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Extended Care Career Ladder Initiative (ECCLI): Baseline Evaluation Report of a Massachusetts Nursing Home Initiative

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Extended Care Career Ladder Initiative (ECCLI) Round II: Baseline Evaluation Report

Prepared for the Commonwealth Corporation

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– Susan C. Eaton and Claudia Green

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List of Abbreviations Used in this Report

BWDC:	Boston Workforce Development Coalition
CBO:	Community Based Organization
CNA:	Certified Nursing Assistant
CommCorp:	Commonwealth Corporation
DoN:	Director of Nursing
ECCLI:	Extended Care Career Ladders Initiative
ESOL:	English for Speakers of Other Languages
GED:	General Equivalency Diploma
KSG:	John F. Kennedy School of Government at Harvard University
LPN:	Licensed Practical Nurse
LWIB:	Local Workforce Investment Board
MDS:	Minimum Data Sets
MEOCC:	Massachusetts Executive Office of Community Colleges
MMQ:	Management Minutes Questionnaire
MWIBA:	Massachusetts Workforce Investment Board Association
OSCAR:	On-line Survey, Certification and Reporting
OSCC:	One Stop Career Center
PC:	Project Coordinator
PHI:	Paraprofessional Healthcare Institute
QI:	Quality Indicator
TA:	Technical Assistance
UMB:	University of Massachusetts at Boston

ECCLI Round II: Baseline Evaluation Report

Executive Summary

Purpose

The Commonwealth of Massachusetts has initiated the Extended Care Career Ladders Initiative (ECCLI) as part of a broader Nursing Home Quality Initiative, adopted by the Legislature in 2000. Both are a response to high turnover and vacancies among paraprofessionals in long-term care, creating instability that threatens quality and access to health care. Basic to these initiatives is the equation of good care for consumers with good jobs and opportunities for frontline caregivers.

Commonwealth Corporation (CommCorp), a quasi-public organization, has been charged with the administration and operation of ECCLI under the legislation. From the beginning, CommCorp established an Advisory Committee, representing industry, unions, workforce development and policy organizations (see Appendix B for Committee membership list) to help shape the initiative, and this evaluation. While the legislation calls for a career ladder initiative, and ECCLI is that, it is due to the generous participation of Committee members and the open process created by CommCorp that ECCLI was designed to address the complex issues facing nursing homes and their workforce.

ECCLI is ambitious. Its primary goals are to improve quality of care, promote skill development, institute career ladders and other workplace practices that support and develop workers, and improve retention of CNAs. To achieve these goals, long-term care providers partner with other organizations (including community based groups, unions, work force development agencies, community colleges, and other long-term care providers) to mount demonstration projects of new care giving and workplace practices. The Massachusetts Legislature has invested $5 million in three rounds of the ECCLI project, with $2 million of those monies devoted to the Round II project, that is the focus of this evaluation report.

Evaluation

This is the first of three evaluation reports on ECCLI. It is a baseline study covering the initiative's start-up period, from March to June 2001. Further reports will be released at the midpoint and conclusion of the project.

This evaluation over time will assess the effectiveness of ECCLI and the Commonwealth's use of legislation as a means of improving quality of care and worker standards of living through workforce development. To do this, we begin here by using a "wide angle lens" approach, collecting general information from every participating consortium on plans and baseline conditions.[1] The baseline data presented here represents a "starting place," from which all future efforts will be measured. The data were compiled by studying proposals, plans, and other documents from ECCLI partners, and by conducting a total of 57 interviews with project coordinators at the seven consortia and administrators and directors of nursing at the 27 participating long-term care facilities.[2]

Current Status of the ECCLI Consortia

As of the end of June 2001, the seven consortia have moved from planning to implementation of seven distinct programs and strategies. Each partnership is unique, and each facility begins from a different starting place. While most are led by nursing homes, in three consortia other groups (a union, a community college, or a career center) played pivotal roles. But all face common challenges (detailed below) to reaching their goals. Despite these challenges, each consortium has moved to implement ambitious programs of training and workplace change, chosen partners, and established governance structures for oversight and decision-making. Along the way, some partners have been added, one partner has dropped out, and some require clarification of roles and program activities.

While nearly all consortia enlist the aid of community colleges and training agencies, a smaller number are collaborating with career centers, community-based organizations, workforce investment boards, or unions. These partners, in turn, overlap in their roles and in the resources they bring to ECCLI. These include recruiting, screening, and training workers; writing curriculum; evaluating current jobs and developing new job descriptions; and coordinating the projects. They act not only as training partners but as "brokers," putting nursing home managers in touch with education and training resources in the wider community.

All consortia share the basic goals of improved recruitment or retention, career mobility for staff, and improved quality of care giving. Their paths to these goals vary widely, however, suggesting a range of models that will be generated by ECCLI. Some emphasize career steps beyond the CNA ladder, with counseling and coursework for college. Others target entry-level staff, such as dietary and housekeeping, with assistance in English, knowledge of aging, and CNA certification. Computers are put to creative use by some consortia, whether in self-paced instruction or in assembling databases on the

[1] Evaluation reports to be released after the program's midpoint and conclusion will also incorporate in-depth case studies of several consortia.

[2] Frontline workers and their supervisors have not yet been interviewed, nor have representatives of home health agencies or the work force partner organizations. These groups will be represented in subsequent evaluation reports.

entry-level staff. Support services such as child care and transportation, and supervisory training for nurses also receive varied emphasis.

The leadership teams have generally high expectations for the initiative. Most expect to see improvements in recruitment, retention, career mobility, and quality of care. In their view, this could occur by making their facilities more desirable places to work and live in, with better trained, better motivated workers and improved teamwork. Partnerships with workforce organizations were expected to help overcome the isolation of nursing homes. Managers qualified their optimism in some cases by noting areas on which ECCLI by definition could not affect directly: low salaries for direct care workers, nursing staff shortages, or poor staffing ratios.

ECCLI makes available a significant level of technical assistance (TA) for its funded projects, both for the facilities themselves and for their workforce development partners. The Paraprofessional Healthcare Institute (PHI), a non-profit training organization that is a recognized leader in quality care practices for frontline workers and cultural change processes in long-term care, is the primary TA provider to the Round II long-term care facilities. The Boston Workforce Development Coalition (BWDC), the Massachusetts Executive Office of Community Colleges (MEOCC), and the Massachusetts Workforce Investment Board Association (MWIBA) will provide technical assistance to the workforce development partners. While it is still early in the project cycle, satisfaction with TA provision to date has been generally good. The project coordinators, one of the main audiences for TA, rate assistance they have received from PHI at a 4.1 on a scale of 5 (1 = totally unsatisfied to 5 = totally satisfied).

Challenges

The ECCLI projects are operating in a highly challenging environment, where financial pressures lead nursing homes to the edge of bankruptcy, meeting regulations is difficult, and short-staffing leads directors of nursing to work overnight shifts. Nursing assistants supplement their low wages by working overtime, double shifts, or second jobs. In these conditions, the performance of care is threatened, while the morale within facilities is often low. These problems gave impetus to ECCLI, but they also act as potential barriers to its implementation.

According to top managers, ECCLI employers face three major everyday operational challenges: the life context of nursing assistants, financial constraints, and staffing shortages. More than half of those surveyed cite child care, lack of time, language barriers and managing multiple cultures among the top inhibitors to CNA performance. Financial problems, including low reimbursement rates for Medicaid and high costs of staffing agencies limit staffing and training resources. Staffing shortages extend to licensed nurses as well as paraprofessionals. Lack of staff leads to overloaded aides and difficulty giving residents quality care.

Managers are also encountering barriers to implementation of their ECCLI plans. Among them are the growing pains of creating new partnerships and getting all stakeholders fully

engaged. For many nursing homes, their new partners are competitors; moreover, some have had limited experience with workforce development organizations. Building trust with fellow employers, and utilizing training partners fully loom as key challenges. Gaining full understanding and cooperation from charge nurses and CNAs is another challenge reported by some managers we interviewed. In a few cases, the project exists mainly in the minds of upper management. And managers in general are focused on "operations" and keeping things running, making them feel unready at times to take on larger changes.

Other critical challenges to implementation include a lack of understanding about cultural or organizational change; lack of teamwork; a need for managerial training for nurses; managers' limited views of their facilities' ability to change; and constrained expectations about ECCLI's potential impacts on key workforce problems, such as shortages and language or cultural barriers. In unionized facilities, the need to renegotiate labor/management relations also presents challenges as well as opportunities.

Promise

The seven partnerships have traveled a long road since award of the ECCLI grant. Despite a turbulent and difficult environment, all are laying the groundwork for ambitious and important demonstrations.

The consortia leaders are now beginning activities ranging from training sessions to care practice redesign, from child care needs assessment to 'issues resolution' for CNAs, from language and culture awareness courses to management and leadership training for LPNs and managers, to address the challenges we have described here. Most leaders are eager to see what changes can be made through this promising new initiative.

Managers on the whole are supportive of ECCLI and eager to improve the situation for their workers and their residents, both of whom are too often forgotten by society. Each consortium has at least one leader with drive, energy, and vision to move the project forward. Facilities have already started doing things differently, for example, by asking CNAs to identify what they themselves think they need to succeed in their jobs, and adjusting the project goals and activities accordingly. Nursing Home managers and their staff have done an admirable job of learning the basic language and goals of the workforce development community in a scant three months, just as their workforce partners have taken a crash course to learn about the long-term care industry.

We are beginning to see a change in mindset, if not everywhere, then in select pockets. It includes a sense that change is possible, and that facilities need to look hard at internal issues (such as work patterns and managerial choices) as much as external ones (such as financial problems and turnover). Most of all, it is a shift from taking the short-term view – focused on daily operations – to the longer view. We interviewed one administrator who spoke of learning to take off her "operations hat" during the planning process. She discovered that:

> *"It's not about operations, it's about human relations and improving the quality of life. So we really have to celebrate our employees as much as we celebrate our residents, and do everything we can, as they choose to, to support them in their development. And once you separate yourself from the operations side of it, it's so much more rewarding."*

This baseline report presents a view of the ECCLI project as it begins. Future reports, measured at the midway and endpoints of the project, will assess the progress of the participating facilities to achieve project objectives. Future reports will include perspectives of the ECCLI project from workers themselves; any continuing organizational struggle; the status of training, career ladder implementation, and quality of care delivery; and any improvements in satisfaction, turnover, or quality of care. We look forward to reporting the progress of the ECCLI program in our mid-term evaluation.

I. Introduction

This baseline report covers the period between March and June 2001, the initial planning period for the seven consortia that received grants under Round II of the Extended Care Career Ladder Initiative (ECCLI), administered by the Commonwealth Corporation. It was prepared jointly by the research teams of the Center for Community Economic Development of the University of Massachusetts Boston and the Kennedy School of Government of Harvard University[3].

The report is directed to members of the ECCLI evaluation sub-committee, the ECCLI Advisory Committee, ECCLI partners, long-term care and workforce development policy makers and other stakeholders in the process. It is the first of three that will be shared with all stakeholders, including a mid-term progress report and a final wrap up report. The evaluation is intended to determine *how well* and *how* the projects have achieved the stated goals of both participants and program designers.

The report begins by briefly reviewing ECCLI's overall goals and structure, the evaluation plan (found in full in a separate document dated May 22, 2001) and methodology, and the purpose of this report. We then describe the set of problems ECCLI addresses and how, as well as what, changes are expected, based on the collective knowledge and experience of the designers of ECCLI, the evaluation team, and major literatures on the relevant themes. The third section focuses on the status of the seven ECCLI consortia, establishing a baseline for future reviews and evaluation (additional information describing the current status of the seven consortia participating in ECCLI Round II can be found in Appendix A). The fourth section outlines the challenges the ECCLI participants report facing, both in the difficult field of nursing home administration and staffing generally, and in the ECCLI projects specifically. We conclude by looking ahead to implementation of the ECCLI plans, and offer initial lessons for the project.

Without Commonwealth Corporation support, this project would not be evaluated in as comprehensive a manner as this. Many policy projects only attempt an evaluation after a program is over. This precludes real and irreplaceable comparisons with the initial state of the participants. It also limits program operators in their ability to learn from their own progress, and from that of their counterparts across the Commonwealth. Without evaluation, most of the lasting lessons possible from an innovative project like this can be lost. This baseline report, and the two others that will follow, will permit this learning, reflection, and program adjustment to occur. Ultimately, this should benefit both nursing home workers and their employers.

[3] Research team members from CCED, U Mass Boston included Claudia Green, Co-principal investigator, and Randall Wilson, Maria Estela Carrión, Mary Spooner, Carole Upshur, and Udaya Wagle. Research team members from Kennedy School of Government included Susan Eaton, Co-principal investigator, and Theresa Osypuk, David Stevenson, and Allyson Kelley. Ruth Glasser from PHI also conducted interviews. The four principal authors of this report were Eaton, Green, Osypuk, and Wilson.

A. The Extended Care Career Ladder (ECCLI) Program

Program Purpose

The Commonwealth of Massachusetts initiated the Extended Care Career Ladder Initiative (ECCLI) as part of a broader Nursing Home Quality Initiative, adopted by the Legislature in 2000. The Massachusetts Legislature has invested $5 million in three rounds of the ECCLI project, with $2 million of those monies devoted to the Round II project, that is the focus of this evaluation report. This legislation is a response to high turnover and vacancies among paraprofessionals in long-term care, creating instability that threatens quality and access to health care. Basic to these initiatives is the equation of good care for consumers with good jobs and opportunities for frontline caregivers. Round II asks long-term care providers to partner with other organizations (including community based groups, unions, work force development agencies, community colleges, and other long-term care providers) to mount demonstration projects that offer insight into new care giving and workplace practices that improve the quality of care and the quality of jobs. These projects should also demonstrate how the accomplishment of care giving and workforce quality goals can be mutually reinforcing. Sponsors hope that such projects will offer clear and replicable models for both the long-term care industry, and the workforce development community that supports the industry and its potential and existing labor force.

Commonwealth Corporation (CommCorp), a quasi-public organization, has been charged with the administration and operation of ECCLI under the legislation. From the beginning, CommCorp established an Advisory Committee, representing industry, unions, workforce development and policy organizations (see Appendix B for Committee membership list) to help shape the initiative, and this evaluation. While the legislation calls for a career ladder initiative, and ECCLI is that, it is due to the generous participation of Committee members and the open process created by CommCorp that ECCLI was designed to address the complex issues facing nursing homes and their workforce.

ECCLI'S overall program goal is to promote systemic change and build capacity within the long-term care and work force development communities in support of the following goals and objectives:

Primary Program Goals:

1. Improve quality of care
2. Promote skill development
3. Create and institutionalize career ladders and other workplace practices that support and develop workers

4. Improve employee retention

Primary Program Objectives:

1. Identify and operationalize new care giving practices that provide better workplace environments and higher quality of care
2. Upgrade skills of low-wage frontline workers to support new care giving practices
3. Demonstrate use of learner-centered education methods to support skills
4. Utilize model workplace supervision and –organizational practices to attract, support, and develop the long-term care workforce;
5. Create pathways for wage and career advancement for direct care and other entry-level workers within long-term care
6. Improve employee retention rates

B. The ECCLI Evaluation

Evaluation Purpose

The evaluation will assess the effectiveness of ECCLI Round II [4] and the Commonwealth's use of legislation as a means of improving quality of care and worker standards of living through workforce development. It will assess the workforce development intervention itself, as well as the effects of this intervention on the quality of care. It will also assess and document the experience of community-based organizations, long-term care providers, community colleges, unions and others in developing career pathways for entry-level workers to increase worker advancement, and improve workplace retention and quality of care. It will help inform future efforts by the long-term care industry and workforce development community to meet these goals, both in Massachusetts and nationally.

Evaluation Goals

The goals listed below form the framework for the evaluation design.

1. Document and analyze the process of planning and implementing changes in work, the workplace, care giving practices, training, and systems (show *how* the intervention works, or the *process* of setting goals and putting activities and supports in place).

2. Report and analyze the emerging outcomes for work, workers, the workplace, care giving practices, consumers, and systems, with comparisons to baseline data (show *what* the intervention has produced, or the *outcomes*, intended and unintended, for the quality of care and the quality of work).

[4] From this point forward, we will use the acronym "ECCLI" to refer to ECCLI Round II only.

3. Draw lessons about the relative contributions of different activities and supports to achieving changes in work, the workplace, care giving practices, and systems (show *why* the process of change led to the outcomes that occurred).

In sum, program activities and supports that change workplace and care giving practices are expected to lower turnover and improve the skills and mobility of caregivers. These outcomes, in turn, will support activities that change the way that residents are cared for. In combination, these changes are expected to foster longer-term improvements in the quality of care and the quality of work, both in individual sites and eventually throughout the system.

Evaluation Approach

In this baseline analysis, we report on our research on all seven consortia during the first four months of the grant projects. Our goal for this period was to establish a baseline "fix" on plans of the partners, and to gather data with a "wide-angle lens" that will enable us to see both anticipated and unanticipated changes in care giving practices, career ladders, low-wage worker participation in education and training programs, organizational cultures, etc.

The data on which this report is based are primarily drawn from two sources. First, the partnerships themselves submitted and Commonwealth Corporation staff reviewed, helped revise, and approved "Planning documents and budgets" for the first 10 weeks of the grant period, lasting approximately from early March through mid to late May 2001. We have reviewed those planning documents that were submitted to date,[5] along with the partners' initial proposals to the Commonwealth Corporation to draw data from the partners' own words about their plans and concerns.

Second, we have undertaken an intensive interviewing project collecting original first-hand data from nursing home administrators, directors of nursing, and project coordinators in all the 27 participating long-term care facilities located in the 7 consortia.[6] We conducted 57 interviews total. With administrators and project coordinators, we asked approximately 55 questions. With directors of nursing we collected data on 83 survey questions during our interviews. Most interviews, lasting from 40 minutes to more than 2 hours, were conducted in person, with some conducted on the phone. Only two facilities were unable to make their personnel available to us for these interviews during the six-week interview period.

Additional information from the May 2001 ECCLI Round II retreat and from ECCLI Advisory Committee Meetings supplement this report.

[5] Not all planning documents were available for this writing.

[6] Although the evaluation team interviewed top managers at *every* participating nursing home, some nursing homes within the consortia had not yet become involved to the level of intensity that is planned over the course of the project.

The extensive data we collected in these interviews will provide an invaluable baseline for understanding the changes and improvements that are hoped for through the ECCLI project, as well as help the stakeholders understand the concerns and priorities of the actual leaders who are taking on these projects in addition to many other responsibilities. We do not analyze responses to every question here, but similar interviews will be repeated at the end of the ECCLI project in June 2002 and we will look for changes and continuities at that time.

To supplement the holistic look at the activities and changes occurring in all seven consortia, the evaluation team will use a case study design. Some standardized questions and methods will be applied to all targeted partnerships, and others will be tailored to the specific program components and context of each consortium. This work began in July 2001. We plan to select four or five specific partnerships for an intensive on-site approach, based in part on the knowledge gained from the initial round of interviews reported on in this report. These selections will be made to maximize variation and learning. The evaluation design anticipates a tension between broad conclusions relevant for the entire initiative, and more specific lessons that emerge from day to day work within specific long-term care facilities and with their educational and organizational partners. However, both kinds of evaluation are important.

Additional data to be gathered

Data collection from additional sources is already being (or will be) collected, and will be analyzed in the coming months for the second and third reports. These include voluntary participant surveys issued by Commonwealth Corporation, interviews with CNAs and other workforce members including human resource and staff development personnel, quality of care data provided by the facilities, and interviews with the three home health providers and the one hospital that are also part of the partnerships, as well as with the workforce development partners. Omission of these data in this report in part reflects time constraints on the evaluation teams, but also those on participants who are busy getting this program underway.

II. The Problem, Solutions, and Predicted Outcomes: Workforce and Quality Issues

A. The Problems ECCLI Addresses

The evaluation will draw on extensive research on long-term care and on workforce development in assessing the effects of ECCLI. The main focus will be workforce and quality outcomes. In this section, we lay out problems that long-term care providers are experiencing, both from research literature and interview data we have collected. Then we describe how ECCLI proposes to help solve these problems, and what type of changes or outcomes we expect to find during the course of the project.

1. Workforce problems: Retention, Turnover, and Mobility

The long-term care industry is in crisis. Frontline workers (Certified Nursing Assistants, or CNAs, in Massachusetts) provide 80 to 90% of the direct care to residents, yet there are not enough of them – now or in the foreseeable future – to meet the demands of an aging and increasingly frail population (Frank and Dawson 2000). More than one in ten nursing positions in Massachusetts is unfilled; other states report vacancies topping 20% (Scanlon 2001). The recruitment gap has both economic and demographic causes. As the baby boom generation ages, demand will increase for long-term care. Yet the supply of new workers in the most likely groups (women aged 25-44) is projected to slow down, after steady rates of increase in the past three decades (Dawson and Surpin 2001). In recent U.S. Senate hearings, witnesses predicted that the shortage of nursing staff, including CNAs, would only worsen in coming decades (Scanlon 2001). CNAS and other frontline workers are essential to all long-term care provision. But this report, like the ECCLI project, will focus primarily on nursing homes and staff who work there.

Retention and Turnover

While selected Massachusetts administrators reported that 61% of the CNAs working at their facilities have been in their jobs longer than one year (Massachusetts Extended Care Federation 2000), national figures indicate that the average turnover for CNAs is 100% (Harrington *et al* 2000). In comparison, other industries have turnover between 10 and 20%. CNAs who work in this industry tend not to stay long in their jobs. Most turnover takes place during the first six to nine months, meaning for many this is a short-term job. Indeed, the Directors of Nursing interviewed confirmed that CNAs are most likely to leave after approximately seven to eight months on the job. Replacing CNAs is expensive (averaging $4,000 per position change), eating up dollars that could be better spent on training and/or salary enhancements to keep staff longer and to improve quality.

Turnover of nursing aides has many causes, but most studies point to a few key ones: low compensation and benefits, heavy workloads and poor staffing levels, high stress levels, frequent injuries, and a lack of recognition or respect for the work (Banaszak-Holl and Hines 1996, cited in Scanlon 2001; IOM 2000; Hegeman 1999). Roughly one-third of CNAs live below the federally defined poverty level. Yet many employers feel they are unable to improve wage levels, benefits, or training incentives, because of low Medicaid reimbursement levels for resident care. Indeed, 71 percent of resident beds in Massachusetts are currently covered by Medicaid.[7]

But not all contributors to high turnover rates are economic. As an ECCLI Director of Nursing noted, "*Money will bring them in, money's not going to keep them, it's the environment that's going to keep them*." Both national data and ECCLI interviews show that compensation is only one factor in retention. Childcare problems were ranked higher than compensation by nursing directors in our survey (see **Table 1** below).[8] Interestingly, transportation, basic life issues, stress, scheduling all were ranked higher than mobility, benefits, relations with co-workers and supervisors, residents, and training and skills by ECCLI DoNs as contributing to turnover of CNAs.[8]

Table 1: Percentage of Directors of Nursing in Consortia reporting Reasons Why Nurses' Aides Leave Facilities

Reasons	C1* (%)	C2 (%)	C3 (%)	C4 (%)	C5 (%)	C6 (%)	C7 (%)	Aggregate (%)
Child Care Issue	**100**	**33**	**100**	**100**	**80**	**100**	**50**	**83**
Inadequate Compensation	**100**	**67**	**75**	**67**	**40**	**75**	**100**	**70**
Transportation Issue	**50**	**67**	**50**	**67**	**40**	**75**	**50**	**57**
Other Basic Life Issues	50	67	25	67	40	75	0	48
Stress	100	30	33	33	40	50	0	41
Scheduling Issue	50	33	50	33	20	50	50	39
Injury (Illness)	50	67	50	0	20	50	0	35
Problems with Coworkers	50	67	75	0	0	0	50	30
Lack of Upward Mobility	0	33	50	67	0	25	0	26
Inadequate Benefits	0	33	25	33	20	0	50	22
Problems with Supervisors	50	33	50	0	0	25	0	22
Lack of Recognition (Respect)	50	33	0	67	0	0	0	17
Difficult Residents	0	33	25	0	40	0	0	17
Perception of Racism	0	33	25	0	0	0	0	9
Inadequate Training	50	0	0	0	0	0	0	5
Lack of Basic Skills	0	33	0	0	0	0	0	4

**C = Consortia. This table, as with several of the other tables shown in this report, break down results by consortia. The seven consortia have been assigned random numbers (1-7) to protect confidentiality.*
Sample Size = 23 Directors of Nursing.

[7] "Massachusetts Division of Medical Assistance Nursing Facility Utilization Surveys, July 1, 1993 Through May 1, 2001," MA Division of Medical Assistance.
[8] We note that future interviews with CNAs themselves may attribute turnover to different causes.

One ECCLI manager summarized these issues well:

> "*The core issues are that it's a hard job. Not everybody's built to be a CNA. It's physically demanding work. Because of the low compensation, most try to work more hours than they can tolerate. They're working WAY too many hours for their life issues. So they get very stressed, physically and mentally… They're all [family members] relying on them to bring home the paycheck.*"

Finally, teamwork, or its absence, appears also to be a problem. One ECCLI interviewee said:

> "*I believe that anybody who gets up in the morning and feels good about their job is going to do a good job…When you feel that you're in a dead end job, and the nurses think that you're just a glorified ass-wiper, what kind of care are you going to provide to somebody? But, if you walk into that job and say, 'I'm part of this team, it's important that I be here today, because the team and the residents depend on me to be here to do the job,' that's what it's all about.*"

Mobility

One reason CNAs do not stay in jobs long, noted a recent Institute of Medicine study (2000), is the "lack of opportunities for career advancement" i.e. career ladders. Nursing homes are for the most part relatively flat organizations. Moreover, few formal "rungs" exist between non-licensed and licensed care positions, as nearly two years of schooling beyond high school are required to earn LPN or RN credentials. That is a formidable task for many direct care workers, who are typically women, often supporting children by themselves, working second jobs, extra shifts, or both. Many have little education beyond high school, if that much. Some, particularly immigrants, need basic English skills to advance on the job, and considerable remedial course work before attending college.

For these employees, entry-level jobs in nursing homes are all too often a "dead end." Unlike less-educated workers in blue-collar jobs in a previous generation, many of whom earned a steady improvement in wages by moving up in one organization, nursing aides do not see an economic benefit to staying in one organization. Thus direct care workers find themselves in a "vicious cycle" of low paying, stressful jobs, with a high rate of turnover that makes employers reluctant to invest in training.

In its ideal form, a career ladder is a sequence of formal steps, or "rungs" that guide a worker's progress between jobs. The ladder provides incumbent workers and employers with a guideline for the skills, credentials, and competencies necessary to advance from lower to higher steps within a firm, an industry, or between industries. Accomplishment of these steps, in turn, should be tied to job titles, descriptions, and wage improvements.

In addition to such formal steps, it is important to see career ladders as part of an overall approach to worker advancement. That means attention to the supports that make

mobility possible, including career counseling, skilled supervision, access to higher education, and services such as child care or transportation. It also includes building strong linkages between employers, career centers, educational institutions, unions, and other interests. Formal ladders and support systems thus allow for an orderly progression of skill acquisition, training, and promotion (Dresser and Rogers 1996:2).

In the ECCLI project, career ladder segments include pre-CNA training leading to employment as a CNA, steps within the CNA classification that reflect increasing skills and responsibilities, and steps from CNA leading toward the licensed practical nurse (LPN) educational requirements. One purpose of ECCLI is to develop and evaluate existing career ladder opportunities in the nursing home industry.

2. Quality of Nursing Home Care

Improved quality of resident care is the ultimate goal of the ECCLI project. ECCLI addresses quality issues because the public is not satisfied with the level of quality most nursing homes can provide. Recent government studies (U.S. Governmental Accounting Office 1999, U.S. Department of Health and Human Services 2000) show a large percentage of nursing homes regularly regularly fail to meet quality requirements. Workers and their unions are concerned about quality because they feel they have too many residents for whom to care and too few supplies, too little time, and too few support systems to do the kind of job they would like to do, or can do safely. Family members are concerned with insufficient and inconsistent caring staff at the bedside. Employers feel that all nursing homes are tarred with the same brush, unfairly.

The problem of skills has become more apparent as sicker patients with more complex medical needs have become the norm. As people live longer, today aides and nurses need more skills and knowledge of dementia and cognitive problems. Caring for these more needy residents requires more training than is provided in the 75 hours of class time that CNAs typically receive. Yet, despite the agreement of everyone concerned that more knowledge and training is needed, CNAs must care for these residents the best ways they can at present.

In our ECCLI interviews, while most managers said they were relatively satisfied with the quality of care offered in their nursing facility (perhaps a predictable response), these same individuals said they were not as happy (averaging 3 on a scale of 5) with the skill levels of their CNAs. See **Table 2** below.

Table 2: Satisfaction Level with Overall Quality and Direct Care Staff (As Reported by Directors of Nursing and Nursing Home Administrators)									
Informants/Areas	**Consortia**							**Aggregate**	
(Scale: 1=totally unsatisfied to 5=very satisfied)	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**N***	**Mean**
Directors of Nursing									
Overall quality	3.5	3.4	4	4.1	4.8	3.5	3.5	24	3.92
Skills of Nurses' Aides	3.5	3.2	3.75	2.93	3.7	3.25	4	24	3.46
Nursing Home Administrators									
Overall quality	4	4.17	4.25	3.83	4.42	4	4	25	4.14
Skills of Nurses' Aides	3.7	3.5	3.5	3.83	3.92	3.75	4	25	3.73

The satisfaction levels for C1 through C7 represent mean satisfaction levels for each Consortium.

N = Sample Size

One ECCLI project coordinator noted:

> *"It's an industry problem…. Starting out at nine bucks an hour, you can go to McDonalds or Pizza Hut, and not that those aren't noble professions, but you couldn't convince me that that is as hard a job as it is for these CNAs. We expect them to do all the dirty work in addition to that because the licensed staff is so overtaxed with what they do, we expect them to be the first line of clinical defense – they have to be able to say, 'someone looks a little different today.' The nurse may not be in there for three or four hours. And so, if I'm taking care of you, I'm the one that really does see the subtle changes in you, it's not the nurses . . . I'm surprised sometimes at how good the CNAs are. People don't see that. They hear about the CNA that stole someone's money. . ."*

Many managers in ECCLI facilities are also aware of the need for interpersonal skills – for supervisors and front line workers – as well as clinical or diagnostic skills. As in many service jobs, "quality" often depends on the interactions of employees with customers, as well as those between employees themselves. Thus as the consortia develop their training initiatives, they are paying heed to communication skills, including English abilities; teamwork; leadership skills; and supervisory practices, including attention to cultural differences and respect for front line workers' perspectives.

Of all staff, nursing assistants have the most knowledge of residents, based on intimate, daily contact. Yet their awareness of resident needs and changing conditions is often untapped. Indeed, one study cited "*the degree of nursing aide involvement in resident care planning*" as the second most important factor affecting turnover – only local economic conditions had greater influence (Banaszak-Holl and Hines 1996, cited in Scanlon 2001). When one ECCLI director of nursing was asked about CNA involvement in care planning, she said, "*Here, that's always been the ideal. But we're flying by the seat of our pants*." This reflects the reality of the day-to-day pressures on managers, but also their knowledge that things should change.

B. Evaluating Changes in Quality: The Challenge and the Plan

Even more than other areas of health care, the quality of nursing home care is difficult to define and evaluate. It is easier to characterize in negative than positive terms. Researchers, consumers, and policymakers have a relatively clear idea of what quality nursing home care is **not** (especially at the extreme), but have a more difficult time conceptualizing high quality nursing home care and the outcomes of such care. In the words of one expert, quality nursing home care is usually defined as the "absence of bad events**"** (Kane 1995). Although research into nursing home quality is a very active field (Harrington 2000) policymakers and scholars still face many challenges in drawing conclusions. As policymakers seek to move beyond regulatory approaches to quality (e.g., identifying and correcting instances of poor quality through the survey and certification process) to strategies more focused on encouraging and facilitating positive outcomes (e.g., linking reimbursement incentives and quality, or supporting training for frontline workers), they confront a great deal of uncertainty. ECCLI is one innovative attempt to learn more about quality by connecting workforce practices and quality outcomes.

The quality of nursing home care can be measured in terms of structure, process, and outcomes. Structural measures of quality typically refer to the level, mix, and training of staff, in addition to other facility characteristics (e.g., minimum staffing ratios). Process measures of nursing home quality refer to care that is delivered to residents (e.g., proper skin care, nutritional care, and incontinence programs). Outcomes of care include effects on health status attributable to care that is or is not delivered. Outcomes commonly examined include incidence of pressure sores, malnutrition, and incontinence. This team will also be seeking more positive measures.

For this evaluation, all three measures will be used. The relationship between staffing and quality has become a focus of research and practitioner attention recently. While most research examines effects of staffing levels on quality, some is focused on maintaining a stable workforce and its importance to care quality. The effects of high vacancies and the "revolving door" are well known. When nursing homes are short-staffed, aides rush through their shifts, unable to devote sufficient time to individual residents and establish strong relationships with them (Eaton 2000). High turnover interrupts those relationships that do form, forcing some homes to hire costly temporary staff from agencies or to work with too few staff. In either case, the work environment is likely to become even more stressful– a factor that can lead to further turnover, recruiting problems, or both. An ECCLI Director of Nursing described one way that turnover affects patients:

> *Continuity. The elderly need and want consistency. They don't want to explain their peculiarities again. It's bad enough that they have to deal with an institution. It's tiring to explain over and over. Plus some residents can't communicate.*

Sources of data will include: On-line Survey, Certification, and Reporting data (OSCAR); the Minimum Data Set (MDS) and MDS Quality Indicators (QI's); and the Management Minutes Questionnaire (MMQ), a Massachusetts document. In addition, researchers will collect primary data from residents, family members, and nursing home staff, and through observation.

C. ECCLI Solutions to Workforce and Quality Issues: What Do We Expect?

The Nursing Home Quality Initiative that created ECCLI takes an unusual approach in combining workforce development strategies with nursing home-specific training. The goal is to make frontline care giving jobs more attractive, by creating reliable steps on a longer career ladder. If CNAs see that one job is very much the same as the next, then moving from one facility to another for a relatively small wage increase, or for personal or schedule reasons, makes perfect sense. If these same CNAs have wage increases *combined with* greater skills, more confidence, more job satisfaction, and more commitment to a given organization and specific residents, we believe the quality of care can improve in measurable ways (using clinical outcome measures as well as satisfaction surveys and inspection results at the facility level) without unacceptable cost increases. Turnover, after all, is expensive.

Our evaluation of ECCLI is based on hypotheses drawn from the literature on work organization, organizational change and nursing home quality about requirements for positive changes in both the 'work system' and the quality of care for patients. The following expectations and design parameters are based on the knowledge and experience of the initiative's designers, Commonwealth Corporation, the ECCLI Advisory Committee, and the evaluation team. Where there is supporting literature and research, we have included it. They are ordered from "a" to "q" and grouped into four broad areas: changes in work organization and career ladders; development of partnerships; organizational change; and quality of patient care.

1. Changes in work organization and career ladders

"Work systems" include the way jobs are defined, how workers are hired, paid, and trained, how supervision occurs, and – most importantly for our purposes – how (and whether) workers can move up to more skilled and higher paying jobs (Herzenberg 1998). In large manufacturing firms, for instance, less skilled workers could attain decent wages by staying with one employer and climbing clearly defined "job ladders." In many service-oriented firms, such as nursing homes or retail stores, wages are lower, job ladders are almost non-existent, and turnover is high. Employers in these firms also invest little in worker training, relying instead on recruitment of low skilled workers to fill vacancies. A key difference between these models of organizing work is the degree

of commitment to the organization. In today's economy, that distinction is blurring, as many industries that traditionally offered job security, career ladders, and other rewards to workers no longer do so (Osterman 1999; Capelli 1999). This model of labor markets is clearly not working for the nursing home industry, nor is it serving lower skilled workers more generally. ECCLI is predicated on the hypothesis that the cycle of low commitment and high turnover can be broken and replaced by something better.

a) We expect that ECCLI will result in more well-rounded and vertically-integrated task responsibilities, leading to greater job satisfaction and higher commitment. This prediction is drawn from literature on job design (Hackman and Oldham 1980). We are interested in commitment because of its close ties in the literature to "intention to stay," productivity, and willingness to do more than one is required to do. This would be valued in nursing homes.

b) ECCLI should create a motivating job that provides a strong sense of responsibility for outcomes, feedback on the results of one's effort, an important task, and sufficient autonomy to take responsibility for the job. ECCLI is designed to help address the current shortcomings in aides' jobs, in which they have little or no authority to make decisions, less feedback on the results of their work than they would like, and insufficient autonomy to make the tasks whole, fulfilling and interesting. The evaluators will ask both workers and managers to evaluate the success of the project in this context.

c) ECCLI will result in wage increases, better structure of opportunity within individual nursing homes and the industry, making workers more willing to stay in the industry. This will help reduce the rapid turnover now characterizing the industry. ECCLI addresses several of the factors that make long-term care jobs a "dead-end" for workers: low wages and little prospect for advancement. Rates of pay (77%) and lack of opportunities for promotion (54%) rank among the largest sources of dissatisfaction for nursing home workers (Noelker 2001). By offering wage increases tied to demonstrated career progress, employers have a chance to make direct care work competitive with other industries hiring lower-skilled workers, such as retail stores or food service (Dawson and Surpin 2001).

d) By increasing wages, providing information on career opportunities and developing skills and knowledge, ECCLI will enable workers to advance their standard of living.

Earlier studies of the Massachusetts nursing home industry (Hunter 1994, 2000; Wilson 2001) suggest that some small steps were being taken to create a more committed relationship between worker and employer. These and recent reports on training of low skilled workers (Giloth 2000; Demos and Kazis 1999), suggest the following hypotheses about building career ladders in ECCLI:

e) Career ladders will require a variety of supports, ***both inside and outside the organization, to succeed***. For instance, facilities that establish strong mentoring programs, career counseling, and rewards to supervisors for developing their staff, should

reap better results, as do those that pay heed to worker concerns such as child care, transportation, or family demands. Those that invest deeply in basic skills, as well as pre-college course work, should also see dividends for their workforce.

f) Successful projects will approach race and culture directly with supervisory training and other organizational measures emphasizing teamwork and communication, as well as diversity training. Minorities, and women of color in particular, are over-represented in lower-paying direct care and support positions (housekeeping, dietary), and under-represented in nursing and other managerial areas (Tilly and Tilly 1998). Thus existing tensions over race, ethnicity, and differences in power or status, present major barriers to mobility in nursing home work that must be addressed.

g) Successful career ladders will require inter-industry cooperation, as well as creation of new licensing and training opportunities, to bridge the gap between CNAs and other licensed nursing positions. For instance, home health workers and CNAs have a good deal of overlap in their responsibilities, but are not usually mobile between industries. Career ladders may need to also deal with extension of opportunity into hospital employment and/or licensed nursing positions. As one ECCLI Project Coordinator pointed out:

> *"If you have 20 or 25 CNAs how much career ladder movement can you give them unless they become nurses in your facility or elsewhere? I really think that's where the next focus will have to be…We can't let that problem linger. There is only so much you can do with career ladders, only so many moves that CNAs can make – the next focus has to be on nurses so that CNAs can move up to nursing positions."*

2. Development of Partnerships

The ECCLI program assumes that bringing change to workplaces depends on team effort, both inside organizations and between them. ECCLI partners are breaking new ground by forging relationships between nursing homes and work force development organizations, two groups that have generally worked in isolation from one another. Equally noteworthy are the ties being developed among partner nursing homes, entities that are used to competing with one another for workers and customers.

A partnership approach has become more prominent in workforce development in general, and will be of special importance in long-term care. The emerging model of workforce development emphasizes close relationships between training agencies and employers – to ensure that the training is relevant, to connect workers to good jobs, and to provide services, such as case management and counseling, to help workers stay on the job and develop a career (Giloth 2000; Melendez and Harrison 1998; Plastrik 2001).

h) The durability of career ladder programs, and their effectiveness at improving employees' living standards, will depend, in part, on the quality of partnerships that

employers develop with education and training organizations, as well as with other employers who build common standards for training and career steps. These relationships will be vital to career ladder development in long-term care for several reasons. One reason is capacity. Human resource systems and training capacity are often limited in nursing homes (Hunter 1994). Workforce development organizations can expand the capacity of employers to build career ladders and ensure that employees' new skills can be used. At the same time, these organizations can customize and improve their services when employers provide clear signals about their needs and "speak with one voice" (Rogers, *et al* 2000). Another concern is sustainability. By building enduring relationships with training providers – such as community colleges, one-stop centers, or community organizations – employers and their workers can gain access to resources beyond the term of the grant. A final factor is overcoming employer disincentives to invest in worker training. Economists (Becker 1975) have long theorized that employers under-invest in general, rather than job-specific training, for fear of losing trained workers to "poaching" from other employers. Formal partnerships allow a number of firms to aggregate demand and share the risks and rewards of training, lessening the burdens for any single firm (Rogers, *et al* 1999). And partnering with other nursing homes will make it easier for ECCLI employers to agree on common standards for skills, advancement, and job roles, and to create systems for replacing (or sharing) workers who move "up and out."

i) The vitality of ECCLI partnerships will vary with the ability of partners to attain trust and "speak the same language," as well as with the internal management capacity of member organizations. Trust will be of special importance among nursing homes, who have traditionally operated as competitors. Research about alliances in general (Ferguson 1999) suggests that trust among partners will depend on overcoming doubts about one another's motives, competence, dependability, and collegiality. For partnerships to become effective, both employers and work force development organizations will also need to learn each others' "language" (terms, funding and regulatory systems, work styles, assumptions). Partnerships can add capacity to an organization (employers or workforce partners). But to be a successful partner, organizations themselves must already have certain capacities, such as adequate resources and competent staff, supportive management and boards (where relevant), and a clear sense of their own mission. Most of all, they must have the capacity to manage partnerships successfully (Harrison and Weiss 1998).

j) For employers, success at building trust and effective relationships will vary with prior experience and knowledge of work force development, just as work force development organizations will have varying exposure to long-term care. Employers who bring previous relationships with other employers into ECCLI should be advantaged, as should workforce development organizations that bring experience designing industry-specific training.

3. Organizational change

In an industry as stressed, both financially and operationally, as long-term care, organizational change is exceptionally difficult. One respondent said:

> *"[People in the consortium] feel stressed in trying to get all of the things that they're doing operationally, their regular job done, [as well as doing] the work that needs to be done to affect change within an organization. We're like just about everyone else. Change is very difficult for people…Developing culture change within one organization is difficult enough. Doing it cohesively with [several] organizations is going to be very difficult, just because of the differences."*

The difficulty of organizational change, particularly from a traditional nursing home culture to a more resident-centered and employee-centered one, is one reason that the ECCLI project provides for Technical Assistance (TA) for the partnerships during their projects. This assistance is provided by individuals with extensive experience in long-term care and/or workforce development communities. Two TA providers are registered nurses (RNs) with unique credibility because of their licensed status and work experience. The TA has just begun, and cannot be provided to all 27 individual facilities except in larger group settings, but TA providers have visited all partnerships, and have provided help in thinking about how training fits into overall organizational work processes, in curriculum development, in workforce assessments, in site-specific evaluations, and in other areas. At this early stage those who have received TA have rated it positively, as is discussed in the next section.

Although an entire literature exists on organizational change, evaluators will be looking at very specific issues in the ECCLI grant projects. One is a shared vision of how the nursing home should run (also called organizational culture). During the baseline interviews we found many administrators and nursing directors did not share a common definition of their nursing home's organizational and care giving 'culture.' Some described theirs as "family like" or "homey," while others simply did not know what our question meant. Many interviewees thought questions about care giving culture referred to the different ethnic or national cultures of the employees.

Many nursing homes share a traditional culture that one evaluator has termed "custodial," where they try to do their best for residents within limited constraints, but do

not expect much beyond decline (Eaton 2000). On the other hand, some employers, including some in the ECCLI partnerships, focus on achieving high medical and nursing quality to address clinical problems. A third innovative view is found in the "Pioneer" or "regenerative" organizations, in which aging is viewed as another stage in life and growth, where people need engagement, activity, the ability to give as well as receive care, and as much choice as possible to thrive in a nursing home.

k) ECCLI participants who consciously seek culture change or regenerative cultures will have more improvements in quality outcomes than those who do not. Relatively few nursing homes have adopted these kinds of regenerative cultures, but several facilities within the ECCLI partnerships are considering them. Some are pondering the Eden alternative as one way to change their approach to care giving (see Thomas 1992). Some are crafting their own blend of holistic, spiritual, and intergenerational environments. We will be evaluating both the process of their efforts to change organizational cultures, and the success of these efforts, as well as challenges they present.

Change in organizations is highly dependent on leadership.

l) A strong, unified message about the ECCLI goals and consistent leadership from the top administrators will support an organizational culture that promotes high quality.

m) Those facilities where leaders feel a sense of efficacy about the ability to change should have greater success than those where leaders do not feel hopeful.

We will also assess the leadership's sense of efficacy. Some administrators and DoNs feel quite optimistic about change in their organizations, particularly in the quality area, while others feel more hopeless, constrained by forces beyond their control. We found that Directors of Nursing, on average, were more optimistic about their facility's ability to change than were administrators (Mean DoN score: 4.17, vs. mean administrator score: 3.67, on a 5-point scale).

n) Any organization can only accept and take on a limited amount of change at once, without adverse consequences such as increased turnover. Therefore focus on implementing a limited number of desired changes will be important to success.

4. Quality of Patient Care

Improved quality of resident care is the ultimate outcome of the ECCLI project. As such, we will focus our evaluation of changes in the quality of care on three areas.

o) We expect to see subtle but important positive changes in the relationship of residents to care givers that are related to the specific training the caregivers are receiving during the ECCLI initiative. These might include better communication, more individualized care, more knowledgeable clinical reporting, more sharing of

positive interactions, and fewer behavior problems. They could also include quality of life outcomes.

p) We expect to observe subtle but important improvements in the overall quality of care that are related to the organizational culture and work process change goals of the ECCLI project. For instance, if more CNAs are involved in care plan meetings, the care plans may be more responsive to resident needs and interests, or to small changes in their conditions. If bathing becomes a more individualized process, we would expect to see fewer unhappy bath and shower episodes between residents and CNAs. We might also see less agitation and more calm for residents, especially those suffering from dementia. Similarly, if consistent assignment is implemented in a way that permits and encourages long-lasting individualized relationships between CNAs and residents, we would expect to find fewer behavior problems that affect others, and more affection and care between the employees and residents. These are but a few of the many specific hypotheses that emerge from literature on culture change, individualized care, and the 'social model' of nursing homes.

q) In addition, we believe that standardized measures of clinical quality outcomes will show improvement in a majority of facilities after the ECCLI project concludes. This might mean better Quality Indicator (QI) reports for participating facilities, fewer facility-acquired pressure sores, or less malnutrition or dehydration than at the baseline quality "snapshot." We realize how difficult it will be to adjust these for resident acuity, but we will do our best to use indicators that are likely to be responsive to the ECCLI goals of organizational development, workforce training, and improved communication and management.

D. Summary

This brief review shows that the Massachusetts nursing home industry is faced with multiple interrelated workforce, quality and financial challenges. The ECCLI intervention is aimed to address some basic workforce issues, such as high turnover and low skills, for paraprofessional staff by addressing the nature of the job, the organization of work, relationships with the supervisors and the culture of the organizations. The theory is that by addressing some of the critical workforce issues, a major outcome will be not only to improve the working conditions, pay and rewards for CNAs, but also to impact on the quality of care delivered to residents. Staff will be more knowledgeable and more consistently involved with residents with greater skills and longevity on the job, and provide better care as experienced by patients and families.

At the same time, the evaluators appreciate the complexity of addressing these complex, interrelated problems and issues for the nursing home industry. Therefore we anticipate describing the outcomes of the project both in relation to the specific activities and intervention of ECCLI in the various sites, as well as monitoring and reporting other contextual changes and issues that may impact the efficacy of the ECCLI project.

III: Current Status of the ECCLI Consortia: An Overview

In this section, we discuss common themes and differences among the seven consortia. These include the structure and governance of each group, background and context, proposed goals and activities, planning, use and perceptions of technical assistance, and expectations about the project. We draw the data from descriptions from participants, documented in plans and proposals, and from what coordinators and senior managers said about their experiences in interviews.

All consortia emerge from a common experience of a turbulent labor market and industry. While the experience at individual homes varies, members of every consortium reported some degree of difficulty with finding staff, keeping staff, and/or making room for long-range projects, such as improving skills and mobility of staff. Each is "stretched" as it tries to balance the everyday demands of delivering health care and residential services with creating long-term change, amidst restricted financial resources. And despite these challenges, each consortium has moved to implement ambitious programs of training and workplace change. Tables 5-7 on page 34 present the goals and activities that each consortium as identified as of June 30, 2001.

Striking variations emerged in the ways that ECCLI participants are going about this process. Researchers found marked differences in leadership and membership, forms of participation, and program focus. These are illustrated in Tables 3 and 4, on pages 30 and 31. (See Appendix A for a description, as well as enumeration of goals, activities, and governance of each individual consortium.)

A. Partnership Structure and Composition

While all consortia contain the building blocks of long-term care employers and workforce partners, they vary in size and make-up. The number of residential facilities participating in each consortium ranges from two to six, while the number of workforce partners, such as community colleges, community based organizations, or one-stop career centers, ranges even more widely, from three to ten or more. The types of partners, and their roles, also vary widely among the seven consortia.

- **Health care partners**: while every consortium has at least one skilled nursing facility involved, some engage other types of providers: assisted living and retirement communities, home health agencies, and even a hospital.

- **Workforce partners**: community colleges are the most common type of education and training partner, present in six out of seven consortia. In contrast, one-stop career centers and local workforce investment boards (LWIBs) have a role in four consortia. All partnerships have contracted with nonprofit training vendors, such as the American Red Cross or Health Care Training Services, but

only three have partnered with community based organizations (CBOs) that serve a specific low-income community or neighborhood, such as Greater Holyoke Community Development Corporation or Jamaica Plain Neighborhood Development Corporation. Unions and union-related training programs are also partners at several sites in three consortia.

- **Roles of workforce partners** vary considerably. Community college involvement ranges from ESOL (English for Speakers of Other Languages) instruction to counseling, curriculum development, and teaching a wide range of courses, from technical and supervisory skills to pre-LPN preparation. Non-profit training vendors and CBOs are providing both soft skills and technical training, as well as potential employee recruitment and screening, and participant case management – ongoing support, coaching, and referral to ancillary support services such as childcare or transportation. CBOs are also helping their employer partners to connect with both their resident communities, and with other workforce development resources. Career Centers' role also involves screening, assessment and recruitment of new employees, some case management, assisting with participant retention tracking, and, in one case, overall project coordination. Union involvement ranges from approval of new job titles and tasks to project coordination, teaching, and curriculum development.

- The consortia are also distinguished by the **type of organization that initiated the project and provide leadership**. While in four out of seven cases this was the nursing home that also functions as the lead site, in others it was an outside partner, such as a union-based education program, a community college, or a career center (refer to Table 3, page 30).

- The consortia (and their members) enter ECCLI from **different starting points**. Three include facilities with prior experience in formal alliances with other long-term care providers. Some have cooperated with outside partners, including training agencies, on workforce improvements, but others' experience of workforce development is more limited.

The participating facilities also vary a great deal. They serve urban and suburban Boston, rural western communities, and smaller, industrialized cities and towns in southeast, northern and central Massachusetts (see Table 4, page 31). Their residents differ in frailty or acuity of condition, as well as by financial status. Their direct care workforce varies in racial and ethnic make-up, including Hispanic and white workers, as well as immigrants from the Caribbean and Africa. The difference in workforces makes for differences in context, issues to be addressed, and activities. While some facilities are independently owned, others are owned or managed by a for-profit, corporate chain or a nonprofit group, often but not always religiously affiliated. A common thread tying all types of facilities together, however, is financial stress. Typically, revenues and expenses are just balancing, though a few facilities had access to generous endowments or other resources.

Table 3 below describes the types of partners involved in each of the consortia, the number of total partners involved, and the driving force ("driver") of each consortium. Table 4 describes whether all the participating organizations in each consortium have partnered together prior to the ECCLI project, the region of Massachusetts where the facilities are located, unique characteristics of the consortia, and the structure and profit status of each consortium's lead facility.

Table 3: ECCLI Consortia: Leadership and Partner Composition

Consortium	"Driver"	Number of LTC partners	Home Health Partner	Union	CBO/ Nonprofit	Comm College	Career Ctr	Workforce Investment Board
Brandon Woods	OSCC*/WIB*	6	No	No	Yes	Yes	Yes	Yes
Coolidge House/Genesis Elder Care	Union	4	Yes	Yes	Yes	Yes	No	No
Holy Trinity	Nursing Home	4	No	No	Yes	Yes	Yes	Yes
Leo P. LaChance Center	Nursing Home/ Comm College	4	No	No	Yes	Yes	No	No
Loomis House/Pioneer Valley	Nursing Home	3	Yes	Yes	Yes	Yes	Yes	Yes
Maristhill N & R	Nursing Home	2	No	Yes	Yes	Yes	Yes	Yes
Sherrill House/ACCT	Nursing Home	4	No	No	Yes	No	No	No

** OSCC=One Stop Career Center. WIB=Workforce Investment Board*

Table 4: ECCLI Consortia: Background and Program Characteristics

Consortium	Prior Alliance	Region of MA	Structure (Lead NH)	Status (Lead NH)	Unique Aspects
Brandon Woods	Yes	Southeast	Chain	For profit	Support services (childcare, transportation); "Healthcare 101"pre-vocational assessment curriculum
Coolidge House/Genesis Elder Care	No	Boston	Chain	For profit	Union-led; learner-centered curriculum; use of aides as trainers; Care team participation training
Holy Trinity	Yes	Central	Independent	Nonprofit	CNA IV step: "Leading & coaching the diverse workforce;" trained aides will help write new job descriptions & criteria
Leo P. LaChance Center	No	N. Central	Independent	For profit	Partnerships with hospital and vocational school; Nursing Pathway program to support college-level work
Loomis House/Pioneer Valley	No	Western	Independent	Nonprofit	Self-paced, computerized courses; cross-training of home health aides and CNAs
Maristhill N & R	No	Metro S/W	System	Nonprofit	Eden Alternative to Life practices; alternative therapeutic practices
Sherrill House/ACCT	Yes	Boston	Independent	Nonprofit	Pool for sharing workers, human resources, training

B. Governance

All seven consortia have established consortium-wide governing mechanisms specifically for the ECCLI project. At a minimum, these are committees that include senior managers from the facilities (typically administrators and/or Directors of Nursing) and project management staff from the training partners. In most cases, the committees are chaired by the project coordinator; in a few consortia, a committee is led by the administrator or human resources director.

The majority of governing bodies are two-tiered. Typically one tier is an executive or advisory body that provides oversight, leadership, and decision-making, on the model of a board of directors. The other is usually a working group that discusses program activities, provides updates from facilities and partners, and submits recommendations to the "executive" board on curriculum, hiring, and other areas. In a few cases these tasks are combined in one committee.

The boards differ in several ways, however:

- **Inclusiveness**: frontline workers are represented directly in just two cases, as is the case for family members or residents. (Some consortia incorporate workers

and consumers in facility-specific committees.) Sometimes other stakeholders are present, such as city government or a Chamber of Commerce.

- **Frequency**: meetings range from weekly or biweekly to quarterly. For consortia that are just now finalizing their plans and selecting participants, meetings have just started. Others have been meeting since award of the grant, or earlier, as working groups during the application process.

- **Depth of involvement**: while some committees have essentially offered a "rubber stamp" for all decisions received, others have been far more involved in deliberating program direction and project specifics.

C. Planning Activities

ECCLI consortia have used the ten-week planning period to lay the foundation for their projects.[9] This has typically included creation of governance structures; hiring of project coordinators and other staff; "rolling out" the project through presentations to staff; recruiting frontline and managerial staff for training; contracting with training vendors for services; development of curricula; and gathering of information about specific jobs and conditions at the facilities. In addition, some consortia have increased their outreach and marketing to the public, through creation of websites and other tools, and a few partnerships have actually begun training sessions.

The main variation among consortia consists in the degree of readiness to begin ECCLI projects. Two consortia actually began training activities during their planning period, while they continued planning work. Several consortia were considering the feasibility of proposed items, such as provision of childcare onsite or collaboration with a regional hospital. One was finalizing its roster of nursing home partner facilities, and at least two others were working to increase the involvement of some partners. A more common issue during the planning phase has been that of clarifying the cultural change portion of the initiative: defining what issues (such as bathing) to focus on in pursuing change, and what model (if any) of cultural change to adopt, such as the Eden Alternative. Finally, a number of facilities have not reached out yet to their workforce of CNAs and other frontline caregivers, while others have done so.

D. Project Goals and Activities

We found a core set of goals (reflecting the ECCLI program intent) common to all consortia: improving recruitment and retention, enhancing staff skills, promoting workers' internal job mobility, and increasing quality of care and quality of life for residents. Similarly, nearly all consortia have plans to add one or more tiers or "steps" to the CNA role, whether as Senior Aides, CNA II and III, or otherwise. But there are a

[9] Since all consortia had not submitted their final planning documents at the time of this writing, a full analysis of the impact of planning activities was not possible for this report. A more complete analysis will be included in the midterm evaluation report.

number of variations on these themes, perhaps reflecting the diversity of partners, institutions, and settings present in the initiative. (The similarities and differences of goals and activities across consortia are mapped out in Tables 5-7 on the next page. For more detail on each consortium, refer to the descriptions in Appendix A.)

- **Empowerment**. While most consortia speak of enhanced respect, recognition, or improved status for direct care workers, some are devoting more resources to attaining these goals, through activities such as care team participation, management and supervisory training, and a focus on cultural diversity and leadership development. While some have consulted workers during needs assessment discussions, only two have given workers consistent voice in governance, as noted above. One of these is a union-initiated project.

- **Investment in basic skills and "pre-CNA" instruction**. Training in English, written communication, and remedial coursework are offered in some cases, as are career steps to bring in or include non-patient care workers, such as housekeeping and dietary staff. Several offer G.E.D. (General Equivalency Diploma) or high school equivalency opportunities to staff.

- **Post-CNA steps**. Four out of the seven consortia are building steps "beyond CNA III," through pre-college preparation, counseling, and linkages with community colleges (or a hospital in one case), as well as tuition reimbursement.

- **Cultural change strategies**. Some consortia are targeting specific models, such as the Eden Alternative, or using tools such as Continuous Quality Improvement to promote organizational change. Others are working with TA providers to develop their own unique cultural approach to care giving that ties in with the training.

- **Pooled services**. Two consortia hope to develop centralized hiring, referral and/or training arrangements with their partner facilities. If successful, these could provide workers with a "career lattice" that provides horizontal as well as vertical movement, and help cooperating employers to develop shared standards for training and career steps.

- **Work/life support**. In two cases consortia are targeting support services that help retain direct care workers and enable them to take advantage of career ladders. This includes offering childcare (or making referrals); helping with transportation; and providing basic life supports. One consortium has hired an "issues resolution counselor" specifically to address such concerns.

- **Reaching in versus reaching out**. While most of the consortia rely on outside agencies for training and program development, several are recruiting from their own ranks – including nursing aides - to develop and/or teach curricula. As one coordinator explains, enlisting management-level staff in teaching helps build commitment and "prevent boredom."

Table 5: ECCLI Goals by Consortium						
Consortium	Recruitment	Retention	Improve Skills (non-licensed)	Improve Skills (licensed staff)	Quality of Care	Career Ladders
Brandon Woods	X	X	X	X	X	X
Coolidge House/Genesis Elder Care		X	X	X	X	X
Holy Trinity	X		X		X	X
Leo P. LaChance Center	X	X	X	X	X	X
Pioneer Valley/Loomis House		X	X	X	X	X
Maristhill N & R		X	X	X	X	X
ACCT/Sherrill House	X	X	X	X	X	X

Table 6: ECCLI Activities by Consortium, Part I					
Consortium	Adult Basic Education/ ESOL	Training for non-CNA frontline workers	Care team participation	Counseling/ assessment/ career plans	Health & Safety
Brandon Woods	X	X		X	
Coolidge House/Genesis Elder Care	X	X	X	X	X
Holy Trinity	X	X	X	X	
Leo P. LaChance Center	X		X	X	
Loomis House/ Pioneer Valley	X	X		X	
Maristhill N & R	X	X		X	
Sherrill House/ ACCT	X	X		X	

Table 7: ECCLI Activities by Consortium, Part II					
Consortium	Mentoring	Pooled Services*	College prep & support	Soft skills training	Work/life support
Brandon Woods	X	X			X
Coolidge House/Genesis Elder Care	X		X	X	
Holy Trinity	X		X	X	
Leo P. LaChance Center	X		X	X	X
Loomis House/ Pioneer Valley	X			X	X
Maristhill N & R			X	X	X
Sherrill House/ ACCT	X	X		X	X

** Shared Human Resources Staff, Childcare Services, or Issues Resolution Counselor*

E. Expectations of ECCLI

The leadership teams in the consortia have generally high expectations for this initiative, with some qualifications. Most of those interviewed expect to see improvements in recruitment, retention, skills of licensed and non-licensed staff, career mobility, and quality of care. In several consortia, there was a degree of uncertainty about attainment of career mobility, and how career ladders would work in practice. One director of nursing questioned the level of interest among nursing aides, explaining "*the majority of the CNAs that I have want to be CNAs*." Others felt that their facilities already had career ladders. In another facility, the coordinator and the nursing directors expected better recruitment, but the nursing home administrator thought ECCLI would have no impact on attracting staff.

Those who expect recruitment or retention to improve see several routes to these accomplishments. One is that better training, wages, and career paths will make their facilities "magnets," via word of mouth, for interested candidates. Another is that investing in training will better screen workers, so that those who stay have a real interest and commitment in the field of long-term care. A theme heard in several consortia was that of job satisfaction and self-confidence. Better-trained workers are expected to be more assertive about problem solving, leading to better care and greater attachment to their jobs. And more contact with workforce development partners was expected to have a two-way effect: overcoming the isolation of employers, while improving trainers' understanding of nursing homes.

F. Technical Assistance

Virtually all consortia have had contact with Technical Assistance (TA) providers, principally the Paraprofessional Healthcare Institute (PHI), a training organization. PHI is a recognized leader in developing quality care practices for frontline workers and culture change processes in long-term care. PHI is the primary TA provider to Round II long-term care facilities. Several consortia have also had contact with the Boston Workforce Development Coalition (BWDC), which provides support to community-based and training organizations.

Under Commonwealth Corporation's technical assistance plan, there was no expectation that the project sites would have direct contact with the Massachusetts Executive Office of Community Colleges (MEOCC) or the Massachusetts Workforce Investment Board Association (MWIBA).[10] As Table 8 below suggests, several successful interactions did occur (see Table 8, page 38). Local Workforce Investment Boards and individual community colleges are members of most partnerships at the project level, and are providing direct programmatic and planning assistance to their local consortium partners. MWIBA and MEOCC, both state-level organizations, are contracted to provide technical assistance (TA) to their local constituents as needed and to monitor the work of their

[10] Technical assistance in ECCLI was designed so that these TA providers were expected to focus on specific constituencies: community colleges for the MEOCC, Workforce Investment Boards for the MWIBA, and community based organizations for the BDWC. Lack of interaction with TA providers reflects that all projects are relatively early in their development, as expected, at this time of baseline data collection.

colleagues in order to identify potential best practice information for dissemination throughout the workforce development system across the state. These activities will hopefully lead to a sustainable workforce development support system for the long-term care industry and its workers.

During the planning period, PHI's TA providers visited every consortium at least twice, and spent more time with individual facilities and project coordinators in helping to concretize plans, choose and design curricula. In several cases, TA providers conducted workshops, attended meetings, or otherwise offered advice and assisted project coordinators and other participants to generally move the projects along. The TA area is still evolving to meet the needs of the participants. In some cases, TA providers are still learning to work with the partners, including how to provide assistance, and what kind of assistance is needed. In general, most sites have heard of PHI. However, interviews with managers at the sites suggest a lack of clarity in some cases about the nature and purpose of technical assistance. (A few questioned its relevance, relative to staffing and training needs.) Many of the interviewees did not distinguish between Commonwealth Corporation and the TA provider PHI, which was not surprising, but may have caused some confusion in early services to the sites. The retreat held in May 2001 garnered many good reviews; it was planned and coordinated by the team of TA providers.

Participants have asked for assistance with the following activities during TA sessions:

- Defining, identifying, and evaluating cultural change strategies
- Designing evaluation tools and strategies to assess the success of their programs
- Incorporating home health aides from partner agencies into their programs
- Developing career ladder steps and curricula
- Building enthusiasm for the project, along with broader understanding of project goals, through kickoff events.

Given relatively limited contact, satisfaction with TA provision to date has been generally good, as Table 8 shows:

Table 8: Technical Assistance: Use and Satisfaction

Informants (Scale: 1=totally unsatisfied to 5=very satisfied)	TA from PHI			TA from BWDC			TA from MEOCC			TA from MWIBA		
	Recipients		Satisfaction	Recipients		Satisfaction	Recipients		Satisfaction	Recipients		Satisfaction
	No.	(%)		No.	(%)		No.	(%)		No.	(%)	
Project Coordinators	5	71	4.1	3	43	4	1	14	4	1	14	3.5
Directors of Nursing	3	14	4.33	2	9	N/A	1	5	N/A	2	9	N/A
Nursing Home Administrators	8	33	3.86	2	10	3.5	0	0	N/A	2	10	N/A

PHI = Paraprofessional Healthcare Institute BWDC=Boston Workforce Development Coalition
MEOCC=Executive Office of Community Colleges MWIBA=Mass. Workforce Investment Board Association
The satisfaction levels represent mean satisfaction levels

The project coordinators, one of the main audiences for TA, rate assistance they have received from PHI at a 4.1 on a scale of 5. Nursing directors and administrators have had less contact, especially at non-lead facilities.

G. ECCLI Economics: An Initial Look

As noted in the introduction of this report, the evaluation will analyze the impact of ECCLI on nursing home employees, as measured by changes in wages, retention rates and career advancement. It will also analyze the economic impact on nursing homes, as measured by changes in staffing costs, including recruitment, agency costs, overtime and lost worker productivity.

While we had hoped to include a baseline on these measures in this report, incomplete data at the time of this writing makes that impossible. At this time, just 13 of 27 nursing homes had provided an initial bi-monthly report to CommCorp. We report below some initial data on staffing costs, wages and wage increases. The data are not broken out by consortium because of the low number of responses.

As Table 9 shows, reporting nursing homes spend an average of $21,200 on CNA recruitment, $98,700 on CNA agency fees, and $65,400 on overtime costs. Average total staffing costs for all categories of CNA staffing are $133,500 per nursing home. We would expect to see some reduction in those costs during the course of the ECCLI projects.

*Table 9: Initial Data on Nursing Staffing Costs**				
	CNA Recruiting Cost (n=9)	**CNA Agency Fee (n=7)**	**CNA Overtime Cost (n=11)**	**Total CNA Staffing Cost (n=12)**
Average	**$21,172**	**$98,741**	**$65,435**	**$133,460**
Standard Deviation	**$24,325**	**$97,102**	**$65,348**	**$100,142**

**These data represent just less than half of all nursing homes participating in ECCLI Round II.*

Fewer facilities provided information on their current CNA wages; of those 7 that did the average hourly wage was $10.44, with a low of $9.40 and a high of $11.75.[11]

Two consortia had already begun training activities and between them had 199 participants in training as of June 15, 2001. Among these, there were 18 cases of wage increases ranging from $0.15 to $0.30, with the vast majority being $0.30. The average amount of wage increase was $0.29 -- approximately three percent increase on the trainees' average $10.00/hour wage.

[11] We note that this figure may be biased toward an urban labor market.

IV. Challenges for the ECCLI Project to Date

Researchers held extensive interviews with the leaders of ECCLI partnerships about the everyday challenges they face as managers of their own nursing homes in general, and about the challenges they face as consortia, as they get their ECCLI projects off the ground. Leaders of nearly all of the facilities reported some challenges about the industry, the regulatory environment, and the workforce and labor market that surfaced as everyday operational challenges. In addition, a set of challenges specific to the ECCLI project emerged from the interviews. We review both here, focusing mainly on the ECCLI-specific challenges facing sites.

Organization-wide changes are difficult, and take time. It is the role of evaluation to report to the consortia the obstacles identified, so they can address them early in the process. Technical Assistance is planned for both individual ECCLI leaders and for consortia to help them address these challenges.[12]

A. Everyday Operational Challenges

The ECCLI projects do not occur in a vacuum. Most managers described confronting the same serious everyday problems that confront the industry as a whole[13]. We found a number of ECCLI facilities, presumably representing some of the most innovative and creative facilities in Massachusetts, actually struggling to survive. As one director of nursing put it, *"...we're flying by the seat of our pants."* In some cases we found directors of nursing working midnight shifts on the floors, because they could not hire or retain licensed nurses. In other cases, we heard about short staffing or vacancies going unfilled to save money. In some facilities we learned that many Certified Nursing Assistants (CNAs) are working overtime, or multiple jobs, because wages are so low. This affects their performance, energy, and morale. Elsewhere, nurses are working shifts as CNAs, because of the shortage.

The workforce challenges addressed in some ECCLI proposals are very strong barriers for employees, according to most respondents. The three major challenges we found involve CNAs' life context, facilities' financial constraints, and facilities' staffing shortages. Note that this section is based on only top managers' perceptions. We will be gathering workers' perspectives in the next research phase.

[12] Researchers did not interview the TA providers about their plans to address the challenges, but we expect to report on those activities and their effect in the mid-term and final reports.

The Life Context of CNAs

The life context of CNAs affects the everyday functioning of nursing homes, and may also affect the implementation of ECCLI projects. As shown in **Table 10** below, when asked what they felt inhibits CNAs' performance, administrators and directors of nursing ranked lack of child care, language barriers, and managing multiple cultures as top issues.

Table 10: Factors Inhibiting Effective Performance of Nurses' Aides (As Reported by Directors of Nursing and Nursing Home Administrators)

Informants/Factors	C1 (%)	C2 (%)	C3 (%)	C4 (%)	C5 (%)	C6 (%)	C7 (%)	Aggregate N	Aggregate %
Child Care Issues	**83**	**100**	**63**	**83**	**55**	**83**	**25**	**50**	**70**
Lack of Time	**50**	**43**	**75**	**67**	**55**	**83**	**100**	**50**	**64**
Lack of Communication	**100**	**57**	**50**	**0**	**64**	**63**	**50**	**50**	**56**
Language Barriers	**83**	**86**	**75**	**33**	**27**	**12**	**100**	**50**	**54**
Multiple Cultures	**83**	**71**	**75**	**50**	**9**	**0**	**100**	**50**	**48**
Low Compensation	**50**	**29**	**50**	**67**	**36**	**75**	**25**	**50**	**48**
Lack of Training	50	14	38	50	27	63	50	50	40
Lack of Upward Mobility	33	43	50	17	18	63	50	50	38
Scheduling Issues	75	67	50	33	17	0	0	*26	35
Transportation Problems	50	57	38	33	18	37	0	50	34
Lack of Recognition	50	0	38	17	36	12	75	50	30
Paperwork	0	14	50	17	36	49	0	50	28
Lack of Basic Skills	33	14	25	33	36	39	0	50	29

**Only Administrators were offered the category of 'Scheduling Issues' in their interviews.*

Moreover, because of the low compensation of CNAs, many hold second jobs or work overtime, to work a total of 60-80 hours a week plus travel time. Many CNAs are young, single mothers with young children. Facilities thus must take the severe time constraints of CNAs into account when scheduling education and training for ECCLI.

Many administrators and directors of nursing described similar life challenges that CNAs deal with outside of their job that inhibit their ability to get to work or to remain focused while at work. These included sick children, lack of adequate child care, unreliable transportation, abusive husbands, and the lack of a support network to help them. Many CNAs are recent immigrants, struggling with a new language and culture. The nursing home as an institution does not even exist in many of the countries from which they emigrated.

Lack of adequate childcare causes aides to phone in more often than anyone would like, and to be out of work at times, whether for ill children or for lack of a babysitter. "*Of course, child care is an issue. Most of our aides are young, single moms.*" "*Childcare is always an issue. I'd love to be able to offer free or subsidized child care. That'd be huge*." Special childcare issues arise in this industry where two shifts either begin or end

late at night; child care during nights and weekends, like public transportation at those times, is scarce and hard to find.

According to management, communication problems between supervisory and line staff, lack of time, language barriers and handling multiple cultures are the next most important reasons why aides have trouble performing effectively. A large part of the nurses' aide workforce is foreign born. Managers voiced different reasons why these issues (communication, time, language, multiple cultures) were problematic for their staff, and many of the issues are related. For instance, one manager noted, "*Paperwork is aggravated here by language barriers."* Another said, *"A lot of people don't have the time to communicate*." It is for good reason, then, that some of the consortia are addressing communication and language issues within their ECCLI projects.

Financial Constraints

A substantial number of managers interviewed for ECCLI identified the fiscal constraints facing nursing homes as a significant barrier to everyday operations. Many told us they, or their parent company, were in bankruptcy. "*We've been in and out of bankruptcy in the past few years*." *"We're drowning. There are no two ways about it."* Some said they were losing staff to facilities "down the street" that were offering significantly higher pay or sign-on bonuses, which they themselves could not offer. When asked why recruitment was such a problem, one manager replied, *"It's all money."* Managers also cited limited finances as factors inhibiting them from changing: *"Economics limits our ability to change."* Low Medicaid rates were frequently mentioned as one of the many things nursing homes would like to see changed: *"Our institution loses $25 a day on every Medicaid resident."*

Most of the facilities experienced financial constraints, with very few exceptions. While these are undoubtedly serious problems, ECCLI does not and cannot address reimbursement rates. But the financial stress may challenge the program's goals and managers' willingness to innovate.

Nursing Staff Shortages

The issues of staffing are ubiquitous. Some facilities are struggling to maintain an adequate staff. Typically at least one or two shifts' staffing goals were met only 75% of the time in reality. One facility virtually cannot staff Sunday morning shifts. Several managers believe financial problems restrict their ability to staff the floors. Many homes have created policies prohibiting the use of nursing agencies, because they are too costly and because strange faces reduce the quality of patient care. Other facilities have forbidden nursing staff to work overtime until all available nurses have put in 40 hours; this goes for management staff as well, causing multiple facilities to fill the staffing holes with their own directors of nursing or unit managers covering late and weekend shifts.

Many facilities are experiencing severe nursing staff shortages: *"I'm living by a thread. The nursing shortage affects everything here. We're hanging onto nurses for better or*

for worse because there are no people working as nurses. Period." Staffing shortages increase the workload for each staff member on duty: *"Lack of time for CNAs is caused by poor staffing ratios. Vacancies and absences mean an overloaded workload."* Some directors of nursing are considering leaving their jobs, or the industry altogether, because of having to cover shifts themselves. *"I will probably leave when the staffing burns me out."*

The staffing shortages contribute to difficulty in meeting quality goals. For example, although many of the nursing directors believe that CNAs should be involved in care plans and care plan meetings, we found very few situations in which this was actually practiced, and nowhere regularly. *"We'd like to, but there just isn't enough time. They are too busy on the floors,*" is a typical response to the question of whether CNAs are part of care planning meetings. And yet, involvement in care plan meetings is one of the key factors that helps retain CNAs, since they feel respected for their observations, and can contribute to the resident's overall well-being. Advocates also note that nursing home reform legislation from 1988 already requires this kind of participation, in their view.

Summary of Everyday Operational Challenges

In sum, ironically, the very issues that made ECCLI a popular proposal with the industry – addressing workforce barriers – continue to plague the facilities, making it hard to get ECCLI innovations underway. This paradox of implementation may be unavoidable, but it emerged prominently in our interviews. It is hard to convey how much pressure the leaders of these nursing facilities are under: several had to cancel interviews, or miss required meetings, and one director of nursing was unable to meet with us because the facility was expecting state surveyors in the next several months and the facility was in "survey mode." There are really no simple answers to these challenges, though getting ECCLI underway and seeing if it can address some of these problems is clearly the goal. But no one thinks ECCLI alone is going to solve the problems of nursing homes without other major industry-wide changes.

B. Challenges Specific to the ECCLI Project

In addition to everyday operational challenges common across most of the participating facilities, managers have encountered a number of obstacles that affect the implementation of the ECCLI project. Growing pains, as well as concerns about implementation obstacles, are to be expected in a change process context. Managers report experiencing a range of obstacles including:

- the growing pains of creating new partnerships
- neglecting to include in some ECCLI plans ways to address issues core to employee workforce obstacles, such as language issues and multiple cultures
- vague and varied understandings of organizational culture change; more need and demand for technical assistance than there is supply
- managerial challenges
- limited "buy-in" among the staff as well as other stakeholders for the ECCLI project

- constrained expectations of the impact ECCLI will have, and of their ability to change
- developing positive labor-management relationships to be supportive of partnerships and training objectives.

Creating Partnerships

ECCLI faces challenges as facilities enter uncharted territory by partnering with various community agencies, including other long-term care facilities. The difficulty of partnering with outside organizations should not be underestimated. For many nursing homes, these new partners are competitors, and tension underlies the project as they attempt to guard their 'trade secrets to success' or competitive edge in the community. Some consortia have taken longer than expected to reconfirm the partners entering the project. For some partners, it will take awhile to establish trust. Others have already united behind common goals: "*We all recognize we want to do this together to survive. People are usually protective of their own people, but this is different. We all want to keep our people employed in the health care field."*

Figuring out how to work with partners in a completely different sector (such as community colleges, one-stop career centers, etc.) is a complicated task, both relationally and organizationally. The Project Coordinators (PCs), as the backbone of consortia, are the only ones who can realistically be in touch with all participating facilities, and are crucial links for TA providers, evaluators, and Commonwealth Corporation as well as the consortia members themselves. We anticipate that PCs' expert functioning in this initiative will be critical to its success, and based on these interviews, we recommend that CommCorp do what it can to provide them with regular support, feedback, and assistance.

While 27 nursing facilities have signed up for ECCLI, a few nursing homes are not participating as planned. One facility has dropped out of one consortium, and two facilities in another are not fully on board with the current plan in another. This is understandable, but the reasons are not the same in all cases. Sometimes a project coordinator or lead facility did not get everyone fully on board, while in one case someone exceeded his authority in signing on a participant and permission was revoked. This is not an extensive problem, though it has slowed down some consortia.

Other unanticipated events have slowed things down in a few cases. In two instances, a strong proponent of ECCLI left, thus changing the basis of support and requiring new relationships to be negotiated. In one case, ECCLI Round II's requirement to create partnerships between two or more nursing facilities, as well as workforce development partners, seemed to be a surprise. Two consortia have not finalized their participants or consolidated expectations at the time of this writing.

Language, Culture, and Communication

We found that lack of communication, together with widely varying languages and cultures will be a major challenge to the ECCLI project. As shown in Table 10 on page 32, communication was cited as the #3 reason inhibiting CNAs on the job, ahead of even language barriers or multiple cultures. Communication – the successful conveying of information to and fro – is not simply a matter of language, as evidenced by the fact that nearly all the consortia reported it as a main factor inhibiting nurses' aides' job performance. It could mean conveying information about expectations, patient care, problems encountered as they occur, etc. Most respondents did agree that language barriers and cultural differences make communication more difficult, and, in turn, affect the provision of high quality care.

In many facilities, most workers' first language is not English.[14] A large part of the nurse aide workforce is foreign born, and individuals speak Haitian-Creole, Spanish, Portuguese and the languages of various African countries*: "I probably have 22 African nations represented on my staff. And sometimes it's like civil war on the floors."* Another issue for many managers seems to be concern with aides' speaking their native languages on the floors, or in common spaces, instead of using English. While English for Speakers of Other Languages (ESOL) classes are part of several consortia's plans, these classes take time to have an effect.

Language barriers are closely linked with multiple cultures for many respondents. Sometimes licensed and registered nurses come from different cultures than CNAs and other paraprofessionals. DoNs and Administrators noted that cultural misunderstandings arise from varying interpretations of meaning across language/culture, especially when the background of the supervisor (usually a nurse) differs from the background of the aides. *"It's how actions are understood. Aides say to me '[That nurse] is making me do that because she is Haitian, or she's white, or she's African.' No. She asked because she's a NURSE." "Mutual respect is lacking due to cultural differences. It's the tone of voice, the body language which is misinterpreted."* The diversity management classes that some consortia have begun will be very important, we predict, for the success in changing communication patterns and improving teamwork.

Although some sites address language and culture in their ECCLI plans, others do not. Some managers expressed disappointment that these issues were not on the agenda of their ECCLI program. When asked what was missing from the ECCLI project, one respondent said *"ESL",* and another said "*diversity training*." The initial evaluation suggests that there is no reason that ECCLI could not address these concerns for these facilities; perhaps if communication within consortia about priorities were improved, these classes could be added. We encourage PCs to check on these issues specifically.

[14] Note that two consortia do not experience language barriers or foreign culture issues.

Communication problems, among supervisors and nurses' aides and among co-workers will likely persist if they are not addressed with new systems and new norms for effective conveyance of information. Language and cultural misunderstandings left unaddressed will also continue to hamper quality improvements, even in the presence of additional training or education for workers.

Varying Notions of Culture Change and the Resulting Need for Technical Assistance

Some facilities have not embraced the explicit ECCLI Round II goal of culture change. Indeed, some administrators and directors of nursing did not know what we meant or could not answer when asked to describe the care giving culture of their facility. Managers held widely varied understandings of what "culture change" means. Many managers described the culture of their facility as a "*home,*" a "*community,*" or a "*family.*" Many said their culture revolved around "*providing for the individual needs of the resident.*" Often, the interviewee described the multi-cultural ethnic backgrounds of staff and residents. Many mentioned their culture exists in the midst of constant change, "*we must change or perish,"* or conversely, that their long-term staff create a "*culture of stability and tradition.*" Few of those interviewed mentioned care giving cultures described in the long-term care literature, e.g. the social model, the medical model, or the Eden Alternative. But since culture obviously means many things to many people, facilitators such as TA providers or community colleges need to be aware how different facilities may approach culture change, since a more resident-centered culture is a main objective of this long-term care quality initiative.

Making culture change concrete seems to be one of the major challenges for ECCLI Technical Assistance (TA) personnel, especially those from Paraprofessional Healthcare Institute (PHI). That so few leaders could respond to the question on culture itself is a baseline finding. Some declared themselves happy with the cultures they have now, and do not intend to engage in conscious culture change, while others are more open to the ideas, but still seem to have a hard time concretizing them: *"Someone needs to show me how [to change] and I'll consider it."* In making culture change tangible, the first quarterly TA meeting for participants was very helpful, as it focused on an example of culture change in bathing, and addressed the organizational context for bathing residents, with a clear link to training on alternative approaches to this very sensitive and often difficult area of resident care.

We sense a greater need for TA, on issues like culture change, as well as developing curriculum, setting up site and project-specific evaluations, training evaluations, planning training, planning for organizational change, than can possibly be met by TA providers. Deciding on priorities and what will help the greatest number of partners, as well as integrating all TA providers into the projects will remain a challenge. Given the large number of stakeholders and participants, the TA providers will increasingly rely on Project Coordinators to help steer their efforts, we predict.

Residents' increased involvement in care is a specified goal of culture change in the ECCLI project, related to training of CNAs. Our survey of managers indicates that on average, cognitively able residents can decide what activities to pursue, and perhaps have limited decision-making in other areas like diet, but most are constrained by institutional waking, bedtime, and eating schedules.

An example of the challenge confronting facilities and TA providers is the definition of "consistent" assignment of nurses' aides to residents, since consistent assignment is hypothesized to improve resident care through more durable relationships, and sense of mutual responsibility. Some facilities felt that a weekly assignment to residents was consistent, while others felt that monthly was consistent. Such issues will need to be clarified for quality and organizational goals to be met.

Management Issues and Priorities

Cultural misunderstandings may heighten nurses' apprehension in their role of managing aides. Overall, managers noted that management training for nurses is critical in many cases. Many managers said their nurses felt it was not their job to supervise the CNAs. According to one Administrator:

> *"I have a friend who says that's the best kept secret in health care, that nurses, who are the direct supervisors of the CNAs, were never trained how to manage. We assume that just because they have an RN by their name that they know how to motivate, lead, inspire, resolve conflict. And they don't. Most of us don't, there are very few born leaders. Most of us have to learn it by trial. It's a horrible mistake [to assume they have management skills]."*

Many of the consortia have included management training as part of their projects. We anticipate that technical assistance and training for nurse supervisors of CNAs will be one of the most important parts of ECCLI.

In general, ECCLI managers are concerned so much with "operations" and keeping things running that they sometimes don't feel ready or able to make larger changes. One administrator explained that she went to planning meetings initially resistant to getting on board with the initiative. As she described it, she was wearing her "operations" hat -- focused narrowly on immediate problems, bottom lines, etc. After reflecting, she saw the benefits of taking a broader view:

> *"For the first meeting of the career ladders initiative, from an operations standpoint it's a little intimidating, because you're looking for opportunities to possibly lose some very good staff to higher positions, that you might not have so many positions available on board. And then, of course, there is the cost associated with improvements, as they meet their goals and improve their educational status. But I realized that is the role of this program. It's not about operations, it's about human relations*

> *and improving the quality of life. So we really have to celebrate our employees as much as we celebrate our residents, and do everything we can, as they choose to, to support them in their development. And once you separate yourself from the operations side of it, it's so much more rewarding. And I believe that when this program has all of the aspects totally operational, it will actually satisfy operations. Because they'll have a temporary labor pool that will result in more consistent staffing and lower overtime and agency costs."*

Staffing shortages might affect the efficacy of ECCLI if they prevent CNAs from taking advantage of training opportunities. As one Director of Nursing noted*, "I can't spare them. I need them on the floor."* This is a dilemma ECCLI managers must resolve if the initiative is to succeed.

Generating Buy-in Among Numerous, Diverse Stakeholders

The large number of diverse stakeholders is a challenge for the ECCLI project to date. Some nursing homes are just in the process of spreading the word about ECCLI. Even four months into the project, in some cases buy-in from the charge nurses and CNAs was limited, and the project existed mainly in the minds of upper management. Most facilities in one consortium had not communicated with CNAs or other nursing staff at this point. Some facilities require the support of their corporate owners, for whom pressing issues such as bankruptcy are front and center. Internal stakeholders are crucial to the success of this project. Communicating with all shifts across the work week is not easy. Yet as ECCLI partnerships begin implementation, we see more needing to be done across most consortia to bring everyone on board.

Managers' Expectations of ECCLI Efficacy

The expectations of the facility leaders will play some role in shaping ECCLI's outcomes. Most of those we interviewed expressed positive expectations of the grant to help their facility in some way. Forty-two percent of respondents felt the ECCLI plan fully addressed the reasons for turnover/retention problems. But 36% felt their plan did not fully address those problems; Eighteen percent were not sure yet. This is not surprising since some of the problems are beyond the scope of ECCLI.

Many managers noted that the ECCLI plan by definition could not *fully* address the retention/recruitment needs of their facility. They cited that ECCLI did not address the low compensation of the CNAs that they believe causes the turnover. One administrator remarked, *"The CNAs do the vast majority of the work, so I don't think they are fairly compensated."* A few managers mentioned that ECCLI does not address the issue at the center of their staffing problems: the shortage of licensed nurses. Other issues that interviewees cited that their ECCLI plan does not address included: ESL, CNA's self-proclaimed needs, diversity training, childcare or transportation issues, higher Medicaid reimbursement, money to improve staffing ratios, degree programs, money to pay higher wage rates once people are trained, or lost income during training/education. These

issues obviously differ across consortia, since each consortium has crafted its own program.

The challenge for ECCLI is to show that while ECCLI certainly cannot solve all problems, it can make a serious contribution to the structural internal and organizational reasons for turnover. Research shows that compensation is far from the only reason people stay at nursing homes, or leave them. Giving workers mobility, a sound work environment and the culture of care giving, as well as a meaningful role, and the ability to make a difference, have documented positive effects on turnover and employee satisfaction.

One facility went through the painstaking exercise of scheduling not only the floors each day, but also scheduling workers' attendance at the ECCLI training. They found that workers were not showing up to the training because of their scheduling constraints, so they revised their procedure to ask CNAs to sign up for paid ECCLI training at times of their own choice during their time off. This simple but important adjustment to accommodate workers' lives has been a substantial improvement for the ECCLI project at that facility. It suggests the kind of changes that could be achieved by extending this example of self-scheduling to work scheduling, as well as training scheduling.

Labor Relations Changes and Challenges

Some facilities have found that partnering with outside agencies and CNAs requires renegotiating the relationship with a union representing CNAs. In one case a union-sponsored education project is leading the ECCLI training process. While no specific labor-management problems were reported by project and nursing home staff,[15] clearly ECCLI calls for a new level of union cooperation in operational issues, as well as greater skills and more involvement of union members. We predict that this will present both challenges and opportunities for the ECCLI partnerships with union representation.

C. Summary

In sum, both the broader, everyday, operational challenges and ECCLI-specific challenges (and some combinations) emerged from the interviews with top managers. With assistance from TA providers, and with continued willingness to change and adapt, we predict that these challenges can be addressed, overcome, or at least learned from for future projects. We encourage in the partnerships and in all participants an attitude of learning that will make these demonstration projects of great value to others to come.

[15] Note that we have not interviewed the union staff or members to date.

V. In Conclusion: Lessons and Promise

Twenty-seven long-term care facilities and three home care agencies across the state have stepped forward to participate in the Massachusetts ECCLI project, to improve the skills and mobility of front line caregivers, and ultimately to improve the care delivered to long-term care recipients. Working alongside community colleges, training partners, workforce investment boards, and technical assistance providers, as well as other health care providers in their local area, seven consortia will implement seven different strategies over the coming year. Each partnership is unique, and each facility begins from a different starting place. Facilities have different organizational cultures, different resource capacities, and different perceptions of their ability to change.

But the threads tying these facilities together and to ECCLI are the challenges which confront them every day in the nursing home industry: severe financial constraints; limited training resources; shortage of nursing staff at all levels; high staff turnover and low retention; frequent call-outs due to childcare problems, transportation issues, and life situations facing low-wage workers; lack of teamwork and poor communication among the staff; language barriers and cultural misunderstandings among staff. Many of these challenges are shared across facilities because their front line workers share a similar life context: Certified Nurses' Aides are predominantly women, many are foreign born, non-native English speakers, and many are single mothers of young children.

A number of lessons have surfaced from the ECCLI project at this early stage, which can inform ECCLI's development as it grows over the next year. The consortia must be allowed time to build solid partnerships. Partnering with outside organizations is difficult for nursing homes, especially to achieve organizational change. Partnership and formal workforce development strategies are also quite new for most of those in long-term care. The role of the Project Coordinators (PCs) will be critical to solidifying these partnerships and carrying out successful ECCLI programs. Many of the planned activities seem to answer the needs of the facilities involved. Supervisory training for nurses as well as diversity, communication, and mentoring training for aides will be important for improving the working relationships among staff, and ultimately for improving quality of care. Helping the nursing homes and their staff to make culture change concrete will be a challenge for the Technical Assistance personnel. As well, the paths to achieving change will most likely differ across and within consortia, and will most likely result in varying iterations of career ladders.

Despite challenges confronting the nursing home industry, the ECCLI project wields enormous promise. Managers report that just the knowledge that the Commonwealth of Massachusetts as well as their own managers are interested in helping these dedicated, often disrespected workers has generated excitement among CNAs. Most managers we interviewed are supportive of ECCLI and eager to improve the situation for their workers and their residents. The partnerships have adapted their proposals into concrete plans, and many have accommodated their plans to the needs of additional partners: *"We were brought in late in the grant making process. Coming away from the meeting about the*

grant, I realized that we need to ensure the grant needs to work here for this organization. That the [career] ladder is meaningful."

Most partnerships have finalized their plans, and are now beginning their ECCLI activities. They've hired staff, they've created their governance structures, they're rolling out the project through presentations to staff, and it appears that more and more people are starting to *see a concrete place for themselves and their facilities within the ECCLI projects.* Facilities have already started doing things differently, for example, by asking CNAs to identify what they themselves think *they* need to succeed in their jobs, and adjusting project goals and activities accordingly. And many of the homes, project coordinators, and managers alike have already overcome significant barriers in the project's first four months.

Next Steps

This baseline report presents a view of the ECCLI Round II project as it begins. Future reports, measured at the midterm and endpoints of the project, will assess the progress of the participating facilities to achieve project objectives. In future reports, we will address:

- The context of the project as reported by workers themselves;
- Whether any consortia or facilities continue to struggle organizationally;
- The degree of training that is taking place, career ladder implementation, and any processes that are being put into place to change how care is delivered;
- Whether we see any indications of improvements in satisfaction (among workers, residents, family), turnover, or quality of care.

Round II of the Extended Care Career Ladders Initiative (ECCLI) is an ambitious Massachusetts demonstration project: an undertaking that could have implications for the entire United States. Since consortia are taking different paths to achieve similar goals, we will have many paths to analyze and share with ECCLI participants and partners, policy makers, and the industry when the project is complete. We look forward to documenting the improvements and changes in nursing home quality care and the professional development of Certified Nurses' Aides in the 2002 midterm evaluation report.

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Appendix A: Consortia Descriptions

Brandon Woods Consortium

The Brandon Woods Consortium comprises five long-term care facilities - Brandon Woods of Dartmouth, Blaire House of New Bedford, the Oaks Nursing Home of New Bedford, Kristen Beth Nursing Home, and Sunbridge Care and Rehabilitation Center of New Bedford - as well as the Greater New Bedford Career Center, New Directions, the New Bedford Workforce Investment Area administrative entity. The long-term care facilities represent 899 beds and employ approximately 625 CNAs. Two of the facilities are independently owned and operated, and five are members of other corporations or management groups. All facilities are members of the Health Care Partnership of Southeastern Massachusetts and were involved in the development of the Health Care 101 curriculum, a career exploration program for potential employees that includes job shadowing and mentoring.

Brandon Woods is the lead partner in this consortium and will have the primary role in developing new workplace models. Other partners in the consortium are Health Care Training Services (HCTS), a five-year-old licensed training school and S Corp., that provides a wide variety of health care related training services to individuals and organizations in Massachusetts and Rhode Island. New Directions is the administrator for Title I and Welfare to Work programs in the Greater New Bedford area and the principal partner and fiscal agent for the Greater New Bedford Career Center.

Goals

- Increase the skills, abilities and wages of CNAs
- Reduce turnover and workplace stress of nursing home staff
- Improve the quality of care of residents of nursing homes

Activities Planned

- Refine of the Health Care 101 curriculum to provide an opportunity for participants to make informed and firm career decisions by experiencing the job before starting occupational training or entering employment as a CNA
- Conduct feasibility study on providing childcare facilities at one or more long-term care facilities
- Hire an Issues Resolution Counselor to serve the needs of the employees of all Health Care Partnership members
- Hire a project manager/paraprofessional pool coordinator to coordinate the grant activities and to establish a pool of paraprofessionals for employment across facilities
- Provide adult education opportunities and ESOL classes, as needed, at long-term care facilities
- Identify skills gap and training needs
- Develop and deliver professional development training to assist managers and supervisors in adopting new workplace models
- Develop career ladders for CNAs through a three-step system and or specializations in areas such as nutrition, restorative care, and nursing resource and delivery of required clinical training
- Investigate the feasibility of developing a web site and online network among partnership members for professional development
- Conduct survey of consumers and CNAs employed in partnership facilities to identify issues and develop internal goals to address these issues

(Brandon Woods Consortium continued)

Governance

Two committees – a partnership and representative committee – govern the consortium. The partnership committee comprises the Administrators, Directors of nurses, HR directors (if relevant), plus representatives from Bristol Community College and HCTS; the issues resolution counselor; a WIB representative; and the Project coordinator and the ECCLI Administrator. The committee identifies and brainstorms ideas for staff recruitment and retention, education and training, wage levels, and workplace environment issues. This committee also monitors progress on issues discussed and make the necessary adjustments for feasibility purposes. The representative committee meets bi-monthly and voices concerns and gives suggestions and feedback regarding program ideas. Issues related to the work of the CNAs and residents' care are also addressed. The committee is chaired by the project coordinator and comprises two residents, two CNAs, two family members, and one member of the management (usually the Administrator, but can be the Director of nurses) of each facility.

Coolidge House/Genesis Eldercare Consortium

The Coolidge House/Genesis Eldercare Consortium is managed by the Worker Education Program, a joint labor/management project affiliated with the Service Employees International Union, Local 285. Employer partners include the lead applicant, Coolidge House Genesis Eldercare of Brookline, as well as Courtyard Nursing Care Center (Medford), Village Manor Nursing Home (Hyde Park), and Provident Nursing Home (Brighton). All but Provident are managed and/or owned by Genesis Eldercare, whose regional staff, based in Andover, help support and govern the project. Each is a skilled nursing facility; the Provident serves psychiatric and behavior-difficult residents. The Home Health Services Division of the Women's Educational and Industrial Union (WEIU) is also collaborating. Training partners, anchored by WEP, also include the American Red Cross; Bunker Hill and Roxbury Community Colleges; and the Massachusetts Coalition for Occupational Safety and Health (MassCOSH).

Coolidge House/Genesis Eldercare is the only ECCLI consortium that is fully union-based; SEIU Local 285 represents all workers in the sites. The Worker Education Program has worked on career ladder and adult basic education initiatives in former collaborations, including current partners such as Coolidge House and Courtyard Nursing Care Center. The WEIU has been both an advocate and developer of career ladders for home health care workers.

Goals

- Improve and better coordinate observation and reporting of residents' care needs and conditions
- Address communication issues between CNAs, residents, or clients and family members
- Address high turnover rate among less senior nursing home and home care workers; develop strategies and training to support long-term-staff
- Address lack of career advancement opportunities for CNAs, housekeepers, dietary workers and home care workers
- Provide skill enhancement and career ladder opportunities for entry-level workers
- Develop all employees' teamwork, problem-solving, cultural diversity, and communication skills, and explore strategies for working together more effectively; develop coaching skills for supervisors

Activities Planned

- Develop and support full CNA participation in care teams
- Develop Senior Aide skills at facilities and develop their role as mentors and team leaders; for facilities not currently utilizing Senior Aides, examine their role and associated pay increases, and provide training
- Provide ESOL and Adult Basic Education instruction
- Develop counseling and access to information about career steps and community college programs in the health care field; provide access to remedial courses needed to enter programs
- Develop worker centered basic skills, pre-CNA-tailored literacy and 'soft skills' curricula and training modules that can be shared with other facilities

Governance

The project is governed by an Advisory Board, chaired by the Project Coordinator, which is expected to meet quarterly. Its membership includes the administrator and Director of Nursing (or another supervisor) from each site, two union representatives, two trainers from the coordinating entity, a representative from each of the training partners, and a human resource official from the corporate regional offices of the employer. The Board is charged with reporting on program progress at each site, sharing lessons, and obtaining updates from the training partners. Its first meeting was scheduled for June 26, 2001.

Holy Trinity Consortium

The four institutions that form the Worcester ECCLI Consortium are: Holy Trinity Eastern Orthodox Nursing and Rehabilitation Center, Lutheran Home, Notre Dame Long-term Care Center and Oriol Health Care Center. All ECCLI partners are members of a larger group of licensed long-term care providers from throughout Worcester County known as the Intercare Alliance. When funding for ECCLI became available, a sub-set of four (4) institutions from the Intercare Alliance came together as the ECCLI Worcester consortium to collaborate the project. There are five workforce development partners to the project: The local Department of Transitional Assistance office, the Regional Employment Board and Workforce Central (the Career Center in Worcester) which will all counsel and recruit potential CNAs to be trained; the American Red Cross, which will provide CNA certification training and Quinsigamond Community College, which will provide ESOL training to existing unlicensed staff.

Goals

- Attract new entry-level workers into the Long-Term Care field
- Enhance the knowledge and skills of current entry level workers
- Enhance the quality of life for residents and
- Demonstrate effective collaborative and replicable efforts in Career Ladder Programs.

Activities Planned

- Work with the Department of Transitional Assistance, the Regional Employment Board and Workforce Central to counsel and recruit entry level workers and workers looking to make career changes
- Provide CNA certification training for new entry level workers, enabling current staff to be freed up for participation in Career Ladder training
- Offer a four-level Career Ladder training program with five training modules, including specialized training in Alzheimer's care, Death and Dying, Restorative Nursing, Mentoring and Precepting, and Leading and Coaching a Diverse Workforce
- Address the training needs of non-CNA entry-level staff, including activity assistants, housekeepers, laundry, and dietary staff, including those who want to learn more about caring for residents with Alzheimer's and/or increase their leadership skills
- Offer English as a Second Language (ESOL) preparation for entering Career Ladder training
- Prepare employees to explore college training, utilizing tuition reimbursement benefits or other scholarship programs for eventual career destinations in licensed nursing or rehabilitative therapy fields.

Governance

The administrators and human resource members that came together to write the ECCLI proposal serve as the principal governance unit for the ECCLI consortium. The ECCLI Consortium reports informally to Intercare Alliance to keep other institutions not involved in Round 2 of this grant informed of their activities. The Worcester ECCLI Consortium is comprised of three non-profit long-term care institutions that are religiously affiliated and one private, family owned long-term care company that operates 3 separate facilities as one corporate entity.

Leo P. LaChance Consortium

The Leo LaChance consortium represents the unique collaboration of Leo P. LaChance Center for Rehabilitation and Nursing, Wachusett Manor (a Genesis Eldercare Facility), Baldwinville Nursing Home, Quabbin Valley Healthcare, Heywood Hospital, the Montachusett Regional Vocational Technical School District, the Greater Gardner Community Development Corporation and the Mount Wachusett Community College. Leo P. LaChance is the lead facility in this consortium and oversight and management of the project has been delegated to Mount Wachusett Community College.

Montachusett Regional Vocational Technical school district currently operates a variety of allied health programs including an evening LPN program. The Greater Gardner Community Development Corporation serves Gardner and the five adjacent communities of Winchendon, Ashburnham, Westminster, Templeton and Hubbardston. Mount Wachusett Community College offers an array of academic certificate and associate degree programs whose foundation includes dynamic personalized teaching and comprehensive support services such as career development, academic counseling, and assistance to students in overcoming mental and physical barriers.

The partners are located in north-central Massachusetts. This consortium was built upon a prior partnership of three partners (Leo LaChance, Heywood Hospital, and Mount Wachusett Community College), who cooperated on an LPN training program prior to the ECCLI project.

Goals

- To increase the pool of individuals available for employment
- To improve retention rates of current employees
- To improve the quality of care provided at each member facility

Activities Planned

- Development and implementation of a modular career ladder program for frontline CNAs.
- Development and implementation of a modular peer-mentoring program for frontline CNAs.
- Development and implementation of a modular program for supervisors of CNAs.
- The addition of at least three new long-term care facilities to the consortium (already achieved)
- Reduction of the number of unfilled CNA, LPN and RN positions at consortium member facilities by 25%.

Governance

An executive steering committee and a curriculum committee govern the Leo LaChance consortium. The executive steering committee is the overall governing body with responsibility for providing leadership, making decisions, accepting recommendations of the curriculum committee, managing the budget, and approving consultants. The committee is scheduled to meet monthly and is chaired by the administrator of the lead nursing home. The committee comprises administrators of the long-term care facilities, and the project coordinator. Since this committee is newly formed no substantial issues have yet been discussed.

The curriculum committee is responsible for reviewing the needs of sites, of curriculum, of cultural changes and the evaluation of subcontractors. The committee meets weekly to undertake the needs assessment for the ECCLI project. The committee's membership comprises directors of nurses from every facility, educational specialists from the sites, and the project coordinator.

Loomis House (Pioneer Valley Consortium)

The Pioneer Valley ECCLI Consortium is managed by Loomis House, based in Holyoke, in western Massachusetts. The Consortium spans a wide area, from Greenfield south to the Connecticut border. The employer partners encompass three demonstration sites, all skilled nursing facilities: Loomis House, Riverdale Gardens of West Springfield, and Center for Extended Care/Amherst. Other extended care partners include two home health care providers, Collective Homecare of South Deerfield and Capuano Homecare of Holyoke. Education and training partners include three community colleges (Holyoke CC, Springfield Technical CC, and Greenfield CC); the Franklin/Hampshire Career Center and two Hampden County One-Stop Career Centers (Career Point and Future Works); two Regional Employment Boards (Franklin/Hampshire REB and Hampden County REB); the Greater Holyoke Chamber of Commerce; and the Greater Holyoke Community Development Corporation.

The Consortium is distinguished by its geographic reach and variety, as well as by the large number of partners. Its employer partners comprise urban and rural environments, for-profit and nonprofit organizations, and union and non-union settings. Some of the partners, including Loomis House, CareerPoint, Collective Homecare, and the Chamber of Commerce, have worked together in past training ventures, including ECCLI Round I and the Workforce Training Grant.

Goals

- Improve the quality of care provided at the three demonstration sites
- Improve employee retention in a difficult labor market
- Create career ladders that can support and sustain professional, economic, and educational advancement of entry-level workers
- Cross-train Home Health Aides and Certified Nursing Assistants
- Improve the perceived status of entry-level workers
- Improve and enhance the skills of licensed/supervisory staff
- Achieve systemic and sustainable improvements in the operation and physical environments of participating facilities
- Provide an analysis of best practices in order use this demonstration project as a replicable model

Activities Planned

- Identify and operationalize new care giving practices
- Identify core values and environmental issues; use management assessments to develop strategies for achieving organizational and cultural changes
- Conduct “Work Keys” job profiles of nurse aides, dietary workers, and housekeepers
- Upgrade the skills of direct care, housekeeping, and dietary workers to support new care giving practices; skill areas include English for Speakers of Other Languages, GED preparation, computer training, soft skills, clinical skills, homemaker training, and sanitation
- Demonstrate the use of learner-centered educational methods to support development of workers’ skills, including PLATO computer-based learning systems
- Utilize model workplace supervision and management practices that attract, support and develop the long-term care workforce
- Counsel employees on careers, develop personal career development plans, and provide ongoing case management services

(Loomis House/ Pioneer Valley Consortium continued)

Governance

The project is governed by an Advisory Committee with membership drawn from all partners (nursing homes, education and training providers), as well as other regional entities, including the Chamber of Commerce. Its role is to oversee the project and offer direction and problem-solving strategies. An Executive Committee, a working subcommittee of the Advisory Committee, guides the implementation process, makes strategic decisions, and ensures that the plan is carried out as proposed. Meeting weekly during the planning phase, it now meets monthly  is chaired by the Project Coordinator. Membership includes the nursing home administrators, the workforce development deans of the community colleges; the staff developers at the home care agencies; the project managers at the one-stop career centers, and representatives from the regional employment boards.

Maristhill Consortium

The Maristhill Consortium comprises two long-term care facilities – Maristhill Nursing and Rehabilitation Center and St. Joseph Manor Health Care – as well as the Middlesex Community College, Mass Bay Community College, and Massasoit Community College, the Metro south/West Career Center, Career Works of Brockton, the Education Development Center, Inc., Breaking Barriers Project, Alzheimer's and Related Dementia Association, Norton Associates, Covenant Health Systems, Caritas Christi Hospice, Red Cross, and Catholic Charities.

Maristhill Nursing and Rehabilitation Center is the lead agency of the consortium. It is a 30-year old, 123-bed, not for profit, skilled nursing facility that is part of Covenant Health Systems (CHS), a not for profit, Catholic health system. Maristhill has its own board of directors and for the most part operates autonomously except for certain policies and actions that must be approved by CHS or when operational assistance is needed. Maristhill has 125 employees, including 60 CNA positions.

St. Joseph Manor Health Care is a 118-bed, not for profit facility located in Brockton, MA. It has 150 employees, including 63 CNA positions. St. Joseph Manor Health Care also operates an adult day health care center and sponsors a child day care center. St. Joseph Manor Health Care will offer the same educational and training programs as Maristhill with the aim of building its organizational capacity to provide better quality patient care. It will evaluate all training and share dissemination efforts with Maristhill.

The community colleges in this consortium have an established reputation for offering high quality workforce training programs. They will provide the consortium with curriculum development assistance, employee training programs, classroom and experiential instruction and participation on the advisory board. The One Stop Career Centers will provide support and resources for job seeking, skills training and career counseling, as well as wide array of employer services. The centers will assist with recruiting and screening new employees, preparing employees for job interviews and conduct career, aptitude and skills assessments.

Goals

- Affirm the role of the nursing assistant as a valuable, integral team member with unique expertise in caring for the infirmed elder by providing a CNA career ladder
- Create an organizational environment that recognizes and appreciates the cultural diversity of its staff and patients and stresses respect at all levels – management, staff and patients
- Restructure care giving practices to integrate the Eden Alternative to Life philosophy and practices into the organizational structure

Activities Planned

- Hire a project manager.
- Establish an advisory board and working committees.
- Finalize CNA career ladder, including CNA curriculum, career ladder application procedures and job descriptions.
- Begin the process of developing program evaluation tools.
- Order supplies required to facilitate program implementation.

(Maristhill Consortium continued)

Governance

A main advisory board governs the Maristhill Consortium with responsibility for overseeing the implementation of the project. The board receives updates on project activities as well as information regarding the project and issues such as resident care. The advisory board meets once every three months and is chaired by the Human Resources director of the lead facility. Committee members include representatives from all consortia organizations, the city, a family member, directors of nurses from the lead facility, chief executive officers of member facilities and representatives from other organizations.

Sherrill House/Alliance for Continued Care and Training Consortium

The Sherrill House/Alliance for Continuing Care and Training consortium is based in Jamaica Plain, MA. Its lead partner, Sherrill House, a 164-bed skilled nursing facility, is partnering with three other ACCT members: Mount Pleasant Home, a retirement residence; Springhouse Continuing Care and Retirement Community (owned by Mount Pleasant), and Rogerson Community, a sponsor of various elder services, including grant partner Boston Alzheimers Center, an assisted living community. All facilities are nonprofit. The ACCT is also partnering with Jamaica Plain Neighborhood Development Corporation, WorkSource Staffing Partnership, and the American Red Cross.

The Consortium is distinguished by prior membership of the partners in the Alliance, a nonprofit established in 1998 to improve the quality of work and care, and offer a neighborhood-based continuum of care to local residents. Partners have collaborated previously on education and training ventures, including a Workforce Training Grant project focusing on dementia and palliative care. The Alliance has also sought since its founding to establish pooled human resource and training capacities between the participating work sites.

Goals

- Support the skills development, and career and wage advancement, of direct care workers and their supervisors
- Improve employee recruitment and retention rates, as well as the career and wage advancement of direct care workers
- Create efficient systems and practices when implementing project goals
- Improve quality of care and become the long-term provider of choice for the elderly and their families
- Become the employer of choice for direct care workers in the health care field

Activities Planned

- Creation of a centralized system for planning and delivering training programs to workers and their supervisors/managers, and pathways within and between ACCT partner organizations
- Building a better 'front end' system to recruit workers into long-term care and creation of a network to support new workers after they are hired
- Consolidation and centralization of recruitment, training, career advancement counseling and human resource functions; invest the 'savings' in initiatives for frontline workers
- Strengthen the continuum and continuity of care for elderly in the area through more seamless staffing, consistent philosophies and practices among Alliance members, closer ties with the neighborhood and local community

Governance

This consortium is governed by two committees. The Executive Committee is comprised of executive directors from each of the sites, and provides general oversight of the project coordinator's work. It is chaired by the Executive Director of the lead site. Implementation is guided by the Steering Committee, which is chaired by the Project Coordinator. Members include representatives from the training organizations as well as the executive directors of each facility. This group is also charged with offering leadership to the sites, "energizing the process" and providing vision. Specific issues include development of career ladder steps, the hiring process, training schedules and outreach programs for the grant. It now meets biweekly, with weekly meetings during the planning phase.

Appendix B: ECCLI Advisory Committee

Blanks, Carolyn	MA Extended Care Federation
Beauvais, Chris	Commonwealth Corporation
Chernow, Harneen	MA AFL-CIO
Dawson, Steve	Paraprofessional Healthcare Institute
Deschenes, Julie	Home and Health Care Association
Dreyer, Paul	MA Department of Public Health
Fox, Elaine	Commonwealth Corporation
Frank, Barbara	Paraprofessional Healthcare Institute
Gillis, Don	MA Workforce Investment Board Association
Gonzalez, Carlos	Worker Education Program/SEIU Local 285
Green, Claudia	Center for Community Economic Development/University of Massachusetts Boston
Griffen, Sarah	Jamaica Plain Neighborhood Development Corporation
Harris, Constance P.	MA Department of Transitional Assistance
Kane, Fran	MA Dept. of Education
McLaughlin, Kim	MA Dept. of Labor and Workforce Development
Misiorski, Susan	Paraprofessional Healthcare Institute
Motta, Janice	MA Community College
Munro, Peggy	MA Council for Home Care Aides
O'Neill, Paul	MA Dept. of Labor and Workforce Development
Osterman, Mary	Executive Office of Health and Human Services
Ostrander, Curt	Service Employees International Union Local 285
Palais, Lisa	Executive Office of Elder Affairs
Papadakis, Eleni	Commonwealth Corporation
Perrault, Andrea	MA Dept. of Labor and Workforce Development
Prins, Betty Jo	Alzheimer's Association
Ridley, Sandra	Commonwealth Corporation
Romanovitch, Theresa	MA Executive Office of Community Colleges
Sheridan, Laurie	Boston Workforce Development Coalition
Sherman, Elissa	Mass Aging
Singer, Emily	Boston Private Industry Council