



An Evaluation

NORTHERN
NEW ENGLAND

LEADS
INSTITUTE

A report to:

Jane's Trust

The Jacob and Valeria Langeloth Foundation

Submitted by:



Leadership,
Education,
and
Advocacy
for Direct
Care and
Support

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Quality Care
THROUGH
Quality Jobs

PHI (www.PHInational.org) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers and employers improve long-term care by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

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Executive Summary

The “culture change” movement within long-term care offers strategies to enhance person-centered care through new staffing and organizational structures, as well as practices aimed at creating a new environment in which elders and people with disabilities can live with dignity, shaping the daily rhythm of their lives. Culture change can demand extensive behavioral and organizational changes that direct-care staff and their supervisors are often unequipped to implement effectively.

In 2005, PHI launched the Northern New England LEADS Institute¹ in three states—Vermont, New Hampshire, and Maine—with funding from Jane’s Trust and The Jacob and Valeria Langeloth Foundation. The goal of the LEADS Institute was to improve, over the course of three years, the quality of direct-care jobs by providing training, technical assistance, and cross-learning opportunities among 12 provider partners. The initiative offered long-term care employers a set of individual, team, and organizational skills aimed at creating truly person-centered care.

This report presents findings from a mixed-method evaluation that included qualitative interviews with key stakeholders, pre/post job satisfaction and work environment surveys, pre/post data on turnover and absences, document review, and “lessons learned” discussions with PHI staff. The report documents the process of program implementation, successes and challenges. Most importantly, it provides measurable evidence that sustained attention, commitment, and resources can lead to improvements in organizational management, long-term care jobs, public policy, and the quality of communication within long-term care settings.

LEADS participating providers included seven nursing homes and five home care organizations throughout the three states. Specific project objectives were:

- **To institutionalize supports for direct-care workers** by using a train-the-trainer model to create a core of leaders able to deliver peer mentoring and coaching supervision training within their organizations;
- **To support the re-design of caregiving practices** around the interaction between the caregiver and the consumer, through training and technical assistance provided to supervisors and administrators;
- **To establish leadership teams** inclusive of direct-care workers within each organization to lead quality improvement efforts;
- **To create a network of support** across the region to facilitate cross learning among long-term care leaders; and

- **To move public policy agendas** in each state, designed to improve the quality of jobs for direct-care workers and thereby support quality care for consumers.

PHI partnered with state-based organizations in each state to support LEADS practice and policy activities.

Each participating provider site received training and technical assistance in coaching supervision, peer mentoring, and person-centered care. Each site furthermore received PHI technical support to establish cross-functional leadership teams and work groups aimed at improving specific organizational practices related to quality jobs and quality care identified by the leadership team.

Impact—Turnover and Call Outs

PHI collected monthly data on staffing, terminations, call outs,² and staffing agency use. The LEADS logic model hypothesized that LEADS initiatives would improve the quality of jobs for direct-care workers, improve their job satisfaction, and ultimately reduce turnover and absences such as call outs. **Turnover for direct-care workers decreased from 2006 to 2007 for five of the ten sites for which there are complete data.**

Nursing homes tracked the number of call outs by month; in order to assess trends, we calculated an average annual ratio of call outs per direct-care worker. Four out of nine sites that reported call-out data experienced a decrease in this ratio. **Only one nursing home chose to focus significant energies and work group time on decreasing call outs; this site reduced its annual call out ratio from 9.5 to 8.5 per worker.**

Interpretation of these trends calls for a better understanding of the depth of program implementation. Nine sites were reported by PHI staff and partners to have very strong implementation of one or more LEADS initiatives. **Two of the three sites with very strong, sustainable coaching supervision and peer mentoring programs achieved reductions in both turnover and call outs.** Another site that had reductions in both indicators is reported to have a strong peer mentoring program and did a great deal of work on team building. **Five of the nine sites with strong implementation of one or more LEADS initiatives achieved improvements on at least one of two indicators—turnover and/or call outs.**

Impact—Systemic Change

Executive leaders at participating sites, state partners, and PHI staff alike emphasized the importance of changes in policies and procedures to maximize sustainability of LEADS practices. **Eleven sites implemented**

changes in organizational policy or structure during the course of the project. Five sites made changes in their hiring process, including involving direct-care workers in interviewing prospective hires; incorporating expectations around communication in job descriptions; expanding orientation to cover communication, coaching, and person-centered care; making peer mentoring a requirement; and providing peer mentors with an hourly bonus. **Three sites overhauled their disciplinary process**, changing their more traditional punitive approach to one of coaching and problem solving. **Two of these three sites achieved a decrease in turnover rate from 2006–2007**. Other changes that sites implemented included formalizing the participation of direct-care workers on committees, in organizational policymaking, and in care management; changing care planning to include family members and residents; instituting consistent assignment; changing smoking policy; and creating a career ladder for direct-care workers.

Impact—Work Environment and Job Satisfaction Surveys

PHI partners administered Work Environment Surveys that measured standard scores on elements of the work environment to 760 employees at baseline and 892 employees at end-line. Most relevant to LEADS initiatives were the scales measuring Clarity (in expectations and policies), Supervisor Support, Peer Cohesion (extent to which peers support one another), Involvement (commitment to one's job), and Work Pressure.

- **In the LEADS nursing homes, direct-care workers recorded improvements from baseline to the final survey in all of these five scales**, with the largest increase in the Clarity scale.
- **Scores for nurses in nursing homes also showed improvements on all five scales**, again with the largest improvement in Clarity.
- **Scores for direct-care workers in home care settings improved in four of the five scales**, with Clarity again registering the largest increase to a score two standard deviations from the norm.
- **Nurses from home care recorded improvements only in Clarity**; however, the number of respondents was quite small, making it difficult to generalize these results.

The Job Satisfaction Survey was comprised of 23 statements measured on a five-point Likert scale and was administered to 768 employees at baseline and 894 employees at end-line. We tested for statistically significant changes from baseline to final survey. **Statistical significance was demonstrated in the following areas:**

- The percent of **direct-care workers in home care settings** responding positively to: “I am treated fairly by my supervisor,” and “I am satisfied with the support I receive from my co-workers and/or peer mentors.”
- The percent of **direct-care workers in nursing homes** reporting satisfaction with the opportunities for ongoing or advanced training; the percent satisfied with the career development opportunities; and the decrease in those reporting “I often feel frustrated at work.” (However, there was a statistically significant decrease in the percentage of DCWs agreeing that they would like to continue this job for the next two years.)
- **Nurses in nursing homes** indicating they would like to continue to do this job for the next two years; those reporting satisfaction with the opportunities for ongoing or advanced training; and the decreased numbers reporting “I often feel frustrated at work.”
- **Nurses in home care** agreeing that “My supervisor provides adequate supervision,” but a decrease in the percentage of those reporting “my work gives me a feeling of personal accomplishment.”

Public Policy Outcomes

In each of the three LEADS states, public policy activities achieved meaningful outcomes. PHI established strong partnerships with similarly committed stakeholders. Policymakers sponsored legislation on behalf of direct-care workers in each of the three states.

LEADS partners made compelling arguments to legislators about the need to learn more about the direct-care workforce and the need to better compensate them for their work. Comprehensive studies of the workforce have been completed in two states, and a study is underway in a third in part as a result of LEADS efforts. LEADS also raised awareness in the media and among members of the general public about the need to improve the working conditions of the direct-care workforce through newspaper articles, radio, and television shows.

A great value of LEADS was bringing resources to established leaders already committed to LEADS public policy objectives and helping to maintain momentum that had been already established through Better Jobs Better Care and other policy efforts in the states.

Qualitative Findings on Project Implementation

- **The State Partner Model**—Despite initial lack of clarity regarding their role, state partners reported overall good communication and cooperation between their organizations and PHI. One disappointment was that

the LEADS work remained very state-based and therefore a sense of a “Northern New England” network among state partners did not develop.

- **Participation, Cross-Functional Leadership Teams, and Work Groups**— Respondents highlighted the critical importance of direct-care workers’ participation in leadership teams, work groups, and decision making around program implementation and policy. The sharing of power and decision making with different levels of staff and the empowerment of direct-care workers were viewed by many respondents as important LEADS outcomes in their own right.
- **PHI Technical Assistance**— Executive leaders overwhelmingly reported high-quality technical assistance received from PHI. They were impressed with the responsiveness of PHI staff and PHI’s ability to tailor technical assistance to the specific needs and desires of the sites.
- **Scope of Work**— Respondents reported that neither provider site leadership nor PHI had a good understanding at the outset of the level of effort that would be required to implement LEADS initiatives. Nearly half of the site leadership reported that the amount of work was often overwhelming.
- **Coaching Supervision, Peer Mentoring, Person-Centered Care**— Provider sites were introduced to all three key LEADS interventions. PHI trained 29 coaching supervision trainers who in turn trained 350 staff in coaching supervision. PHI trained 33 peer mentor trainers, who in turn trained an estimated 39 direct-care workers at their sites. A total of 47 staff representing all 12 LEADS sites attended a day-long workshop on person-directed caregiving practices. When asked which LEADS interventions were the most valuable, 10 executive leaders identified coaching supervision either alone or in combination with other interventions. In addition, coaching supervision reportedly affected communication and relationships at sites in important ways. Peer mentoring provided a vehicle to improve new-hire orientation, to provide a career ladder for direct-care workers, and to further imbed culture change within the organizations.

Results from this evaluation show evidence that through specific, sustained interventions supported by strong leadership and ongoing commitment, it is possible to achieve greater job satisfaction and improved retention in long-term care settings. It further highlights the importance of going well beyond training to institute systemic changes in organizational culture that support culture change. Qualitative interviews consistently revealed a palpable shift in the way participating organizations viewed the roles of the direct-care worker in decision

making and the consumer in shaping his or her daily life. Communication and relationships improved across the board.

Organizational change is a long-term commitment and is influenced by economic pressures, changes in leadership, and many other factors, both external and internal. This evaluation highlights the range and depth of implementation at participating provider sites. While many sites were able to achieve quantifiably measurable results over the two-year period that data were gathered, others were not. PHI looks forward to continued work with a subset of the LEADS sites that will enable us to track change on a longer-term basis.



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