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Extended Care Career Ladder Initiative (ECCLI) Round 2: Evaluation Report

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Extended Care Career Ladder Initiative (ECCLI)
Round 2:
Evaluation Report

Prepared for the Commonwealth Corporation

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–Randall Wilson, Susan C. Eaton and Amara Kamanu

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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

Executive Summary

Purpose

The Commonwealth of Massachusetts initiated the Extended Care Career Ladders Initiative (ECCLI) as part of a broader Nursing Home Quality Initiative, adopted by the Legislature in 2000.[1] Both acts were 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 2 asks long-term care providers to mount demonstration projects that test this equation, by partnering with other providers, and with workforce development organizations (including community-based groups, unions, workforce development agencies, and community colleges). Sponsors hope that such projects will offer clear and replicable models for both the long-term care industry and the workforce development community.

ECCLI's 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 Certified Nursing Assistants (CNAs). To achieve these goals, The Massachusetts Legislature invested $5 million in three rounds of the ECCLI project for Year 1 (FY 2001), and an additional $5 million for Year 2 (FY 2002), with approximately $2.4 million of those monies devoted to the Round 2 project.

[1] 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 of the Baseline Report on ECCLI* for Committee membership list) to help shape the initiative, and this evaluation. While the legislation calls for a career ladder initiative, the particular form of ECCLI, including Round 2 covered here, was designed with stakeholders to address specifically some of the complex organizational and quality issues facing nursing homes and their workforces. The Baseline Report published by CommCorp in November 2001 (Eaton, Green, Osypuk, and Wilson, 2001) explains the history of the initiative in more detail.

Evaluation

This report is the second and final report of the first full year evaluation of the ECCLI program.[2] It covers activity and achievements of the Round 2 consortia of nursing homes, home health agencies, and workforce partners during the period July 2001 through April 2002. It serves as a "progress report" and follows a case study approach as its main evaluation method, as well as reviewing project-wide data where available. Case study data were gathered from six individual facilities in five of the seven Round 2 consortia. The in-depth cases were selected to reflect a range of strategies, conditions, and partnership arrangements. In total, more than 80 interviews were conducted for this report.

Between August 2001 and April 2002, the researchers interviewed 41 frontline workers, nine of their supervisors and 10 workforce partner organizations associated with the five case study sites. Seven Project Coordinators (PCs), representing all consortia, were also re-interviewed after nearly one year of ECCLI implementation activity. The researchers also interviewed a union representative, a director of a participating home health agency, and seven additional facility managers, such as HR directors, staff developers, or assistant directors of nursing, where their role in ECCLI Round 2 implementation was key. Survey data were collected from 161 training participants (who completed anonymous voluntary short survey forms distributed to them at training by their trainers). These were complemented by information that researchers obtained from attending 10 project coordinator meetings and multiple technical assistance sessions for ECCLI sites. In addition, researchers documented and evaluated an innovative bathing "care practice" in one consortium. Finally, researchers utilized spreadsheet data reported by facilities on consortium activities, participant data, and certain trends in each workplace, such as hiring, exits, and recruitment costs. These latter data, however, were not always complete or current, and will be supplemented in a future report if funding and data become available.

[2] A baseline evaluation report was completed by two university-based research teams and published by the Commonwealth Corporation (CommCorp) in October 2001 that describes the initiative more fully (see Eaton, Green, Osypuk, and Wilson 2001.) Based on general information collected from all seven consortia

Current Status of the ECCLI Consortia

As of April 2002, all seven Round 2 consortia had instituted programs to increase workers' skills and career mobility, and to enhance residents' quality of care. The design of these programs and their approach to career ladders varies widely, befitting ECCLI's role as a demonstration project or "learning laboratory." There is diversity in the length and formality of career ladders, the content of instruction, the attention paid to changing care practices – and even in the definition of a career ladder itself. But common to all is an effort to change the way work is done, by building skills and changing the way that managers, workers, and consumers see the nursing aides' job. And each project has a story to tell. Most tell of improved skills, increasing wages, lower turnover, better employee attitudes and signs of improved quality of care. However, they also reveal important roadblocks to these goals.

Training is one of ECCLI Round 2's most visible accomplishments to date. More than 600 workers in 27 facilities or home care agencies have received training in a wide array of skills, ranging from clinical knowledge and care giving skills to generally applicable skills, such as English for Speakers of Other Languages (ESOL), Spanish for Health Care Employees, teamwork, communications, and problem-solving in difficult work situations. Both workers and managers have expressed positive reactions to the training, and some expressed reservations as well. Workers we interviewed believe that they are acquiring valuable skills, and that the training is helping them do their jobs better. Managers and project coordinators mirror their perceptions, remarking on improved clinical skills, more demonstration of leadership and self-confidence, and enhanced communication skills. A few managers and workers, however, have questioned the applicability of certain training courses – such as computer instruction intended to help employees gain access to information – to their work lives. Others had problems with the logistics of taking courses, especially scheduling time away from overworked colleagues and the nursing floors, or with supervisory

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and all participating facilities, it covered the startup period for ECCLI's most complex initiative, known as Round 2, which ran from February through June 2001.

practices that restricted using their new skills in their units. Certain courses that were popular in some consortia had limited or no demand in others.

Most ECCLI consortia have also taken small steps in improving the earning power of nursing aides and service workers. Most case study sites reported wage increases, whether for completion of career ladder courses, or for moving to certified nursing assistant from dietary or housekeeping roles. (In one case, wage increases were on hold pending union negotiations with management and finalization of career ladder steps.) The wage increments are modest, generally in the range of 3-4%, or from 30 to 50 cents per hour. More than seven in 10 workers surveyed had received a pay increase because of the training; the majority found their raises moderately helpful but not significantly so. Some workers expressed frustration with the size of pay increases relative to their increased responsibilities in areas such as patient assessment. Workers and supervisors agree that "inadequate compensation" continues to be a prime cause of workers leaving their jobs, and, for workers, a "big problem" in their lives.

ECCLI employers are also finding it easier to find and keep workers since implementing the program, particularly in nurse aides and ancillary staff. Licensed nurses continue to be scarce in some cases, although the program was not directed to solving this problem. While data on employment by facility are incomplete, what is available shows that participating workplaces are seeing fewer vacancies, lower staff replacement costs, and some reduction in employee exits or turnover. For nearly all facilities providing data, the number of CNA openings was down; half of these reported virtually no openings for nurse aides. This is a major change from the time period when ECCLI began, in February 2001. A majority also reported lower recruitment costs and "agency fees," or costs paid to employment services. But this good news cannot be attributed solely or definitively to ECCLI, though interview data show there is a direct relationship with the program. Economic recession, aggravated by the effects of September 11's events, cloud the picture. Still, a number of facilities report that ECCLI – in tandem with its companion program for nursing aide scholarships – has been a "huge recruitment tool," as one project coordinator put it.[3]

[3] Another part of the Nursing Home Quality Initiative included a scholarship program for workers entering CNA training. This portion, funded with $1 million in FY 02, was administered by the Massachusetts Extended Care Federation, and open to all Massachusetts residents who met certain criteria.

In nearly all cases, the ECCLI consortia have progressed in establishing career ladders in their workplaces. At most participating facilities, structures are being established to guide frontline direct care and service workers along paths leading to higher wages, skills, and recognition. In all but two cases, the career path does not provide formal titles, promotions, or job descriptions, but does recognize and encourage educational attainment. One project coordinator explained, "The training is mainly an opportunity to improve confidence levels, team [work] and to expand their knowledge base. A CNA is a CNA." This reflects the fact that the state licensing and certification agencies do not recognize multiple levels of CNA training, although nothing prevents nursing facilities from doing so. Another administrator described the variety of worker perspectives sparked by career ladder programs:

> *"Some are going back to school. Some are getting better with English. They feel that they can improve their lot in life. They say, 'I'm not going to be a nursing assistant forever,' and they never said that before. They want to go on. Or they want to be the best nursing assistant in the place, and that's fine. They're proud of what they do."*

One consortium de-emphasized formal CNA career steps, choosing instead to focus on certification of nursing assistants and remedial education, in part because the lead facility believed its existing corporate training/career program was a sufficient career path. While the consortia have some distance to travel in making the ladders and their associated gains sustainable beyond the first full year's ECCLI contract, the facilities' leaders are seeing good effects now on the climate of work and interpersonal relations in the facilities. Most workers report very high commitment to the success of their long-term care employers as well as to their residents, and they attribute this to their training specifically. CNAs are taking on more leadership roles, according to supervisors, including serving as role models or mentoring newer employees, as well as doing such basic but vital teamwork tasks as covering for each other on breaks. Employees have been especially positive about curricula that help them deal with emotional issues such as death and dying, and understanding better the experience of a resident with dementia or Alzheimer's disease. Aides are

enthusiastic about improvements in care practices, such as bathing becoming more individualized, where these have occurred. Diversity training has helped make cultural differences more transparent and understandable and this was a popular program especially in urban and suburban areas. Even attending classes together has helped some employees from different departments get to know each other better, thereby improving working relationships.

Progress in changing the practices of care giving has also occurred, though not evenly across the participating consortia. One of the most significant changes is the "individualized bathing" initiative adopted by several facilities in one consortium, documented below (Section II F, Culture and Practice Changes, and Appendix B). It is intended to reduce anxiety and distress in residents with dementia. One facility has instituted "neighborhoods" for residents and staff to create a more homelike environment. Another is providing more holistic and alternative care. Several consortia and coordinators have expressed interest in learning more about 'culture change' and a more resident-centered and worker-centered approach to care giving. Over 150 people from ECCLI consortia deepened their learning by attending an April technical assistance (TA) session with Dr. William Thomas, founder of the well-known "Eden Alternative" model of care. A smaller but substantial number (about 70) heard a similar presentation in May by Tom Zwick, also an advocate of changing the culture of care giving. Two ECCLI facilities sent 20 individuals altogether to a more in-depth 3-day Eden Associates Training.

Judging the effects of ECCLI on quality of care is difficult at this early stage, especially since necessary data were not available to the evaluators by April 2002. But reports from workers, supervisors, and project leaders we interviewed paint a positive portrait. Residents are ambulating more with assistance from newly trained aides. Aides are more patient with residents and understand their perspectives better in some cases. Self-confidence and self-esteem are up among workers who have gained skills, whether in English, in care giving, in food service, or in other areas. Morale seems to have improved at several facilities, and some nurses have been able to spend more time with resident care since aides have taken over some coordination and leadership functions, or even dining hall duties in one case.

Barriers to Progress

In a project as complex and novel as ECCLI, barriers to progress are inevitable and can provide an opportunity for learning. Some, especially those internal to the provider organizations and their partners, are to be expected in ventures of this kind. Others, arising in the legislative and administrative context of the project, are harder to predict and manage.

Perhaps the greatest "internal" obstacle has been balancing the implementation of a complex project with daily operational demands of running a 24-hour nursing facility. The compressed project schedule (of one year for implementation) contributed to these problems. Despite the initial planning process of three or four months, implementation simply took longer than expected, hindering progress on achieving training, career ladder, and quality of care goals. This is especially true of organizational change efforts.

Other barriers have included difficulties in developing employer partnerships, variations in the performance and responsiveness of community colleges and other training providers, and greater needs than expected for remedial or basic education for workers. Turnover of staff at CommCorp early in the ECCLI project, repeated turnover in leadership at some facilities, and changes even in the project coordinator roles have been problematic. Paying full costs of wage replacement while training is wonderful and effective for workers, but hard for facilities. Paying less than full costs reduces participation and increases the burden on workers. Organizing and sustaining career ladder training programs requires serious investment at the facility level, sometimes at a time when staffing is still a problem and when funds are falling even shorter than usual for basic care provision. Finally, most nursing facilities were not prepared and did not have internal capacity readily available for the administrative and quality data reporting requirements that accompanied ECCLI contracts. As a group, they also probably required much more intervention and technical support than was planned.

Less predictably, ECCLI contracts were slowed or halted by the extended state budget process in 2001, in some cases for six months or longer. In addition, legislative language in FY02 severely reduced the

amount of funding available to Commonwealth Corporation (CommCorp) to administer the program and discouraged project-wide technical assistance. This left CommCorp with the responsibility of administering a total of $10 million in ECCLI contracts, with only one full-time director and one part-time program manager dedicated to the project. The budget process and administrative staff shortages have resulted in delays in getting all planned activities up and running and enabling staff to meet proactively with sites in all rounds to assess progress. And the loss of planned statewide technical assistance and documentation of best practice information may have slowed the learning and implementation of these practices at the Round 2 facilities.[4]

Lessons Learned to Date, and Next Steps

These lessons are preliminary, reflecting ECCLI Round 2 projects that have not completed their work and the lessons have not yet been reviewed by ECCLI participants or advisors. However, they are based on the evidence presented in this report, drawn from interviews, project documents, and observations. We welcome feedback on these lessons.

A. Training

- *Entry-level workers – especially those in service departments such as laundry, housekeeping, or dietary – often need more educational preparation than expected by Round 2 project staff.*

- *Training in Alzheimer's disease and Related Dementia (ADRD), Dementia Care, Restorative Care and Therapeutic Activities has positively affected care giving.*

- *To improve attendance, schedulers and nurse managers should be fully involved in the planning of training activities with vendors and facility staff.*

[4] As explained later in the report, the main TA provider on organizational and cultural care practice change, the Paraprofessional Health Institute, did not have a contract after June 30, 2001, and a new

- *For classes on Diversity, or one-on-one career counseling where workers might be asked to share more openly, educating participants about the benefits of such training can encourage this openness.*

- *Beyond their instructional benefits, trainings create a forum for the interaction of workers from different departments. This helps to foster building of relationships across departments (such as nursing and dietary) and between frontline workers in different facilities. This can help in breaking down "turf" barriers, aiding cooperation, and enhancing understanding of different approaches to care giving.*

- *Modifying curricula to make them more "learner-centered" – interactive, visual and/or better attuned to learners with little (or negative) formal school experience – has been valuable and valued by employees.*

- *Consortia need more support and guidance in establishing systems that will ensure more complete, consistent, and detailed record keeping of their training activities. Current capacity often does not exist to do this.*

B. Career Ladders

- *Individual mobility and overall progress for the facility are furthered by having a discrete staff development function, either in the organization or shared across facilities.*

- *A few rounds of classes, by themselves, are not enough to change jobs, attitudes and care giving outcomes. Other areas of work are also necessary.*

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contract was never negotiated. This report is not designed to evaluate why that occurred, but restricts itself

C. Wage Improvements

- *Wage increases need to be meaningful so as to foster worker commitment to the program and to allow workers to reap the tangible benefits of ECCLI in the long run.*

- *Clarity about wages increases, how much to expect, when to expect them, and what is required to earn them, is valued.*

D. Worker Attitudes

- *Nearly 90% of employees interviewed and surveyed are either very committed or highly committed to their jobs and their facilities' success.*

- *Fewer, only about half of participating employees, are satisfied with their jobs, but more than that are motivated to do a good job.*

E. Recruitment and Retention

- *The presence of a career ladder program in a facility can serve as a recruitment and retention tool for incumbent and prospective frontline workers.*

F. Culture And Practice Changes

- *ECCLI projects to date appear to have had greater impact on the informal environment, or 'climate' of work in facilities, than on formal structures of mobility or economic advancement.*

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to noting the effects on the projects we are evaluating.

- *The projects will be successful to the degree they succeed in bringing nurse-supervisors on board. But nurses need assurance that organizational change will serve residents.*

- *Great potential exists for renewing motivation of staff, volunteers, and residents through cultural change activities, especially those that are more general and include a careful examination of the values, philosophy, mission, and humanistic role of the care providing institution and staff.*

G. Quality of Care

- *At least two facilities have achieved deficiency-free surveys since beginning their ECCLI projects.*

- *Both workers and managers report improved quality of care in the key areas of ambulation and range of motion, of palliative care and understanding of death and dying processes, of improved assessments by some CNAs, of more sympathetic dementia care, and relationships with residents.*

- *Working relationships have improved in concrete ways to enhance teamwork, communication, understanding of diverse backgrounds and cultures, and relationships between departments as well as between aides and supervisors, aides and residents, and aides with each other.*

- *Where effective supervisory or leadership training is part of ECCLI programs, managers have become more understanding of ECCLI's goals and more reflective about their own handling of conflict, discipline and training.*

- *Quality of care changes are inhibited where training is not well integrated with workforce practices, care practices, or supervisory practices.*

- *Improved retention in and of itself improves quality of care, as has been documented in other studies.*

- *The facilities require more support and capacity in reporting consistent quality data to evaluators and CommCorp, and perhaps should be involved in a discussion and agreement as to what quality data are most relevant, to increase their motivation to provide it.*

III. Partnerships and Working Relationships

A. Internal Partnerships

- *Having a "first mover" (such as a lead facility that moves more aggressively into training and organizational improvements) offers a model and makes risk-taking easier for more reluctant partners.*

- *Sharing expertise and program models builds knowledge and capacity among partners, and helps disseminate the lessons learned in individual facilities. It can also help overcome employer reluctance to collaborate with their competitors.*

- *Allow sufficient planning time in the early phase of projects to enable partners to build relationships and secure "buy in" of employers, their managers, and other staff.*

- *While formal, regular group meetings are essential to project governance, informal, one-on-one contact between coordinators and individual administrators is equally necessary to building and maintaining multi-employer consortia.*

B. External Partnerships

- *Involve workforce partners early on and consistently in project conception, governance, and operational decision-making, to ensure that needs and goals are well established, and that administrators on all sides are "bought in."*

- *Successful partners serve "dual customers" – both employers and workers.*

- *Work with the workforce network, rather than just individual providers.*

C. Project Administration

- *Provide deeper administrative capacity in the funding agency.*

- *Funding or reimbursement delays are debilitating to this community of providers.*

- *Multi-year initiatives are essential in organizational change initiatives.*

- *Facilities require the ability to adapt and change their training plans as they learn from their employees and experiences.*

Conclusion and Implications for Future Projects

If an additional report on Round 2 projects is commissioned, and pending funding, we will capture as much additional data as possible, and will return to evaluate the hypotheses laid out in the baseline report. We include our current interview protocols and summary case studies of each consortium, as well as an evaluation of the "bathing" initiative, in Appendices to this report. This will include an assessment of lessons of ECCLI for future projects, within Massachusetts or around the United States.

ECCLI Round 2

Evaluation Report – May 2002

I. Introduction

This report is the final Phase 1 evaluation that assesses effectiveness of Round 2 of the Extended Care Career Ladder Initiative (ECCLI) and the Massachusetts Commonwealth's use of legislation as a means of improving quality of care and worker standards of living through workforce development in long-term care facilities.

Methodology

The data that inform this report were drawn primarily from six facilities in five case study consortia. We interviewed 41 frontline workers, nine of their supervisors and ten workforce partner organizations associated with the five cases. All seven project coordinators were re-interviewed after nearly one year of ECCLI implementation activity. The researchers also interviewed representatives of the two participating home health agencies and additional managers, such as HR directors, staff developers, or assistant directors of nursing, where their roles made them key informants. In total more than 80 interviews were conducted for this report.

Data collected from 147 training participants (who completed voluntary short survey forms) were complemented by information obtained from attending ten project coordinator meetings and multiple technical assistance (TA) sessions for ECCLI sites. In addition, a small subset of the team, along with one Project Coordinator (PC), worked to develop, initiate, document, and evaluate a specific "care practice" innovation in one consortium. Some researchers observed training sessions and interviewed participants. Finally, we drew from training data reported by the facilities in the consortia. These data were in the form of spreadsheets that report the training activities of each consortium and some participant information. These data, however, were sometimes incomplete and not current. We hope to report training data and

participant feedback based on more complete information if there is a future final report for ECCLI Round 2.

Context

It is important to review this evaluation of the ECCLI program with an understanding of the external factors that have impacted the state economy and the contract administrators during the phase of the program that we are evaluating.

Part 1: The State Economy

The state economy entered a recession during 2001, along with the U.S. as a whole. This has translated to lower employer demand for workers, and fewer alternatives for employed workers seeking to leave their jobs for better opportunities. Unemployment in Massachusetts has risen since the inception of the ECCLI program in September 2000; the unemployment rate rose by almost two percentage points, from a near-full employment figure of 2.6% to 4.4% in March 2002.

Economic problems were aggravated by the attacks of September 11, particularly in tourism and travel-related industries such as hotels and eating establishments. In the state of Massachusetts the long-term care industry competes with hotels and eating establishments for lower skilled workers. These two industries were among 15 industries statewide that laid off the most workers in 2001. Hotels and other lodging places ranked 7th, laying off 1,000, while eating and drinking places ranked 11th, laying off 864 during the year.[5] As a result, long-term care facilities, typically short staffed and unable to recruit enough workers, become more attractive to the influx of low-skilled unemployed workers in the labor market. These effects may obscure the impact that this initiative may have had on recruitment and retention of long-term care workers, areas that ECCLI seeks to address.

[5] Source: Mass. Division of Employment and Training, http://www.detma.org/MassStats/WebSARAS. Unemployment figures are seasonally adjusted. In addition, "Nursing aides, orderlies and attendants" made up the largest single group of workers registered in 2001for Employment Security at the state's career centers, among workers employed in "service occupations."

Part 2: The State Budget Crisis and Commonwealth Corporation

Another important contextual development during the past year relates to funding and other related difficulties. Three major events occurred. First, the Massachusetts state budget for FY 2001 was not completed until November 15, 2001, a full five and a half-months after the fiscal year began. Commonwealth Corporation (CommCorp, the quasi-public agency responsible for administering and coordinating this project) itself was under contract to the Massachusetts Department of Labor and Workforce Development, which was operating on emergency short-term extensions. It was, therefore, neither possible for CommCorp to write any new contracts affecting the sites effective June 30, 2001, nor to guarantee that any expenses incurred would be paid, until the legislature passed all necessary authorizations. No long-term contracts were signed until after the final budget was approved and signed in November, and after all necessary authorizations had come down through the state Department of Labor and Workforce Development.

Second, it was during this same time period that a new ECCLI Project Director within CommCorp was hired, in July 2001. Upon her arrival, the new Project Director found that sites were at various stages of development. Some sites were still working on their planning contract activities, others had finished those initial contracts but had no replacement contracts or plans. Some had run out of money, and others were ready for implementation. In addition, although personnel from the sites had been trained by CommCorp staff on invoice preparation and required reporting of funded activities, virtually no sites were submitting correctly executed information or invoices, much less reports, at that time.

The third event occurred when the funds were approved for Year 2. The authorization imposed severe restrictions on them. The state legislature capped administrative costs at 4% of the total amount spent, and also changed the provision of TA and evaluation as an option to be exercised by the individual sites during the year rather than on an overall project basis or as a result of CommCorp's determination of need. According to a source at CommCorp, the 4% amount would assume that the sites all sent in perfectly filled

out invoices and reports, and that she as program administrator would have little or no interaction with the sites. That was clearly not the case, since administrators spent significant time both on site and in assisting sites to get their invoices and reporting accurate and reimbursable. This included offering multiple TA sessions on invoicing and spreadsheets during the contract period. The findings reported in this Interim Report necessarily reflect these difficult obstacles.

This evaluation proceeds by reporting the progress of the ECCLI program in the consortia. First, we describe the training activities that are underway in each facility and elaborate on the career ladder and wage structures associated with this training. We then proceed to discuss the effects to date of the ECCLI program on worker attitudes, worker recruitment and retention and on organizational culture and practice, and quality of care. We follow this section with a description of the internal and external partnerships in each consortium and the roles that they have played in supporting their ECCLI programs. Finally, we look at the lessons of ECCLI to date, understanding that the program is not yet complete and that more training will be occurring and some results take a long time to achieve or to observe, particularly in the long term care setting.

II. Progress to Date

A. Training

Overview

In the following section, we summarize the skill attainments of workers in ECCLI training, particularly as managers view them. We then catalogue the training accomplishments for each consortium, and present workers' perceptions of skills improvement as well as areas of concern about the trainings.

Training is one of ECCLI's most visible accomplishments to date. More than 600 workers in 27 facilities or agencies have received training in a wide array of skills, ranging from technical knowledge of the aging process and hands-on techniques of caring (such as "therapeutic touch" and Reiki) to generally applicable skills, such as English for Speakers of Other Languages (ESOL), Spanish for Health Care Employees, teamwork, communications, and problem-solving in difficult work situations. Both workers and managers have expressed highly positive assessments of the training received, but some noted reservations as well. Workers we interviewed in general believe that they are acquiring valuable skills, and that the training is helping them do their jobs better. Managers and project coordinators mirror their perceptions, remarking about improved clinical skills, demonstration of leadership and self-confidence, and enhanced communication skills.

- *Clinical skills*. Our interviews of workers and supervisors revealed that trainees have increased their understanding of diseases of aging, such as Alzheimer's Disease and Related Disorders (ADRD), and the effects of aging on the body and the dying process. They have also gained psychological insights and applied them to their care of residents as well as their interactions with family members. In contrast to brief monthly one-hour in-services required by law, these more extensive training sessions allow Certified Nursing Assistants (CNAs) to better "connect the dots" and see the reasons behind required procedures. Workers also mentioned enhanced patience as well as empathy for their residents.

As these project coordinators explain:

> *"They're understanding why Mrs. Jones cries all the time and talking about loss and fear and dementia and the impact of medications and the impact of aging and understanding that better. And their patience level seems to be increasing."*

> *"They're much more aware of the behaviors that residents are going through. I think that they're much more thoughtful about why residents are doing the things that they're doing, rather than reacting to it."*

- *Leadership and mentoring skills*. Participation in the training has reportedly enhanced leadership abilities among CNAs, and deepened self-confidence. Supervisors, as one project coordinator put it, *"recognize that direct care workers are a force to be reckoned with now. They're empowered through the training, they require more explanation as to why things are done."* Workers are formally mentoring their peers as well as acting as role models in restorative care (encouraging others to ambulate their patients), or care of the dying. Managers observed workers taking responsibility for an absent worker's restorative duties, encouraging peers to enroll and attend trainings, and responding ably to patient emergencies. A supervisor found that:

> *"This program helps their confidence and in feeling more comfortable with certain issues concerning the residents [such as rehab, or death and dying] . . . The girls that have been through the team leadership program are able to say with conviction 'this is how we're going to do it' or 'this is what we're going to do.'"*

A senior manager described how designated mentors incorporate their new tasks into their nursing aide role:

> *"They work it into their routine. It's almost seamless how they do it. And they become a role model – and for people who haven't had the palliative care, they will encourage them to sit at the bedside, they will encourage them to get the tapes and put the music on, so they become mentors in palliative care."*

- *Communication and Interpersonal skills*. Workers and managers observed increased skill in worker communication with residents, their families, supervisors, and peers, as well as better cross-cultural understanding. Participating workers are learning "soft skills" to handle (and diffuse) difficult situations, as well as, for some, improving their ability to speak, read, and write English. These skills, in turn, are preparing less-educated workers to continue their education, whether to attain their high school equivalency degree (GED), their CNA certification, or – in some cases – a licensed nursing degree. In the short run, it helps them better understand their patients, peers from other nationalities, and their supervisors. As one union representative explained:

> *"It helps workers to communicate better, especially like housekeeping, or laundry, who are very isolated. You have different ethnic groups – Haitians are CNA.s, the laundry workers are Spanish; if they take the training, they can communicate better. . . They can communicate with their boss, the manager; it's good."*

Neither managers nor workers were universally positive about the trainings; as one manager noted:

"I was hoping the staff would get something more out of it. They say class was good, but they can't pinpoint concrete skills they learned. They're not able to pull it all together, and think about what they sat through two hours to do, and how it applies to their job."

Some workers questioned the relevance or applicability of some topics, such as computer training that they did not see helping them in their work. Others had problems with the logistics of taking courses, especially being taken off the floors, or with supervisory cooperation with using their new skills back at work. Certain courses that were popular in some consortia had limited or no demand in others, including ESOL. While one consortium had high demand for CNA certification, this same class was reportedly "a bust" in two others. While a number of managers expressed positive feelings about their own training in leadership skills, a few supervisors questioned the value of the managerial trainings. One charge nurse said:

"It was not helpful. The times they allotted for the classes could have been more convenient. I went to 4 or 5 of them. I didn't know the point of them. They started at 2 and ended at 4, made me late for my shift. It was inconvenient."

But in general the leadership training courses, in the consortia where they were held, helped both to involve the nursing staff and to give them improved skills in resolving conflict and communicating with CNAs.

Whatever the assessments we gathered, the real test of the training lies in the ability of each workplace to utilize new skills and to support workers' growth with corresponding changes in supervision, work organization, job content, and compensation. In other words, today's career ladder classes, while a good start, require follow-up if they are going to have the desired effects on improvement of work and caregiving. As one manager put it:

"Follow-up from top management on down is the key to making sure it happens. You can't just hold a class and then expect everybody to know everything. You have to go afterwards and see how things are going and check up on them and see if they've retained it. It's not isolated, teaching isn't isolated. It's not like you got a tetanus shot – like you're covered for ten years and then you're not. It doesn't work like that."

Training Progress By Consortium

The training information reported below is taken from spreadsheets that each consortium provides to the Commonwealth Corporation under the grant requirements and is supplemented by non-licensed worker interviews conducted as part of the evaluation. Each consortium has a lead facility and with two exceptions, the lead facility served as the interview site for each consortium that was selected as a case study. Consortium 1, 2, 3, 4 and 7 were selected as case studies. The consortia are identified by number, rather than name, to ensure confidentiality.

As reported in the baseline evaluation of ECCLI, there was variation among consortia in the degree of preparedness to begin training under ECCLI. Hence, the consortia are at different progress points in the execution and development of their training programs.

Consortium 1, 3, 4, 6 and 7 have the most comprehensive course offerings to date, with Consortium 4 in the lead. In many cases, these courses have been organized into packages that correspond to training curriculum for a sequence of CNA training such as CNA1, CNA2 or CNA3. (See section on 'Career Ladders' for definitions of these by consortium.)

Table 1a – **ECCLI Training Provided by Consortia**

Consortium	Adult Basic Education /ESOL	Teamwork	Career Counseling	Communications	Cultural Diversity
C1	✓	✓	✓	✓	✓
C2	✓	✓	✓	✓	✓
C3	✓	✓	✓	✓	✓
C4	✓	✓	✓	✓	✓
C5	✓				
C6	✓		✓		
C7	✓	✓	✓	✓	✓

Table 1b - **ECCLI Training Provided by Consortia (cont.)**

Consortium	Leadership	College Preparation	Mentoring	Problem Solving	Work/Life Skills
C1	✓	✓	✓		✓
C2	✓	✓		✓	
C3	✓	✓	✓		
C4	✓		✓	✓	✓
C5			✓	✓	✓
C6		✓	✓		
C7	✓	✓			

Table 1c – **ECCLI Training Provided by Consortia (cont.)**

Consortium	Palliative Care /Death & Dying	Dementia /Alzheimer's	Restorative Care /Therapeutic Activities	Other
C1	✓	✓	✓	✓
C2				
C3	✓	✓	✓	
C4			✓	✓
C5				
C6	✓	✓	✓	✓
C7		✓	✓	✓

We chose workers at the case study consortia to achieve a diverse group of people on different shifts, from different demographic groups (age, ethnicity, race, first language), and with different jobs (mostly CNAs but also dietary and housekeeping workers). We sought out individuals who had participated in training sessions, as well as a few who had not, and who were willing to be interviewed. We tried to achieve a generally representative sample of ECCLI-eligible workers in the five facilities we studied in depth. About two-thirds of the 41 frontline workers in our interview sample identified themselves as African-American/Black (39%) or Hispanic/Latino (29%). Most of the workers in our sample were foreign-born;

61% were born outside of the United States with the majority of this group coming from the Caribbean or Latin America (37%).

Eight in ten (83%) of our interviewees had participated in some form of training (at least one course). Two thirds of those had completed their training. Slightly more (72%) had received a pay raise because of training and nearly nine out of ten (88%) expected to participate in future training sessions. All those who had participated in training felt that they would be able to use what they learned on the job.

Helpfulness of the Training

Workers were asked to rate the helpfulness of the ECCLI training on a 3 point scale where "1" was "helped a lot," "2" was "helped a little," and "3" was did "not help at all."

The data in the following table are based on 41 workers interviews across the five case study consortia. These consortia report that the most helpful aspects of the training, were in helping them provide better care to residents and in making them feel more confident of their skills. Training was also seen as helpful in planning one's future better and feeling more committed to stay and motivated to do a better job.

Table 2: **Rating of ECCLI training by workers interviewed** (N=41)

I feel more confident of my skills	1.25
I can provide better care to residents	1.31
I can plan my future better	1.41
I feel more committed to stay at this facility	1.44
I feel more motivated to do a good job here	1.47
I know more about other cultures and traditions	1.47
I can communicate better with my co-workers	1.56
I can communicate better with my supervisor	1.58
I work better with disoriented residents	1.69
I am better prepared to take college courses	1.72

Note: Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

Consortium 1

The facilities in consortium 1 have enrolled a total of 87 non-licensed workers in their ECCLI program. In our interview site, 36 were enrolled in training, 7 of whom were interviewed for this report. Most of the 7 workers in our sample had completed coursework in career counseling, communications, mentoring, palliative care, and Alzheimer or dementia care.

Table 3a: **Training data for interview site in Consortium 1***

	Lead Facility (Facility 1)				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Mgmt. Or Admin.
ESOL	4	0	20	3	0
Teamwork	1	1	na	na	na
Career Counseling	6	0	na	na	na
Communications	4	1	na	na	na
Cultural Diversity	2	0	na	na	na
Mentoring	5	0	18	0	0
Work/Life Skills	0	0	186*	21	113*
Restorative Care /Therapeutic Activities	1	1	2	3	0
Palliative Care	3	2	18	2	0
Aging 101	2	0	7	0	0
Dementia/Alzheimer's	3	2	6	3	0
CNA Certification	0	2	0	1	0

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Not available; data not provided by facility

Table 3b: **Training data for other facilities in Consortium 1 (data submitted by facilities)***

	Facility 2			Facility 3			Facility 4		
	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.
ABE/ESOL	na	na	na	na	na	na	2	0	0
Teamwork	na	na	na	na	na	na	na	na	na
Career Counseling	na	na	na	5	0	0	2	0	0
Communications	na	na	na	na	na	na	na	na	na
Cultural Diversity	na	na	na	na	na	na	na	na	na
Mentoring	2	0	0	1	0	0	na	na	na
Work/Life Skills	na	na	na	8	0	0	na	na	na
Restorative Care /Therapeutic Activities	2	0	0	4	0	0	4	0	0
Palliative Care	na	na	na	na	na	na	2	0	0
Aging 101	na	na	na	1	0	0	2	0	0
Dementia/Alzheimer's	8	0	0	5	0	0	1	0	0
Other: Supervisory Training	na	na	na	1	0	0	na	na	na

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Not available; data not provided by facility

Table 4: **Rating of ECCLI training by workers interviewed in Consortium 1** (N=7)

I can provide better care to residents	1.00
I feel more confident of my skills	1.00
I feel more motivated to do a good job here	1.00
I can plan my future better	1.14
I feel more committed to stay at this facility	1.14
I can communicate better with my co-workers	1.29
I work better with disoriented residents	1.43
I am better prepared to take college courses	1.43
I can communicate better with my supervisor	1.57
I know more about other cultures and traditions	1.71

Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

All the workers in our sample concurred that the training was helpful, citing their ability to care for residents as a primary area of improvement. They said training also made them more confident of their skills, increased their motivation to do a good job and their commitment to remain at their facility. When asked about the usefulness of the training they had the following to say:

"All of them I found pretty useful, but the one I liked the most was "Palliative care." I learned more about the residents and their families, like when a resident is almost dying, all they need is somebody to come in and say, 'it's okay to let go.'"

"I use them every day, presently. Communication skills – residents' confidentiality, having feelings for their feelings…How to help your co-workers to get along better. On [a specific] floor, we have a very good, strong staff. Even when there's a problem, the problem is dealt with right here and by the time we walk away from each other, the problem is solved… With the skills we all have, we learned to disagree, and to realize it's OK to disagree and still get along as co-workers. So it helps a lot."

Consortium 2

A total of 103 workers were enrolled in the ECCLI program in the entire consortium, with 16 working at our interview site. Only 3 of 8 workers interviewed at this site had participated in training. Across the consortium, courses on teamwork and communications have had higher attendance than other courses.

Table 5a: **Training data for interview site in Consortium 2***

	Lead Facility (Facility 1)				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Admin.
ESOL	2	0	10	2	0
Teamwork	0	0	27*	8	0
Career Counseling	0	0	na	na	na
Communications	2	0	26*	9	0
Cultural Diversity	0	0	na	na	na
Problem Solving	0	0	12	4	0

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Table 5b: **Training data for other facilities in Consortium 2 (data submitted by facilities)***

	Facility 2			Facility 3			Facility 4		
	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.
ESOL	0	34	0	0	8	0	na	na	na
Teamwork	na	na	na	26	11	0	na	na	na
Career Counseling	na	na	na	na	na	na	na	na	na
Communications	18	5	0	23	10	0	na	na	na
Cultural Diversity	0	0	0	2	3	0	na	na	na
Problem Solving	4	2	0	16	8	0	na	na	na
Leadership	na	na	na	na	na	na	0	4	0
Mentoring	na	na	na	na	na	na	5	1	0
Other: Health and Safety	na	na	na	na	na	na	36	9	8

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

For those three workers interviewed, ECCLI training had been mainly helpful in improving their relations with others. In particular, the training impacted their communication with their peers and superiors and gave them a better understanding of other cultures. The training was equally helpful in giving the workers more confidence, more motivation to do their job well and making them feel empowered to plan their futures.

Table 6: **Rating of ECCLI training by workers interviewed in Consortium 2** (N=3)

I can communicate better with my co-workers	1.00
I can communicate better with my supervisor	1.00
I know more about other cultures and traditions	1.00
I feel more confident of my skills	1.00
I can plan my future better	1.00
I feel more motivated to do a good job here	1.00
I can provide better care to residents	1.33
I am better prepared to take college courses	1.67
I work better with disoriented residents	2.00
I feel more committed to stay at this facility	2.00

Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

Consortium 3

Consortium 3 enrolled 136 non-licensed workers in ECCLI training with 35 originating from the interview site. All 8 workers interviewed in this site had taken at least 2 courses. Workers across the consortia have received training primarily in mentoring, restorative care, and palliative care.

Table 7a: **Training data for interview site in Consortium 3***

	Facility 2				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Admin.
ESOL	0	0	0	7	0
Teamwork	0	0	na	na	na
Career Counseling	2	0	na	na	na
Communications	0	0	na	na	na
Cultural Diversity	0	0	na	na	na
Leadership	0	2	0	1	3
Mentoring & Preceptor	3	1	12	1	na
Restorative Care /Therapeutic Activities	3	1	12	na	na
Palliative Care	2	2	6	3	na
Dementia/Alzheimer's	2	1	11	2	na

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Table 7b: **Training data for other facilities in Consortium 3 (data submitted by facilities)***

	Lead Facility (Facility 1)			Facility 3			Facility 4		
	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.
ESOL	0	3	0	na	na	na	na	na	na
Teamwork	na	na	na	na	na	na	na	na	na
Career Counseling	na	na	na	na	na	na	na	na	na
Communications	na	na	na	na	na	na	na	na	na
Cultural Diversity	na	na	na	na	na	na	na	na	na
Leadership	0	0	3	0	0	4	0	1	2
Mentoring	5	6	1	12	1	0	4	0	0
Restorative Care /Therapeutic Activities	8	2	0	11	1	0	11	5	0
Palliative Care	5	6	1	13	3	0	11	1	0
Dementia/Alzheimer's	5	8	0	14	3	0	11	2	0
CNA Training	0	5	0	0	5	0	0	3	0

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

The workers rated the training as helping a lot in deepening their understanding of other cultures and giving them a greater sense of loyalty or commitment to their facility. The training also helped them provide better care to residents, particularly when dealing with residents who were terminally ill. Two people shared that:

> *"Death and Dying was wonderful. I learned more in this class than in the Leadership class. This was totally new for me. I could immediately relate what I learned to my work when residents are dying."*

> *"The teacher we have is excellent. Palliative care was good. It showed us more about the stages and what you should do. I learned things that I am doing that I shouldn't."*

Their general outlook on their work and life was also enhanced; they felt more confident of their skills, greater motivation to do a good job and more equipped to plan for their futures. A CNA noted that:

> *"[the training] makes you have more experience and to want to go further in your education. The classes help to improve teamwork, self-esteem, how to talk to people and how to treat the elderly."*

Table 8: **Rating of ECCLI training by workers interviewed in Consortium 3** (N=8)

I know more about other cultures and traditions	1.13
I feel more committed to stay at this facility	1.13
I can provide better care to residents	1.25
I can communicate better with my supervisor	1.25
I feel more confident of my skills	1.25
I can plan my future better	1.25
I feel more motivated to do a good job here	1.25
I can communicate better with my co-workers	1.38
I work better with disoriented residents	1.50
I am better prepared to take college courses	1.50

Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

Consortium 4

Consortium 4 offers the most comprehensive training program of all the consortia, with up to 140 courses being available to nursing home staff. The course offerings provided to date are listed below with 76 non-licensed staff having enrolled for ECCLI training. Two facilities were designated as interview sites here because they were different kinds of sites that would illuminate different issues in the consortium (See case study in Appendix A for detailed discussion of these facilities.)

Training in both sites has focused primarily on work and life skills such as customer service and computer training and CNA2 or 3 training (See 'Career Ladder' section for definition of these terms.)

Table 9a: **Training data for interview site #1 in Consortium 4***

	Lead Facility (Facility 1)				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Admin.
ESOL	0	0	na	na	na
Teamwork/Working Relations	1	0	1	13	4
Career Counseling	2	0	na	na	na
Communications	0	0	3	8	8
Cultural Diversity	1	0	na	na	na
Leadership	0	0	0	2	3
AMA abc's of Mgmt	0	0	0	7	17
'Train the Trainer"	0	0	9	11	23
Mentoring	4	0	13	7	2
Problem Solving		0	3	4	2
Work/Life Skills					
Budgeting		0	3	0	0
Sign Language	0	0	3	1	1
Coaching	0	0	3	0	4
Customer Service	0	0	0	22	27
Domestic Violence	0	0	3	2	0
Time and Stress Mgmt.	0	0	1	5	3
Human Behavior	0	0	0	4	20
Computer-related training	1	0	1	26	38
Priorities	0	0	0	7	16
Finance	0	0	0	8	17
Clinical Updates	0	0	0	0	6
Restorative Care /Therapeutic Activities	0	0	1	9	3
CNA 1 Training	1	0	na	na	na
CNA 2 Training	3	0	18	6	0
CNA 3 Training	2	0	na	na	na
Housekeeping Career Ladder			0	6	0
Other					
Computer Therapies			8	2	0
Humor WS			18	0	9

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Table 9b: **Training data for interview site #2 in Consortium 4***

	Facility 3				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Admin.
ESOL	0	0	na	na	na
Teamwork/Working Relations	0	0	na	na	na
Career Counseling	1	0	na	na	na
Communications	0	0	na	na	na
Cultural Diversity	0	0	na	na	na
Leadership	0	0	na	na	na
AMA abc's of Mgmt	0	0	0	0	20
'Train the Trainer"	0	0	4	2	6
AMA 1st Line Supervision	0	0	0	0	19
Mentoring	0	0	5	2	5
Problem Solving	0	0	na	na	na
Work/Life Skills					
Customer Service	0	0	0	0	19
Domestic Violence	0	0	10	0	0
Human Behavior	0	0	0	0	18
Computer-related training	2	0	10	6	3
Restorative Care /Therapeutic Activities	1	0	7	1	2
CNA 1 Training	1	0	0	8	0
CNA 2 Training	0	0	7	0	0
CNA 3 Training	0	0	11	0	0
Other					
Spirituality	0	0	1	0	4
Spanish for Healthcare	0	0	2	0	14

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Table 9c: **Training data for other facilities in Consortium 4 (data submitted by facilities)***

	Facility 2		
	CNAs	Other Non-Licensed	Licensed /Admin.
ESOL	5	1	1
Teamwork	na	na	na
Career Counseling	na	na	na
Communications	1	0	0
Cultural Diversity	0	0	0
Leadership	0	4	6
AMA abc's of Mgmt	0	7	9
Mentoring	na	na	na
Problem Solving	na	na	na
Work/Life Skills			
Budgeting	6	1	2
Human Behavior	0	5	7
Time and Stress Management	8	0	1
Computer-related training	6	2	14
Restorative Care /Therapeutic Activities	na	na	na
CNA 1 Training	5	0	0
CNA 2 Training	10	0	
CNA 3 Training	0	0	
Other			
"Serve Safe"	0	7	0
Spanish Health Care	9	1	6
Introductory Reiki	6	0	2
Spirituality	7	0	1

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Despite the range of courses, feedback on the helpfulness of the training across both sites in the consortium was moderate, with training helping workers be more committed to the to the facility.

Table 10: **Rating of ECCLI training by workers interviewed in Consortium 4** (N=8)

I feel more committed to stay at this facility	1.25
I feel more confident of my skills	1.38
I can plan my future better	1.38
I am better prepared to take college courses	1.63
I can provide better care to residents	1.75
I feel more motivated to do a good job here	1.75
I work better with disoriented residents	1.88
I know more about other cultures and traditions	1.88
I can communicate better with my co-workers	2.00
I can communicate better with my supervisor	2.14

Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

From the interviews, we learned that workers who had completed training on restorative care/therapeutic activities course found the knowledge very relevant and readily applicable to their work both in handling patients and empathizing with them.

> *"Like in the CNA2, helping them, giving them range of motion…like with the arms, and how to lift them, and how to get them out of bed. Especially with somebody with a broken hip, something like that. When they have the operations and then they send them to us. How to move them around without hurting them."*

> *"Especially the CNA2 and the CNA3 was just being put into the residents' position so we knew how they felt, which was important because sometimes when you're working you don't stop and think…"*

Workers who were enrolled in the computer courses have found them marginally useful to their jobs.

"The computer course was useful because I have a computer in the house and although I knew something about typing it's always interesting to learn more because there are also other jobs such as in hospitals where you have to do the assignments by computer. Now I have at least a little of an idea of office work."

"Well, the computer course, I didn't get a certificate, I didn't get paid for it, and I took a lot of Saturdays from my days off to go over there, I really didn't even understand it still at the end of it." ... "If you got a 6 week course, you've got to rush, but at least give the person a certificate so they feel like they accomplished something...I don't have a computer but I would like to learn this so if I get a job that has something to do with computers then I can—but we didn't get a certificate."

Consortium 5

This consortium has one of the least comprehensive ECCLI programs and reports that 18 non-licensed workers in the consortium have been enrolled in training not including CNA certification. The table below describes training activities to date. This consortium was not included as a case study so no interviews were conducted at its three participating facilities, however; feedback from Project Coordinator interviews report that it has made real progress in meeting the "production" goal of certifying CNAs. According to the PC,

"*I'm satisfied with the progress that we've made. We've produced about 60 CNAs thus far in a year, roughly. We've had three classes of soft skills [intangible skills such as interpersonal skills] that have gone through. We just started our ABE, GED and ESOL this month, and*

we're going to have eight more soft skills classes between now and the end of April."

Table 11: **Training data for facilities in Consortium 5 (data submitted by facilities)***

	Facility 2			Facility 5			Facility 6		
	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.
ESOL	na	na	na	na	na	na	1	3	0
Adult Education	1	0	0	na	na	na	0	7	0
Coaching/Mentoring	na	na	na	2	1	3	0	0	3
Communications	na	na	na	0	0	4	0	3	2
"Positive Response to Negative Situations"	1	4	0	na	na	na	0	0	2

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility. Note: Training data was only available for facilities 2, 5, and 6.

Consortium 6

This consortium had a late start in terms of getting training off the ground, however; it has made fair progress to date. This consortium was not included as a case study for this report, however; the Project Coordinator of this facility informed us that three of the four active facilities are conducting training, and one of four has graduated a new level of CNAs (CNA2) who are on the floors. CNA3 training is in the planning phase.

"*Another facility graduated 20 employees out of their prep series. Another facility has a different type of career ladder. They have a restorative piece as a prep component. This restorative training takes 4 months, with an hour of training a week. They're also working on a mentoring component which is new for them."*

Table 12**: Training data for facilities in Consortium 6***

	Lead Facility (Facility 1)			Facility 3			Facility 4		
	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.	CNAs	Other Non-Licensed	Licensed /Admin.
CNA 1 Training	16	3	0	2	0	0	14	0	0
CNA prep training	31	0	0	na	na	na	28	0	0
CNA 2 Training	14	0	0	na	na	na	na	na	na
Student Success Training	4	0	0	na	na	na	na	na	na

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility. Note: Training data was only available for facilities 1, 3, and 4.

Consortium 7

Consortium 7 has enrolled 177 non-licensed staff in the ECCLI program. Our evaluation of the interview site reports training information from seven of these workers. All seven had participated in the training on teamwork and at least 5 had received training in communications, cultural diversity and spirituality. The majority of workers across the consortium have received training on teamwork and cultural diversity.

Table 13a**: Training data for interview site in Consortium 7***

	Facility 2				
	Interview sample		Submitted by facility		
	CNAs	Other Non-Licensed	CNAs	Other Non-Licensed	Licensed/Admin.
ESOL	0	0	na	na	na
Teamwork	7	0	54	30	66
Career Counseling	4	0	na	na	na
Communications	5	0	na	na	na
Cultural Diversity	5	0	85*	41	98*
Leadership	0	0	0	0	101*
Restorative Care /Therapeutic Activities	2	0	na	na	na
Dementia/Alzheimer's	0	0	na	na	na
CNA 2 Training	1	0	na	na	na
CNA 3 Training	1	0	na	na	na
Other	0	0	na	na	na
Spirituality	5	0	0	2	14
Innovation Training	0	0	0	0	16

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Table 13b: **Training data for other facilities in Consortium 7 (data submitted by facilities)***

	Lead Facility		
	CNAs	Other Non-Licensed	Licensed /Admin.
ESOL	5	10	0
Teamwork	18	4	32
Career Counseling	na	na	na
Communications	na	na	na
Cultural Diversity	84*	16	80*
Leadership	0	10	89*
Restorative Care /Therapeutic Activities	na	na	na
Dementia/Alzheimer's	na	na	na
CNA 2 Training	8	0	0
Other			
Eden Alternative	2	0	10
Spirituality	0	3	18

*Counts reflect the number of people enrolled in a course and do not discount for multiple attendance by an individual
na = Data not provided by facility

Workers who participated in the training rate it as most helpful in enabling them to provide better care to residents. Although diversity training also made an impact, being rated second in its helpfulness to workers, one worker noted that:

> *"Diversity Class -- you have to talk about yourself. It's personal. You talk about the job. It's OK. You shouldn't have to talk about your personal life. It wasn't helpful. To let us talk about why this, that, is not helpful. Because I'm old, it's good for the young kids. But I'm old fashioned."*

Table 14: **Rating of ECCLI training by workers interviewed in Consortium 7** (N=7)

I can provide better care to residents	1.17
I know more about other cultures and traditions	1.33
I feel more confident of my skills	1.50
I can communicate better with my supervisor	1.67
I can communicate better with my co-workers	1.83
I work better with disoriented residents	1.83
I can plan my future better	2.17
I feel more motivated to do a good job here	2.17
I feel more committed to stay at this facility	2.17
I am better prepared to take college courses	2.50

Workers were asked to rate the impact of ECCLI training on a variety of areas, on a 1-3 scale (1 = "a lot," 2 = "a little," and 3 = "not at all.")

B. Career ladders

In this section, we review the progress of ECCLI Round 2 partners in supporting worker mobility, in light of several ways of looking at career ladders. We then discuss how the ladders now in place are similar or divergent.

In nearly all cases ECCLI consortia have made progress in establishing career ladders in their workplaces. One consortium de-emphasized formal career steps for CNAs, opting instead to focus on certification of new CNAs and adult basic education courses. In another case, establishment of new career steps (and

associated wage differentials) has been delayed pending labor-management negotiations and corporate-level decision-making. Among the rest, structures are being established to guide frontline direct care and service workers along paths leading to higher wages, skills, and recognition. But not all have the same definition of "career ladders," nor do all parties within the facilities view this progress in the same way.

Career ladders, in the traditional sense, are formal rules and structures that employers use to promote workers and fill job vacancies from within. They provide workers and employers with a clear "roadmap" of how to advance within the organization. Career ladders typically include formal job definitions and titles, hiring and promotion rules, wage increments, and required skills, certifications, or other demonstrations of mastery as prerequisites for moving between jobs. While not always based on a hierarchy, differing levels of skill, job tenure, compensation, or other measures usually distinguish "rungs" or positions on a career ladder. They are about "moving up" within an organization, or more broadly, within an industry or occupational field.

Common Features and Variations In ECCLI Career Ladders

The new career ladders in place in all but one ECCLI consortia share important features, and also differ in construction in important ways. This reflects the demonstration character of the program as well as distinctive needs and situations among the employers and their workforce. The diagrams labeled by consortia number at the end of this section illustrate some of these features of career ladders instituted under ECCLI.[6]

As the diagrams show, each consortium offers workers a program of advancement marked by attainment of educational milestones -- usually completion of classroom or clinically-based courses. Steps are usually rewarded by wage increases -- a percentage increase of CNA salary at each point, or a fixed raise. (These are detailed in Table 15, "Wage Differentials by ECCLI Consortia," in section 2C, Wage Improvements.) Workers either request enrollment (subject to approval) or are recommended by a supervisor.

The ladders can be grouped into three broad areas:

1) *Preparation for the ladder*: classes to assist less-educated workers with basic educational skills (ESOL, Adult Basic Education (ABE), preparation for GED exams) and in some cases, preparation for successfully attaining CNA certification. This may include skills in studying, test-taking, and medical terminology.
2) *CNA steps*: certification (where necessary) of nursing assistants, with courses meeting or exceeding the 75-hour minimum required training; followed by senior CNA steps involving specialized caregiving skills, deepened knowledge of medical and psychological issues, and (often) leadership or mentoring skills.
3) *Pre-College preparation*: assessment, counseling, and educational readiness for attending college-level licensed nursing or other health degrees and certificates. In addition, the participating sites were required to offer general career counseling.

These three areas, while suggesting an educational continuum, are not necessarily connected in every case. Frontline housekeeping and dietary workers may enroll in ESOL or other basic education, but not pursue career ladders for nursing assistants. Nursing assistants might enroll in ESOL as well. Pre-college preparation, although presented as "post-CNA" on the ladder diagrams, is often used by workers who have not completed the CNA ladder but are exploring their options and abilities. Finally, these categories do not begin to encompass the variety of course offerings that are not formally part of a career path, but help build skills on the job and in life more broadly. In one example, Consortium1 offers a sequence of workshops, "Aging 101," that help workers understand their own aging process, while increasing their empathy for residents.

Beyond these structural similarities, the ladders differ in several ways.

[6] Several ECCLI facilities (in Consortia 1,2 and 5) had instituted career ladder positions prior to participation in the current program, bearing titles such as Rehabilitation Aide or Unit Associate.

- *Formality of structures*. As noted above, just two of the seven consortia (#6 and #7) have established formal titles, promotion, and job descriptions. Two more are discussing creating them, but this will not likely occur within the contract period.

- *Ladder length*. Consortia 1 and 3 have a fourth step, while the others do not. Consortia 5's facilities (some of which already maintained CNA2 and 3 steps prior to ECCLI) have opted not to create new ladders, but are focusing instead on the entry points: adult education (especially ESOL and GED) and certification of CNAs.

- *Sequence of steps*. As the diagrams show, there is no single template for becoming a more skilled nursing assistant, or preparing oneself for licensed professions. Topics such as "Death and Dying" (or Palliative Care) and Alzheimer's disease are taught at different levels among the consortia. One group (Consortia 6) has opted to place a preparatory course, focusing on "soft skills" areas such as teamwork and self-esteem, after CNA certification but to require it as a prerequisite to further steps on the ladder.

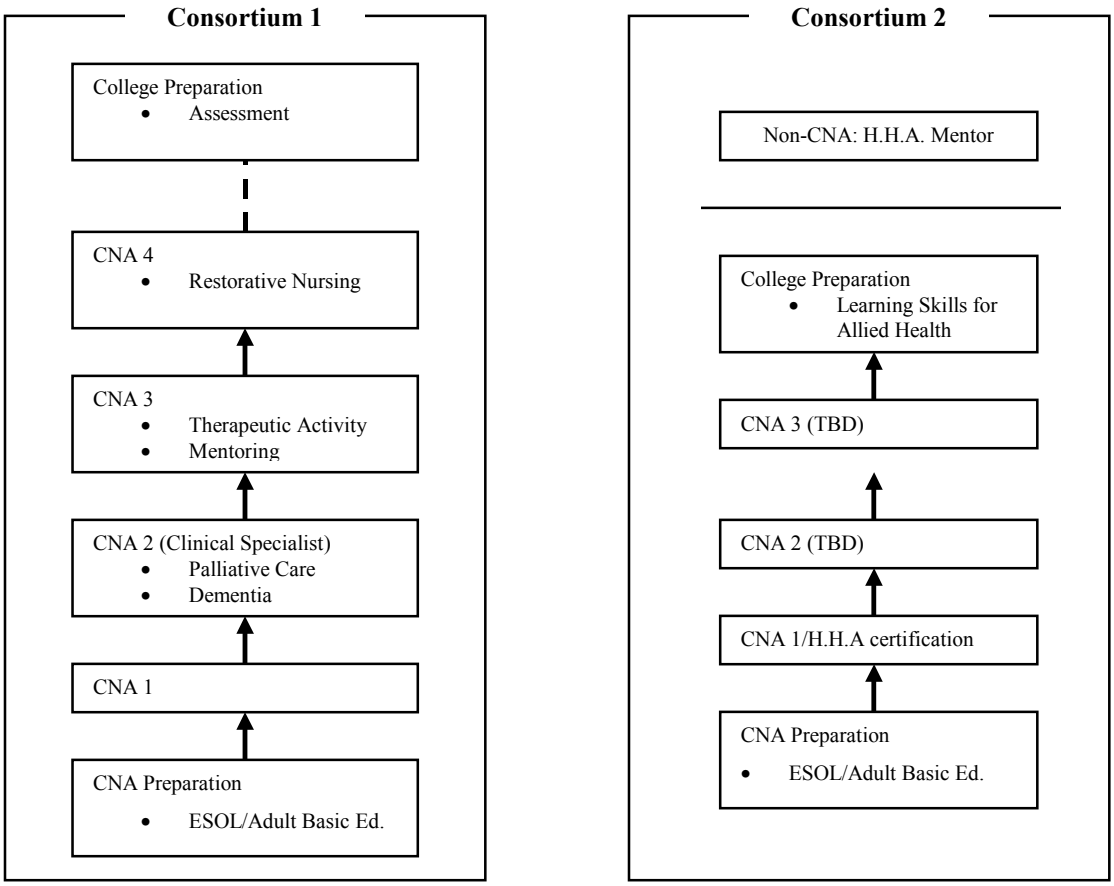
- *Branched steps*. In several consortia, including 1, 3 and 6, CNA2s or 3s have some options for specialization in their skills. In Consortium 3, for instance, CNA2s may take Death and Dying, Dementia, or Restorative Care (or all three, if they wish). Each course completion earns a wage increase. Similarly, trainees at CNA3 level in Consortium 6 may choose between Alzheimer's disease, Restorative Care, or Mentoring. ("Restorative" refers to activities that restore or maintain patients' ability to function, such as ambulation, range of motion, or skin care.)

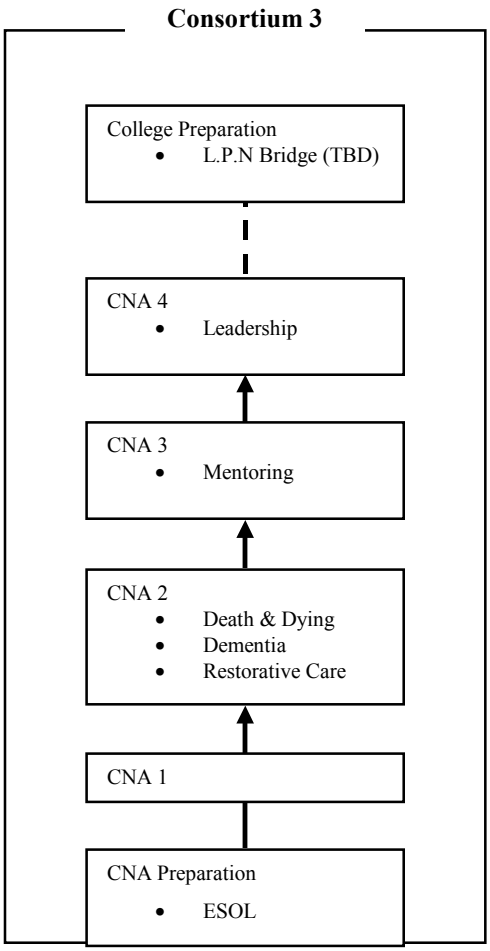
- *Non-CNA steps*. Consortium 4 offers "ladders" tailored to Housekeeping and Food Service employees. Neither is a series of steps; rather, to advance, trainees take a single course series with modules focusing on specialized knowledge of their occupation (sanitary food preparation, or "ServSafe;" handling hazardous cleaners safely) and on general skills, such as teamwork and

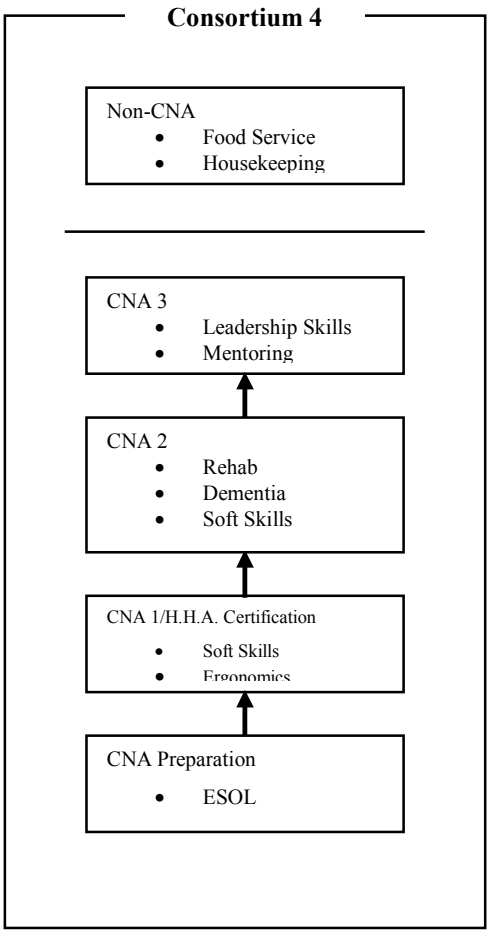
communication skills. Wage increases are granted after completion of the course series. Another consortium – one with a home health organization as well as nursing home partners – augments existing ladders for home health workers.

- *Pre-College prep.* Some consortia, including 1 and 2, have offered or plan to offer college assessment tests, while others have invited college counselors or other personnel to speak with workers about the college experience, various educational and career options, and prerequisites. Workers in Consortia 2, in addition, may enroll in an Allied Health preparatory course that earns actual community college credits towards LPN and related degrees.

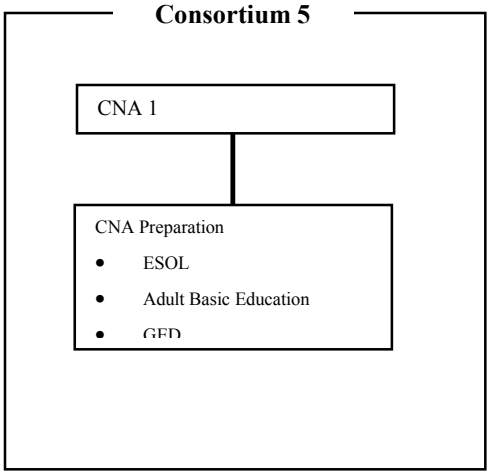
- *Variations within consortia*. Career step curricula have been tailored to specific caregiving and occupational circumstances of different facilities (as well as preferences or needs of managers). In Consortium 1, for example, The CNA 3 and 4 roles in the assisted living partner facility involve medication management, a function prohibited for nursing assistants at the lead facility. The CNA 3 role also involves team leadership, akin to the "responsible person" role in rest homes and assisted living centers. One facility in Consortium 4 has added a restorative nursing component at the "CNA prep" step. Another has substituted infection control as a specialization.


Consortium 1
College Preparation
• Assessment
CNA 4
• Restorative Nursing
CNA 3
• Therapeutic Activity
• Mentoring
CNA 2 (Clinical Specialist)
• Palliative Care
• Dementia
CNA 1
CNA Preparation
• ESOL/Adult Basic Ed.
Consortium 2
Non-CNA: H.H.A. Mentor
College Preparation
• Learning Skills for Allied Health
CNA 3 (TBD)
CNA 2 (TBD)
CNA 1/H.H.A certification
CNA Preparation
• ESOL/Adult Basic Ed.

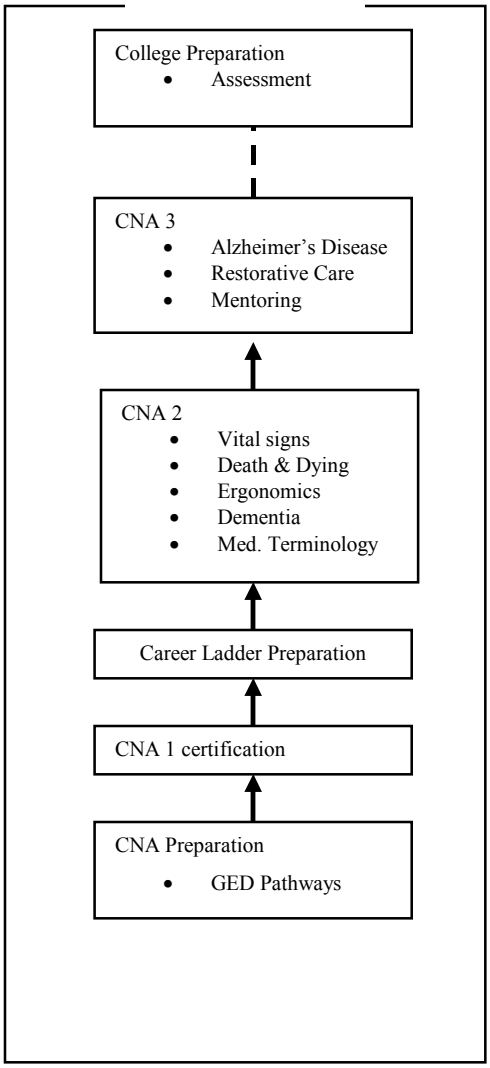

Consortium 3
College Preparation
L.P.N Bridge (TBD)
CNA 4
Leadership
CNA 3
Mentoring
CNA 2
Death & Dying
Dementia
Restorative Care
CNA 1
CNA Preparation
ESOL


Consortium 4
Non-CNA
Food Service
Housekeeping
CNA 3
Leadership Skills
Mentoring
CNA 2
Rehab
Dementia
Soft Skills
CNA 1/H.H.A. Certification
Soft Skills
Ergonomics
CNA Preparation
ESOL

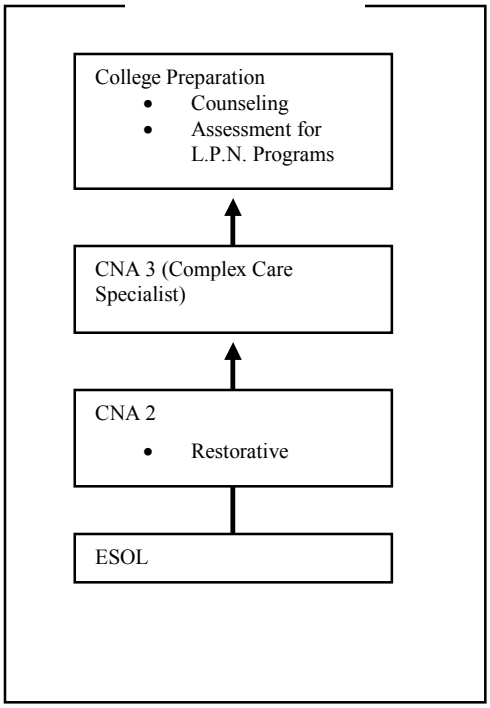
Consortium 5



Consortium 6



Consortium 7



Progress in Building Career Ladders and Supports

The ECCLI Round 2 projects have made substantial progress in building career ladders. Six of the seven consortia are offering courses that provide for increasingly skilled roles for nursing assistants (and support staff, in some cases), and most have granted wage increases for course completion. These new roles, however, are being established with varying degrees of formality. Only two consortia provide new job descriptions, even where daily tasks include specialized work such as restorative nursing. The addition of formal titles and other changes to personnel systems seems to be the exception, not the rule. As one project coordinator using the informal model explained,

> *"There is no change in the job description for different levels of CNA in my consortium. The training is mainly an opportunity to improve confidence levels, teaming and to expand their knowledge base. A CNA is a CNA."*

A supervisor in another consortium reinforced this view of the roles played by senior aides in her facility:

> *"I don't think they're any different from the CNAs. Restorative aide is basically ambulation, range of motion with the resident. And a lot of times, they have to do patient care, and they're involved in helping to feed, do the trays, bus the trays. [What about the other CNA. ladder positions, like those with palliative care or dementia training? Are their responsibilities any different?] I don't think so."*

Even where nursing aides attain new ranking ("team leader," CNA 2 or 3, "Restorative Aide,") this does not always count as a formal promotion. After assuming a new title, the worker may retain the bulk of her prior duties as a CNA, while practicing some of them in greater depth or with more sophistication. At one

facility, workers report that although they have a new position as a CNA2, their workload has increased since they are still doing their old job in addition to the new CNA2 job. At another, a charge nurse did not find much difference in responsibility between CNAs and higher-level aides. From her perspective, workers were going through training but remained "CNAs" with no change in their basic job description. Yet they were acquiring deepened knowledge of caring for the dying, or for those with dementia.

ECCLI consortia have made greater progress in building career ladders in a broader sense of an *overall approach* to worker advancement. That means attention to the supports that make mobility possible, such as career counseling, skilled supervision, access to higher education, and services such as childcare or transportation. These supports extend to partnerships with employers, career centers, educational institutions, unions, and other interests. It also means changing the orientation of both workers and employers to value and support education and training.

The partners' own definitions of career ladders encompass many facets of this broader conception. For instance, one project coordinator asserts that a "pre-CNA" course (preparing candidates to enter certification courses) constitutes part of a career ladder, even if completion of it does not result in a wage differential. Another coordinator, echoing an idea presented to ECCLI participants by Bill Thomas, founder of the Eden Alternative, says she now looks at CNA progress in terms of a "path of mastery" rather than a (hierarchical) ladder. On such a path, nurse aides would deepen or expand their caring skills as they progress, whereas (in Thomas' words) a ladder "implies people on the bottom are worth less than those on top" (Thomas, 2002). In another consortium, the career ladders are seen as "synonymous with the training," according to the coordinator. Thus steps are seen more as educational milestones than as rungs on a promotional ladder – as when two dietary workers in this facility completed CNA certification and moved "up" in salary and title to the nursing department.

Some workers view ladders in the traditional sense, as a route to job mobility – typically from nursing assistant to licensed occupations such as LPN. For them, taking the classes is seen as a "step towards licensure." But others, while participating in classes and "soaking it up like sponges" (in the words of a

project director) express no interest in moving up the nursing hierarchy. For some, life circumstances place extended schooling out of reach; others express a preference for the kind of constant, hands-on caring that distinguishes a nursing aide's job from other vocations (including professional nurses who spend much of their time passing medications and filing documents). This spectrum of reactions to career mobility was well expressed by an assistant director of nursing in one facility:

> *"Some are going back to school. Some are getting better with English. They feel that they can improve their lot in life. They say, 'I'm not going to be a nursing assistant forever,' and they never said that before. They want to go on. Or they want to be the best nursing assistant in the place, and that's fine. They're proud of what they do."*

Career ladder programs in the broader sense usually include offering career services, such as counseling and assessment. Nursing homes on the whole have rarely offered such services; many ECCLI facilities lack a distinct human resource director or staff developer position. Workers at the lower end of the labor market, such as aides and service staff, often have limited exposure to career planning. Progress in this aspect of career ladders has been mixed. Within the worker sample, almost two in three (63%) had received some form of career counseling, either through support of in-house staff like staff developers, or more often from "one stop career centers," community-based organizations, or community college staff.

Exposure to counseling varied widely, however, among individual facilities sampled, ranging from 33% to 86% of those interviewed in a given facility. In two consortia, for example, project coordinators reported little or no interest in counseling. They attributed this both to lack of knowledge – people didn't understand the concept of career counseling, and thus couldn't see value in it – and to intimidation. Workers in the latter case viewed one-on-one counseling sessions as indications that management found fault with their performance. Another project coordinator reported that, after some initial reluctance on the part of workers (including fear of dismissal), "one stop" career center staff counseled all but 12 nurse aides in the facility. In two other consortia, some functions of counseling – such as discussion of difficult life challenges – have

been shifted to group settings, such as focus groups or classes on "life skills." Workers there are reportedly more comfortable with opening up in a group, versus one-on-one.

Perhaps the greatest spur to individual career development, besides the classes themselves, has been the intervention of a particular staff person, often a staff developer, who made a difference in changing workers' career perspectives. Such a person can spark interest, instill self-confidence, encourage enrollment in classes, and provide career information. Some mentors even help arrange for scheduling changes so workers can go to class. In one facility, a staff developer was "universally cited" in this regard. According to a worker, "*she's an easy person to talk to and she encourages you when you want to go for something; if she can help you, she'll help you."* The staff developer at another consortia was cited by a senior manager for helping workers assume leadership roles in the training process and afterwards:

> *"She allows them to feel like anything is possible, and she has allowed them to try it, and she doesn't get nervous if there's a mistake, or a problem, or something like that."*

In sum, career ladders have been an important part of the ECCLI program, but we found that progress in this area was more often informal and linked to particular skills or classes completed by individual workers than formal and built into the institutional structure of jobs. In the final report we will examine whether these informal 'ladders' or 'lattices' work effectively over time to help promote worker development, increase wages, and contribute to increased quality of care.

C. Wage Improvements

Low wages and the low-skilled character of long-term care work were among the chief issues spurring passage of the Nursing Home Quality Initiative, ECCLI's legislative parent. One in three nurse aides nationally lives under the poverty line. Poor-paying jobs, and the lack of mobility into higher paying work, contribute to the cycle of high turnover, under-staffing, and resulting problems in patient care. Low pay

also hinders workers' abilities to obtain further education and training. Many workers in ECCLI facilities (and in the long-term care sector more broadly) work overtime, including double-shifts, or second jobs, to make ends meet – leaving no time to study or attend classes. Thus an important measure of ECCLI's interim success is the extent to which employers are improving wages for frontline workers, and workers' perceptions of improvement. Moreover, large improvements are often constrained by facilities tight revenue margins. But an assumption of the ECCLI model is that reduced turnover and lower replacement costs will free up funds for wage increases.

Partner facilities are making progress in granting wage increases in conjunction with worker completion of courses. Wage changes are typically made in one of two ways: as differentials associated with steps within career ladders (for nursing aides, and in one consortium, for food service and housekeeping workers) and for moving between occupations, such as Dietary Aide to Certified Nursing Assistant. Partner facilities have discretion over the size, scheduling, and type of boost to wages. While most Round 2 facilities are increasing hourly wages, a few are granting bonuses. In all cases, the differential is modest – generally twenty-five or thirty cents/hour for completion of a class or training step, with two consortia offering fifty cents an hour, or a percentage increase over base hourly wages (three to four percent). Summary arrangements in each consortium are as follows:

Table 15: **Wage Differentials by ECCLI Consortia**

Consortia	Size and Nature of Wage Increase
1	CNA2: 3%; CNA3: 4%; at one facility, one-time bonus instead of wage increase
2	Personal Care Attendant (PCA) Mentors and Home Health Aide (HHA) Mentors: $1.25/hour; PCA → HHA: $0.50/hour; CNA2 and CNA3 steps and wage differentials to be determined
3	$0.30/ hour raise per career ladder class completed
4	CNA2, CNA3, Food service and Housekeeping career ladders: $0.30/hour
5	No ECCLI career ladder in place. Raises associated with CNA certification
6	Career ladder prep: $0.50; CNA3 specializations: $0.60/hour
7	CNA2 and CNA3: 3-4%

In every case where new career ladders are being instituted (six of the seven consortia), wage increases have been granted, with some delays associated with determining the nature and content of career ladders. Some of the sampled workers are "still waiting" for their increase, or for additional differentials – such as an increase from 3 to 4% differential for moving from CNA 2 to 3. (The latter delays mainly reflect the

interview schedule, which found many workers in the middle of their training cycle, but may also reflect a lack of clarity about whether and when raises are granted.)

The majority of workers interviewed stated that "getting paid enough" was either a significant problem or a minor problem, with responses split evenly between these options. (Almost three quarters listed "inadequate compensation" as a reason why CNAs leave their jobs). More than seven in ten interviewed workers had received a pay increase because of the training. Workers were asked "How helpful will the increase be to you, on a scale of 1 to 5, with 1 being 'not helpful at all', and 5 being 'extremely helpful'?" The average rating was "3.6" (between "neither helpful nor unhelpful," to "somewhat helpful.") Some workers expressed frustration with what they perceived as a small increase in pay after participation in the career ladder, as voiced by this CNA:

> *"It's only 24 cents more!... With the restorative aide (CNA2), it's heavier work. I think it's worth more than 24 cents. You make sure the floor is running better."*

In another consortium, where "getting paid enough" was most commonly seen as a "big problem," workers and managers appeared to agree that the small improvements in wages were "not too significant" compared to increases in the aides' patient assessment skills and potential for upward mobility.

But the workers' persistent and consistent concerns about wages raise a question that cannot be answered yet: will 3 to 4% wage increases be enough to ensure retention of better trained workers and to take the "dead end" out of the CNA job? Or will wage increases with multiple training opportunities accumulate to something that is more significant? In one consortium where managers agreed to award workers fifty-cents per hour increases instead of lower ones at the urging of the project coordinator, they were satisfied with this choice because the effect on workers was clearer and they were able to retain a larger percentage than ever before. They found that the money they saved on agency staff and turnover more than compensated for the larger increase in wages.

D. Employee Attitudes: Satisfaction, Motivation, and Commitment

The conclusions reported here on employee attitudes, including key predictors of performance such as satisfaction, motivation, and commitment, are drawn from two sources: evaluator interviews in five case study facilities, and the "participant information forms" collected from all seven consortia. The participant information forms were not received from all consortia, and even those received were relatively few or none in every case except that of Consortium 4, which returned 83 surveys. However, they represent the best source of employee attitudes that we have that is inclusive of those who went through training and who chose to fill out the forms. Because of confidentiality concerns of the Advisory Committee to ECCLI, the forms were made optional; because of funding, coordination, and distribution problems, the forms were first circulated in January 2002, and returned in March 2002. We hope to have a larger set of these forms to analyze for the final report. The figures quoted below are based on 27 respondents from Consortium 2, 40 from Consortium 4 (who answered these questions), and 23 from Consortium 3.

Satisfaction and Commitment from Participant Surveys

We measured job satisfaction after the training classes because one of the premises of ECCLI was that increased training opportunities would help increase employee satisfaction. Because we do not have a baseline for these employees pre-training, we can only report what they said after training sessions. We learned that the majority of responding employees were either fairly satisfied or satisfied – more than half, 47 of 90 employees who responded were satisfied, or "4" on a five point scale. Another 15 of 90 employees, or 1/6 of total respondents, were "very satisfied," with most of those coming from Consortium 4, and 1/3 of them coming from Consortium 3. An additional 19 of 90 employees, or 21%, were "fairly satisfied", while only 6 were "somewhat satisfied," and none were "not at all satisfied."

Perhaps as important as satisfaction is the issue of whether employees are committed to their places of work.[7] Organization commitment (OC) is a key predictor of performance in other studies. The responding training participants reported very high commitment. When asked, "How hard are you willing to work to help this organization succeed?" fully 47%, or 42 of 88 respondents, said they were willing to work "very hard," or "5" on a five-point Likert scale. Another 42 percent said they were willing to work "hard," or "4" on the same scale, while only 4 said they were willing to work "fairly hard," and 3 said "somewhat hard," and 2 said "not at all hard." So 89% of employees in training, or nearly 9 out of 10, were willing to work hard or very hard to help their long-term care facilities succeed.

Worker interviews

In the worker interviews, responses were generally consistent with these findings. A number of people spoke about increased understanding of each other and therefore better teamwork. One nurse said,

> "*Overall there were people from all different fields and we came together and I think that helps so much, just the whole nursing home, because people that barely saw each other, barely even knew of each other, became tight and really worked together as a team."*

One CNA stated that the classes put her in a good mood and made her happy.
"Because of the classes you're more relaxed and happy—you're ready to do the job."
Another said that:

> "*It makes you have more experience and to want to go further in your education. The classes help to improve teamwork, self-esteem, how to talk to people and how to treat the elderly*."

Interviewed workers were even more positive about their satisfaction than those who filled out surveys—averaging 4.8 out of 5 at one facility, for instance, while the participants who filled out forms averaged 3.8. The interviewed workers also described themselves as more motivated to do a good job, and more committed to stay at the facility. Similarly, interviewed employees averaged 4.33 out of 5 at one consortium on being willing to work hard to help the facility succeed, while those who filled out participant forms reported 3.8 of 5, a lower but still positive rating.

Clearly getting wage increases and more job responsibilities contributes to employees' satisfaction. One project coordinator said, "*People are enthusiastic, because they are seeing some upward mobility as far as money that they're making and the skills they're learning*" (see Section 2B on Career Ladders). However, most responding employees felt the wage increases were not satisfactory (see Section 2C on Wage Improvements).

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[7] We measured this construct, "organizational commitment," with only one question, rather than with a preferred scale of multiple questions, because we were trying to keep the questionnaires short and accessible to people with a high school education or less

Most workers also reported being excluded from decision-making in the facilities, and gave relatively low ratings to their communication with supervisors, with some noting that this had improved where there had been supervisory training that was well attended and well received. But these were the minority. To the extent that workers were involved in care plan meetings (fewer than half reporting), they found it helpful. One said,

> *"[It] helps you to relay some things back to the CNAs, not anything personal but things that can help in their care—where they'll say, "Oh, I didn't know that! OK. Maybe we do something else different. She likes to drink water at such and such time of the day, we give it to her at 6 and she really likes it at 7, things like that are good information*."

A vast majority of interviewed workers, 90% in the case of one consortium, felt that the training had helped them to care better for patients, and therefore made their jobs more satisfying.

Project Coordinator and Manager Interviews

Several project coordinators also corroborated these findings. One said, "*Staff morale is definitely improving*." She related this in part to reduced use of pool staff and more retention of existing employees. Another project coordinator reported that 93% of staff surveyed after training sessions said the training and support were more likely to make them stay working at the home, while 90% felt better able to do their jobs with residents. Another one saw a big change in leadership and self-confidence from at least some training participants.

> "*Some of these folks at the celebration that we had…these are people that wouldn't have said anything if you said 'boo' to them a year ago, and they were getting up and making speeches*."

Managers at the facilities who were interviewed were likely to be trainers. One said,

> *"It's been great seeing the CNAs that I've taught in the program. They've become role models, and people that we didn't think we could get a spark of life out of exploded with excitement at the program.*"

In sum, nearly all the data collected to date on employee attitudes showed positive changes that appear to result from exposure to the ECCLI program. These include a sense of empowerment and improved morale, an appreciation that the facility and the Commonwealth were investing in their skill development, an increased sense of teamwork and commitment to work harder for the success of their employers, and a sense of confidence and motivation that their caring work was more effective.

E. Recruitment and Retention

The problem of finding and keeping skilled long-term care staff was one of the prime motives behind the ECCLI program, both in the state legislature and among the employers enlisted to participate. High turnover rates and a shortage of both professional and paraprofessional workers in direct care reached crisis points in 1999-2000, and were still noted by ECCLI administrators and other senior staff when they were interviewed for the baseline evaluation in the summer of 2001.

Today, in spring 2002, the picture looks different at the ECCLI facilities, at least. This is apparent from word of mouth accounts in every consortium, and from data gathered for the period November 2000 – November 2001. The participating facilities are experiencing fewer vacancies, some reduction in employee exits (turnover), and lower staff replacement costs. And, as we explain below, this good news must be considered in the context of rising unemployment rates and other indicators of economic recession that have emerged over the past year.

- During the first six months (roughly) of the ECCLI projects (May 15, 2001- November 15, 2001), the number of CNA openings was down in nearly all facilities that provided data (21 of 28). In half of these facilities, there were no openings for nursing assistants by November.

- In over half of the facilities providing full data (10 of 16), the total level of full-time CNA staff increased from the period before ECCLI (November 15, 2000 – May 15, 2001) to the first six months of the project.

- Exit data were more mixed, with the number of nurse aides leaving the facility dropping in just under half of the reporting facilities.

Cost data reported by all but one consortium offer qualified support for this picture. As Table 16 below shows, recruitment costs, fees paid to agencies, and overtime costs went down in the majority of reporting facilities. This was especially pronounced in the area of recruitment. In two thirds of the cases (eight of the twelve reporting) recruitment costs went down. Agency costs went down in the majority of reporting facilities as well, but these represent a smaller part of the sample (five of eight responding). Changes in overtime, however, were almost evenly divided between facilities spending less in the period May 2001 – November 2001. While six facilities reported decreases in overtime costs, another five saw such costs increase in the second six-month period. This could represent a better use of facilities' costs than agency costs, if existing workers who know the residents are working voluntary overtime, but obviously it is better to have less overtime required and to be fully staffed.

Table 16: **Recruitment, Agency and Overtime Costs***

	Recruitment Costs	Agency Costs	Overtime Costs
C1 Lead Facility	↓	↑	↑
C1 Facility 2	NA	NA	NA
C1 Facility 3	NA	*NA*	NA
C1 Facility 4	NA	NA	NA
C2 Lead Facility	↓	NA	NA
C2 Facility 2	↑	↓	↓
C2 Facility 3	↓	NA	↑
C2 Facility 4	↓	NA	↓
C3 Lead Facility	↓	↓	↑
C3 Facility 2	↑	↑	↓
C3 Facility 3	↓	↓	NA
C3 Facility 4	NA	NA	NA
C4 Lead Facility	↓	↓	↓
C4 Facility 2	NA	NA	NA
C4 Facility 3	NA	NA	NA
C6 Lead Facility	↓	↑	↑
C6 Facility 2	NA	NA	NA
C6 Facility 3	NA	NA	NA
C6 Facility 4	No Change	NA	↓
C7 Lead Facility	NA	NA	↓
C7 Facility 2	↑	↓	↑

*Recruitment and retention data was not provided by consortium 5.
NA = data were not provided in these categories by the facility.

This generally good news for the nursing home partners, however, cannot be traced clearly or only to the effects of ECCLI. The onset of economic recession in 2001, accelerated by the events of September 11, changed labor market conditions dramatically. Nursing aides and service workers had reduced reasons to leave their jobs, as there were fewer incentives to do so. Thus, sorting out the role played by ECCLI in providing fewer labor market problems for nursing homes is complicated by the economic downturn. We do not have comparable turnover or agency cost data for all facilities in the state, for instance, as a comparison group. Any statistics or statements about labor supply must be understood in this context.

That said, it is worth reviewing the perceived effects of ECCLI (working in concert with external factors, such as the recession) on recruitment and retention.

Recruitment

Recruitment is part and parcel of the retention equation. Employer costs for recruiting (placing ads, screening, etc.) vary inversely with retention rates. A number of ECCLI facilities report that they had few or no vacancies in the first months of 2002. But from those needing to fill positions, we heard reports of "word of mouth" on career ladders creating interest among new applicants. People who have been through the training sessions inform others in their networks of family and friends about the project, even if the employee is no longer working in the industry, but especially if she is.

According to one project coordinator,

> *"I have noticed from the reports that [recruitment at] two of the three facilities are better. They are spending less money on agency costs and on recruitment. I am not sure though if they realize that ECCLI has been involved. A lot of it could be because of "word of mouth" among the CNAs who are telling their friends."*

Another coordinator acknowledged the effects of the economy, describing the "stacks of people waiting to get in" (and the lack of open positions for these applicants). But he felt that key elements of the ECCLI project had contributed as well:

> *"Recruitment is always going to be an issue. It's a question of right now, because of having the HR presence, because of the training, and*

because of the reputation in the community we have now, people are hearing about it. And they're wanting to come here and work."

A PC at a consortium in another region of the state reported similar effects:

"ECCLI is a HUGE recruitment tool. The workers know there are opportunities because of the reputation in the community; word has gotten out about the career ladder, and that there's a $0.50 increase after each step. That sends a big message."

As another coordinator explained, "*people heard there was a career ladder [at the lead facility] so they applied, even though they didn't know what a career ladder was*." The human resource director for this facility also stressed that recruiting was "way up" since ECCLI training began. Also contributing to improved CNA recruitment over the past year was the scholarship program managed by the Mass. Extended Care Federation – like ECCLI, a product of the overall 2000 and 2001 Nursing Home Quality Initiative legislation. Two coordinators in different parts of the state also pointed to this program as a key source of new recruits. In this sense, these two parts of ECCLI are working together well.

Retention

All consortia report that retention rates are higher, and that employees are staying longer, based on perceived changes more than formal data. One coordinator, when asked what she saw as the most important changes occurring in the facilities as a result of ECCLI, responded: *"Retention. We don't see employees turning over. Facilities are monitoring and reporting this."* Others described retention rates (as of February-March 2002) as "exceptional," or at least "improving greatly." And this climate has increased support for ECCLI goals in some quarters of management, even while lowering the urgency. Managers, notes a project leader, have

"...seen the attrition drop, so they're feeling more comfortable giving salary raises, and paying for the training. At one place, their attrition has gone from 100% to 54%!"

As with recruitment, there is no simple way to separate out the effects of ECCLI from those of economic recession. Several coordinators reported that worsening conditions and having more well trained candidates and workers have allowed them to "weed out" workers who were performing below par, but whom they felt they could not release earlier because of the labor shortage. Evaluators' observations also suggest that investments in training and related ECCLI activities are sending employees a message that their jobs need not be dead-end. On "necessary" turnover, one project coordinator put it this way:

"I think we have some turnover, but it was people that needed to leave the organizations – people who weren't committed to it. Those were the people that were the "warm bodies" that were hired a year and a half, two years ago when the big crunch was on and we'd literally take anybody who walks in the door. So I think there's been a "correction in the market," so to speak."

This view was echoed by another coordinator, who said:

"I think initially we saw that the numbers weren't as significant as we thought but we also saw all three facilities getting rid of people that they've wanted to get rid of for a long time but they didn't have anyone to replace them. And now employees who did marginal at best work…[they] were able to move those people into other departments or to replace them."

Coordinators noted in several cases that they hadn't seen enough to data to draw firm conclusions, but believed that future documentation on the project (due in May 2002) would demonstrate improved retention rates.

Despite these tangible improvements, the problem of short-staffing has not disappeared. It remains acute for licensed nurses in many facilities, and, in some cases, also for nursing assistants. (Where one consortium is based, the regional unemployment rate still hovers between one and two percent.) As a charge nurse there reported,

> *"Staffing-wise, we're having an extreme shortage of nurses, CNAs, which makes it very difficult as management or part of a management team to focus on anything that we're hoping to achieve. It really takes away your primary job responsibility, you're always covering the floor, you're always dealing with staffing issues."*

In sum, recruitment and the quality of applicants overall are up in ECCLI- facilities, agency costs are generally down, and retaining existing higher-skilled workers seems also to be more successful. In this area, ECCLI is achieving its objectives, at least in conjunction with the economic changes the state and US have experienced.

F. Culture and Practice Changes

Efforts at "culture change" or changing "care practices" to more holistic, more cross-functional, and more patient-centered approaches through organizational renewal and revitalization is one of the key factors that has made Round 2 distinctive in comparison with Rounds 1 and 3 alone. In general the "culture change" goals of ECCLI have been the least well understood and least universally adopted part of the initiative. In part this is because "culture change" is a difficult and complex concept, playing out differently in each

specific context and depending very much on the leadership and motivation of key actors. It also requires an ongoing process of organizational change that includes intensive focus on one or more specific practices that may affect many departments in a facility.

Care Practice Changes – Formal, and Informal

ECCLI's model evolved to support culture change primarily in the context of specific "care practices" that could be tied to specific ECCLI training courses or organizational development. One consortium did the upfront work of reviewing their mission statements and core values to come to common understandings in each long term care facility (and as a group) as to the vision of individualized, responsive, homelike care that they were striving to achieve. Then some members of the consortium began to translate that into the daily care practices, and the training sessions, as well as the ongoing development of the management and leadership teams and the renovation of the physical space of the facilities. These included changes in such activities as assignments of staff, death and dying rituals and observances, bathing, and "family–style dining." Some changes in care practices have occurred as a result of ECCLI trainings.

- *Training on teamwork*: CNAs are helping out residents to whom they are not assigned (e.g., answering call lights when another CNA is busy or on break); one even noted that more nurses were helping, and being "nicer."

- *Training on Restoration*: CNAs are helping residents move and walk more. (See Section on Quality). This practice change was noted by CNAs as well as supervisory staff, and was reported in three of the five case study sites. One aide noted,

> *"It's changing because they're walking, exercise. Not staying in one place. I just started range of motion (ROM) on this one patient. ROM is helping him though it's not on the program. Because I started it. He*

thinks it's feeling better. I want someone to watch and see if I'm doing it right. We're still waiting for paperwork to get him in the program. Before his leg and foot was numb. Now he's feeling something. I said, let me try ROM. It's more work for myself. But I love to do it. He's not numb anymore."

- *More empowered CNAs*: The move towards a higher skilled workforce often results in more empowered frontline workers, and this is also an explicit goal of "culture change." Training in and of itself can help create this capacity, but managers, in order to reinforce it, and organizational leaders at all levels also have to be open to hearing ideas and acting on them. In some cases, aides report feeling more comfortable taking initiative and speaking up with their ideas. One CNA noted that she had come up with an idea to move the food cart outside each resident's room rather than keeping it by the nurses' station, to keep the food warmer. This was after the facility had been cited for cold food in a DPH survey. The facility adopted the practice and she felt that her contribution was valuable both for residents and managers. One charge nurse also reported noticing that CNAs were encouraging each other more on the floors while another said the CNAs were acting as "ambassadors" for the classes.

- *Supervisors becoming coaches:* Managers and charge nurses play a critical role in setting the organizational culture and expectations. Some of the consortia engaged in supervisory and leadership training. One charge nurse described learning how to manage conflict better in his management classes, and also to give positive reinforcement in the moment to CNAs he observed doing something well. This is a coaching style of supervision that can change the entire relationship between managers and frontline staff. He also said he had learned not to discipline CNAs in public.

- *Change of "heart:"* In some cases, the "care practice change" is more of a renewal of commitment, or a way to work reflectively with residents. One rehabilitation aide stated that after training, it wasn't the job that changed, it was the "heart" that changed. She said,

> *"You become more caring…you tend to be more patient, you tend not to do the job for them….You tend to slow down and stop and realize, this is THEIR WORLD. This is their space, their time. You're just in there to help them, you're not in there to control them…Whereas at one time, you probably would've walked in there like that. But after you go through the career ladder, and everything you learned, you know you learn, 'that's not right. I got to stop doing that. I never even asked you, do you want to wear this with your red dress. I never even asked you, can you wash your own face. I just went in and did it.' It comes from…you learn that in the career leader, but your heart just changes." She continued, "You're going to renew your spirit when you go through…You remember exactly why you're doing the job."*

Global Culture Change Efforts

Two consortia have developed global culture and practice changes as a result of ECCLI support. One is Consortium 7, which sent ten people from one facility to the three-day Eden Alternative training that allows them to become "Eden Associates" to help transform their facilities into more homelike environments. The other facility in this consortium will send key staff members to a training June 2002. In the second facility, three new "teams" have been created to help implement some changes, including "quality improvement," "customer service," and "CNA career ladder." We have not yet been able to observe any specific changes as a result of these teams, partly because they were created very recently.

Another global culture change project is found within Consortium 4, which hired an organization development consultant to help each facility define its core mission. As a result of this consultation the facilities have undertaken a variety of changes, in physical space as well as in philosophy of care, to help implement a more holistic set of work and care practices that match the new core missions of the three facilities.

At least two of the three facilities (where we undertook case study interviews) have solved key organizational problems that contributed to less than ideal care levels. For instance, the dietary department at one facility was able to work together with the nursing department to arrange better service for new residents, for those needing or desiring special meals or changes from the fixed menu, etc. After years of conflict between departments over getting menus and meals correct, the dietary supervisor now walks the floors an hour before mealtime to review plans and take updates from nursing staff. This has meant a major improvement for residents that should contribute to better nutrition and hydration. Even the staff lounge or kitchen at one facility has received positive attention, once administrators realized they only used it as a storage room rather than eating their meals with the aides there. Several facilities have begun to implement "family-style dining," another hallmark of resident-centered facilities.

Another facility in Consortium 4 has worked hard to turn its four separate units into "neighborhoods," complete with names, primary assignment of staff to residents, and cross-functional patient care teams. At this facility, managers and the project coordinator have reported much better working relationships up and down departmental hierarchies and across departments. Turnover has declined, and the use of pool staff is down, allowing for a climate of more continuous care. Neighborhood councils have been created, though some problems with getting needed environmental changes in the building are reported by participants. A tub room has been transformed into a "bath spa" in this consortium as a result of CNAs taking initiative. The neighborhoods have logos and personalities as well. This has contributed to improved morale and sense of teamwork.

After the presentation about the "Eden Alternative" by Dr. William Thomas in April 2002, several facilities and consortia requested further support from ECCLI to attend these training sessions for "Eden Associates." Twenty people attended a June 2002 Eden Alternative training and were sponsored by ECCLI, including 12 from one ECCLI Round 2 site and 8 others from around the state. This may be an additional avenue to "global culture change" for some facilities in the future.

Individual Care Practice Change

Consortium 3 has designed a quality improvement project focused on bathing agitated or aggressive residents with Alzheimer's disease and Related Disorders (ADRD). By introducing individualized bathing approaches for ADRD residents, this consortium intends to decrease combative behavior, increase enjoyment of bathing routines for residents who are often resistant to bathing, and improve the safety and job satisfaction of CNAs responsible for bathing the residents.

Implementation of this project began in January 2002 with the participation of all four participating nursing homes. Each nursing home developed a bathing team that includes two CNAs, a nurse, and a staff developer. CNAs had all been trained previously in general ADRD care. During this project they learned: (1) the significance of customizing bathing practices to the preferences of each resident; (2) a new towel bathing technique that allows for complete bathing without requiring the resident to leave his or her bed; and (3) massage techniques for the frail elderly to augment the towel bath procedure.

Prepared with these new techniques and an enhanced understanding of the importance of matching the appropriate approach to each resident, CNAs have selected ADRD residents with a history of negative behaviors during bathing. With each of these residents CNAs are beginning to change their approach to bathing, one feature at a time, working to find the most comfortable bathing approach for each resident in the project. After repeated trials, bathing teams will write the most successful bathing approach into residents' care plans.

Evaluation staff conducted pre-project surveys, with both project participant CNAs and comparison non-participant CNAs. We found that bathing was a task that was experienced as more unpleasant than other tasks that CNAs conduct on their jobs.

CNAs and supervisors/observers, using project-specific documentation forms and surveys, are tracking specific bathing difficulties and results of bathing changes. At this writing, all participating CNAs have completed baseline baths for each resident they chose for the project. Evaluation staff will be analyzing the change process from these sources, as well as monitoring the process by discussing specific experiences with the CNAs and listening to the sharing of experiences among the participating nursing homes during consortium meetings.

Although no final bathing practice has yet been selected for any resident, CNAs have reported that by varying their original bathing procedures formerly combative residents experience more calm and pleasurable bathing. The CNAs, themselves, also feel less stress at bath time. Successful changes thus far have included adoption of the towel bath, use of gentle massage, and increase in calming conversation between CNA and resident.

Some Did Not Seek Culture Change

At least one consortium did not find the concept of "culture change" useful as a motivating way to describe their goals, perhaps indicating a problem with this particular term. This could be one reason why ECCLI participants and coordinators have come to focus on work culture and work process reorganization that results in care practice improvement, which is more concrete and has a clearer relationship to improved quality. Other groups of facilities, specifically Consortia 1, 2, and 5, had not built organizational culture change into their proposals, and, as a result, have done nothing concrete in this area to date, although some are considering future activity. Their accomplishments and efforts have been focused on training workers and developing their career ladder programs, or in the case of Consortia 5, on recruiting better-prepared CNAs and providing social support for existing staff to reduce problems that led to poor retention.

Barriers to Culture Change

Some consortia reported that they did not have the resources needed to make culture change. One project coordinator said the smaller independent homes in his consortium could not afford to let staff off or pay their wages for training, while the corporate facilities were inhibited by "corporate culture" and rules from establishing care practice changes or in some cases even career ladders. In addition, distance and commuting time, and short staffing problems generally, prevented some people, such as a few individuals in Consortium 5, from attending the training about bathing practice changes, for instance.

Most project coordinators said that they wished additional technical assistance had been available to them. Some wanted additional resources made available, or expressed frustration with not knowing where to look for the kind of help that they needed. This feeling about a need for more organization development-related TA was not equally felt by all coordinators, perhaps because they were having a challenging time getting the training program implemented without adding complex organizational initiatives. However, the evaluators believe that more TA would have assisted the sites in developing more sustainable and perhaps more quality-oriented practice changes and workforce organization plans.

G. Quality of care

A major goal of this demonstration project is to improve nursing home quality. Specific quality goals, however, were not articulated. Most observers agree that many factors affect total quality of care in any setting, and that standard clinical measures are difficult to adjust properly for acuity or seriousness of disease and the residents' projected medical status. Further, few measures actually track "quality of life,' something that is hoped for as a result of the ECCLI initiative. Quality indicators originally to be analyzed for the evaluation were not made available to the researchers. Our assessment of quality, therefore, wholly depends at this time on qualitative information provided by persons we interviewed.

Methods

Quantitative Data

We did not receive any quality of care data from the facilities as of the date of the interim report, so we are not able to report on any quantitatively documented changes in quality of care.[8]

[8] It has not proved possible to make individualized comparisons between residents' health status at the beginning of ECCLI and later in the process as more workers were trained. While the originators of the program were rightfully skeptical that ECCLI could lead to documented health improvement given the many complex factors that contribute to clinical outcomes, the evaluators planned to review data in key areas, such as range of motion (which could be affected by ambulation and restorative care), pressure sores, and aggressive behaviors, that could be affected by CNA work. We found that at the facility level or the ECCLI project level, no one had resources to eliminate all identifying information from each record.

Researchers have worked assiduously, along with Commonwealth Corporation staff, trying to access the Minimum Data Set (MDS) and Management Minutes Questionnaire (MMQ): these are state and federal data sets that are collected regularly on individual residents that can be produced electronically without patient identifiers to maintain privacy. The MDS data can be accessed through the federal government after extensive review and justification, but the costs are prohibitive under the current budgetary constraints, running at least $25,000 just to acquire the data and more to transfer it to a statistical program that can be used by researchers even before beginning analysis. ECCLI facilities have suggested getting the data from the Department of Public Health, which collects MMQ data, but the researchers have not been granted access to these data. States can also provide the MDS data to researchers under a "data use agreement," but this also has not been accessible.

State Surveys

At least two facilities in Consortium 4 that have hosted substantial numbers of ECCLI trainings experienced their first two state Department of Public Health surveys in which they were found deficiency-free (a relatively rare and laudable experience) since the grant program began. On the other hand, at least one facility in a different consortium had a problematic state survey. That facility, however had not held many ECCLI trainings at the time, and since then managers have adjusted its ECCLI project goals to work on improvements in areas defined by the surveyors as needing attention.

Improved care giving

Many employee and charge nurse interviews indicated significant improvement in specific aspects of care. In general, workers felt more satisfied knowing "why" they were doing things with residents, not just that they had to do them. Very often the classes combined to make them better CNAs and to know more about their work, they reported. One worker said,

> *"It helped with taking care of patients better, range of motion, get to stay at a higher level of functioning, to be more patient, help with the job, why and what sickness causes impaired patients, to explain things."*

One project coordinator confirmed the importance of increased understanding on the part of the aides.

> "*It's not so much that the job descriptions have changed, but their skill level has changed and that has had a major impact on the quality of care. Understanding why you do something is as important as how to do it*."

Following are frequently mentioned areas of quality improvement discussed in our interviews:

Ambulation: Many aides and nurses commented that after they learned the importance and techniques of moving patients, they increased this aspect of patient care with the residents. A CNA said,

> *"There used to be only 2 people who did it [restorative care] before, now there's one [restorative CNA] on every unit. We walk them, range of motion, help to feed them in the dining room. [Is the CNA2 position helping residents, do you think?] Yes, they're walking more. Some refused to, but most do it every day now. Before they would do this, but not as often as now."*

Assessments and other clinical skills: One manager said:

> "*The CNA3 role is mainly clinical, some nursing things, more than just taking temps. They're doing assessments, things that the nurses used to do*."

A project coordinator reported that:

> "*CNA3s have been a HUGE help to [the nurses]. Nurses were amazed at how much more work they were able to get done on the shifts with the CNA3s here."*

Dementia Care: The dementia care courses helped some of the aides learn to feel and see the world more from the perspective of their residents. A senior aide talked about helping aides understand more about what it was like to experience non-sensitive care. She said:

"*I had a meeting with the aides upstairs and I had them sit on cushions that were wrinkled and then I had one of the aides sit in a recliner, with a cushion that was backwards, recline back, put the table up here in front of him, gave him an ice cream and told him, now I want you to eat your ice cream and he told me I can't. And I said, now how do you feel? How do you think these people feel when you do that to them?"*

Death and Dying: These classes have been among the most popular and well received by aides. One said:

"*All of them [the classes] I found pretty useful, and…I learned more about the residents and their families, like when a resident is almost dying, all they need is somebody to come in and say, 'It's OK to let go.' I found that interesting*."

Several facilities have changed care practices related to death and dying, including ringing chimes in the facility, and holding brief bedside memorials. Another said:

"*It helps make my job easier. It's hard working with people because of emotions, feelings, dignity issues. They come here to die. Very few people leave, go home."*

Palliative Care: These classes have also been helpful. One CNA noted:

"*The teacher we have is excellent. Palliative care…showed us more about the stages and what you should do. I learned things that I am doing that I shouldn't*."

This is an important and understudied area of quality improvement—not only doing new things, but not doing things that could be harmful to residents.

Teamwork: Many aides found the classes on teamwork helpful. Nurses in several facilities said that people were working together better, covering each other's resident calls when one was on break or lunch, and acting more nicely and more respectfully toward each other. One facility has put together subject-specific teams to work on particular areas, such as laundry, to improve the process of cleaning and sorting residents' clothes. However, teamwork was also identified by several workers as something that needed continued work in their settings. One worker who did not attend trainings, by her choice, said that:

> "*A good team watches for the patient, shares the work. I have to go, chase the patient. Sometimes I'm the only one who comes on time, answers call bells*."

Communications Skills: One nurse manager said, "*I'm hearing from some that communication is better. They're looking at a person as a whole. It's not as tense on the unit*." In general, communication with residents and supervisors was reported to be improved – very different but both equally important areas.

English for Speakers of Other Languages (ESOL): One supervisor said, "*Some are getting better with English. They feel they can improve their lot in life."* Particularly with dietary and housekeeping workers whose English skills are sometimes not as developed as those of CNAs, the ESOL classes have been popular and allowed them to communicate better with residents as they do their jobs.

Diversity and Cultural Competence: These classes have been especially well received. One aide said:

> "*I found it helpful for communicating with others from other countries or cultures. Also it helped me overcome shyness and work better with others."* Another said, "*You work with people beside you and you*

don't know their customs. You get to know people better. [How?] *It helps you understand how they work, how they speak, and understand them*."

Some facilities have been especially creative in how they introduced these courses, such as sponsoring a diversity luncheon with international foods and dress. This is also an area for continued work, as in one case where workers reported a "split" between African and Haitian workers on the floor:

"*There tends to be cliques, the workers are split up on the floor. So the African workers tend to work together, but don't help a Haitian CNA on duty. That's why we've instituted the cultural diversity trainings*."

Another nurse aide reinforced this about her facility, "*Most of the people of different nationalities want to work together…Makes you feel left out. It's a big problem."*

Supervisory and Management Training: One project coordinator said:

"*Probably if there was one program that's had more impact than anything else, it's been the supervisory and management training. We have managers and supervisors who've been doing their jobs for 20 years and never had any formal training, and the response has been tremendous. I think we budgeted for 8 people to attend each of the classes and almost all of the classes have had over 20 people at them."*

In addition, the management training has helped to facilitate coordination between departments. In one facility, "*they had major infighting between departments and they are working much more cooperatively together*," according to a project coordinator.

Future Plans to Obtain Data on Possible ECCLI Outcomes on Care Quality

The researchers do not yet have sufficient observation data from the facilities to draw any conclusions on quality of care from them. We hope to interview residents if the evaluation phase continues in FY03 and we have recently received Human Subjects approval from Harvard University to do so. The researchers will review resident and family surveys, and Department of Public Health facility surveys, to the extent they are made available to CommCorp, for a future Phase 2 report if there is one. Finally, we anticipate CommCorp and the evaluation team will continue efforts to obtain MDS and MMQ data from the state and federal government or finding a way for the facilities to provide it without compromising resident privacy.

III. Structure of Partnerships

A. Internal Partnerships

The most carefully monitored aspects of ECCLI happen within individual facilities: workers receive a boost to skills, earnings, and (ultimately) career prospects; patients and peers benefit from these boosts; and we also observe related changes in the climate and organization of work, as reported above. The program will succeed or fail at this level of individuals and their organizations. But also vital are the relationships between employers in each consortium. The ECCLI Round 2 program model assumes that long-term care employers can get more done together than singly.

Information from this section was drawn largely from interviews with project coordinators in the seven ECCLI consortia, observations at monthly project coordinator meetings, and information gathered for the ECCLI baseline report, including review of project documents and interviews with project coordinators, nursing home administrators, and directors of nursing.

Overview

All seven consortia are multi-employer projects. Each has one designated lead facility responsible for contracts management and project administration.[9] And each has one or more governance committees composed of representatives from the partner facilities (and, in some cases, from the workforce partners), that meets regularly to plan and implement training and related activities, respond to problems, and monitor progress. Beyond that, the internal partnerships among employers vary widely in terms of how closely the partners work together, what activities they have in common, and how they make decisions together.

The ECCLI consortia span a continuum, from very loose to very tightly knit partnerships. The loosest partnerships are essentially operating separate projects in each participating facility, though under common contract administration. As one project coordinator of such a consortium explained:

> *"The differences between the nursing facilities and the home health care agency have meant running two basically separate programs, since the managers of the home health agency did not want their HHAs [Home Health Aides] trained as CNAs for fear they would leave the agency."*

The more tightly knit collaborations shared membership in formal alliances prior to ECCLI, and have plans for workforce activities beyond the present contract horizon. Another distinguishing feature is the circulation of staff among facilities in the training process. More integrated partners send their staff to each other's facilities for joint training sessions. And these collaborations worked together more closely to develop curricula and activities for joint use. In the middle of the spectrum are consortia with aspects of both models: a fairly high degree of independence in training activities, but generally close collaboration in governance and decision-making.

Interestingly, being part of the same corporate structure or system does not guarantee closer links among facilities in ECCLI activities. Two of the less integrated partnerships include homes that share a corporate parent or system membership. In one case, the partners are in different parts of the Commonwealth. In another consortium, the group includes non-corporate members (linked by common union representation of workers) as well as a home health care organization. Even among the facilities under a corporate umbrella, local circumstances (such as frequent turnover in administration in a home) have made cooperation difficult.

Benefits of Employer Partnership

ECCLI employers have benefited in several ways from cooperating with other facilities.

- Sharing costs and coordination of instruction, administration, and assessment promotes efficiency and makes the investment in staff more feasible, especially for financially vulnerable members.

- Having a "first mover" (such as a lead facility that moves more aggressively into training and organizational improvements) offers a model and makes risk-taking easier for more reluctant partners.

- Sharing expertise and program models builds knowledge and capacity among partners, and helps disseminate the lessons learned in individual facilities. Staff members (as well as residents in one case) have taught courses. One project coordinator described the benefits of cooperation that emerged from a group of employers that had been initially very resistant to working with their competitors:

[9] In one group, these are functionally separated, with the lead facility acting as the fiscal agent of the contract, and another facility managing day-to-day program operation, including implementation of training

"We see them sharing best practices. [At one facility], they have an excellent restorative program. They agreed to take that program and teach that program at [another facility]. At [another facility] they've agreed to train the other sites in Alzheimer's. People talk together, those in similar positions are networking. This is big! Administrators had never really talked to each other. [How about the facilities' stance as competitors?] They've lightened up on this. They still have their niches, and they're not losing anything [by cooperating]. They realize that it's not going to hurt them, and it may even stop the puddle jumping from site to site."

Another consortium, through its joint meetings of employers, discovered the need to expand the career ladder curriculum to include more emphasis on team leadership and customer service training for aides and other staff.

- Exposing staff to other facilities (through rotating of training sites) has been beneficial, despite the fears of some employers who feared defections of their workers. Employees have learned about other modes of care and increased their opportunities to practice new skills with patients, such as those with Alzheimer's disease. Workers gained perspective by learning that *"the issues that they face are ones that are shared by other facilities,"* in the words of a project coordinator.

- Informal networking has helped solve childcare or transportation barriers to participation. In one instance, a worker was able to transfer to a position in another member facility that was more accessible to her home; in others, partners made referrals when emergency child care needs threatened to prevent a worker from attending training.

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and cultural change activities.

Challenges to Employer Partnerships

Despite these benefits, building and maintaining cooperation among some ECCLI employers has been difficult. Several areas of challenge have arisen:

- Coordinating training and other activities across organizational boundaries. Taking direct care workers off the floor is complicated enough in a single facility, but planning this process with several employers only multiplies the difficulties. One solution, touted by a project director, is to be sure that governance committees include someone responsible for scheduling workers from each facility. This was an arrangement this consortium came to belatedly but it has made a positive difference since they discovered it.

- Establishing trust between employers, given historical competition for patients and staff. Coordinators in some cases have had to play shuttle diplomacy, coaxing competitors into participating together, long after the partnerships were established and funded. But trust is never a given, even when the partners are not direct competitors. For one consortium, which links a skilled nursing provider with other, non-nursing providers, the trust hurdle remained – simply because the partners, who had been prior members of a formal alliance, didn't know each other all that well. Explained the coordinator,

  > *"If I were to do it over again, I would have spent more time developing relationships with those folks. We hit the ground running with the contract, and no one even knew each other. They didn't trust each other. There was a lot of work to really develop those relationships."*

  Competition can create other wrinkles besides reluctance to invest jointly in training. At one consortium, employers vie for holding steering committee or training sessions at their own facilities, fearing that staff might otherwise be lured away.

- Coordinators' lack of direct authority over the administrators and staff in the partner establishments. This (like the problems of scheduling and creating trust between firms) is not unique to long-term care. But ECCLI is an important case of a growing phenomenon: managing in networks or other collaborative structures, where lines of authority are unclear or nonexistent. When partners resist, it can prevent workers from attending training, and make the joint implementation of projects all the more complicated.

  As one project coordinator explained:

  > *"That's one of the things that's been a bit of an annoyance – is the level of my authority varies from place to place. While generally I'm pretty well received, [Partner X] has its own mentality. The best thing I can liken it to is sibling rivalry."*

- Inconsistent or slackening participation in training and project governance. Almost all consortia have one partner that has participated at lower levels or otherwise not been fully "on board." In some cases, employers have not cooperated fully with requests to advertise trainings, recruit staff, release staff for training, or otherwise provide support. Financial problems or other issues have forced three facilities to bow out completely from ECCLI participation since the project's inception, one because it closed. A few other less active partners remain in the project, but at sharply reduced levels of participation, in governance meetings, staff sent to trainings, or both. One coordinator attributed waning interest to the recession; in other words, with fewer staffing problems, a few employers felt less pressure to participate in ECCLI.

Ebbs and flows of involvement are not always due to reduced commitment. Short staffing, from nursing aides to RNs to management, is a recurring problem. Scheduling problems with one community college partner, leading to repeated class cancellations, caused demoralization and effectively slowed the process

significantly in one facility. Several facilities have experienced severe turnover in administrators, delaying the onset of training until early 2002 in one case. The occasion of state surveys has also created delays, or, in the case of one facility, an abrupt shift from career ladders training to team-building focused on addressing deficiencies.

Another factor that sometimes affects training participation is "organizational" – the lack of a "point person," such as a staff developer or human resource director, assigned to recruiting trainees and getting them off the floor. In some homes, top-level managers juggle these functions with other responsibilities, making follow-through on ECCLI tasks difficult. In other facilities, workers are responsible themselves for scheduling themselves off which is nearly impossible, according to them.

Responding to Challenges

Leaders in each consortium have relied on a variety of methods to address gaps in participation and promote partnership. The most commonly cited one is sheer effort, "perseverance," or "just diligence." Building relationships, and the trust that cements them, takes time and patience – especially with partners who feel buffeted by staffing problems, patients with challenging physical and mental needs, and financial issues, such as gaps in Medicaid reimbursement. As one coordinator explained:

> *"At the [facility with the most reluctance to participate], we have really persevered. The morale is so low there. We have had lots of meetings with them. We try to push. We try to meet their specific needs. For instance, we tried to offer soft skills, and continued it as English for Speakers of Other Languages (ESOL) because that was what their workers needed."*

In cases where a new administrator or nursing director appears repeatedly, a Sisyphean effort is required to restart the relationship and bring the new executive on board once again. Coordinators have also been forced to adapt, scaling back initial expectations about consortium-wide training programs and levels. They come to realize that not all facilities are going to do all of everything (nor should they), or "move at the same pace." One lead facility has revised its plans to adopt a centrally coordinated mentoring program in all facilities, opting instead for more localized experimentation.

To work around their limited authority, finally, coordinators must sometimes appeal to a higher level. One project coordinator refers recalcitrant managers back to their own administrators or owners. Another consortium had to appeal to regional corporate staff to persuade a facility that was resisting trainers' access to workers.

But ultimately, genuine cooperation cannot be coerced. Where participation across workplaces has been strong, the employers have built a shared "culture" that helps overcome competition and promote trust. In one case, staff developers meeting across facility lines reinforce trust. As one coordinator, herself a staff developer, explained:

> *"It's the culture of [our partnership]. The administrators pretty much set a tone that it was all right [to collaborate] – if you guys want to share resources, share ideas, get together and pool your resources and do things together, that's ok."*

In sum, internal partnerships have required more investments of time, energy, and effort than was perhaps anticipated by ECCLI Round 2 framers. At the same time, they have made possible increased scope, scale, learning, and development of leadership.

B. External Partnerships

The ECCLI Round 2 project is notable not only for its ambitious goals for long-term care workers and residents, but also for the range of external partners enlisted to help realize these goals. Partners include community colleges (often several per consortium), one-stop career centers, a union education program, and a variety of community-based training organizations. In this section, we describe the nature of external partnerships, how employers and workforce partners have benefited from these relationships, barriers that have prevented the workforce partners from meeting ECCLI goals, and responses and lessons to date.

Information for this section was gathered through a series of interviews with ten "external partners" (workforce development organizations), focusing on two organizations from each of the five case study consortia. The respondent was generally an administrator or project manager responsible for his or her agency's contract with ECCLI. The organizations include community colleges from different regions of the state, one-stop career centers, a union-based education program, and several nonprofit education and

training organizations. We also asked ECCLI project coordinators a series of questions (in the course of wider-ranging interviews), asking them to describe and assess the roles played by external partners. Observations from monthly project coordinator meetings also supplemented the data.

Overview of External Partnerships

Every ECCLI consortium has contracted with an array of outside partners to provide various workforce development services. Contracts range from one-time lectures or workshops (in areas such as therapeutic touch or hospice care) to full-time coordination and management of all contract activities. Partner activities clustered into several areas:

- Instruction
- Counseling, screening, assessment
- Support services (provision or referral)
- Planning, administration, facilitation, brokering

The consortia differed in terms of what kinds of organizations were employed to fill these roles, and the degree of reliance on outside organizations for them. While nearly every consortia looked inside for resources to provide some training (including a line worker in one case and residents in another), one consortium placed much more emphasis on their own resources and minimized their use of outside partners, except for discrete lectures or courses -- such as ESOL, taught by a community college. The organizers of this project felt that such arrangements would make for a more economical, hence sustainable project, as well as affording them greater flexibility in terms of curricula and instruction.

At the other end of the spectrum are those consortia (three out of seven) that are administered by outside organizations (a union education program, a community college, and a regional workforce organization). In between are projects that are nursing home-driven, but rely to varying degrees on their partners for

developing, overseeing, and troubleshooting their activities as well as direct training services. Where partners are more integrated, they are also regular participants in project governance meetings.

Virtually all of the nine workforce organizations interviewed had worked previously with long-term care employers in some capacity, though not with the ECCLI partners in every case. (Just under half, or 44%, had worked with employers in their consortium before ECCLI.) Eight of the nine (89%) had worked with career ladder programs before ECCLI.

The most common activities that external partners participated in were teaching leadership, communication or mentoring (79%); proposal development, career counseling, help with program management or coordination (67%); and needs assessment, recruitment, screening, referrals for services, and teaching basic education (56%). Smaller proportions of the partners did the following; teaching medical, supervisory, cultural diversity, or job readiness skills (44%); enlisting other organizations to the program (33%) or introducing the employer to other organizations (22%).

Workforce partners were unanimous in their views on the importance of several ECCLI Round 2 program goals. Virtually all of them ranked "improving the quality of care" and "promoting skill development" as "very important"; other high-ranking goals (varying from somewhat to very important) included "identifying new caregiving practices" "creating and institutionalizing career ladders."

On average, workforce partners rated their relationships with ECCLI employers as "very good," with responses ranging from "good" to "excellent." The majority felt that their access to workers, support from employers, and level of trust was "very good" to "excellent", and most had similar high marks for the employers' willingness to listen to suggestions and follow them.

The roles of external partners have evolved over the life of the ECCLI project. For instance, a consortium working with three community colleges in its region sought originally to match each institution with its closest nursing home partner. In practice, each employer "bid" for services from all training vendors, and

one college (with the greatest depth in teaching non-credit, industry-focused courses) has taken on most or all of the training at the work sites. Due to reduced worker interest, career centers in this consortium have shifted from offering one-on-one employee counseling to holding seminars on specific topics, such as balancing work and life, childcare, and personal finance. These provide "*entree for employees into the career centers, so it's made them familiar with what's available*," according to one workforce partner.

Community-based organizations and union-based educators have also seen their roles shift. One nonprofit workforce agency, hired primarily as a vendor to teach supervisory skills, "life skills" and other courses, has seen itself evolve into a de facto "training director" for the partner facilities. This involves both curriculum development and coordination – finding the right person at the community college, or a local rehab facility, to lend expertise; working with employees, supervisors, and managers to get the right mix of training and make it work operationally within a facilities' schedule, and related tasks. A union-based program's roles expanded from coordination and instruction to "mediation," in the words of one staff member. This has involved meeting with staff, administrators, and eventually, a regional vice-president, in order to win the acceptance of training and curriculum at individual homes.

Benefits Of External Partnerships

The ECCLI Round 2 consortia have clearly benefited from their workforce development partnerships. The scale and complexity of these projects, both in the number of workers served at different sites, and in the scope of organizational changes sought, would be impossible without them. They provide capacities normally absent from nursing facilities, where managers are prone to wearing "a hundred hats," human resources being just one of them. These capacities include expertise in specific instructional areas, but are much broader, extending to network contacts, program ideas and vision, day-to-day management of project implementation, and – on occasion – mediating conflicts within or between facilities.

Each of the workforce partners brings its own distinctive capacities and approaches to developing and supporting career ladders:

Community-based organizations (CBOs) bring knowledge of the needs of low-income workers, as well as contacts with neighborhood residents and organizations. Some also have strong capacities for strategic planning and project management. One consortium relies extensively on CBOs to "brainstorm" and implement its project, as well as to market the partner facilities to potential workers and consumers in the community. Others utilize nonprofit agencies for more discrete purposes, such as teaching CNA certification or work readiness courses. As the contact from a CBO on the former model explained,

> *"We focus on the needs of entry level workers. As a CDC [Community Development Corporation], we bring the needs of our immediate community to the project. Members of the community recognize that they may be future residents of the facilities in the project."*

Community colleges bring distinctive capacities as well. Beyond an infrastructure for hiring instructors, developing curriculum, assessing learners, and (ultimately) placing them on a well-defined, credit-based career path, colleges bring the legitimacy or reputation of higher education to bear on the project. Explained one coordinator:

> *"I've seen a heightened interest in education, not just in training. It boosts people personally; they want to pursue their personal education. When you have a college come in, it's really, it's different than just regular in-services. It brings a value, a reputation to the table. People are asking questions about getting themselves to college."*

A college administrator and instructor described the institutions' mission this way: *"to meet students where they are and bring them into the system."*

Union-based education is distinguished by the trainers' roles in "the labor/management context." This framework – based on collectively-bargained rights and duties – ensures workers a voice in decision-making about training and job changes, and helps enforce arrangements such as release time for training. It also stresses intimate knowledge of workers' situation on the job (and off the job, as well), and schedules and tailors training accordingly. For instance, in one unionized facility, a "communications" course was modified and expanded to serve workers needing more development of English skills. The trainer, himself a nursing aide and union member, was "immersed" enough in the workplace context (and trusted enough by workers) to recognize these needs and respond to them. Employers, initially skeptical of relying on union-based trainer, have been reportedly won over by the quality of ESOL instruction in their facilities.

One-stop Career Centers have been a valued "gateway" for workers entering long-term care jobs in ECCLI and/or ascending career ladders. They bring capacities for matching workers and employers, managing information, assessing skills and training needs, and providing counseling and referral to services. Career centers were created to serve employer and worker customers equally; the two centers interviewed in our sample take this mission seriously, and received high marks from project coordinators. Some also bring a focus on serving less-skilled or disadvantaged workers. One of them is also teaching a variety of non-career ladder classes, including soft skills, mentoring, teamwork, diversity, and computer skills.

Beyond the unique capacities that each institution has to offer the employers, the workforce partners have also contributed by helping the latter to expand their network of contacts and their familiarity with education and training resources. They connect them to resources and prevent them from "reinventing the wheel." As one coordinator explained about his two main training partners:

> *"[Training partner A] has been our link to the community colleges, to [Training partner C], to other resources out there that we could take a look at, and say, okay, how do we want to provide this training. I see that as huge, because these guys all had their own resources out there, they had already built the relationships . . . So I think the whole*

experience has broadened the way we look at the resources in the community."

"The major contribution of [training partner B] was helping us to facilitate rolling out the contract. Helping us identify who we were going to partner with, how to make those contacts, what's out in the community, educating us about making that leap from being kind of a stand-alone, insulated nursing home, with our other sites, to now having penetration in the [residential] community."

Benefits to Workforce Partners

Just as long-term care employers have benefited by overcoming their isolation from education and training organizations, so have the latter, by extending their knowledge and familiarity with long-term care. . As a community college contact explained:

"It's really made us much more aware of what the needs are out there. It's almost like a needs assessment tool. We are much more aware of the needs of the health care industry, especially long term care. As a result, they are now refocusing their resources to work with home health care aides."

A project coordinator, describing the experience of college and career center representatives in her consortium, echoed this view:

"Community colleges are modifying curriculum…[and] the career centers are developing curriculum…to meet the needs of the long term care facilities."

In the process, nearly every workforce partner interviewed spoke of increased contacts with employers (with the potential for future business, beyond ECCLI), and enhanced understanding of working with nursing homes and their staff. They also spoke of the benefits to them of making employers and workers more aware of the workforce development system.

Challenges to External Partnerships

Obtaining these benefits has been complicated by a number of challenges arising between the employers and their external partners.

Lack of adaptiveness or flexibility.

ECCLI employers were most satisfied with those workforce partners who took the most flexible, responsive approach to their work, and designed programs and services accordingly. This is of special importance in long-term care, where moment-to-moment demands can shift dramatically. When providers were seen as lacking in this quality, it was traced in some cases to a lack of capacity, and in others to a problem in the institution or its mission. As one coordinator explained,

> *"Certain trainers have had much more success than others and it's been based on their flexibility and their ability to accommodate the needs of the facilities. So the bigger community college had a much easier time providing faculty and adjusting to the kinds of offerings we wanted than the smaller community colleges had."*

Another coordinator described an instructor whose approach was rigid at first:

> *"The instructor won't do the class without 6 people, she won't hold class. And, if a person can't show up, she wants to know WHY. She doesn't understand that this is how health care works. Things change."*

In another facility, disruption of class schedules by a survey visit created problems for trainers. Even for highly capable training institutions, notes the coordinator, *"it's difficult . . . to understand that the residents come first and that sometimes their training needs to be rescheduled for good reason."* In two other consortia, coordinators distinguished between lower and higher-performing institutions on a similar basis. One reportedly took an attitude of "take it or leave it" when challenged about scheduling rigidities and other concerns of employers. The other was viewed as far more accommodating and responsive. Coordinators traced the problem to the strengths or weaknesses of administrators, finding that – once instructors were made available – the quality of curricular support and teaching was commendable. Less responsive administrators failed to return calls, or to make ECCLI instruction a priority.

Lack of clear expectations and goals.

According to training providers, long-term care employers sometimes failed to clarify their goals, and otherwise appreciate the institutional situation of workforce development. This was the result, at times, of bringing in the college, career center, or other provider late in the planning or implementation process, rather than making them integral to development of the contract – as was the case in two consortia. College officials also noted that some consortia had done fuller needs assessments than others concerning training. Problems also ensued when facilities had incomplete support of management or line supervisors – resulting in poor turnout for classes, and poor utilization of the workforce partner. And some colleges felt that employers had unrealistic expectations of their ability to dedicate faculty to meet the needs of ECCLI's pressured timelines: "*we can't be all things to all people*."

Instructor mismatch or performance problems.

In several consortia, trainers' material was not well attuned to a health care setting, to the skill and education level of the audience, or to the gravity of the topic (elders with dementia, in one case). And on occasion, instructors have simply not shown up, or arrived on the wrong day. (To be fair, there are instances where instructors arrived, but no trainees showed up.) These glitches may be due in some cases to miscommunications and are probably not unexpected in any new relationships of this type.

Establishing trust.

All of these problems – inflexibility, non-responsiveness, poor performance, and mutual misunderstanding – get in the way of creating trusting and cooperative relationships. Trust is also hindered when employers question the motives of their partners. This caused special problems in some unionized facilities, where employer suspicions of unions have delayed training and even prevented access to one external partner, a workplace health and safety organization. The program sponsors have had to work hard with employers to make clear the distinction between the union, with its organizing and advocacy mission, and the education program, which is dedicated to training.

Responses and Lessons Learned

Consortia have responded to these problems by seeking better-qualified instructors, re-evaluating curriculum, and seeking better coordination and scheduling with college administrators. They have also modified contracts, sometimes shifting responsibilities to more appropriate vendors.

Certain performance issues resist such "fixes." In some cases, there are institutional constraints that are beyond the control of instructors or their managers. Some community college administrations and faculties are unsupportive of non-credit workplace education, or ignorant of the contingencies of teaching in the nursing home environment. Labor/management negotiations can slow down the process, and some employers will continue to mistrust union-based training.

To improve communication and understanding among partners will also simply take more time. But several lessons are emerging about easing this process:

- *Early and consistent involvement* of workforce partners in project conception, governance, and operational decision-making, to ensure that needs and goals are well established, and that administrators on all side are "bought in."

- *Openness and candor are essential.* When asked what made their relationships with employers work, external partners consistently cited the need for transparency of motives and concerns by all parties – as with any relationship.

- *Successful partners serve "dual customers."* As one workforce organization described itself:

> *"We know how to work with people, working with supervisors. The people that we have in the field have a combination of business savvy and counseling-slash- social work-slash-people skills. We're company-driven, customer-driven, all that. I think we do that well."*

- *Work with the workforce network*, rather than just individual providers. The most fruitful partnerships include external partners who can monitor the quality of other partners, guide employers to the right contacts in those organizations, and troubleshoot problems when necessary.

- *One size does not fit all.* Just as every worker (and resident) in long-term care has distinctive needs and capacities, so do employers and workforce partners. Successful partners are not "all things to all people," so consortia must mix and match a variety of organizations to their appropriate niches – from one-time lectures and seminars to full-scale project management. They should also expect partner roles to evolve over the life of the relationship, and adapt accordingly.

C. Technical Assistance

Technical Assistance (TA) in Round II was designed to reach the long-term care facilities through a form of direct assistance from the Paraprofessional Healthcare Institute (PHI) and private consultants. The facilities were also to receive indirect assistance from the Boston Workforce Development Coalition (BWDC), Massachusetts Executive Office of Community Colleges (MEOCC), and Massachusetts Workforce Investment Board Association (MWIBA). Direct assistance was provided in the form of on-site

training and access to off-site workshops. Technical Assistance from the Paraprofessional Healthcare Institute (PHI) was intended to provide consortia-level and project-wide support on organizational change and "culture" or "care practice" innovations, along with their contractor the Boston Workforce Development Coalition. In contrast, the Massachusetts Executive Office of Community Colleges, and the Massachusetts Workers Investment Boards' Association were not intended to provide direct TA to individual sites, but rather to serve as convening function and to disseminate information from the work of their individual members working with the various consortia.[10]

The project period was 16 months long and ran from February 2001 to June 2002. During the planning period, PHI representatives assisted sites in moving from start-up and planning to implementation. Technical Assistance needs varied from site to site and ranged from continuing to help one consortium engage its partners to helping develop curricula in another, and helping yet another understand the meaning of "culture change" within its own environment. A "care practice" project initiated at one of the consortia pertained to bathing. The goal of this project was to develop customized bathing practices for residents with Alzheimer's Disease and Related Disorders (ADRD) who were prone to agitation or aggression during bathing. These practices would then provide for a more enjoyable bathing experience for the resident and safer and more satisfying work for the CNA responsible for bathing them. Preliminary results from this project indicate that a positive bathing experience can be created by optimizing bathing sessions along three dimensions; communication with the resident, timing of the session and the bathing technique.[11] Other kinds of technical assistance related to reviewing particular 'care practices' that were causing difficulties for residents or facilities, such as revolving CNA assignments (rather than consistent assignment to residents), organizing the best and most individualized possible dining and feeding arrangements (particularly in offering more choice of meals and even times they are consumed), creating 'neighborhoods' with more homelike environments, and generally focusing on resident-centered care, with more freedom for residents to rise and retire at a time of their choice, for instance. These care practices are complex

[10] The MEOCC and MWIBA were expected to focus on assisting their specific constituencies (community colleges for the MEOCC, Workforce Investment Boards for the MWIBA) who in turn provided workforce development training to their partner long-term care facilities.

[11] Bathing Project Culture/Practice Change Initiative, Interim Report Lois Camberg, Ph.D. Janet Strassman Perlmutter, LICSW, 2002 (Appendix B).

organizational interventions, and not easily adopted by any facility, but were in discussion and at various stages of being implemented at several ECCLI projects during the period covered by this report.

The other TA providers, Boston Workforce Development Coalition (BWDC), the Massachusetts Executive Office of Community Colleges (MEOCC) and the Massachusetts Workers Investment Boards' Association (MWIBA), have played a smaller but still important role, mainly through linking their local constituents to the consortia, troubleshooting some problems in communication and coordination and laying the foundation for individualized TA through needs assessment evaluations of the sites.

As with other aspects of this round of ECCLI, the provision of TA was affected, in part, by delays in the state budget (see Introduction). After June 30, 2001, all the technical assistance contracts expired and were not renewed until after the budget settlement in November. After the contract with PHI expired in June, some PHI providers, such as Susan Misiorski, RN, continued to work with sites through September, helping to guide "neighborhood" development in one consortium, providing assistance with "I-centered" care plans at another, and offering a general training on bathing practices with expert Pioneer Network leader Joanne Rader. However, no additional contract between PHI and Commonwealth Corporation was successfully negotiated after November 2001, and most organizational or cultural technical assistance ceased until spring 2002.

The lack of organizational development-oriented Technical Assistance for most of FY02 meant that proposed individualized assistance tentatively planned with the sites and consortia was never implemented. All parties interviewed agreed that the amount of assistance the nursing facilities needed to make significant organizational change and to approach cultural and care practice changes was underestimated in the planning for ECCLI Round 2. While some sites (as described above) succeeded in making changes along these lines, this absence was a significant factor in other sites emphasizing training over culture or quality initiatives, although these are of course intertwined.

Towards the end of the ECCLI Year 1 implementation period, Technical Assistance was re-introduced but only with moderate intensity. The Commonwealth Corporation co-sponsored private consultants who provided Technical Assistance on culture change and organizational development. Dr. William Thomas, president and founder of the Eden Alternative was one of such consultants. The stated objectives of his workshop, held in May 2002, were to help attendees (1) develop an understanding for the need to improve the quality of life for facility residents, (2) understand the philosophy of the Eden Alternative committing to surrendering the institutional point of view and adopting the human habitat model, (3) to be able to recognize the "Ten Principles" of Eden Alternative, and (4) to be able to have a better understanding of the limitations of the medical model and to distinguish "care" from "treatment." Of the 103 attendees who evaluated these objectives almost all said they had fully or partly attained these objectives from participating in the workshop. Another consultant, Tom Zwicker of the National Direct Care Alliance, also gave a spring workshop on *Changing the Culture Aging in Long Term Care*. Although formal evaluation results are not yet available for this workshop, it was generally well received by attendees. The stated objectives of this workshop were (1) to identify new care practices and innovative programs that improve the quality of life for residents, (2) to identify the limitations of traditional medical models of care and treatment, (3) to identify national movements and organizations that support changing the culture of long term care, (4) to be able to have a better understanding of the specifics of culture change at one facility, and (5) to identify the challenges facing direct care workers in long term care. A third workshop was geared towards organizational change and was conducted by Sharon Seivert from the Great Work Consulting Group. This October 2001 two-day workshop was based on the management system called *The Elements of Success* [12] and entailed bringing senior managers together to evaluate and address the issues within their facilities. The organizational change initiated by this workshop sought to help the facilities revitalize their organizations, to improve the leadership in their facilities and their ability to problem-solve and to better acknowledge the voices of frontline workers. This workshop was attended by three facilities in one consortium and described as very useful.

[12] The Elements of Success is an innovative management system that is featured in The Balancing Act: Mastering the Five Elements of Success in Life, Relationships and Work by Sharon Seivert (November 2001/Inner Traditions-Park Press).

The Technical Assistance to date has been both widely appreciated and probably under-provided given the needs of the consortia. Project coordinators continue to express the need for additional TA in the areas of curriculum design, culture change in the work place, evaluation, worker training and advancement and identifying education and training providers. The single-year funding mechanism, with an extensive delay after six months, has been disruptive to implementation. While most required work of training and documenting has continued, it will need continuing careful attention for the facilities' evaluations of their progress to be accurate and useful. Additionally, further TA on organizational development, care practice changes, and "culture change" is likely required for any sites that have not fully implemented their project proposals.

IV. Lessons Learned

This final section draws lessons from the ECCLI Round 2 projects based on the evidence presented above, as well as on additional data presented here only in summary form. We believe that these lessons have implications for the success of the current ECCLI project and possibly for those adopting similar strategies linking workforce development to quality of care.

II. Progress to Date

A. Training

- *Entry-level workers – especially those in service departments such as laundry, housekeeping, or dietary – often need more educational preparation than expected by ECCLI consortia.*
    - More Adult Basic Education, ESOL, and GED preparation, as well as specific preparation for health careers, such as studying for CNA certification and taking tests, is required than was anticipated;

- Greater depth of ESOL is needed than that allowed in short, workplace-based courses – particularly for those with basic spoken English competency, but needing more assistance with reading and writing English.

- *Training in Alzheimer's disease and Related Dementia (ADRD), Dementia Care, Restorative Care and Therapeutic Activities has positively affected care giving.*
    - The workers in our sample have a better understanding of these conditions, and thus more insight about why they are asked to perform certain procedures. This has enabled them to provide better care to their residents, by all accounts. The training has also given them more compassion and patience with the residents. Managers and workers alike have noted these changes.

- *To improve attendance, schedulers and nurse managers should be fully involved in the planning of training activities with vendors and facility staff.*
    - Having schedulers on steering committees planning training is extremely useful. Also, nurse managers need to be involved since they will be ultimately responsible for care given if staff is in training classes.

- *For classes on Diversity, or one-on-one career counseling where workers might be asked to share more openly, educating participants about the benefits of such training can encourage this openness.*
    - This is particularly important for diversity training as most nursing home workforces and resident populations are multi-ethnic and multi-generational, and can be prone to tensions that affect teamwork and communication, important ingredients in this environment.

- *Beyond their instructional benefits, trainings create a forum for the interaction of workers from different departments. This helps to foster building of relationships across departments (such as nursing and dietary) and between frontline workers in different facilities. This can help in*

breaking down "turf" barriers, aiding cooperation, and enhancing understanding of different approaches to care giving.

- *Modifying curricula to make them more "learner-centered" – interactive, visual and/or better attuned to learners with little (or negative) formal school experience – has been valuable and valued by employees.*
    - At times, community college staff or contractors lack experience with this workforce and need assistance with developing learner-centered pedagogy.

- *Consortia need more support and guidance in establishing systems that will ensure accurate and detailed record keeping of their training activities.*
    - This includes cooperation in getting complete records from facilities, and assisting facilities that experience technical difficulties in completing the electronic spreadsheets, even after sending representatives through training sessions. Also, the importance of record keeping needs to be made clear to those responsible for it, including trainers and administrative staff.

B. Career Ladders

- *Individual mobility and overall progress for the facility are furthered by having a discrete staff development function, either in the organization or shared across facilities.*
    - In the absence of a staff developer, we see a need for at least one senior or middle manager that champions the project, and provides direct and continual support to individual workers.
    - When senior managers must balance staff development with other functions, project priorities can easily fall by the wayside.

- *A few rounds of classes, by themselves, are not enough to change jobs, attitudes and care giving outcomes. Other areas of work are also necessary:*
    - Training enough employees, over time, to achieve a "critical mass" of desired skills in the organization.
    - Formal mentoring programs are useful, along with informal modeling of new practices, to spread new skills and attitudes.
    - Follow-up by supervisors and other managers to ensure that new skills are being utilized, and to reinforce their use when aides are observed practicing them, is critical.
    - Rewarding supervisors for developing their staff, encouraging them to use new skills, and acquiring new skills themselves, is essential.
    - Documenting and monitoring change to make the case for continued career ladders investment to management is an important responsibility.

C. Wage Improvements

- *Wage increases need to be meaningful so as to foster worker commitment to the program and to allow workers to reap the tangible benefits of ECCLI in the long run.*
    - Workers will perceive the opportunity costs of training as high if the training provides increased skills and responsibilities that are not accompanied by a commensurate or "helpful" increase in wages. Even though they may value the training as a symbol, concrete wage increases are extremely important.

- *Clarity about wages increases, how much to expect, when to expect them, and what is required to earn them, is valued.*
    - Unions and management should plan ahead for these increases and agree before training starts on any corresponding increases for completion.
    - Written explanations of wage increases are helpful to workers.

D. Worker Attitudes

- *Nearly 90% of employees interviewed and surveyed are either very committed or highly committed to their jobs and their facilities' success.*
    - Training in and of itself represents an investment in the workers' development and also encourages them to feel better about their jobs and future potential, which has a positive impact on their attitudes to work.
    - Virtually all employees in ECCLI training programs are willing to work 'very hard' to help their employees succeed.

- *Fewer, only about half of participating employees are satisfied with their jobs, but more than that are motivated to do a good job.*
    - Issues such as staffing shortages and relatively low pay are not in themselves solved by ECCLI and still contribute to lower than desired job satisfaction, although morale overall is reported to be higher than before ECCLI began.

E. Recruitment and Retention

- *The presence of a career ladder program in a facility can serve as a recruitment and retention tool for incumbent and prospective frontline workers.*
    - If a career ladder program is well structured and has apparent benefits, incumbent workers are more inclined to remain in their jobs and prospective workers will be attracted to this environment.
    - While ECCLI alone may not provide a full explanation, most facilities participating in ECCLI report many fewer paraprofessional vacancies, lower agency staff costs, and higher retention rates.

- Solving recruitment problems contributes to quality by allowing facilities to hire and retain employees whose skills and aptitudes are most suited for long-term care, and to have more choice in avoiding employees who should not be in such settings.

F. Culture And Practice Changes

- *ECCLI projects to date appear to have had greater impact on the informal environment, or 'climate' of work in facilities, than on formal structures of mobility or economic advancement.*
  - Workers and managers in several consortia spoke of increased civility (being more polite, respectful, or tolerant) as well as greater camaraderie, and peer support.
  - Certain trainings (particularly hospice or palliative care or related end-of-life seminars) have offered workers a needed emotional outlet – particularly in light of the September 11 tragedy, as well as day-to-day stresses and losses that occur in the course of their jobs.
  - Improved individual self-esteem and confidence is having effects in some cases on aides' relationships with supervisors – making them "a force to be reckoned with," as well as challenging the hierarchical "caste system" of many nursing homes.

- *The projects will be successful to the degree they succeed in bringing nurse-supervisors on board. But nurses need assurance that organizational change will serve patients.*
  - Involving nurses, including directors of nursing, in planning and implementing training and other career ladder activities, and otherwise ensuring their familiarity with all aspects of the program, is key to success.
  - Gaining nursing staff support for training CNAs and utilizing their new skills is essential or frustration will develop.

- Rewarding nurse managers for developing staff, following up on aides' patient care suggestions and observations, and encouraging participation in care planning, is also necessary for organizational success.
- Working with licensed nursing staff to incorporate new care practices and work structures into broader systems (documentation of patient care; human resources, including supervisory and CNA evaluations; etc.) is an important part of taking full advantage of ECCLI programs and resources.

- *Great potential exists for renewing motivation of staff, volunteers, and residents through cultural change activities, especially those that are more general and include a careful examination of the values, philosophy, mission, and humanistic role of the care providing institution and staff.*
  - Managers and administrators, as well as frontline workers, appreciated the alternative vision set forth in the Eden Alternative training by Dr. William Thomas.
  - In most 'culture change' efforts, empowerment of frontline workers and improved quality of care.

G. Quality of Care

- *At least two facilities have achieved deficiency-free surveys since beginning their ECCLI projects began.*

- *Both workers and managers report improved quality of care in the key areas of ambulation and range of motion, of palliative care and understanding of death and dying processes, of improved assessments by some CNAs, of more sympathetic dementia care, and relationships with residents.*

- *Working relationships have improved in concrete ways to enhance teamwork, communication, understanding of diverse backgrounds and cultures, and relationships between departments as well as between aides and supervisors, aides and residents, and aides with each other.*

- *Where supervisory or leadership training is part of ECCLI programs, managers have become more understanding of ECCLI's goals and more reflective about their own handling of conflict, discipline and training.*

- *Quality of care changes are inhibited where training is not well integrated with workforce practices, care practices, or supervisory practices.*

- *Improved retention in and of itself improves quality of care, as has been documented in other studies.*

III. Partnerships and Working Relationships

A. Internal Partnerships

- *Having a "first mover" (such as a lead facility that moves more aggressively into training and organizational improvements) offers a model and makes risk-taking easier for more reluctant partners.*

- *Sharing expertise and program models builds knowledge and capacity among partners, and helps disseminate the lessons learned in individual facilities. It can also help overcome employer reluctance to collaborate with their competitors.*

- *Allow sufficient planning time in the early phase of projects to enable partners to build relationships and secure "buy in" of employers, their managers, and other staff.*

- *While formal, regular group meetings are essential to project governance, informal, one-on-one contact between coordinators and individual administrators is equally necessary to building and maintaining multi-employer consortia.*

- *The high turnover of administrators and DONs in some cases, as well as the myriad pressures and distractions facing them, make such contacts especially critical to workforce development in long-term care.*

B. External Partnerships

- *Involve workforce partners early on and consistently in project conception, governance, and operational decision-making, to ensure that needs and goals are well established, and that administrators on all sides are "bought in".*

- *Successful partners serve "dual customers" – both employers and workers.*
    - Not all workforce organizations have equally strong capacities in these areas; particular difficulties have emerged in conforming to the unpredictable and demanding work environments of long-term care.

- *Work with the workforce network, rather than just individual providers.*
    - The most fruitful partnerships include external partners who can recruit additional partners, guide employers to the right contacts in those organizations, monitor their performance, and troubleshoot problems when necessary.

C. Project Administration and Technical Assistance

- *Technical Assistance is critical.*
    - Sites have used several methods – sharing lessons and resources with one another, attending PC meetings, and relying on their workforce partners.
    - Organizational change initiatives are complex and not easy to predict, so flexibility is essential for all participants.

- *Provide deeper administrative capacity in the funding agency.*
    - It is unrealistic to staff a complex $10 million initiative of this magnitude with one full time project director and one program manager.
    - Onsite assistance from the administrative staff may be necessary to train facility staff to fill out required documentation and submit reports and invoices correctly, but this is time consuming and expensive.
    - Delays in invoice processing were demoralizing and problematic to sites.

- *Multi-year initiatives are essential in organizational change initiatives.*
    - This makes Massachusetts funding legislative practices, at least in the last two years, problematic for the success of this type of initiative.

Conclusion and Implications for Future Projects

The final report on ECCLI Round 2 project is presently scheduled for completion in Winter 2003. In the final report, we will capture as much additional data as possible within time and funding constraints, and will return to evaluate the hypotheses laid out in the baseline report. This will include an assessment of lessons of ECCLI for future projects, within Massachusetts or around the United States.