Practice Concept Paper

Mercy Health Partners of Southwest Ohio: Senior Health and Housing Services Recruitment and Retention (R & R) Initiative

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Biography

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Executive Summary

This report describes one nursing home-based initiative that strives to improve quality by changing the prevailing culture in its four long-term care facilities. Preliminary evidence suggests that Mercy Health Partners of Southwest Ohio: Senior Health and Housing Services in Cincinnati, Ohio offers a promising approach to improving the quality of care and quality of life of its nursing home residents. Their recruitment and retention (R & R) initiative was designed to address the problem of recruitment and retention of frontline workers using a total quality management (TQM) approach.

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Background

Nursing homes touch the lives of an increasing number of Americans. Today more than 1.5 million individuals live in 17,300 nursing homes, and nearly 2 million employees work in them (Harrington, Carrillo, Thollaug, and Summers 1999). The nursing home population is expected to double in 25 years and triple in 35 years. In Ohio, the demand for personal care aides is expected to increase 85% between 1994 and 2005, and the demand for aides is expected to increase a similarly dramatic 75% during that same time (Ohio Bureau of Employment Services 1996). Nationally, the number of beds has mushroomed from 500,000 in 1963 to 1,175,865 in 1973, and to 1.8 million in 1997. Because of this growth, long-term care is also a big business. The industry grossed 87.5 billion in 1996, with projections of more than $100 billion by 2000 (Harrington et al. 1999).

The quest to improve quality in nursing homes is a continuous struggle (Institute of Medicine 2001). The last few years have produced an almost constant stream of reports and media accounts about inadequate nursing home quality (Scalon 2001). Not since the late 1980s, when the Institute of Medicine issued its groundbreaking report and Congress enacted the nursing home improvement sections of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), has this kind of attention been focused on nursing homes (Straker and Atchley 1999). What sets the present debate apart from earlier debates is that it is occurring in a labor market so tight that many states report that they cannot hire or retain the staff they need to provide adequate care (Cramer, Harmuth, and Gamble 1999). For example, on November 9, 2000 the Ohio Department of Aging's (ODA) Director,

Joan Lawrence, hosted a meeting entitled "*Governor's Summit: Health Care Workforce Shortage*," to address the issues of labor shortage. The Director reported that "labor shortage is a grave issue in the health care industry and needs to be addressed." (Ohio Department of Aging. (2001, p. 1).

According to the Institute of Medicine, success in improving the quality of nursing home care requires a combination of strategies. These include:

- Developing and implementing practice guidelines (evidence-based practice guidelines) (Institute of Medicine 2001);
- Strengthening clinical information systems (for example, the MDS data set which helps nursing homes organize their clinical activities to meet regulatory expectations for quality of care) (Institute of Medicine 2001);
- Improving regulatory standards (Institute of Medicine 2001);
- Establishing quality improvements systems internal to nursing homes (Institute of Medicine 2001).

This report describes one nursing home-based initiative that strives to improve quality by changing the prevailing culture in its four long-term care facilities. Preliminary evidence suggests that Mercy Health Partners of Southwest Ohio: Senior Health and Housing Services in Cincinnati, Ohio offers a promising approach to improve the quality of care and quality of life of its long-term care residents. Their recruitment and retention (R & R) initiative was designed to address the problem of recruitment and retention of frontline workers using a total quality management (TQM) approach.

Before examining the core elements of Mercy's R &R initiative and its applicability to other long-term care facilities in Ohio and across the county, it is important first to

summarize the key issues in nursing home quality and current research concerning quality as it relates to labor force issues.

Workforce Issues and Quality in Nursing Homes

Concerns about the quality of nursing home care and ineffective government regulation of facilities date back at least 30 years (Institute of Medicine 1986). OBRA '87 raised quality-of-care standards for homes that participate in Medicare and Medicaid and strengthened federal and state oversight (Edelman 1998; Hawes 1998). Following the law's implementation, several studies found evidence of improvement in nursing home care, including a decline in the use of physical and chemical restraints, reduced prevalence of dehydration and pressure ulcers, and less frequent use of catheters (Institute of Medicine 2001).

Despite these improvements, studies indicate that many nursing homes continue to provide inadequate care (Phillips 2001). The U.S. General Accounting Office (USGAO) has found that one-fourth of nursing facilities have serious deficiencies that have resulted in actual harm to residents or placed their health and safety at risk (Scalon 2001). Many of these facilities have had repeated serious deficiencies. Even when problems were identified, state and federal enforcement policies were not effective in ensuring that they were corrected and remained corrected (Institute of Medicine 2001).

There is a growing awareness among nursing home directors, state and federal regulators, consumer advocates, and others that staff shortages, high turnover, and insufficient staff training contibute to the problem (Cramer, Harmuth, and Gamble 1999). High turnover in nursing home staff-currently at 40 to 75 percent nationally and as high

as 500 percent in certain facilities-makes it difficult to recruit and retain a high quality workforce (Harrington et al. 1999). Staff turnover among certified nursing assistants (CNAs), who are at the front lines of nursing home care, is particularly detrimental to overall quality of care (Straker and Atchley 1999). Instability in the CNA workforce results in residents constantly receiving care from new people who often lack experience and knowledge of individual residents (Banaszak-Holl and Hines 1996). In such an environment, continuity of care is compromised (Tellis-Nayak and Tellis-Nayak 1989). The cost of continually training new staff, moreover, drains resources from resident care (Remsberg, Armacost, and Bennett 1999).

Low pay and hard work have always been obstacles to recruiting and retaining qualified staff in nursing homes (Atchley 1996). Near-full employment and stiff competition for entry-level workers in the last decade have exacerbated the situation (Ohio Department of Aging 2001). With far less physically demanding and less emotionally draining jobs in plentiful supply, the job of the nursing assistant has limited appeal (Straker and Atchley 1999).

Even with future downturns in the economy, the challenge of improving quality of care and staff retention will undoubtedly grow as the U.S. population ages. The anticipated five-fold increase in the proportion of the population age 85 and over in the next 30 years will increase demand for long-term care down the road (Mehdizadeh, Kunkel, and Ritchey 2001). For instance, William Scalon, Director of Health Care Issues at the USGAO reports, " the number of persons over age 85, those most in need of health and long-term care services, will more than double from 4.3 million in 2000 to 8.9 million in 2030, when the baby boomers first begin to reach age 85" (Scalon, 2001, p.9).

At the same time, there will be fewer workers to meet the needs of the disabled elderly population (Ohio Department of Aging 2001).

Without significant changes in employee incentives and the work environment, nursing homes will continue to encounter difficulties in recruiting and retaining committed paraprofessionals (Straker and Atchley 1999).

To improve our understanding of the issues surrounding recruitment and retention of frontline workers, this exploratory, collaborative analysis was designed.

Methodology

The most appropriate investigative methodology for problems where mechanisms are not well understood is qualitative, hypothesis-generating research. Through direct observation, interviews, and an intensive case study method, research was conducted on Mercy Health Systems Recruitment and Retention (R&R) Initiative. This paper reports findings from observational field research in four long-term care facilities. Numerous interviews with workers, managers, and a corporate official were conducted.

Research on Quality and Workforce Issues

Nursing home quality has a number of components that interact to affect residents' health, functional status, and quality of life (Phillips 2001). Over the past 20 years, researchers have attempted to understand better how policy (i.e., regulation and reimbursement); clinical interventions; management practices; and individual worker, resident, and family characteristics account for variation in nursing home quality. Although the literature is equivocal on the relative magnitude of the impact of each of these domains, clinical and management practices appear to be most responsible for the

outcomes experienced by nursing home residents (Bowers and Becker 1992). As an illustration, the Institute of Medicine, reports "Training, supervision, environmental conditions, leadership and management, and organizational culture (or capacity) are essential elements in the provision of quality care to residents" (Institute of Medicine, 2001, p.190).

Davis argues that research into the relationship between quality and organizational or workforce factors have been largely anecdotal (Davis 1991). Most of the work has simply described various management or job redesign efforts, training activities, and financial reward and non- monetary reward programs. A few empirically based studies, however, have identified several important factors related to staff satisfaction and lower turnover rates (Flood 1994). Dimant's 1991 study of a nursing home transformed through a comprehensive CQI/TQM program exemplifies how the methods of modern quality improvement can be used in nursing homes. A formal structure for continuous improvement cuts across functional and hierarchical division and includes suppliers and vendors as well as residents and their families. Interdisciplinary patient care teams were implemented. Nurse aides were given increased responsibility for psychosocial care and relieved from housekeeping duties. However, because the study focuses on a single facility, its generalizability may be limited.

In one of the most ambitious studies to date, Banaszak-Holl and Himes (1996) examined factors that determine turnover among certified nursing assistants in 254 facilities in metropolitan areas of 10 states. The authors examined the effect of intrinsic rewards such as job satisfaction and sense of belonging, and extrinsic rewards such as wages and benefits. The elements of job design, including the extent of CNA

involvement in resident care planning and assessment, in-house training, and workload, were also examined. Finally, the researchers considered ownership status (commercial, nonprofit, or public), average number of beds, proportion of residents insured by Medicaid, and strength of the local economy.

Not surprisingly, Banaszak-Holl and Himes found that local economic conditions had the strongest effect on turnover rates. But one of the most important findings was that nursing homes in which mid-level managers were receptive to their nursing assistants' advice, or at least discussed care plans with aides, reported turnover rates one-third lower than those in nursing homes without this nursing management philosophy. Furthermore, homes where CNAs were involved in the care plan meetings experienced turnover rates 50 percent below those of other facilities. Turnover rates were not affected, however, by greater CNA involvement in resident assessments.

The researchers suggest that CNA involvement in care planning meetings might give aides a greater sense of responsibility for, and authority over, actual resident care. Based on this research, simply involving CNA in resident assessments is not sufficient. Frontline workers must be able to observe a direct link between the information they provide about residents and the subsequent tasks undertaken. The study underscores the importance of formal communication channels between management and paraprofessional staff and the value of group problem solving.

Given the challenges of addressing quality (of care) and workforce issues in nursing homes, it is crucial to examine systematically models that work in the real world (Sainfort, Ramsay, and Monato 1995; Berwick 1989). Those that combine effective practices identified in the research studies with tested quality-improvement methods used

in business and industry offer new opportunities to change the way care is delivered to residents (Ramsay, Sainfort, and Zimmerman 1995; Gagel 1995).

The individual worker is fundamental to the quality improvement paradigm (Gaucher and Coffey 1993; Milakovich 1991). Staff at each level of an organization must understand the processes that relate to specific outcomes the organization values-that is, all members need to see how their work affects the end products (Phillips 2001; Shortell, O'Brien, and Carman 1995). Quality improves when employees understand the data used to measure outcomes, are able to make necessary changes in the way they perform their jobs, and can reexamine data to see if their changes have made a difference (Institute of Medicine 2001). Critical to the quality improvement paradigm is an organizational culture that stresses staff involvement in quality monitoring and empowers staff to alter work activities as needed (Gaucher and Coffey 1993).

Mercy Health Partners

Although there is a plethora of literature that addresses quality assurance in nursing homes, there is very little information on quality improvement. One example comes from Ohio, where Mercy Health Partners (MHP), Senior Health and Housing Services has initiated a total quality management/continuous quality improvement program to address recruitment and retention problems.

Mercy Health Partners is an integrated, holistically based, healthcare delivery network with more than 85 care delivery sites in Southwest Ohio. Mercy Health Partners encompasses six acute care hospitals, four long-term care facilities, two social service agencies, four urgent care centers, and a number of health centers, home health agencies,

surgery centers, hospice programs, centers for health and wellness, outreach programs and an array of other programs and services.

MHP is a member of Catholic Healthcare Partners, the seventh largest not-for-profit health system in the United States and the largest in Ohio. It serves the healthcare needs of people in Ohio, Indiana, Kentucky, Michigan, Pennsylvania, Tennessee and contiguous states.

With four long-term care facilities, senior housing and specially designed programs, Mercy Health Partners provides a range of healthcare and housing options and services for the unique needs of older adults.

Mercy Franciscan at Schroder (MFS)- provides skilled nursing, assisted living and Alzheimer's units. Cottages are also available. **Mercy Franciscan Terrace (MFT)**- provides multiple levels of care including independent living, residential care, long-term/skilled nursing, outpatient rehabilitation with a warm water therapy pool, an Emmanuel Unit (a unit for nuns) an Alzheimer's Unit. **Mercy Franciscan at West Park (MFWP)** provides multiple levels of care including independent living, residential care, long-term/skilled nursing, respite care, an Emmanuel Unit and an Alzheimer's Unit. **Mercy St. Theresa Center (MSTC)** offers congregate living, assisted living, Alzheimer's assisted living, general nursing care, transitional care and the McAuley Unit specializing in Alzheimer's and dementia care.

MHP aims to ensure that its facilities use best practices to deliver high-quality care at an affordable price. Mercy Health Partners operates under the assumption that providing excellent care is cost-effective, and that an investment in setting up a data- driven quality-improvement system benefits all the long-term care facilities in the long run. For the past

year, Mercy facilities have been dedicated to creating an organizational culture centered around its residents. According to the data, Mercy Health Partners, Senior Health and Housing Services have made substantial progress in improving quality, recruiting and retaining frontline staff, and redirecting resources to care-related activities.

MHP decided that they needed to understand their turnover problem and that in order to succeed they must establish a positive retention environment. Furthermore, MHP learned that if they were successful in retaining their CNAs there would be little need to recruit CNAs. They felt that there would not be much long term value in hiring, even high quality CNAs if most of them were going to leave almost before they started. Therefore, they learned that they must be able to retain their high quality CNAs. They started by hiring a consultant, Clint Maun, who helped them to identify their six primary causes of turnover.

- Ineffective Orientation
- Lack of fun
- Inflexible scheduling practices
- Ineffective supervision
- Negative attitudes (on the part of staff)
- Poor employee selection

Creating a Positive Organizational Culture, the Cornerstone of Retention

To address MHPs turnover issues they started by creating a positive organizational culture. Organizational cultures consist of commonly held beliefs and values about work life. For example, “a strong culture, with well-socialized members, improves

organizational effectiveness because it facilitates the exchange of information and coordination of behavior" (Denison, 1990, p.9). The actions and decisions of organizational leaders create and reinforce key values and shape the culture. MHP learned that their current management practices caused anxiety, lack of trust, and self-protective behaviors among its workers. It wanted to move to a culture where there were strong feelings of trust, collaboration, and practices that contributed to the development of each worker's competence and self-esteem.

A positive culture is one where employees experience pride in their work, where everyone is involved and committed to continuous improvement, where people freely help each other to achieve goals and have fun during the process. In positive cultures people feel appreciated, their opinions are solicited, and action follows suggestions. Berry describes a positive culture as "one where there is an attitude based on trust, teamwork, objective problem solving, and shared accountability" (Berry, 1991, p.23). With a positive culture there is positive thinking, which is an organizational energizer. People are able to see new possibilities and are open to change. They develop confidence that they can solve problems themselves, and they need little or no supervision. They also take calculated risks and stretch their learning potential. Peak performance becomes possible in this type of environment.

After establishing a positive organizational culture, MHPs focused on retaining quality CNAs. MHP learned that their good, faithful CNAs (those who had been with the company over two years) had an appetite for satisfaction that was bred deeply in their personal value system. Creating a positive organizational culture helped MHP retain higher quality CNAs. Working for years in one nursing facility requires commitment.

CNAs do not make long term commitments to stay at a facility based on the rules, regulations, policies, procedures, limitations and restrictions. These were the primary issues covered in MHP's previous orientation program.

MHP also redesigned its orientation process to make it a values-based orientation process. The theory behind this was that MHP would get commitment from its new CNAs by offering them a value based orientation. Good CNAs who find shared values at MHP usually stay. MHP incorporated six values to CNAs: a chance to serve, love, care, be compassionate, be with people, a chance to help others and a chance to be part of a quality long-term care organization. They arrived at these values by asking workers the following four questions:

"What do we, as an organization, really care about?"

"What do we stand for?"

"What are we willing and able to deliver to our customers?"

In additon, they asked their long-time aides, "Why have you stayed?" and "What keeps you going?"

As a result of creating a positive organizational culture, MHP was able to retain its quality CNAs. For instance, one of the things that MHP learned was that failure to orient new CNAs causes 36% of all employee turnover (Maun, Lind, and Efta 2000). No other single cause accounts for more with respect to turnover. Furthermore, Maun-Lemke research also showed that 75% of all employees who eventually self-terminate, made their decision to leave during the first three days on the job. Many had implemented the decision within hours of reaching it whereas other CNAs had put it off until they could find a better job. This showed that the first three days in the employment life of new

CNAs are vital to retention. In addition, this coincided with the old marketing adage that states, " You never get a second chance to make a first impression." MHP learned that a positive organizational culture helps to make that critical first impression during those first three days when the decision to leave or to stay is being made.

Education and Training

Successful implementation of a quality effort depends on strong, customer-responsive education and training. MHP learned that without an appropriate quality curriculum, the required change can not occur. As an illustration, Deming said, "long-term commitment to new learning and new philosophy is required of any management that seeks transformation. The timid and the fainthearted, and people that expect quick results, are doomed to disappointment" Deming, 1986, x).

The quality of line supervision plays a major role in the ability of a facility to recruit and retain quality CNAs. A major problem in MHP facilities was the fact that beyond the Administrator and Director of Nursing (DON) in the nursing department, no one took responsibility for supervision. This was a result of a lack of training and education of supervisors. Nurses said that they were so busy passing medications, giving treatments and doing assessments and the endless paperwork that came with their job that they felt that they could not possibly take time to supervise. As a result of these issues MHP came up with a skill-training program for line supervisors. The skill-training program consisted of six areas:

- Self-awareness
- Role acceptance
- Team building

- Employee development and discipline
- Solution orientation
- Personal organization

MHP's skill-training program for supervisors began with self-awareness. It was important, if not essential, that the supervisor have a firm understanding of his/her own individual personality and its attendant strengths and weaknesses. Line supervisors needed to know how they impacted on others, how they came across to their employees, what they did well and they did not do so well. Clint Maun says that a number of tools are available to enhance self-awareness. Simple personality inventories can be quite useful in this area, as long as there is practical discussion with the supervisor on how to capitalize on what is learned (Maun, Lind, and Efta 2000).

The second element in skill training for line supervisors is role acceptance. One of the things MHP learned was that a lot of their line supervisors did not know how to supervise and that they did not even accept the fact that they should supervise. Since most supervisors started out in line positions, many did not change their internal vision of themselves. They remained "just one of the workers," never acknowledging the change in their management status. It is very hard to get nurses, whose focus is on passing medications, giving treatments and other important tasks of resident care, to accept the fact that management and supervision are legitimate roles in their jobs. One of the things that MHP learned was that many nurses did not accept responsibility for their supervisory role because they lacked confidence in their own judgment. This was addressed by giving them practice in decision making by presenting them with a problem, asking them for a solution, and offering a constructive critique of the solution. In addition, MHP learned

that nurse supervisors have to be led to see that much of the work they are held accountable for is controlled by their CNA staff. Effective, timely supervision increases the quality of that work and therefore the perceived effectiveness and reputation of the nurse supervisor.

The third essential supervisory skill for line supervisors is team building. MHP thrived on a feeling of family, a feeling of a team. Essential to the heart of effective employee retention is the ability of a nurse supervisor to forge that sense of a team in the working unit. In developing strong teams, loyalty was a very important issue because it is essential that staff (at all levels) be loyal to the facility.

Nurse supervisors also needed training on employee development. MHP wanted their nurse supervisors to do more than just discipline. They also learned how to conduct ongoing performance evaluations. Good employees like to know how they are doing and who could better tell them than their direct supervisors? CNAs need to feel that their work is appreciated. Appreciation consists of such things as patting employees on the back and letters suitable for framing. MHP learned that appreciation is the most important motivational factor to CNAs. Therefore, showing appreciation to CNAs is very important.

Line supervisors also need training in solution orientation. Line supervisors should see their job as preventing and solving problems, not commiserating about them. Nearly every problem has a solution if a manager is committed to finding it. Finally, personal organization skills help to bring the whole supervisory picture together. Once the management role has been accepted, considerable time needed to be spent showing nurse supervisors how to manage their time so supervision became a by-product of doing their

work and not an add-on. MHP learned that high quality supervision could be accomplished by a sharp, observant nurse as she went about her rounds passing medicine. In those rounds the nurse had the opportunity to observe several CNAs in action and could quite effectively handle counseling situations while passing medications.

CNAs training was a little different. One of the first and most important issues to address for CNAs is relationship skills. MHP integrated this training into CNAs orientation process. MHP learned that issues like poor communication, lack of teamwork, conflict, stress or customer complaints drive CNAs to leave. MHP felt that it had not given CNAs the proper tools to deal with these issues, and as a result MHP had created an opportunity for new CNAs to fail. MHP incorporated six relationship skill areas into its orientation material:

- Conflict resolution
- Teamwork
- Stress management
- Resolving customer complaints
- The impact of negative attitudes and
- How to break into the social structure

In addition, MHP required a minimum of four contacts with the supervisor within the first three days of a new CNA's work. This helped the new CNAs feel comfortable because they knew that their supervisor was interested in them. A very important lesson that was learned was the new hires need acceptance into the work group social structure. MHP also created a buddy system in which new CNAs were paired with existing CNA's.

Furthermore, MHP gives a small reception for all new hires to help them get acquainted with current CNAs on their shift. This helped new CNAs feel welcomed by their peers.

Effective Recruitment

MHP's recruitment program started by focusing on the high quality CNAs that they already had. They learned that their turnover problem was partly a result of the CNAs they had been hiring. They started by identifying the characteristics of high quality CNAs. This was done by surveying department heads and asking them to list the five most important characteristics they valued in a quality CNA. They also identified their three best CNAs and then listed the five most outstanding performance characteristics that each CNA exhibited. The pattern that emerged was the kind of CNA that MHP wanted to recruit and hire. The following is a list of the characteristics that were identified by this process.

Essential CNA Success Characteristics

Dependability	Positive Attitude	Compassion
Reliable	Upbeat, not a complainer	Caring
Conscientious	Flexible with change	Kind
Good attendance	Cooperative/does extra	Patient
Follows instruction	Eager to learn/improve	Thoughtful

Initiative	Loyalty	Efficiency
Self starting	Truthful	Thorough
Enthusiastic	Supportive	Safe
Resourceful	Honest	Timely
Creative	Trustworthy	Not wasteful

Effective recruitment also consists of accurate targeting; targeting based on understanding the high quality CNAs that MHP already possessed. The information from the surveys provided MHP with the information that they needed to formulate their interviewing questions.

Next MHP put together a Talent Group (a group of MHP CNAs that exemplified all of the positive performance characteristics) that was composed of MHPs best CNAs. This group told MHP what it was doing right and what MHP was doing wrong. They told management what benefits they'd like to have, and what it takes to solve MHPs turnover problem. As an illustration, Mercy Franciscan at West Park awarded its talent group different color name badges to display their involvement in the Talent Group.

This group was brought together for a meeting and was asked the following question. "Why do you like your job?" Here are some comments that emerged:

The personal contact with my residents is a major plus. Getting close to my residents and their families. Also, helping families learn and deal with the hardship of Alzheimers' Disease. Every day, on the job, is different. New challenges and several rewards arise from my job. I enjoy getting close to and knowing my residents, not just a quick hello-good-bye relationship.

The residents. The elderly are a very special people which we are able to learn a great deal from. I enjoy the people I work with. Good working conditions. The atmosphere always has a great deal of love and caring.

An opportunity to lend a hand to people forgotten by society and in such desperate need of medical assistance. To develop a long-term relationship with the patients and their families, not easily attainable in the hospital setting.

Research by Maun-Lemke Inc. showed that for every three CNAs a long-term care facility have on their Talent group, CNAs will refer, on the average, one good employee

every six weeks who will work for a long-term care facility at least eighteen months (Maun, Lind, and Efta, 2000, p.69).

MHP also featured high quality CNAs in their advertisements. MHP used a five part targeted ad approach to recruit high quality CNAs. The first part of the ad was the greeting. It began with a simple statement like this:

"Meet Mary Smith, one of the very special CNAs at Mercy Health Partners."

The introduction set the focus for what was to come. It showed that MHP was looking for high quality CNAs.

The second part of the ad was the "Why We Like Mary" section.

Since MHP was targeting to a specific type of CNA, the ad made it clear what MHP considered to be important characteristics of a high quality CNA. [Referring to the key performance characteristics of high quality CNAs] The listing in this part of the ad looked like this:

Mary is exceptional in so many ways. Her:

Dependability
Positive attitude
Compassion
Initiative
Loyalty
Efficiency

"Would take her to the top of any profession she chose."

In writing the ad this way, MHP was able to show the kind of CNAs that they wanted to hire.

The third part of the ad was the "Why Mary Likes Us." This part of the ad featured the statements of CNAs in the ad, along with a picture of a high quality CNA.

The appeal was the fourth part of the ad. The appeal began with a statement like this: “If you are like Mary and want to join her and the many others like her at MHP…” The ad also included the name, telephone number and suggested times to call the CNA. The fifth and final section of the ad was the picture of an actual CNA.

Targeted advertising turned out not only more applicants than traditional advertising had but also better quality applicants. Moreover, these ads were uniquely effective in encouraging high quality CNAs not currently active in health care to give it a try again. Targeting for recruitment took time, but was time well spent. The results for MHP were higher quality applicants, better quality staff, better resident service and infinitely fewer management issues.

Conclusion

In conclusion, using the principles of TQM, MHP was able to effectively address its recruitment and retention problem. They started by identifying the primary causes of turnover. MHP learned that understanding the causes of turnover would not be enough. Next they established a positive retention environment. They started with a passionate orientation program. This was effective because it convinced new CNAs that they were part of something really important and good. Their orientation system tuned new CNAs into MHPs shared value system. MHP also began to have fun at work. CNAs began to smile, laugh and enjoy their jobs more. MHP learned that without fun on the job, the environment can become frustrating and depressing. A fun work environment produces quality, profit and it contributed to higher retention rates for all four facilities. Quality of supervision also played a major role in their retention effort.

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