faced was the depth of the need for basic and remedial education among its aides. The agency had not been aware of how significant this need was among its very culturally diverse staff. It recognized that this deficiency, unless addressed, could impede the success of the career ladder training. As a result, training in ABE and ESOL was expanded and incorporated more fully into all ECCLI training activities. B4 also faced challenges because of its nature as a home health organization. It proved quite difficult for the agency to get staff to the home office for training but still provide consistent, quality service to clients in the field.

B4 was awarded its supplemental grant shortly before the time of the follow-up visit. Thus, all ECCLI activities were still in place. It was management's hope and intention that the activities started with the support of ECCLI would continue once the agency was no longer receiving funding.

C1 Case Study Executive Summary
C1 is a modest-sized, nonprofit Medicare/Medicaid-certified nursing home. The organization serves adults who are severely disabled by progressive neurological disease. According to the most recent state survey, C1 averages higher licensed nurse staffing hours, as well as higher CNA hours compared with statewide statistics. The survey found six regulatory deficiencies at C1.

C1 received ECCLI funding in Round I, as well as subsequent supplemental funding. In addition, C1 partnered with two other nursing homes, with C1 as lead applicant, in Round VI of ECCLI funding. C1 created a four-step career ladder for CNAs consisting of CNA, CNA II (Senior Aide), CNA III (Senior Aide Specialist) and CNA IV (Nurse Technician). CNA II training focused on restorative care. The level of CNA III consisted of three training tracks—mentor, technology assistant and team leader (later replaced by resident life assistant)—and training was provided in these areas. CNA IV training consisted of a four-month program of on-unit clinical practice as a nurse technician. Those reaching the level of CNA II received a wage increase of $1.00 per hour. Upon advancement to CNA III, they received an additional $0.50 per hour wage increase.

Overall, as a result of ECCLI, at least 26 CNAs had an increase in skill level, salary and/or position level; at least eight of these went on to receive LPN and/or RN degrees.

As part of the career ladder program, C1 offered training and coursework in a variety of areas, including career planning and guidance, ESOL and written communication, communication and conflict resolution, practical living skills and manager training (mandatory for all managers and supervisors). Much of this training was conducted by external partners such as local colleges.

With the receipt of Round VI ECCLI funding, C1 worked with two other nursing homes to help advance CNAs to external training at educational institutions. With this goal in mind, the facilities developed an educational program known as *Passages*. This program consisted of a centralized training course teaching literacy and basic study skills in the context of introductory nursing material.

Communication within C1 improved considerably as a result of the communication classes and training implemented as part of ECCLI. All levels of staff developed a greater respect and understanding for others' work roles and responsibilities. Communications training also led to increased staff empowerment. Prior to ECCLI, there were significant communication problems due to language barriers and the inability of many staff to speak fluent English. With ECCLI training in English and literacy, staff became more comfortable and confident in their own speaking abilities, creating an environment of more open communication. Overall, ECCLI communication classes helped to significantly improve communication at C1. However, the classes ended a few years ago, and new employees have not had the opportunity to attend. As a result, it has been somewhat difficult to sustain the initial progress made in communication.

Frontline staff, supervisors and managers all expressed strong overall satisfaction and enjoyment with working at C1. They spoke of a very community-oriented work environment, and some stated it was superior to other facilities at which they had worked. Management noted that turnover was low, and staff was a very stable group.

Frontline staff and supervisors alike spoke of a strong community atmosphere at C1. Staff spoke often about their colleagues and superiors being true team players who supported and worked well together. Many related the team atmosphere at C1 to improved communication among staff at all levels and in all departments.

Management expressed that, overall, there had not been any change in work roles (other than career ladder rungs) or flexibility of work roles. Instead they saw the biggest change in how staff worked together. They felt it was the quality of teamwork that really made the difference. Frontline staff, also, did not speak of any significant changes in work roles or flexibility. However, they did mention an increased sense of empowerment in resident care. They believed their opinions were listened to and valued in a way they hadn't been prior to ECCLI.

Overall, residents seemed satisfied with the care they were receiving at C1. They felt they were generally treated with respect and that staff was attentive. However, two residents did speak of not having a lot of choices, particularly with regard to meal times and meal options. Some residents also complained about staff not listening to their concerns. Most family members were satisfied with the care their family members were receiving. Almost all residents and family members, as well as one frontline supervisor, discussed difficulties in communication between residents and staff. These difficulties were thought to be due primarily to the staff's poor English skills. However, residents, family and supervisors all mentioned seeing improvements as a result of the English classes staff had been taking.

C1's barriers to ECCLI implementation were mainly internal. C1 experienced difficulties in sustaining differences between the roles of those CNAs advancing to CNA III (Senior Aide II) and the roles of their lower-level CNA colleagues. In addition, the facility is now at a point where it has too many CNAs. The facility's organizational structure is not such that it can support or utilize all the senior-level skills available.

Despite its difficulties, the senior aide program (CNA II and CNA III) continues at C1 and is capped at a pay increase of $1.50 more per hour than entry-level CNA wages. C1 has one budgeted position for a CNA IV. C1 continues to provide leadership training and has begun offering some internal computer courses. When internal resources are available, CI also offers English courses for staff. In addition, C1 is looking into offering more nursing classes through a local college. Scholarship money is available to those interested in pursuing external coursework. C1 continues its collaborative relationship with the two other nursing homes with which it partnered in Round VI of ECCLI funding.

C2 Case Study Executive Summary
Located in small, economically depressed city, C2 is a modest-sized, nonprofit, non-unionized nursing home. C2's nurse staffing levels are lower than state averages, but CNA staffing levels are dramatically higher than either state or national averages. No deficiencies were reported in most recent reports.

C2 is governed by a volunteer board of directors with strong community ties. The current administrator came to C2 shortly before ECCLI with a vision of creating a resident-focused program and viewed ECCLI as an opportunity to initiate the process of culture change that would achieve her vision. C2 has been receiving ECCLI funding continuously since the inception of the program, participating in Rounds I, II and VI, as well as supplemental funds.

C2 developed an extensive career ladder system available to all entry-level staff. Employees first take a basic career ladder, which includes an introduction to aging, death and dying and soft skills training. CNA I, geared to employees from other departments, includes core courses for state certification. CNA II and CNA III provide successively advanced clinical and leadership training. There are two food services and one

environmental career ladder step. Participants are paid for 100 percent of time spent at classes, and each career ladder step results in a $0.30 per hour pay increase.

With a goal of increasing staff retention, C2 offered mentor training to long-term employees who then would assist newer employees with work and personal issues. Mentors receive $0.25 per hour above their salary for each hour mentored and $100 bonuses at three and six months if the employee stays.

In the most recent round of funding, C2 developed a process for supporting CNAs wanting to become LPNs. The partnering community college guaranteed slots for three qualified candidates, C2 received guidance from a partnering nursing home and ECCLI provided funding. Three candidates have successfully completed the program.

Related to its culture change goal, C2 initially sent 14 managers to an Eden Alternative workshop and continues to provide staff this training. C2 also adapted LEAP, a national leadership training program for supervisors aimed at recruiting, developing, empowering and retaining quality LTC staff.[14] Using a train-the-trainer model, employees do on-site LEAP trainings, one for LPNs to learn how to delegate and empower CNAs, and the other for CNAs to understand their role in decision making within the LTC setting. C2 opened LEAP training to employees from all disciplines.

C2 helped form a consortium of community colleges, regional employment boards, career development organizations and long-term care organizations. C2 was one of three demonstration sites that served as models to demonstrate the impact of workforce development strategies in combination with new caregiving practices and culture change activities. The consortium made it possible to offer additional staff trainings, such as soft skills, computers, GED prep, ESOL, American Sign Language and diversity training.

With culture change, C2 transformed the physical and social environment. There are now live plants and animals, a more home-like physical environment and frequent interactions between staff and residents. Residents and family members plan life enhancement activities, and family members are encouraged to become involved in their loved ones' care.

C2 organized residents into "neighborhoods" and restructured the nursing department. Neighborhood coordinators (NCs), who are experienced CNAs with specialized advanced training, have responsibility for day-to-day operation of their neighborhoods. NCs take care of scheduling, take the lead on communications with family members and are the first-line problem solvers.

Each neighborhood has an interdepartmental work team (housekeeping, nursing, maintenance) led by NCs. Permanent assignments to teams encourage staff to develop close relationships with residents and family. Interdepartmental team problem-solving

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[14] LEAP is a nationally recognized program that stands for Learn, Empower, Achieve, Produce. LEAP is a comprehensive LTC workforce initiative aimed at recruiting, developing, empowering and retaining quality LTC staff, with residents as the center of the workforce initiative.

sessions have improved interdepartmental communications. Team members often pitch in to help regardless of the task or assignment. The team approach has promoted greater flexibility to accommodate resident preferences and improved communication between shifts.

C2 strives to flatten the staffing hierarchy by giving more responsibility to CNAs and LPNs, making management more accessible to frontline staff and using a group process to resolve problems. Upper management has an open-door policy and makes a point of interacting with staff and residents and helping with nursing care. C2 uses a team process to interview prospective employees, involving nurses, CNAs, residents and family members.

ECCLI training and culture change has led to reduced staff turnover and recruitment costs. Annual turnover rates declined more than 50 percent between 2000 and 2004, and there has been a 50 percent decrease in new employees between 2000 and 2005. For most positions, recruiting has become easier because employees act as ambassadors for C2. The new hiring practice that includes CNAs, residents and family members with interviewing and hiring decisions has resulted in hiring a more committed workforce. C2 also increased its CNA/resident staffing ratio, which gives CNAs time to provide more personalized and better quality care.

Communication at every level appeared excellent at C2. Entry-level staff members are empowered to express their opinions and spend time with residents and family members. Upper management and supervisory staff reported dramatic improvement in interdepartmental communication, which they attributed to LEAP training and problem solving in-services.

While frontline staff spoke positively about training opportunities, career ladders seemed less important to CNAs than the benefits of learning new clinical information and feeling more confident and valued for their work. ECCLI training motivated some CNAs to become LPNs and some entry-level staff to become CNAs. Supervisors perceived the benefits of management training not in terms of career advancement, but as enabling C2 to make person-centered organizational changes. Greater mutual trust, reported by both supervisors and CNAs, was attributed to clinical and soft skills training, the resident-centered team approach and management's open-door policy.

Residents and family members were largely satisfied and enthusiastic about resident care and quality of life. Residents reported more freedoms and choices at C2 than at other nursing homes. Family members appreciated the choice of activities and the constant open communication with staff. Supervisors and CNAs reported that the resident-centered philosophy encouraging personal relationships between staff and residents has increased resident quality of life. Residents have greater autonomy as long as it is safe and because of restructuring, resident problems are resolved more quickly, improving resident care.

C2 has made a long-term commitment to career ladders, neighborhood coordinator positions and resident-centered care. Career ladders and NCs are now an integral part of the regular C2 organization and budget. C2 uses a train-the-trainer model to continue leadership training. C2 is looking at ways to restructure partnerships to share training costs with other nursing homes.

Resident-centered care is now a philosophy that can be sustained, as existing employees train new employees on how things are done. Staff continues to be trained in the Eden philosophy. C2 has planned future resident-centered environmental improvements to be funded from non-ECCLI sources that will improve quality of life for residents and staff.

C3 Case Study Executive Summary
C3 is a nonprofit corporation that operates an affordable assisted living facility and home health agency in an urban, predominantly working class area. It employs frontline home care workers (mostly home health aides) with a few CNAs. Responsible for more than 500 clients, the staff is ethnically diverse, while the client base is predominantly Caucasian.

C3 is part of a partnership that has received ECCLI funding continuously since Round IV. It was the lead of approximately nine other organizations for Rounds IV and VII. It also has been receiving supplemental funding to add to its ECCLI-related activities. Its partners included other home health agencies, nursing homes, hospitals and assisted living facilities, as well as a local WIB, an employment resource organization and community colleges.

According to C3's initial Round IV proposal, it had a variety of goals, all aimed at elevating and permanently upgrading the role of the direct care worker within the organizations in the partnership. To tangibly meet these goals, C3 outlined a program that included four major components: career ladder training, formation of ongoing continuous quality improvement (CQI) teams including employees of all levels, training to strengthen supervisory and management skills and career counseling. Between the proposal submitted for Round IV funding and the implementation of Round VII activities, several elements had changed. In its Round VII proposal, C3 intended to continue implementing the "advanced clinical training" it had put in place, instead of a three-tiered career ladder. This training included specific clinical skills, as well as soft skills. It also planned to continue offering ABE and ESOL classes that had been included after Round IV. Supervisory and CEO training would continue.

What was actually implemented in practice was somewhat different than what was proposed. First, it included advanced clinical training, a career ladder devised by a staff member at C3. Though it no longer included specific levels, the end result for successful program participants was a certificate and the title of personal care specialist (PCS). In this first funding round, 18 employees from C3 completed the program. In the second round for which it was the lead organization, it reported 20 employees successfully completing the program. Once employees successfully completed the training, they earned a wage increase of approximately $0.50 per hour. C3 and its partners quickly

realized after the first implementation that ESOL instruction was as important as (if not more important than) the actual clinical training. ESOL, soft skills, ABE classes and advanced clinical training then were offered in various levels throughout the funding. This was considered part of the career ladders. Like many other ECCLI-funded programs, there were activities other than career ladders that were implemented simultaneously. At C3, these included supervisory and management training, peer mentoring, career counseling and CQI teams.

It was difficult to attribute outcomes seen at C3 directly to the ECCLI program. The clearest outcome was improved communication due to the ESOL classes offered as part of the program. Management claimed there was improvement in other areas, such as improved retention, as well. Overall, however, the positive changes that were due to ECCLI programs did appear to make a difference in the work environment at C3.

One of the most successful components of the ECCLI-funded programming was ESOL. Like many other sites, C3's workforce was comprised of primarily non-English speaking individuals who needed assistance with basic English language skills. Improved understanding of the English language then influenced communication in the workplace. Even the direct care staff noticed that their communication improved overall and had an impact on their work life. One individual stated (in reference to the ESOL training): *"I'd have to say that communication is better. They do listen to us more."* Even the supervisors recognize the improved communication.

C3 also reported that the goal of reducing turnover of direct care staff was successful. Management reported an overall increase in retention. They commented that it is so markedly improved that they no longer have to advertise for staff, and they have basically no advertising budget. Specifically, they reported that their original turnover rate was approximately 30 percent to 50 percent.

There were three areas where C3 encountered inter- and intra-organizational challenges. The first was in its partnerships, the second was in terms of logistics and the last was programmatic in nature. In terms of partnerships, C3 encountered problems with retaining a community college partner that had the same interests as their partnership. It also found it difficult to work with its WIB. One logistical challenge C3 encountered involved transportation. Because its partnership involved several sites and the different activities were distributed among these sites, participants in the ECCLI program had to be transported to these external places. This held unanticipated problems in the basics of getting employees from one place to another. The final area where C3 experienced barriers was in its program implementation. It encountered difficulties with the peer mentoring component of the program. It found that it included this activity too soon in the process because participants hadn't even completed the advanced clinical training and were not yet ready to enter the mentoring role.

Currently, C3 is implementing a continuation of the ECCLI using the supplemental Round VII funds it was awarded. Because of this, it has not completely developed a detailed plan for sustainability. Management, however, is broadly thinking of long-term

sustainability. For example, its primary objective with the supplemental funding is to focus on training ECCLI graduates to gain skills in middle-management leadership.

Overall, ECCLI seems to have affected positive changes among the paraprofessional staff at this site. Benefits and changes were seen through efforts to improve soft skills such as communication. These included ESOL and basic skills courses. What C3 found was that by improving these basic skills, the quality of care and quality of communication between staff improved much more than through career ladders.

C4 Case Study Executive Summary
C4 is a private, nonprofit home health agency serving a large number of economically depressed and working-class communities. Primarily, this organization offers supportive programs for homebound individuals. Its paraprofessional workforce (targeted for participation in ECCLI) provides personal care, meal preparation, medically supervised supportive care and assistance for frail elders living in the community.

It received two rounds of ECCLI (Rounds IV and VII) and was part of a partnership for two other funding rounds. Most recently, it received supplemental funding to complete its ECCLI-related activities.

The program C4 implemented included several elements. First was a three-tiered career ladder for the paraprofessional staff members, enabling them to become homemakers, personal care homemakers and finally home health aides. There was also advanced specialty training in specific topic areas. Both of these initiatives were associated with wage increases upon successful completion. Also, C4 implemented basic skills and enhanced skills trainings, which were less intensive and a shorter time commitment (each topic was offered as a two- to three-hour seminar). It also implemented an ESOL course and ABE courses. Finally, there was peer mentoring, supervisory training and cultural competency training.

Overall, the area that saw the most improvement and changes directly attributable to ECCLI-funded activities was the work lives of direct care staff. There was better communication and improved self-esteem of direct care workers at C4, which in turn improved quality of care. The communication improvements were primarily influenced by ESOL classes (approximately half of C4's employees are Latino). This is what empowered the direct care workers to speak up more and join in discussions about their clients, which increased their self-esteem and confidence levels. This indirectly improved the quality of care.

The areas where the most barriers were perceived were primarily intra-organizational. First, management reported that there were many workers who completed the career ladder training simply to receive the wage increase and not to apply the new skills they had learned. Second, they found their organization offered no assistance to help people integrate their new skills into their roles and practice. This is being addressed with the supplemental funding C4 recently received.

Finally, C4 is currently in the process of moving toward sustainability, but is not there yet. At the time of this evaluation, it was still using ECCLI funds to implement programmatic elements. Thus, it has not been able to devise or enact a specific plan for sustainability.

Overall, this home health agency did benefit by participating in ECCLI. Though the numbers it trained in proportion to its actual staff size were somewhat modest, the individuals who were trained did show improvement in certain areas. The most impact was seen in the influence of the ESOL and basic/enhanced skills courses on the increased self-respect and self-confidence of the paraprofessionals. The skills learned in these courses made participants better employees in terms of improved communication and being more aggressive in offering their input on clients. Although C4 did encounter barriers (such as recruiting the most appropriate participants or assisting staff to integrate their skills), it attempted to address some of these issues in subsequent funding rounds.