



An Evaluation

NORTHERN
NEW ENGLAND

LEADS
INSTITUTE

A report to:

Jane's Trust

The Jacob and Valeria Langeloth Foundation

Submitted by:



Quality Care
THROUGH
Quality Jobs

Leadership,
Education,
and
Advocacy
for Direct
Care and
Support

NORTHERN
NEW ENGLAND

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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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Acknowledgements

The PHI evaluation team would like to thank all of the participating LEADS sites for their commitment to LEADS and their willingness to share openly their opinions and stories of their experiences. We thank all the staff at the sites who participated in the employee surveys, those who provided us with quarterly staffing data, and the executive leaders who took the time to be interviewed for this evaluation.

Thanks also to PHI state partners Christa Baade of Coastal Enterprises, Inc.; Elise Scala of the Muskie School of Public Service at the University of Southern Maine; Terry Lochhead of the New Hampshire Community Loan Fund; and Kathy West and Dolly Fleming of Community of Vermont Elders

for their hard work on LEADS, their assistance with survey data collection, and their willingness to be respondents. We thank all PHI staff who participated in lessons learned discussions and, in particular, Alexandra Olins, Susan Misiorski, and Kate Waldo for their tremendous devotion to the LEADS initiative and their interest in learning from the work and sharing those lessons.

Thanks go to Roy Feldman, as well as to Robyn Stone, Cynthia Duncan, and Peter Kemper, for their guidance on the initial LEADS evaluation design. We greatly appreciate the work of Jodi Sturgeon and

Alexandra Olins, who established important evaluation systems and analyzed all of the baseline survey data. Thanks also go to our consultant, Suzanne Siegel, for conducting the executive leader interviews. We also thank Teta Barry for her review of the quantitative data analysis.

This evaluation work would not have been possible without the support of Jane's Trust and The Jacob and Valeria Langeloth Foundation. We appreciate the opportunity this evaluation has afforded PHI to continue to learn and refine our approaches to improving the quality of direct-care jobs and, thus, the quality of long-term care.

PHI Evaluation Team

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Photography: The images used throughout this report were provided by the Vermont Association of Professional Care Providers.

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.



I. Introduction and Background

Grant History

In 2004, PHI received funding from Jane's Trust and The Jacob and Valeria Langeloth Foundation to establish a training institute that would focus on improving the quality of jobs for direct-care workers in Northern New England. The impetus for this project was threefold:

- PHI had established contacts and a base of relationships with key stakeholders in Maine, New Hampshire, and Vermont, and wanted to leverage those relationships to further its *Quality Care through Quality Jobs* vision.
- These three states were noteworthy for their rapidly growing elderly populations and flat or declining populations among the key caregiving demographic (women between the ages of 25–44), necessitating new approaches to making direct-care jobs attractive and viable.
- PHI desired to work intensively with a small group of providers for a relatively long time period to deepen organizational culture change at the provider level.

The project was developed and implemented in the context of a “culture change” movement within long-term care. The concept of culture change has defied easy definition. It involves a re-examination of attitudes and behavior in order to create a new environment in which elders and people with disabilities can live in dignity, playing a large role in the shaping of the daily rhythm of their lives. Culture change proponents work toward creating caring communities in which frontline staff, consumers, and their families are empowered to ensure that each consumer's needs and desires are recognized and met.

Culture change has excellent aspirations, good ideas for new staffing structures and (in nursing homes) new physical design, but is generally weak in providing staff the skills necessary to implement these changes successfully. This new project offered long-term care providers a set of individual, team, and organizational skills aimed at creating truly person-centered care.

PHI received funding to commence work on the Northern New England LEADS³ Institute in January 2005, for a period of three years. In early

2005, PHI selected the following 12 long-term care providers with whom to partner across the three states:

LEADS Provider Partners

Maine

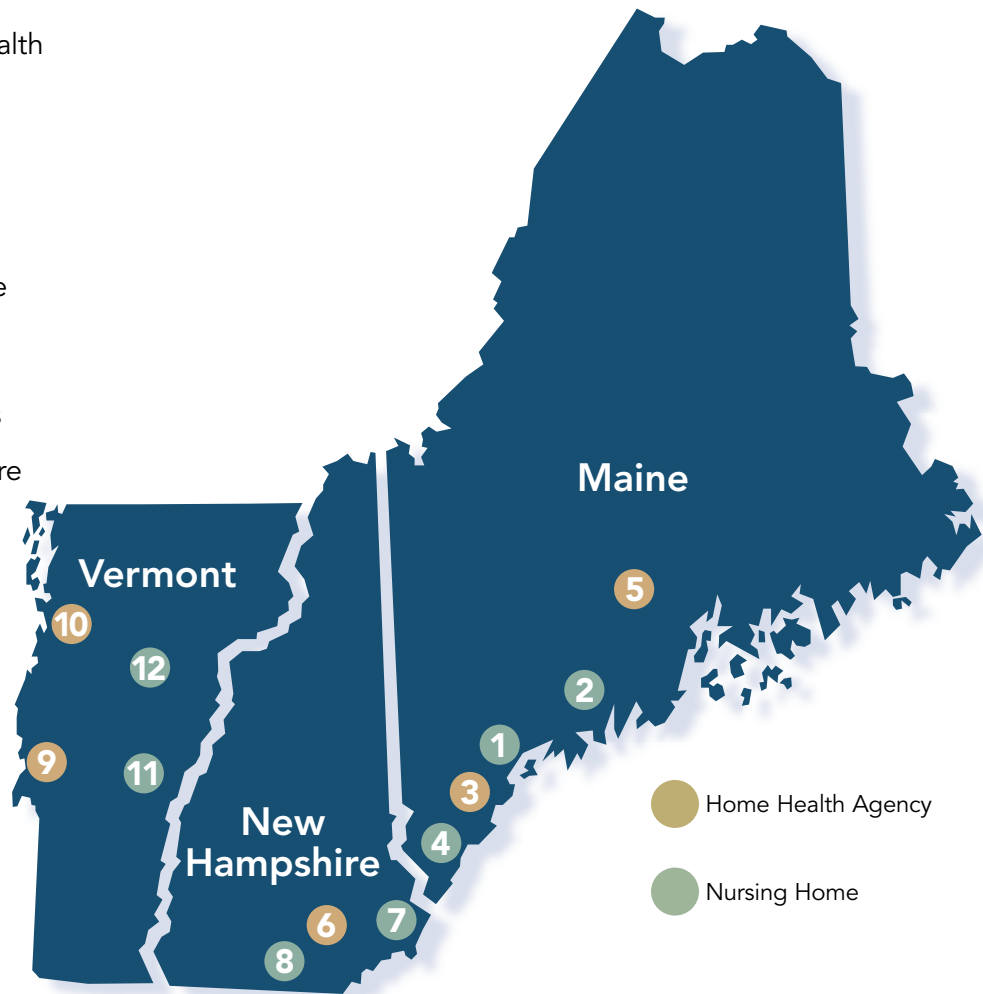
- 1 Cedars Nursing Care Center
- 2 Mid Coast Senior Health
- 3 Sandy River Home Resources
- 4 Springbrook Nursing Home
- 5 Home Care for Maine

New Hampshire

- 6 Quality Care Partners
- 7 The Edgewood Centre
- 8 Ridgewood Nursing Home

Vermont

- 9 Rutland Area VNA and Hospice
- 10 VNA of Chittenden/Grand Isle Counties
- 11 Mt. Ascutney Nursing Home
- 12 Woodridge Nursing Home



PHI also subcontracted with state partners within each state, to build local relationships, facilitate communication with providers, and lead public policy efforts.

History of PHI's Work in Northern New England Prior to LEADS

Prior to the design of the LEADS Institute, PHI had been active for several years within each of the three northern New England states, undertaking both practice and policy initiatives focused on the direct-care workforce. The earliest work took place in New Hampshire nearly ten years ago,

through PHI's investment in the start-up of Quality Care Partners (QCP), a home care agency in Manchester. This brought PHI in close partnership with the New Hampshire Community Loan Fund, which co-sponsored QCP and later became PHI's state partner for the LEADS Institute. PHI's technical support of QCP led in turn to numerous state requests over the years for PHI's policy expertise, with PHI leadership staff serving on various state direct-care work groups.

Later, in 2003, Vermont was selected as one of five demonstration states for the Better Jobs Better Care (BJBC) initiative, a \$15-million investment in the direct-care workforce by The Atlantic Philanthropies and the Robert Wood Johnson Foundation. The local sponsor of the BJBC project was the Council of Vermont Elders (COVE), and since PHI was the National Technical Assistance Provider for the BJBC project, COVE and PHI developed a close working relationship on a wide range of policy and practice initiatives over the four-year life of the program. The LEADS project was initiated during the latter part of the BJBC program, and PHI selected COVE to be its LEADS state partner in Vermont.

In Maine, prior to LEADS, PHI had more limited field experience, providing technical assistance to a few nursing homes in the state. However, PHI did have long-standing policy relationships with both Coastal Enterprises, Inc. (CEI) and the Muskie School of Public Service. Elise Scala of the Muskie School was the project coordinator for the Maine Personal Assistance Services Association, a strong association of direct-care workers, and LEADS was able to build on the work of this organization. Therefore, CEI and the Muskie School together proved to be natural state partners as PHI launched LEADS in Maine.

Goals

The goal of the LEADS Institute was to improve the quality of direct-care jobs by providing training, technical assistance, and cross-learning opportunities among the 12 LEADS provider partners over the course of three years. As key objectives, PHI worked 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. PHI prepared these leaders to train others, ensuring that PHI's practices would be disseminated effectively throughout each participating organization.
- **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.

- **Establish leadership teams** inclusive of frontline workers within each organization, to lead quality improvement efforts.
- **Create a network of support** across the region to facilitate cross learning among long-term care leaders re-designing their organizations to support “quality care through quality job” principles.
- **Move public policy agendas** in each state that improve the quality of jobs for direct-care workers and thereby support quality care for consumers.

Partners & Staff

PHI’s state partners in the three states were as follows:

LEADS State Partners

Maine	Muskie School of Public Service, at the University of Southern Maine— <i>Elise Scala</i> Coastal Enterprises, Inc.— <i>Christa Baade</i>
New Hampshire	New Hampshire Community Loan Fund— <i>Terry Lochhead</i>
Vermont	Community of Vermont Elders (COVE)— <i>Kathy West</i>

At PHI, three senior staff comprised our LEADS team:

1. **Alexandra Olins**, full-time LEADS project manager, based in Vermont;
2. **Susan Misiorski**, Director of Organizational Culture Change, based in New Hampshire, devoted 70 percent of her time to LEADS technical assistance and culture change; and
3. **Kate Waldo**, Organizational Culture Change Specialist, also based in New Hampshire, devoted 70 percent of her time to LEADS.

All three PHI staff, and all four state partners, remained with the LEADS project throughout the three-year initiative, providing an important degree of stability and consistent organizational knowledge and history.

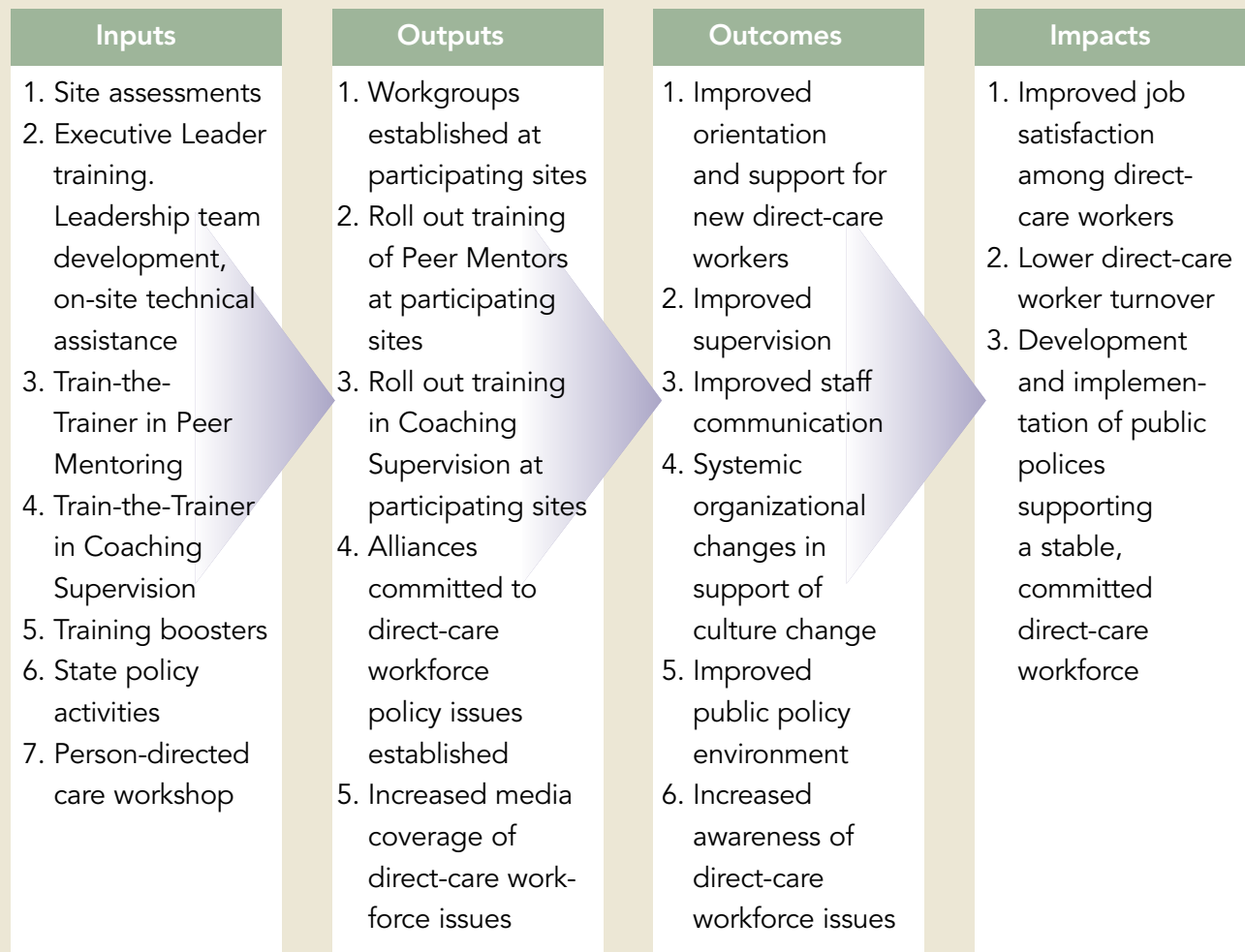
This report presents the evaluation findings from data gathered during the duration of the LEADS initiative. Section II presents the evaluation methodology. Section III presents the findings from qualitative data analysis, discussing both project implementation and outcomes. Section IV describes LEADS public policy activities and outcomes. Section V presents quantitative survey data collection and analysis, Section VI offers an overview of the affect of LEADS activities on turnover and staff stability, and Section VII provides a summary discussion and conclusions.

II. Evaluation Methodology

The evaluation for the Northern New England LEADS Institute (LEADS) was a mixed method design intended to document outcomes of LEADS initiatives both qualitatively and quantitatively.

The evaluation design was guided by the LEADS logic model (see the figure below) and included the components presented on the following pages.

LEADS Logic Model



Evaluation

Job Satisfaction and Work Environment Surveys

PHI utilized a pre/post survey design to measure changes in employee satisfaction and experiences with their work environment after the introduction of LEADS activities.

Employees in all departments were asked to complete a Work Environment Scale (WES) and a Job Satisfaction Survey (JSS).

- The **Work Environment Scale (WES)**⁴ assesses the social climate of work settings. It contains ten scales measuring relationships, personal growth, and systems maintenance and change. This tool contains multiple true/false questions, probing similar areas repeatedly in order to ensure validity of answers. Employees' sense of *involvement*, *peer cohesion*, *supervisor support* and *clarity* are particularly important to the work of the LEADS project. Scales are further defined in Section V of this report.
- The **Job Satisfaction Survey (JSS)** contains 23 statements; respondents rate their level of agreement or disagreement with each item on a five-point Likert scale. The survey has one open-ended question at the end allowing for more detailed feedback. PHI adapted this survey tool from one that was successfully used in one of our New Hampshire-based affiliate organizations.⁵

Both the WES and the JSS are pen-and-paper self-administered surveys. Surveys were distributed by the LEADS state partners to direct-care workers, nurses, and administrative and other staff. In all but one case, state partners distributed the surveys at the provider sites to as many staff as they could recruit to participate.⁶ PHI evaluation staff and consultants entered the data into SPSS, a data analysis software package. PHI evaluation management spot-checked the data entry for accuracy. A total of 760 employees responded at baseline to the WES and 768 to the JSS. The final survey included 892 respondents to the WES and 894 to the JSS. Response rates ranged from 23 percent to 90 percent, with a mean response rate of 55 percent. A copy of the JSS can be found in Appendix A. The WES is copyrighted so cannot be reproduced here.

Data on Turnover and Absences

PHI gathered monthly data on the number of employees, terminations, call outs, and staffing agency use. While data collection began in 2005, the original paper system was modified to a web-based data submission system in 2006. As it took some sites time to put together systems for collecting and reporting these data, we consider the data from 2006 forward to be more reliable than 2005 data. Data reports were presented

to sites on a quarterly basis, and sites used the information contained in these reports to inform the work of the leadership teams and work groups. An analysis of data trends is presented in this report in Section VI.

Qualitative Data Collection

PHI evaluation staff and consultants conducted in-depth interviews with key stakeholders involved in the project, using qualitative interview guides to explore the following aspects of the project:

- Project structure
- Project implementation
- Roles and responsibilities
- Challenges and opportunities
- Outcomes and impacts
- Sustainability

Interviews were completed by telephone with 14 executive leaders representing the 12 participating sites, 6 representatives from the 4 state partners, and 1 representative from a funder of the initiative.

In addition to these qualitative interviews, PHI evaluation staff helped to organize a number of structured “lessons learned” discussions with PHI staff who were involved in program planning and implementation. We used an “emergent learning” model to document what the project was intended to accomplish, whether and how the interventions and activities were implemented, what we learned from implementation, what we hypothesized would improve this or similar programs. All discussions were carefully documented in text files.

Document Review

PHI evaluation staff had a wide range of materials to review in order to inform the documentation of project implementation, challenges, and successes. These included twelve site assessment reports produced by PHI training and organizational development staff prior to program implementation; quarterly reports submitted by the state partner organizations over the three project years; and progress reports submitted annually by PHI to the funding organizations, Jane’s Trust and The Langeloth Foundation.

Limitations

This study has several important limitations. First, no sites were identified to serve as comparison groups, so we cannot compare the outcomes for these sites against sites that received no PHI support. Second, the response rates for the staff surveys, although comparable to response

rates reached by many researchers of the direct-care workforce, are lower than we would have liked. We lacked the resources to examine non-respondents in any systematic way, so there could be inherent biases in the samples. Finally, data on staffing and turnover were difficult to collect, and we do not have data from 2005 or earlier. Every quarter, however, PHI examined the data from all 12 sites for anomalies and addressed these with the participating sites, acquiring more accurate data with which to report, when necessary.

This report is an internal evaluation report conducted primarily by PHI evaluation staff (an independent consultant conducted the interviews with executive leaders of participating sites, and LEADS state partners distributed and collected the employee surveys). However, none of the PHI evaluation staff were involved in any aspect of the implementation of the LEADS initiative.



III. Findings:

Qualitative Data Collection and Analysis

Start-up

PHI subcontracted with **in-state partner organizations** to assist with project coordination, implementation, and policy work. State partners were not-for-profit organizations or educational institutions with an established local track record in workforce and long-term care issues.

PHI established **provider site selection criteria** with state partners that included elements such as financial stability, relative stability in upper management, demonstrated values related to person-centered care, sufficient size to cover staff replacement time, support from board of directors or corporate office, and stated commitment and excitement regarding participation with LEADS.

PHI developed a **Memorandum of Understanding (MOU)** with each participating site. When asked if the roles and responsibilities of PHI and participating organizations were clear, 9 of the 14 executive leaders affirmed that the roles were clear and cited the MOU they signed at the beginning of the project as a basis for that clarity.

PHI and their state partners conducted comprehensive organizational assessments with each participating site. Data were gathered through focus groups and in-depth interviews with a wide range of staff and through on-site observations. The assessments examined strengths and opportunities related to the organizational mission and leadership, person-centered care practices, personnel policies and practices, relationships and communication, worker participation, and the overall environment.

LEADS was structured as a **demonstration project**. As such, not all materials were developed ahead of time nor were the structure and process of the project fully mapped out, and as lessons were learned, changes were instituted. This element of uncertainty proved stressful to some stakeholders, particularly the state partners.

Timeline—Major Activities

The timeline below highlights key milestones for the LEADS project. Project inputs included preliminary site assessments, establishment of cross-functional leadership teams and work groups at each of the participating sites, train-the-trainer seminars in coaching supervision and peer mentoring, and on-going technical assistance provided by PHI staff and state partners, where needed and appropriate.

January 2005 through April 2005—Site selection phase

April 2005 through October 2005—Established cross-functional leadership teams at each site.

May 2005 through August 2005—Conducted on-site assessments to initiate the LEADS project, collect information on organizational strengths and challenges, and establish a profile of each site's interests and priorities to inform the development of an implementation plan.

September 2005, January 2006, April 2006—Staff at the provider sites completed the nine-day Coaching Supervision Train-the-Trainer seminar (three days each month).

Fall 2005—PHI staff presented organizational assessments at each site; baseline survey collection commenced.

October 2005 through February 2006—Established work groups at each site.

November and December 2005—Site staff participated in PHI-facilitated Peer Mentoring Train-the-Trainer seminar.

June 2006 through December 2007—Site trainers led two-day Coaching Supervision training seminars for their organizational staff.

February 2006 and May 2006—Site staff who were trained as peer mentors participated in PHI-led Peer Mentoring booster sessions.

April 2006 through June 2006—PHI presented baseline WES and JSS reports to individual sites.

December 2006, January 2007, September 2007, October 2007—Site coaching supervision trainers participated in PHI-facilitated Coaching Supervision boosters.

Summer/Fall 2007—State partners collected final staff survey data from LEADS sites.

January 2007—47 staff representing all of the LEADS sites attended a day-long workshop on pioneering approaches to person-directed care; one workshop was held in Maine and another in Vermont.

April 2005 to December 2007—PHI staff and state partners provided ongoing technical assistance to LEADS sites through cross-functional leadership team meetings and other on-site technical assistance.

Winter 2008—PHI presented final WES and JSS reports to individual sites.

State Partner Model

This model proved to be important in establishing local credibility, according to PHI staff. The state partners were: the New Hampshire Community Loan Fund, Community of Vermont Elders (COVE), and Coastal Enterprises, Inc. (CEI) and the Muskie School of Public Service in Maine. Each state organization identified a paid project coordinator. Maine had two partners: the Muskie School focused primarily on policy efforts, while the staff person from CEI focused mainly on site-based logistics and technical assistance.

State partners participated in coordinating the initial organizational assessment that was completed at each site, attended leadership and work group meetings, drafted meeting agendas, took meeting minutes, and coordinated the collection of baseline and end-line employee survey data. They also were engaged in policy and advocacy work at the state level. Initially, there was a lack of clarity around whether the state partners were expected to play solely a coordinating role or if they were expected to provide substantive technical support to sites. The extent to which state partners played the latter role depended in part on their level of comfort and expertise. In some instances, state partners reported it was “challenging to add value,” stating that PHI staff had the technical expertise while there was a steeper learning curve for state coordinators (state partner interview).

State partners reported generally good communication with PHI and between the state coordinators themselves. In the second year, monthly phone meetings were scheduled that enabled state partners “to trouble-shoot” (state partner interview). One partner reported: “In terms of communication, I think it was an effective model; the way information flowed back and forth to PHI partner sites was good. The communication of the states coming together was fabulous as well.” However, there was also a reported feeling that “in terms of a true Northern New England academy or pool, it was geographically challenging to do that: the distances and cost and time of truly doing it together” (state partner interview).

Participation, Cross-Functional Leadership Teams, and Work Groups

PHI staff and site executive leaders alike viewed the establishment of cross-functional leadership teams and particularly the engagement of

direct-care workers in discussion and decision making as an important element of the LEADS initiative. 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 staff viewed this approach as a critical vehicle to effecting organizational change.

Getting the “right mix of individuals on the team” was often difficult, and PHI staff reported a trial-and-error period when “some individuals

All three [case communication, employee involvement, peer mentoring work groups] were successful...because we came together as a group and people were...allowed to be heard. We had home care aides and nurses and therapists and social workers. It was widespread and everyone felt like they were a part of the process. People felt a part of the decision making so in that way, all the work groups were successful.

—Executive leader, home care

The biggest [achievement] was really understanding in an integrated way that everyone has to be at the table, including direct-care workers. It's easy to say that but it's very difficult to have that happen and you have to manage it and [the direct-care workers] don't work in the building and you have to wait for them to get here. There's a lot to it. Direct-care workers now sit on the leadership team. I always felt we were backward managing. They do the work and know the work. They should be leaders, too.

—Executive leader, home care

It's not much good if [cross-functional leadership teams and workgroups] are not given the leeway in making changes and that's what happened a little bit. Staff didn't have a clear understanding of the level of authority they had. Do they have the authority to turn the whole system upside down or just the authority to make little changes? We went in there thinking we had more authority than we did.

—Executive leader, nursing home

self-selected out”(PHI lesson learned discussion). PHI had to consistently encourage greater direct-care worker representation and participation. According to one nursing home executive leader, it was not only getting the right people in the room to talk about the issues that was important, but also ensuring those individuals had the power needed to make change happen.

PHI staff provided technical support and modeling for the leadership teams, beginning with chartering processes with each site to come to an agreement on the purpose and function of the cross-functional leadership team. The first year was spent establishing roles and responsibilities, which varied across sites (PHI lessons learned discussion). PHI also guided sites in establishing site-based work groups to address specific issues related to quality jobs and quality care identified by the leadership team, based on the findings of the initial site-based assessments. Examples of issues the groups addressed include staffing issues such as call outs or retention, team building, communication in home care, and person-centered care.

One challenge was the high level

of turnover among direct-care workers on the leadership teams and work groups—often due to outside forces in their lives (PHI lessons learned discussion; quarterly state partner reports).

A key project funder reported that over the three years she witnessed a “transformation of leadership at the sites at every level, at every organization.” She reported that from the kick-off meeting to the end-of-project conference, when site leadership and direct-care workers came together to discuss LEADS accomplishments, the site leadership was “so different in terms of people’s engagement, enthusiasm, and real working relationships. There was a meaningful change in providers’ articulation of the model, the work, their depth of understanding. There was a commitment to continue, a desire to take the workplace culture change concept into the future in their organization, and a transformed relationship with direct-care workers.”

PHI Technical Assistance

PHI staff offered a wide range of technical support to participating sites. Technical assistance was tailored to the specific needs and desires of the site executive leadership and cross-functional leadership teams. “The on-site TA was incredibly customized by site, dependent on what the site was ready for and interested in” (PHI lessons learned discussion). The vast majority of respondents—state partners and participating sites alike—expressed a high level of satisfaction with the technical assistance provided by PHI staff and with the sites’ relationship with PHI overall.

Sites also received different levels of technical support from PHI depending on interest and engagement, what the site requested, availability of PHI staff, and what the sites chose to implement. PHI staff estimate that five sites received

While work groups have been successful in forming and recruiting new members, many groups have struggled with consistent attendance.... The report from staff is about limitations and constraints of time and the need they have to be out in the field with their clients [for home care]. It would have been helpful to be more clear and explicit about time and attendance expectations as well as the length of service prior to recruiting group members.

—State partner quarterly report

I have nothing but fabulous things to say. I can’t think of anything that could have worked better. They were so accommodating.... They met us on our terms. They always came; they always followed up when they said they would follow up. They were just awesome, so encouraging, always cheering us on to do good work.

—Executive leader, nursing home

What worked well was the very targeted expertise that PHI brings in coaching supervision, peer mentoring, site assessments. The sites that have taken advantage of that are clearly better off for it.

—State partner

[PHI staff were] wonderful: great energy, great ideas, terrific vision. Their skills were wonderful. They were very, very helpful. Inspiring.

—Executive leader, nursing home

[Roles and responsibilities were] really kind of blurry at the beginning. As long as we did peer mentoring and coaching supervision and culture change, then we could do whatever we wanted as far as goals. We came up with 17 goals which is a little aggressive. I wish we had pared it down to the three areas...it wasn't real clear: what is the vision? How are we going to do it together?

—Executive leader, nursing home

“intensive” technical assistance, three to four received “moderate” technical assistance, and three to four received a small amount of technical assistance.

Sites did indicate that roles and responsibilities of the sites and or PHI were not clearly defined at the outset, and that was a source of some confusion.

Scope of Work and Level of Effort

The general sense from PHI staff and executive leader respondents was that neither the sites nor PHI had a

good understanding at the outset of the level of effort that would be required to implement LEADS initiatives. Many sites did not anticipate the amount of time required for planning, training, leadership team meetings and work groups. When asked whether the work to implement LEADS was manageable, five leaders said “no,” often using the word “overwhelming” to describe it. Nine of those interviewed said “yes,” the work was manageable but their answer in most cases included caveats indicating, for example, that the work was only possible if there was teamwork and the team was comprised of the right people. One state partner also articulated the opinion that working with twelve sites “and throwing in the leadership teams” was “too ambitious.”

The initial LEADS plan was to introduce the full package of interventions at each participating site concurrently, including coaching supervision, peer mentoring, person-centered care, and public policy. PHI modified its approach, however, to give sites a choice of what interventions to focus their main energies on — to see “what sites were motivated around” (PHI lessons learned discussion). Ultimately, given the level of commitment, time, and resources required to implement all of the interventions, sites focused most of their efforts on specific interventions, with some sites fully taking on more than one intervention.

The intention to link public policy work with the sites did not materialize as planned. The initial assumption was that sites would come together in each state to identify policy issues to work on together. The reality was that sites were extremely busy implementing the LEADS interventions, and public policy work proved to be complex and opportunity-oriented. Some

states already had policy initiatives that PHI and LEADS staff joined. While a few individual sites did engage in and influence policy efforts, on the whole their focus remained on integrating the LEADS practices into their organizations.

The comprehensive assessment conducted by PHI staff and partners at each site raised a wide range of additional issues that sites then were inclined to want to address. For example, team building and improving communication practices were experienced as pressing issues in some sites. PHI staff reflected that this may have gotten in the way of implementation of coaching supervision, peer mentoring, and person-centered care. However, they also reported that the assessments “invited opportunities into the projects,” and providing technical assistance in these areas served the overall goals of “creating better stability, communication, and relationships.” PHI staff saw the value of “a lot of flexibility and customization.” (PHI lessons learned discussion).

It turned out to be a lot bigger undertaking than we thought—the training was three times as long. That didn’t come across in the memorandum of understanding.... I can’t underestimate the importance of the funding [in] year one to get us hooked in.... It took an incredible amount of time for people to spend away from their jobs.

—Executive leader, home care

I think that it was very hard for sites to engage in policy work. They really needed the practice help. They didn’t have too many people turn out for policy events.... They had limited time and limited resources.

—State partner

Coaching Supervision, Peer Mentoring, Person-Centered Care

Sites were introduced to all three of the key LEADS interventions. As shown in the timeline on page 16, coaching supervision and peer mentoring training took place earlier than any formal training in person-centered care, which happened in the project’s third year.

Coaching supervision introduces supervisors of direct-care workers to skills they need to work more effectively with those they supervise. These skills include listening and communication, tools to help direct-care staff develop problem-solving skills, and supportive means to hold workers accountable for high performance.

Peer mentoring is an initiative aimed at improving the retention of new direct-care hires and providing a career ladder for experienced caregivers. Through training, peer mentors develop leadership, communication, and problem-solving skills. They orient mentees to job responsibilities, give constructive feedback, and model good caregiving, communication, and problem-solving skills.

Person-centered care is a philosophical approach to long-term care that honors and respects the voice of elders and people with disabilities and those working closest with them. Person-centered care is customized care that is respectful of and responsive to an individual's circumstances, preferences, needs and values. The approach is usually accompanied by changes in organizational structure and physical design that puts more authority for decision making into the hands of direct-care staff.

PHI trained 29 coaching supervision trainers in the three LEADS states. They, in turn, trained 350 staff, the majority of whom supervise direct-care workers, at their respective sites in coaching supervision. PHI trained 33 peer mentor trainers. PHI estimates that they, in turn, trained 39 direct-care workers at their sites to mentor new employees. In addition, 47 staff representing all 12 LEADS sites attended a day-long workshop on person-directed caregiving practices in the winter of 2007.

When asked which LEADS interventions were the most valuable, ten executive leaders said coaching supervision either alone or in combination with other interventions. Coaching supervision reportedly had important effects on communication and relationships at sites. For example, a home care executive leader stated: "The coaching supervision, the management training was very helpful. It made me think about managing people in a more respectful low-key, non-attacking manner." Another stated: "Three

things that go together, coaching and supervision and learning circles....

Communication was a big issue. We thought we were communicating well but over the years we learned we weren't. They [PHI] gave us tools so everyone was speaking the same language." And another observed: "The things we learned in coaching supervision were new. They brought us fresh content that was usable and very practical. The training sessions incorporated enough opportunities to include practice so we could get comfortable with the material."

Peer mentoring was also cited as an important intervention by executive leaders. Six organizations that chose to focus on peer mentoring had an existing program that they

One nursing home executive leader, in describing the results of Coaching Supervision interventions, indicated that their staff had a pattern of passing problems up the hierarchy:

This means you dump it to your supervisor who dumps it on their supervisor and everything winds up getting dumped in the lap of the director of nursing so she becomes overwhelmed and burns out. That's why the rate of turnover is so high for directors of nursing... We identified this... as a key part of our program. We knew it was an incredible problem and we didn't know how to handle it. That's why the tools LEADS gave us were so powerful.... People stopped running automatically to their supervisors to dump. They learned how to talk to each other in a way that the results were not devastating. They understand now that they are on the same team and their goals are the same.

—Executive leader, nursing home

revamped or built upon based on the PHI training and model. Five other organizations created new peer mentoring programs. Respondents praised the quality of the training and the opportunities that peer mentoring offered the trainers, the mentors, and the mentees.

Both interviews and lessons learned discussions revealed important distinctions between coaching supervision and peer mentoring in terms of amount of time and resources required for implementation and the speed with which outcomes are realized. In lessons learned discussions, PHI staff raised the question, “how much time are people willing to invest before outcomes are seen?” Coaching supervision requires the greatest staff involvement and time, and the impact is not experienced immediately by direct-care workers. First, trainers are trained, then supervisors; then supervisors require time to practice the skills. Peer mentoring has a more visible impact right away: it immediately engages direct-care workers and can have a noticeable influence on staff orientation, satisfaction, and stability.

LEADS organizations often chose the interventions with which they wanted to begin. PHI recommended that sites begin with three (or occasionally four) work groups—one to focus on coaching supervision implementation, another on peer mentoring, and one or two others to focus on issues raised in the site assessments. Beyond coaching supervision and peer mentoring, sites began with areas that “resonated with them” (state partner).

[The peer mentoring training] was very effective, they were very well-trained. It was fascinating to see peers training peers and those trained to be mentors to this day are more skilled at it. If we have a new employee, we don’t send them blindly to the client’s home, we send them with a mentor. But sometimes the mentor is not necessarily someone who went through the [mentoring] training; it could be someone who just knows the case. And there is a real difference between sending a mentor and someone who has not been through [the] LEADS [training]. The trained mentors give constructive feedback, they create a better comfort level; they follow up with the employee. That is meaningful.

—Executive leader, home care

The question of speed of impact extended beyond Coaching Supervision and peer mentoring: *Sites took on really big things and big challenging issues that were systemic and so even though there was movement towards resolving some of these issues, people didn’t see the results. There weren’t a lot of visible results for direct-care workers to see so [they were] wondering if anything was happening.*

—State partner

A nursing home executive leader reflected that coaching supervision and peer mentoring: *...were equally valuable. You need both to address two different issues and we targeted two groups: the peer mentoring for the LNAs and housekeeping and dietary staff [and] the coaching supervision for the leadership team and the nurses. They were equally effective.*

—Executive leader, nursing home

While we were eager to participate we got a little discouraged looking at our three-year plan and understanding how much needed to be done. It took a stick-and-carrot approach to involve the direct-care workforce in leadership and peer mentoring training. But after the first training people came back and said, "Why didn't you tell us it was going to be so exciting?" And peer mentoring is one of the interventions that required minimal management intervention because the staff was engaged and saw immediately the value even beyond the workplace because the peer mentoring worked on communication skills development. When people connected to that it was not only valuable in the workplace but helps you to become a better person in everyday life—with your kids, your family and your community. And our staff was absolutely thrilled to participate. They saw it as a career ladder and a promotion and were fighting to keep the program running.

—Executive leader, nursing home

The consistent assignments part benefits staff and residents. Residents love it, their families love it, and staff loves it. They wouldn't have it any other way. The residents like it because they don't have to tell a different person every day how they like things done and what their preferences are and staff likes it because it helps them manage their workflow better because they know the residents and they can be more efficient.

—Executive leader, nursing home

There were two reasons for this approach: a) each site had different strengths and challenges and had different starting points—some sites were already engaged in culture change and retention efforts, others had little exposure; b) it was thought that sites would feel a stronger sense of ownership and engagement if they chose the order, speed, and content of implementation. While these were realities, PHI staff also reflected that being more “strategic” about the order of implementation may have produced more consistent results, though no definitive conclusion was reached.

Four sites placed a priority on efforts related to person-centered care, and seven other sites also engaged in activities to enhance person-centered care. Among the nursing homes, three sites instituted consistent assignment; two established neighborhoods; two changed their dining program. One site changed their bathing program and two focused on physical plant improvements. One home care site began to establish self-directed teams.

Components of Successful Implementation

PHI is interested in the question of the necessary elements for successful implementation of PHI models. In PHI lessons learned discussions, PHI staff indicated that the cross-functional leadership teams were crucial elements for implementation. PHI staff and state partners noted that for many executive leaders, this was the first venue in which they had worked closely with direct-care workers, and that it had been a powerful experience. One home care executive cited the leadership team as a critical element for sustainability.

When asked what they had learned regarding what is required to successfully implement the LEADS initiatives, “buy-in” was the ingredient executive leaders mentioned most, although four specified buy-in from the top while three others stated buy-in from the front lines was essential.

A home care executive leader said top management had to make LEADS a priority, stay committed and troubleshoot problems as they surfaced. “Because initially you are the one with the enthusiasm and the knowledge and you have to get people on board and not let it wane,” she said.

A nursing home executive leader indicated that direct-care workers were buying in but management was not, leading to what she called “a big disconnect.” “We learned we had to have buy-in from the top. At the very beginning there wasn’t a lot of that. They were trying but they didn’t know their roles. There were little pockets of culture change in the building but it wasn’t organized.”

Another nursing home executive learned the alternate lesson, that buy-in from the front lines was key even though it is difficult getting people away from their day-to-day responsibilities: “During the experience one of the things I learned and other people learned is to get our direct-care staff involved. They had some wonderful solutions.”

One nursing home executive was the only respondent to point out another constituency whose buy-in, although critical, was initially overlooked at her agency—mid-level management such as nursing managers and department heads of nutrition, rehabilitation, housekeeping and maintenance. “I’m not sure we included them as much as we should have. I’m not sure they had the full vision of what we were trying to accomplish,” she said. “We should have spent more time sort of warming the soils and laying out what we were trying to achieve.”

The most important [intervention] was the cross-functional leadership team to get things done. Even at the beginning when they invited people from other departments. This was very powerful; they had never all sat around one table before. Organizationally as time went on, the leadership teams showed to all levels of the organizations that they were committed to making change.

—State partner

We had to make changes to the leadership team of the agency. We had to merge the [project] leadership team with agency leadership. If the changes were to be sustainable, the direct-care workers had to be there to have input into decision making.

—Executive leader, home care

You have to find committed people. First off, you have to have senior managers buy-in to this first and foremost because they need to support the staff doing the work and you have to find employees committed to success and you have to support them. It can be challenging but the concepts are easy. I put pressure on, but there were senior leaders who weren’t stepping up to the plate so we had some good turnover because either you go with it or you get off.

—Executive leader, nursing home

Choosing the right battles, getting the right people at the table, clearly defining how much power staff had to make changes, and implementing systems for sustainability were also mentioned by executive leaders as requirements for success.

"Identifying the biggest problems first and some of the smaller ones so we can see early success," were keys to success, according to one nursing home executive. Another said she is a believer in implementing systems to ensure success: "developing a system to go around it, as opposed to just going to a training program...[ensuring] that your program is not just dependent on one person."

Networking

One of the goals of LEADS as noted in the project proposal was to create a regional network of support: "The Institute will identify the 'natural' leaders among the direct-care workers, their supervisors and administrators. We will then help connect these leaders to each other across facilities/agencies, creating a network of skilled long-term care leaders." A number of executive leaders discussed the effectiveness of networking among participating sites. One stated, "They've also connected us to other facilities. Throughout the process we visited other facilities and they visited us. The networking piece was very helpful. If we had a question, PHI can tell

us who is doing what and can connect us to them, which is very helpful."

When asked what LEADS supports had the most impact, a home care executive stated: "Beyond data collection what was also great was the introduction of entities to each other and creating a LEADS network, support groups, etc. We did informal counseling with each other which was very helpful, too." Another home care executive leader cited the opportunity LEADS brought to direct-care workers for networking and learning from their peers in the industry.

While executive leaders reported the value and effectiveness of networking with other organizations, state partners expressed some disappointment with what they perceived

One [impact] is that our direct-care workforce was able to create connections at their level at other entities. I already had connections with all the area home care agencies to get best practices and stay ahead of the game; the scheduler had that as well and the clinical director. But for direct-care workers to connect with the direct-care workforce at other agencies helped them very much. They started to understand better that the challenges they experience were not just entity-based but globally based as well as based on regulatory structure or some other limitations. They were able to compare good things and bring things back to the agency. They were also able to proudly present their accomplishments—there was a lot of value in the exchange of ideas and just bragging really about their accomplishments. It certainly built confidence and presentation and networking skills. It was good for personal growth.

—Executive leader, home care

as a lack of a sustainable regional network. One state partner voiced that “the whole institute concept that was marketed at the very beginning of the project—this wasn’t really developed a lot. [I] envisioned that an institute would be established and be there forever and have more sticking power.” Another from a different state indicated: “[It would have been] more impactful and more discerning had we done this as a three state project...The geographic split of the New England states was a major challenge.”

Systemic Change and Sustainability

All participants in the LEADS project were interested in and concerned about the sustainability of the effort when the demonstration was completed. PHI staff observed that the strongest LEADS sites were those with “highly invested” senior leadership who “were already open to examining their practices” (PHI lessons learned discussion). The importance of buy-in and commitment was emphasized by all respondents as a key to success and sustainability.

In addition to internal buy-in and good trainers, respondents emphasized the importance of changes in policies and procedures to maximize sustainability. LEADS sites undertook a number of important structural or policy changes during the course of the project.

In interviews, executive leaders from eleven sites stated they had implemented changes in organizational policy or structure related to LEADS. Four administrators said they instituted changes in the hiring process as a result of LEADS. One said the job descriptions were changed to include a statement about “respectful communication” being a requirement. At another organization, direct-care staff are now involved in interviewing new hires. Another expanded the orientation for new employees to cover communication, coaching supervision, and resident-directed care. At a home care agency, peer mentors accompany new hires to first visits to client’s home and are given an hourly bonus to do so.

One of the most common policy changes, mentioned by three administrators, involved overhauling the disciplinary process to align it with a coaching supervision approach. At one nursing home, disciplinary actions are now called “coaching sessions” and the results are better. “We rarely have to give out ‘warnings’ anymore...We use the format of a coaching session which takes the negativity out of it and is much more effective,” said a nursing home executive leader. Another nursing home executive said: “The staff is now being spoken to in a more gentle, kinder way. Instead of a ‘first strike’ when they call out now it’s more like, ‘What’s going on in your life?’”

A nursing home is planning to create a community system so that staff and treatment are organized around where the residents live in the facility. A home care agency revised its policy in order to ban client smoking while the worker is in the house. The organization also changed its admission packet for clients to clarify the role of the LNA, and the in-home introduction to services to the client is now performed by the LNA instead of the RN. An executive explained: "Before, the too-busy RNs sometimes went [to the home] and quickly jumped through things, but now the LNAs explain...and they say to the client 'I want you to understand my role and the value of it.'"

A nursing home changed resident care planning meetings to include family members and residents. "We ask questions about what life was like before the resident came in and what we can do to make that happen. That's exciting," said the home's executive leader. Another nursing home has implemented consistent assignments and a requirement that all employees go through peer mentoring.

One nursing home designated a direct-care worker specifically to LEADS work (eight hours a week) and that continues. She is a "big motivator and keeps things going. This has been a key piece for things to move along for the future and sustainability, a person like her in that type of organization taking on responsibility is really important," explained a state partner.

Another nursing home created an "LNA II" position that provided LNAs who had a good work history with a career ladder opportunity within their organization. The LNA II position was accompanied by a wage increase and peer mentor and in-service training responsibilities. All of these changes were interventions that were taken on by the cross-functional leadership teams at the LEADS sites, as a result of their initial site assessments.

Respondents identified several barriers to sustainability. The first and foremost was the turnover of trainers within organizations. Significantly, ten sites experienced the loss of at least one trained trainer over the course of the three-year project. PHI staff also cited turnover as a particular challenge, noting that the train-the-trainer model depended upon a consistent group of trainers at each site. One state partner confirmed that the amount of turnover had not been anticipated and that sites required strategies for addressing the problem: "The whole train-the-trainer concept, although it was great—to have a plan for what the site is to do when the trainers leave...is something [PHI] could improve on. A couple of sites are interested in sometimes hosting boosters at their sites and inviting other LEADS providers to that training or vice versa if they need some new people to be trained. That, in a way, could further sustain this for longer."

In addition to internal organizational policies and practices that can help sustainability, the question of financial sustainability and capacity was raised by one of the project's key funders. She noted that a key accomplishment was PHI's ability to "build on a platform with an amazing staff team and emerge at a much higher level that really is providing insight into future opportunities." She stated that the overall initiative was "an opportunity for PHI to think about scaling...[and] to have a real and practical experience with the opportunities and challenges of doing this kind of work with real people and places." She went on to note the challenges associated with expansion. "[It] is really important to get that local point of view in thinking through the business strategy.... To change the sector, build deeper understanding, and get some political traction, get those local sites that are humming, show up in the local paper, be places where everyone wants to send their parents.... What we all struggled with was building some kind of real infrastructure that provides ongoing support.... The economic pressures are enormous." She indicated that the "framing of the leadership sites" (a LEADS follow-on that includes a business model) "is creating a way of moving that transformation into more of an infrastructure, figuring out how to support those sites so they become leaders in these states. It is a smart way of naming what happened and moving it into the future so people can understand and invest in it."

We learned you have to do these things continuously. It has to become the way you do business. We have successfully implemented it into our culture. The new LNAs understand they will be mentored in a structured format and not just thrown out on the floor too soon. And also you can't just expect nurses to be managers, they need training. And everyone has to understand you have to play by the rules. So we implemented a Code of Conduct that was developed by two LNAs. It says: I will be respectful to my co-workers, communicate; if I'm not coming in I will let people know I'm not coming in, etc.

—Executive leader, nursing home

IV. Findings: Public Policy Activities and Outcomes

Evaluation of policy and advocacy work is a relatively nascent field. Professionals engaged in such evaluation generally agree on the importance of documenting the milestones achieved along the way to reaching ultimate impacts of improving lives, in this case the lives of direct-care workers.⁷ A recent document outlining a composite logic model for advocacy and policy change, developed by representatives of the Harvard Family Research Project, The California Endowment, The Atlantic Philanthropies, and the Annie E. Casey Foundation, can help frame that effort.⁸ In it, interim outcomes are identified that are considered important benchmarks toward successful policy implementation. These include building partnerships and alliances; developing advocates and champions; raising organizational visibility; media coverage; issue re-framing; increased awareness of an issue; increased political will; and an expanded support base. Below we describe the LEADS policy activities and specific interim outcomes associated with those activities in each state.

It should be noted that policy work, whether successful or not, is rarely accomplished by any one organization or entity. When assessing the impact of the LEADS policy work, it is not possible to decipher what part of a policy victory or accomplishment was achieved by PHI's effort alone, because it was never PHI's work alone, and PHI and its partners do not use foundation funding for any lobbying activities. We report here on activities in which PHI was a primary partner, usually working in collaboration with many other stakeholders at the state level. Since each state presented a distinct political and economic environment affecting direct-care services, the work of LEADS was highly tailored to that environment.

Vermont:

During 2006, PHI's state partner in Vermont, COVE, helped design legislation, HR 723, *An Act Relating to Home- and Community-Based Care Workforce Issues*, to conduct a needs assessment regarding the workforce issues related to the services and supports that direct-care workers provide to elders and individuals with disabilities. This legislation

was signed into law in May 2006, and a final report, *A Legislative Study of the Direct Care Workforce in Vermont*, was issued to the legislature in March 2008.

Due to the fact that the study was not presented to the legislature until the end of March 2008, no legislative action was taken this session in response to the study's nine recommendations. However, news stories about the study, as well as direct-care workers and the critical work that they do, ran in five large newspapers in the state, and also on the local Fox News affiliate. Prior to the study's release, in early March 2008, U.S. Senator Bernie Sanders convened a town meeting on this topic, called "Supporting Caregivers, Improving Care," in response to the legislative study.

A joint hearing on long-term care and the study will take place in early fall 2008. Follow-up legislative action will also take place during the session. PHI will ask the legislature to consider the creation of a commission charged with implementing the study's recommendations. If authorized, PHI staff expects the commission will take on the creation of standardized and portable career lattices/ladders for direct-care workers, one of the study's recommendations. In the meantime, PHI's Northern New England director will meet with the Board of Nursing's executive director and director of LNA education to work with them on the idea of creating a standardized and portable LNA II position in Vermont.

In addition, because of the momentum of LEADS and its predecessor Better Jobs Better Care (BJBC), there was consensus among key stakeholders in Vermont that a direct-care worker registry would help to mitigate some of the problems of finding caregivers that consumers currently encounter. With support from LEADS, COVE worked to achieve key gains toward establishing a direct-care worker registry, including providing technical assistance that helped to achieve passage of authorizing legislation (with funding) to create and begin maintaining the registry. Vermont's direct-care worker registry will be launched in the fall of 2008.

With supplemental funding, and building on LEADS' policy work, LEADS launched a pilot project in response to employers' staffing needs in Vermont. The first iteration of this project, which was sponsored by the John Merck Fund, with additional funding from Better Jobs Better Care, was called the Sharing Staff Pilot. The intention was to use the funds to support the creation of a cadre of workers who were cross-trained to work at participating employers. Employers reported that their turnover rates increased when home care workers lost hours due to changes in client status, such as hospitalization or death. PHI hypothesized that while some employers did not have other cases to assign these workers on short notice, other employers were chronically short-staffed. This project, while

a creative response to an employer need, turned out to be extremely complicated, and the issue of workers compensation insurance made it impossible to implement.

With approval from the Merck Fund, PHI significantly altered the program objectives and changed course with two of the four original employer partners. These employer partners focused on their chronic problems in recruiting caregivers, and from this, the Faces of Caregiving (www.facesofcaregiving.org) campaign emerged—an effort to recruit young workers, new Americans, and retired workers into the field. Since the campaign started in April 2008, it has made over 70 contacts and the employers have begun hiring new workers.

Finally, PHI's Northern New England policy director will partner with PHI's Health Care for Health Care Workers initiative, the Vermont Association of Professional Care Providers, the Vermont Campaign for Health Care Security, and AARP Vermont to focus on ways to ensure that eligible direct-care workers enroll in Catamount Health—Vermont's state-sponsored universal access health insurance program for people between 150 and 300 percent of the federal poverty level.

New Hampshire:

PHI staff report that LEADS has enabled PHI to considerably strengthen its policy presence in this state. Notably, in 2006, LEADS staff were invited to participate in newly revived Quality of Life Councils for nursing homes and home health agencies. The nursing home council worked to design criteria for a new quality recognition program that rewards practices oriented toward workforce retention and culture change. This new program arose from the New Hampshire Department of Health and Human Services' renewed attention to long-term care and workforce issues—due in part to LEADS activities.

Moving forward, in cooperation with the New Hampshire Community Loan Fund, and working with the Edgewood Centre (PHI's leadership site in New Hampshire), PHI plans to pursue a long-term strategy with the state's Bureau of Elderly and Adult Services and other workforce development stakeholders to provide incentives for long-term care employers to implement coaching supervision. Notably, the bureau's administrator recently invited PHI to recommend a funding mechanism to disseminate PHI practices. PHI staff presented coaching supervision to a Workforce Stakeholders Group (which is staffed by our state partner at the Loan Fund) that has identified improving training, wages and benefits for direct-care workers as their primary goal in 2008.

PHI will continue to work with the Workforce Stakeholders Group to identify funding sources for coaching supervision in New Hampshire. In

the realm of improved wages, this stakeholder group is also focusing on establishing wage parity between community-based direct-care workers and institutional workers, as the latter are currently paid considerably more by the state. As an outgrowth of the work of the stakeholders group, a University of New Hampshire wage and benefit survey of providers and their employees is underway.

Rebecca Hutchinson—past President of Quality Care Partners and former PHI Board member—now fills a key staff role in the House Majority Policy Office and remains a key ally in improving the quality of direct-care jobs. Due in part to Hutchinson's work, and the efforts of PHI and its LEADS state partner to raise the profile of direct-care workers and the coming care gap in New Hampshire, two pieces of legislation relevant to caregivers were passed in the 2007-2008 legislature.

The first piece of legislation is SB 496: *"Establishing a commission to study incentives for providers of home and community-based care."* This bill will 1) identify best practices for recruitment and retention of direct-care workers and 2) recommend methods for providing incentives to employers who use these practices. The commission will include direct-care worker representatives and a policy person from the New Hampshire Community Loan Fund, and will have 18 months to complete its work. The second piece of legislation that was passed is called *"HealthFirst."* It is a preliminary step toward creating an affordable health insurance product for small businesses that will attempt to tie premium costs to median state-wide wage. Trish Chandler, the current president of Quality Care Partners, testified in favor of this legislation as a small health care employer.

Maine:

Working in collaboration with PHI's Health Care for Health Care Workers (HCHCW) initiative; Elise Scala, our state partner at the Muskie School of Public Service; and Maine's Direct Care Worker Coalition, LEADS policy work has centered primarily on advancing efforts to provide health insurance for direct-care workers. Significant attention over the past three years was generated around the issue of direct-care workers who lack health insurance.

Maine's Direct Care Worker Coalition (staffed in part by our state partner in Maine) initiated LD 1934: *"Resolve, To Improve Retention, Quality and Benefits for Direct Care Health Workers."* This resolve required the Department of Health and Human Services to study the options for, and cost of, increasing wages and providing health coverage for direct-care workers in state-funded and MaineCare-funded long-term care programs. This legislation led to the presentation of *"A Study of Maine's Direct Care Workforce"* to the legislature in February 2007.

A final piece of legislation, initiated by the Direct-Care Worker Coalition in Fall 2007, LD 1687 *“An Act to Increase Health Insurance Coverage among Frontline Direct Care Workers Providing Long-term Care”* was presented, supported, and negotiated during the January–April 2008 term. LEADS’ policy objectives and support for state partners were extremely helpful since during this time Lisa Pohlmann, the coalition facilitator and a key source of informational support, left her position.

Members of the coalition, representing workers, employers and advocates, continued their pursuit of LD 1687 through the end of the 2008 legislative session, presenting key workforce data to the Insurance and Financial Services (IFS) Committee, a group that was relatively uninformed about this workforce. It must be noted that Maine state government faced major deficits and program cuts during the session and the IFS Committee was deliberating the future or failure of DirigoChoice, the very program named in LD 1687 as central to accessible, affordable health coverage. After a postponement in February 2008, the public hearing and work sessions on LD 1687 were held in March. The IFS Committee voted “ought not to pass” due to a lack of funding and questions on the feasibility of rule changes to Dirigo, but also recognized the direct-care workforce and the need for health insurance coverage options. The IFS Committee formally requested that Maine’s newly appointed Superintendent of Insurance chair a task force to address the issues raised by the bill. The task force convened in June 2008, and direct-care workers and coalition members are key participants in the discussion.

Home Care for Maine, one of our potential post-LEADS leadership sites, was very active in this campaign, and PHI expects that this organization will play a significant role in PHI’s policy efforts in Maine going forward. PHI also plans to advocate for the implementation of recommendations from *A Study of Maine’s direct care workforce: Wages, health coverage, and a worker registry*,⁹ which was prepared with technical assistance from PHI LEADS staff. One primary focus of this work is on helping the state to create an improved certified nursing assistant (CNA) registry as a vehicle for initiating and implementing new efforts to improve direct-care jobs.

How Change in the Policy Realm is Achieved

PHI staff has concluded that the nature of achieving meaningful change through policy work requires being “at the policy table” at the state and local levels, building relationships, and pursuing priorities in many different arenas. PHI staff reflect that sometimes these activities are successful,

and sometimes—often due to circumstances beyond their control, such as budget deficits and changing economic circumstances at the state government level—they are not. However, PHI's experience holds that being a continued presence in policy circles can lead to unintended opportunities and partnerships that, while neither foreseen nor intended, may lead to other opportunities for success. Therefore, concludes PHI staff, "It is essential to be local and opportunistic."

PHI staff also emphasize the importance of patience in policy work, which is "by definition slow." There are many different advocates at various policy tables in every state, each group lobbying members of the legislature that their issue or constituency is in dire need of their attention and resources. PHI's Northern New England director states: "It takes a long time for an issue, such as the critical role played by the direct-care workforce and their need for better wages and benefits, to coalesce in the public sphere. This is by definition an 'invisible' workforce on many levels—they work in nursing homes, or private homes; the public does not value this workforce, as a whole, until they need them to care for an aging or disabled family member; and, we as a country are notoriously uninterested in planning for and talking about issues pertaining to aging, disability, death and dying. And our constituents—direct-care workers—are among the lowest paid members of our communities, meaning, they are the very people least likely to be heavily enfranchised, or to have political influence."

Assessing Outcomes: What Difference Did LEADS Work Make?

In each of the three LEADS states, policy activities achieved meaningful outcomes—both in the advocacy and the policy arena. The establishment of strong partnerships with similarly committed stakeholders is an important outcome of policy work in and of itself. Outcomes in the advocacy arena include new champions, such as policymakers who sponsored legislation on behalf of direct-care workers in each of the three states. LEADS worked with stakeholder groups in each of the three states to make compelling arguments to legislators about the need to learn more about this workforce and the need to better compensate them for their work. In fact, comprehensive studies of the workforce have been conducted in two LEADS states to date, and a third is now underway in New Hampshire, directly as a result of our work on this issue.

In each of the three states, legislation was also introduced by direct-care workforce stakeholders that sought to increase the wages, improve

the training and career ladder opportunities, or increase access to affordable health insurance for direct-care workers.

While none of this legislation has yet passed into law, LEADS has raised awareness in the media and among members of the general public, and perhaps even changed attitudes or beliefs about the importance of this workforce. There have been numerous newspaper articles, radio and cable access television shows about this workforce and the need to improve their working conditions, since the inception of this project (see Appendix B). In the policy arena, LEADS' ability to bring resources to established leaders already committed to LEADS policy objectives was valuable. LEADS most definitely helped to maintain momentum that had been established through Better Jobs Better Care and other policy efforts in the states.



V. Findings:

Quantitative Survey Data Collection and Analysis

The Work Environment Scale (WES)

As explained in Part II of this report, the Work Environment Scale (WES) assesses the social climate of work settings.

All employees who completed the WES were placed into one of the following job categories for reporting purposes:

- Direct-care workers (includes CNA, LNA, HHA, PCA, and PSS)
- Nursing staff (includes LPN, RN)
- Other staff: directors, clerical, medical records, payroll, human resources and any categories not listed above

Respondents were placed into one of the above categories in order to allow us to compare perceptions of different groups of staff serving in different levels of the organization. Respondents who did not specify their job title were included in the All Staff analysis but excluded from the analysis by job category. Analysis was further disaggregated by nursing home or home care setting.

Interpreting Standard Scores

All WES results are converted to “standard scores,” which allow us to compare the scores with work group norms established with data gathered by the WES authors.

Standard Scores can range from 0 to 100.¹⁰ A standard score of 50 on any of the scales is the average score for comparable work groups. A score of 60–70 can be considered a very high score and a score of 30–40 can be considered a very low score. More important for this report, however, is an examination of any changes over time in staff responses for each of the WES scales. Table 1 provides the definition of each scale.

Although the WES measured each of the ten scales, the LEADS interventions were expected to influence only the first five.

WES Scale Definitions

Table 1

Scale	Definition
Clarity	Whether employees know what to expect in their daily routine and how explicitly rules and policies are communicated
Involvement	The extent to which employees are concerned about and committed to their jobs
Peer Cohesion	How much employees are friendly and supportive of one another
Supervisor Support	The extent to which management is supportive of employees and encourages employees to be supportive of one another
Work Pressure	The degree to which high work demands and time pressure dominate the job milieu
Task Orientation	The emphasis on good planning, efficiency, and getting the job done
Autonomy	How much employees are encouraged to be self-sufficient and to make their own decisions
Managerial Control	How much management uses rules and procedures to keep employees under control
Innovation	The emphasis on variety, change, and new approaches
Physical Comfort	The extent to which the physical surroundings contribute to a pleasant work environment

Work Environment Scale Results

Results from the WES are discussed below. A comparison of job categories is followed by data related to direct-care workers. Appendix C presents data and graphs for all other staff.

Comparison Across Job Category

We examined the five scales that fall within the domain of LEADS influence across job categories in order to understand variations that may exist.

Supervisor Support: Coaching supervision focuses on the relationship between a worker and his or her supervisor. The intention is to create clear lines of communication, build supportive relationships, and constructively address problems. In home care sites, Direct-Care Workers (DCWs) and Other Staff recorded increases in Supervisor Support with DCWs showing the greatest improvement of 6 points. In the nursing home settings all job

categories registered improvements. These data provide strong support for the implementation and continuation of coaching supervision at LEADS sites.

Clarity: The clarity scale includes questions about how clear policies and procedures are communicated and the extent to which employees know what to expect in their daily routines. This scale registered improvements across all job categories in both home care and nursing home sites. The LEADS interventions focus heavily on clear communication and these improvements indicate that communication at the sites around policies, procedures and work expectations have improved.

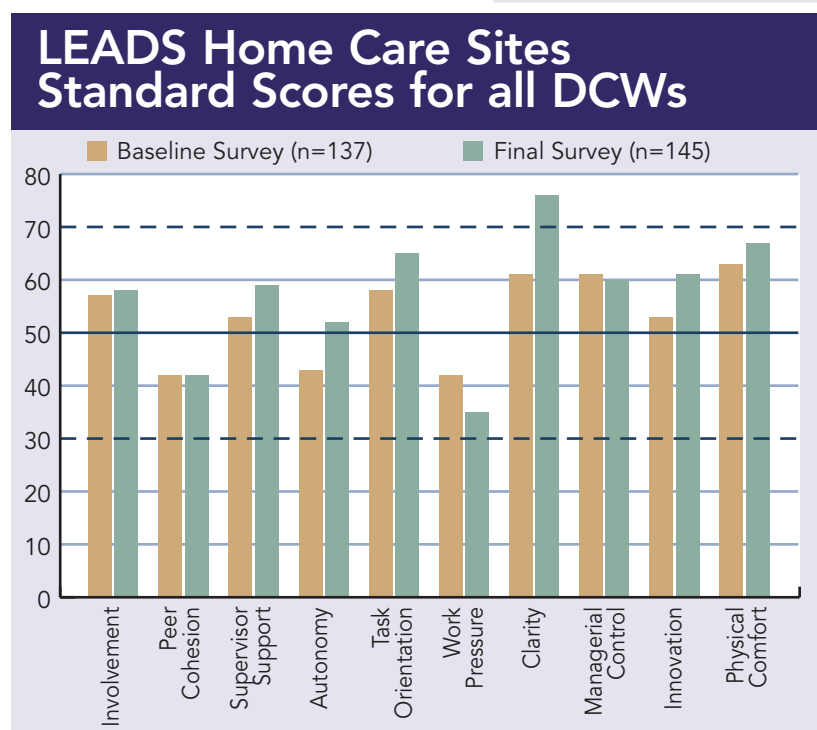
Peer Cohesion: This scale is intended to measure the degree to which employees are friendly and supportive of one another. Increases were recorded across all job categories in LEADS participating nursing homes. However, these improvements were not evident in the home care sites. Items making up the peer cohesion scale, however, have less relevance in home care settings, as much of home care work is carried out independently of one's peers.

Involvement: The involvement scale includes questions related to how engaged workers are with their work and how engaged they perceive others to be as well. The results across all job categories for this scale are mixed. DCWs and Nursing Staff at home care sites and nursing homes registered small improvements in this scale. Other Staff at both home care and nursing home sites recorded small decreases.

Work Pressure: This scale measures the extent to which work demands dominate the work environment. In nursing homes this scale decreased across all job categories; in home care only DCWs registered a decrease in Work Pressure. Nursing Staff at home care sites recorded a 10-point increase in Work Pressure and Other Staff recorded no difference between both rounds of data collection.

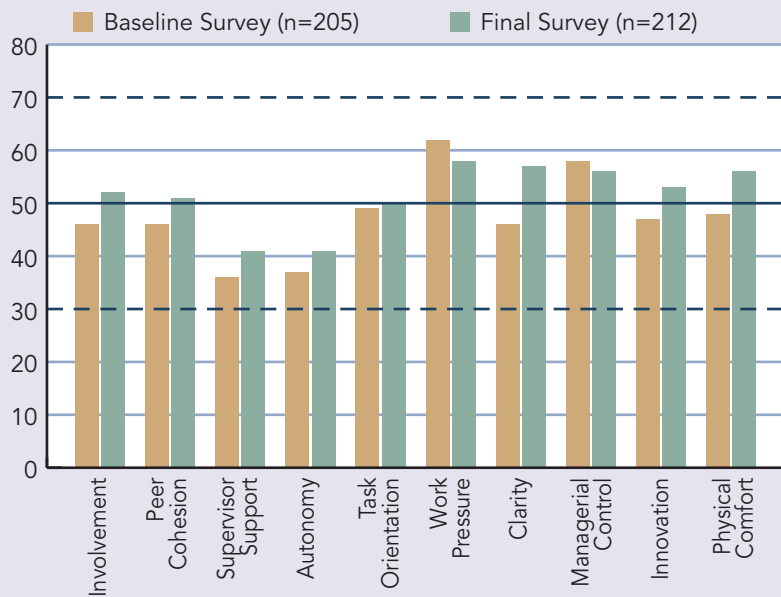
Direct-Care Worker (DCW) Scores

Home Care: The most marked increase among DCWs at home care sites was an increase in Clarity by 15 points to 76 in the final survey.



Improvements were also noted in Supervisor Support (by six points to 59), Involvement (by one point to 58) and a decrease in Work Pressure from 42 in the baseline survey to 35 in the final survey.

LEADS Nursing Home Sites Standard Scores for all DCWs



Nursing Homes: DCWs recorded improvements in all areas in which one would expect the LEADS interventions to have an impact. The largest improvement was in Clarity with an 11 point increase to 57 in the final survey. Involvement increased by 6 points to 52, Peer Cohesion and Supervisor Support both increased by 5 points (to 51 and 41 points respectively) and there was a recorded decrease in Work Pressure by 4 points to 58 in the final survey.

The tables in Appendix C present WES scores for baseline and final survey dates, by job category, work setting, and selected scales.

Findings of the Job Satisfaction Survey

In this section, we compare the baseline results of the Job Satisfaction Survey (JSS) with the data collected in the final survey. As described in Part II of this report, the JSS asked respondents to rate their level of agreement or disagreement with 23 statements concerning experiences at work. Areas we would hope that LEADS would have a marked influence upon include those related to supervision, management, and leadership. Here, we highlight direct-care worker findings. Results of other staff can be found in Appendix D.

Interpreting the JSS Results

The charts on the following pages present a summary of survey items for which respondents agree or strongly agree. Improvements from baseline to final survey are highlighted in light blue, and those showing a decline in satisfaction are highlighted in light green. When analyzing changes between the two rounds of data collection a Mann-Whitney U test of statistical significance (p-value) was calculated. Percentages with a single green asterisk (*) indicate a p-value of <.05 and percentages with two green asterisks (**) indicate a p-value of p <.10. The p-value measures how likely it is that an observed difference between two groups is due to

chance. Differences observed to be significant at $p < .05$ have less than a 5 percent chance of being caused by random effects and an observed significance of $p < .10$ have less than a 10 percent chance of being caused by random effects.¹¹

Direct Care Workers

Home Care: In home care settings, direct-care workers responding 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” recorded a statistically significant change between the two rounds of data collection.

Direct-Care Workers—Home Care

Statement	Round 1 (n = 155)	Round 2 (n = 151)
I am treated fairly by my supervisor	81%	91%*
I am satisfied with the support I receive from my co-workers and/or peer mentors.	65%	77%*
This organization provides enough opportunity for me to upgrade my skills	68%	60%

* $p < .05$ ** $p < .10$

Nursing Homes: Direct-care workers recorded statistically significant improvements in those agreeing with being satisfied with the opportunities for ongoing or advanced training and satisfied with career development

Direct-Care Workers—Nursing Homes

Statement	Round 1 (n = 155)	Round 2 (n = 151)
I am satisfied with the opportunities for ongoing or advanced training	45%	53%*
I am satisfied with the career development opportunities at this organization	41%	50%*
I often feel frustrated at work	69%	59%**
I would like to continue to do this job for the next two years	73%	65%*
I would recommend this organization to others as a good place to work	70%	64%

* $p < .05$ ** $p < .10$

opportunities. Direct-care workers also recorded a statistically significant change in those reporting that they often feel frustrated at work (69 percent in the baseline survey and 59 percent in the final survey). However, there was a statistically significant decrease in the percentage of direct-care workers agreeing that they would like to continue this job for the next two years.

One important constraint when examining differences in the results of the WES and JSS responses is the difference between the survey questions. Questions in the WES that are related to supervisors ask about supervisors in general, while those in the JSS ask specifically about the respondent's personal supervisor. Similarly, questions related to Peer Cohesion in the WES are related to peers and peer activities in general rather than the JSS question which asks specifically about the respondent's peer mentor and /or co-workers. In these instances we regard the JSS as a better determination of satisfaction with peers or supervisors since the questions relate to the respondent's personal supervisor or peers.



VI. Findings: Turnover and Staff Stability

The LEADS Logic Model hypothesized that interventions aimed at improving the jobs of direct-care workers would lead to reduced turnover and other absences such as call outs (when a staff person calls in absent with less than 24 hours notice). As mentioned in the methodology section, PHI gathered staffing data from all participating sites. One limitation was the sparse availability of data for the year 2005—a truer baseline measure. However, we have assumed that it takes time to implement and see impact from these initiatives. In most cases, therefore, we use 2006 as our baseline.

Turnover

The table on the next page presents annual turnover data for the sites for which we had data. The data show that decreases in turnover were experienced by four out of six LEADS nursing homes. The decreases ranged from 3 to 46 percentage points. The majority of home care agencies, on the other hand, experienced an increase in annual turnover rates from 2006 to 2007, with only one recording a decrease (from 41 percent to 38 percent).

These mixed results may be attributed to a variety of factors. First, the scale and strength of implementation of LEADS initiatives varied widely across organizations. PHI staff estimate that three sites fully implemented coaching supervision (including changes in systems to support and encourage ongoing practice), six showed moderate implementation, and three minimal (one or no on-site trainings). Seven sites implemented strong peer mentoring programs, four demonstrated moderate implementation, and one showed minimal implementation. Second, we hypothesize that two years may be insufficient to see marked changes in these indicators. PHI will continue tracking these data with six sites that will continue receiving PHI support through a follow-on grant. Third, the average wages of home health aides are less than those of LNAs or CNAs; these initiatives do not address compensation, which is an important factor influencing turnover.

Annual Direct-Care Worker Turnover

Site	Average no. DCW employed 2005	Average no. DCW employed 2006	Average no. DCW employed 2007	2005 Turnover	2006 Turnover	2007 Turnover	Change
Nursing Home 1	110	101	97	20%	23%	22%	No marked change
Nursing Home 2	13	24	21	50%	57%	48%	Decrease
Nursing Home 3	NA	110	115	NA	52%	45%	Decrease
Nursing Home 4	NA	71	91	NA	90%	44%	Decrease
Nursing Home 5	NA	54	54	NA	52%	49%	Decrease
Nursing Home 6	NA	62	65	NA	50%	54%	Increase
Home Care 1	49	37	47	50%	41%	38%	Decrease
Home Care 2	NA	732	743	NA	51%	54%	Increase
Home Care 3	58	58	49	12%	21%	31%	Increase
Home Care 4	NA	32	21	NA	91%	136%	Increase

PHI did not collect turnover data by hire date. Since peer mentoring generally focuses on new employees, turnover of new hires would be an important indicator, and will be tracked in the follow-on grant. One site did track these data, and peer mentoring appeared to have had an important impact on new hire turnover (see box on page 45).

Peer Mentoring and Turnover of New Hires at a Strong LEADS Site

One nursing home—considered by PHI staff and partners to be among the strongest implementer of LEADS initiatives—with strong leadership and a high level of commitment on the part of staff to change, introduced peer mentoring in the fall of 2005. The initiative began in November 2005 with two nursing home staff members participating in the PHI-facilitated Peer Mentoring Train-the-Trainer seminar. In September 2006, May 2007, and September 2007, these two trained staff trained 19 peer mentors.

Peer mentoring provides orientation and support to new employees. Peer mentors work to ensure that new staff have the tools and support they need to perform their jobs and to understand the policies and procedures of the organization. An LNA's job can be extremely demanding, and the initial weeks and months can be overwhelming without the proper support. Peer mentors are experienced LNAs who “know the ropes” and are able to provide that critical support that helps new employees integrate into their new jobs.

Research has suggested that direct-care worker turnover is often highest in nursing home environments within the first 90 days of employment. This nursing home tracked turnover of new employees to examine the impact of the peer mentoring effort. Results show a large decrease in turnover at the 90-day mark from baseline to the first and most intensive year of the initiative, followed by an increase, but one that did not reach initial baseline levels.

April 2005–March 2006

Peer Mentors Trained	0
New LNAs Hired	87
Terminations within 90 Days	33
90 Day Turnover	38%

March 2006–February 2007

Peer Mentors Trained	10
New LNAs supported by PMs	57
Terminations within 90 Days	7
90 Day Turnover	12%

March 2007–September 2007

Peer Mentors Trained	9
New LNAs supported by PMs	29
Terminations within 90 days	7
90 Day Turnover	24%

Call Outs

In the qualitative interviews, a couple of respondents indicated that the goal of reducing call outs had not been realized during the period of the LEADS initiative. This was borne out by the data that were collected. As can be seen in the chart below, two out of six of the nursing homes that reported call out data experienced a decrease in the ratio of call outs per direct-care worker from 2006 to 2007.¹² The other four nursing homes experienced an increase. However, only one site, a nursing home, specifically chose to focus significant energies on reducing call outs and that site reduced its call-out ratio from 9.5 to 8.5.

Call-Out Ratio in Nursing Homes

Site	2006	2007
Nursing Home 1*	4.9	5.5
Nursing Home 2	13	24
Nursing Home 3	NA	110
Nursing Home 4	NA	71
Nursing Home 5	NA	54
Nursing Home 6	NA	62

* First 3 quarters only

Call-Out Ratio in Home Care Settings

Site	2006	2007
Home Care 1	6.6	5.5
Home Care 4	5.4	9.3
Home Care 5*	1.7	0.8

* First 2 quarters only

In home care settings, two of the three organizations for whom we have data registered a decrease in the annual call-out ratio while one showed an increase.

Turnover and call outs are both important measures of staff stability. In examining these data, one must take into account the context and extent of program implementation. One might expect different outcomes based on the extent to which interventions were embedded into organizational policies and culture.

The tables on the following pages describe each site, observations regarding implementation of coaching supervision,¹³ peer mentoring, and person-centered care, and juxtaposes that information with the turnover and call-out data, where available. Cells highlighted in gold indicate a positive impact (decreases in turnover or number of call outs); those in light green indicate a negative result (increases in turnover or number

of call outs). Those cells highlighted in light blue indicate strong implementation of the intervention.

Three sites—two home care sites and one nursing home—are reported by PHI staff to have very strong, sustainable coaching supervision and peer mentoring programs. Two of these three sites 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, which can influence worker satisfaction and retention.

The third site that was observed to have very strong coaching supervision and peer mentoring programs experienced an increase in turnover from 2006 to 2007 and did not have annual data available on call outs.

Program Implementation and Impacts–All LEADS Sites

Site	Type	Coaching Supervision	Peer Mentoring	Person-Centered Care	Comments	Turnover	Call-Out Ratio
1	Nursing Home	Deepest implementation of all the LEADS sites. Trained all relevant staff, changed staff evaluations, disciplinary process, and handbook.	Very strong program.	Changed dining program.	Focused a lot of effort on reducing call outs.	Decrease	Decrease
2	Home Care	Strong implementation. Trained all relevant staff; modified disciplinary processes.	Very strong program. Taught modified curriculum to all LNAs as an in-service training.	Moderate implementation.	Established a work group to change new employee orientation and have more LNA involvement.	Decrease	Decrease
3	Nursing Home	Trained all staff, though moderate implementation beyond the training.	Strong program.	None.	Did a lot of team-building work.	Decrease	Decrease
4	Nursing Home	Taught CS three times to supervisors with PHI's assistance. Has no trainers.	Moderate level of implementation.	Driven by CNAs. Focused on consistent assignment. Established neighborhoods.	LEADS support for teamwork and communications.	Decrease	Increase
5	Nursing Home	Held one training. None of the originally trained trainers remain.	Has a very strong program with a strong coordinator.	Site was already engaged in PCC prior to LEADS.	Experienced a fluctuation of agency usage.	Decrease	Increase

Continued on page 48

Program Implementation and Impacts–All LEADS Sites

Site	Type	Coaching Supervision	Peer Mentoring	Person-Centered Care	Comments	Turnover	Call-Out Ratio
6	Home Care	CS has been fully implemented.	Very strong program. Lost one trainer.	Site established self-managed work teams.	Developed communications strategies.	Increase	Not Available
7	Nursing Home	Not fully implemented.	Moderate implementation.	Changes to dining program. Has plans for physical infrastructure changes.	PHI conducted a management retreat and team building with LNAs.	No Change	Increase
8	Home Care	Have one trainer left. Modified the training. CS did not reach a systems level.	Strong program.	None	The site provides communications training for all LNAs.	Increase	Not available
9	Home Care	Did not implement. The site felt the agency was too small.	Very strong, CFLT focuses on implementing it throughout the organization. Policies and procedures are in place.	None	Disbanded CFLT after PM was implemented. Top leadership turnover and financial challenges.	Increase	Increase
10	Nursing Home	Moderate implementation.	Adapted their own existing training to include more PHI communication skills.	Neighborhoods, major site renovations	Worked on call-outs but led into other issues and call-outs discussions stopped.	Increase	Increase

Continued on page 49

Program Implementation and Impacts—All LEADS Sites

Site	Type	Coaching Supervision	Peer Mentoring	Person-Centered Care	Comments	Turnover	Call-Out Ratio
11	Nursing Home	Modified training to one-day workshop. Embedded communications in other training.	Although the site expressed interest, had not pursued by the end of LEADS.	Implemented a new person-directed care plan process and made some environmental improvements.	Data submission was incomplete so annual comparisons could not be made.	Not available	Not available
12	Home Care	Moderate implementation.	Good implementation. Changed policies and procedures.	No changes in existing program.	Active CFLT. Financial problems led to site closing.	Not available	Not available

Three other sites were reported to have strong peer mentoring programs accompanied by coaching supervision programs that were less developed. One of these sites—a nursing home—achieved a small decrease in direct-care worker turnover. The other two sites did not display improvements in either indicator. A nursing home reported to have a strong coaching supervision program and a less developed peer mentoring program experienced increases in both indicators.

Finally, a nursing home that chose to focus principally on person-centered care achieved a dramatic decrease in turnover from 90 percent to 44 percent. Its call-out ratio increased.

These results demonstrate the complexity of evaluating such efforts. Of the twelve LEADS sites, nine are reported to have strong implementation of one or more LEADS initiatives. Five of those nine achieved improvements on at least one of the two indicators, turnover and call outs. Four of those nine sites, however, experienced a worsening in one or more of those indicators. Variables such as the business environment, internal politics, site leadership, and quality of the on-site training—variables that PHI had no control over and are difficult to measure—could have influenced the success of an initiative within a given site.

Staffing Agency Use

Data on use of agency staff from participating sites were gathered from the three nursing homes that identified a reduction in the use of agency

staff as a LEADS goal. Reduction in agency use for these sites was expected to contribute to consistency of care, and cost savings could also be realized. We measured change from 2006 to 2007. One site in particular achieved a 57.6 percent reduction in the number of agency hours used. Another site experienced a negligible difference, and the third site experienced a modest increase.

Hours of Agency Use –Monthly Average

Site	2006	2007	% Change
Nursing Home 5	1,486	1,481	-0.3%
Nursing Home 4	1,229	780	-57.6%
Nursing Home 2	719	810	11.2%



VII. Discussion and Conclusions

Because of the complexity and organic nature of the LEADS initiative, we felt it important to employ a variety of evaluation methods to fully explore project implementation and results. Doing so allowed for a greater understanding of the differences in implementation across sites, thus providing greater context for the variations seen in overall impact.

Qualitative interviews and staff surveys showed that LEADS sites achieved a measure of success for each of its proposed outcomes:

- Improved orientation and support for new direct-care workers
- Improved supervision
- Improved staff communications
- Improved public policy environment
- Increased awareness of direct-care workforce issues.

Work Environment and Job Satisfaction

In the LEADS nursing homes, direct-care workers recorded improvement from baseline to the final survey in all five WES scales relevant to LEADS work, including Supervisor Support, Clarity, Peer Cohesion, Involvement, and Work Pressure. Scores for direct-care workers in home care settings improved in four of the five scales.

Results from the job satisfaction questions showed more mixed results—perhaps because questions were more specific than those in the WES, referring to the respondent's own supervisor and peers rather than those in general. Yet the analysis did yield a number of statistically significant, positive changes from baseline to the final survey. Nursing home direct-care workers were more satisfied with training opportunities and career development opportunities. Home care workers showed statistically significant increases in the percent believing they are treated fairly by their supervisor and those reporting satisfaction with support from co-workers/peer mentors.

However, there were other JSS questions for which recorded improvements were not statistically significant, and others for which a decrease in satisfaction was recorded, with some of these changes also statistically significant.

One limitation in the JSS analysis is that each question had a “no

opinion” option, and the extent to which that option was selected could have skewed the results for an individual question. The WES was limited by the fact that the WES authors did not allow for adequate treatment of missing data in the calculation of standard scores. The aggregation of LEADS data across sites also can mask improvements at the individual site level. So interpretation of survey findings must be approached with care and supplemented by other data from other sources.

Turnover and Call Outs

Results from the turnover and call-out data also revealed interesting differences—a greater number and percent of nursing homes experienced a decrease in turnover than home care agencies. This could possibly be accounted for by the fact that the LEADS years were economically very difficult for the home health industry in general and home care workers in particular. The mean hourly wage of PHI’s surveyed home care workers at LEADS sites was \$10.06 and the median was \$9.37. This is compared to the mean hourly wage of PHI’s surveyed nursing home direct-care workers, which was \$12.15, and the median of \$11.97. Home care workers were also more likely to be working less than 40 hours per week.

These wage differentials were likely compounded by the rise in gasoline prices that rose more than 100 percent from the 2005 price of around \$1.75 per gallon, making home care no longer a financially viable option for some workers. These economic pressures can affect turnover even if interventions are showing improvement in the quality of jobs based on qualitative and some quantitative measures.

Because of these differences, the evaluation matched the extent and depth of intervention with the turnover and call-out data. In doing so, we revealed that two of the three sites reported to have 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 was 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 call outs.

Organizational Development

The organizational development efforts stood out as a critical component of program success. Establishment of leadership teams and work groups led to greater direct-care worker involvement and empowerment, which in turn led to systemic changes at participating sites that in some cases have resulted in interventions fully embedded into organizational policy.

Even in sites where this is not yet the case, systemic changes have been implemented that we anticipate will enhance the chances of long-term sustainability of LEADS initiatives.

Organizational change is a long-term commitment, and is influenced by economic pressures, leadership dynamics, the quality of training, buy-in by leadership and front-line staff, and stability at all levels of the organization. PHI looks forward to continued work with selected LEADS sites that will enable us to track change on a longer-term basis and further investigate the elements required for true sustainable change.

On the Right Path...

Quantitative results, coupled with the qualitative data related to program implementation, indicate that some sites are on the right path toward not only culture change but also realizing measurable impacts associated with that change. While we cannot say that all sites with LEADS initiatives in place or underway have yet achieved a high level of staff satisfaction and stability, we do posit that the strongest programs have resulted in positive outcomes and impacts. We further hypothesize that with additional strengthening and a longer time period of measurement, additional sites will show measurable impacts down the road.

Public Policy

In the public policy arena, LEADS successfully brought resources to established leaders who were already committed to LEADS public policy objectives. LEADS helped to maintain momentum that had been previously established through Better Jobs Better Care and other policy efforts in the three LEADS states.

LEADS efforts continued to raise the awareness of key policymakers regarding the important role the direct-care workforce plays, the current and looming challenges associated with changing demographics, and the importance of improving the quality of direct-care jobs. States have made headway in the commissioning of comprehensive studies of the direct-care workforce, authorizing direct-care worker registries, developing campaigns to recruit new workers to the field, developing small business health insurance products, and increasing health insurance coverage of the workforce.

LEADS raised awareness through the media (in newspaper articles, radio, and television) about the need to improve working conditions for direct-care workers. This was all achieved against the backdrop of state budget deficits and general economic downturn. LEADS has contributed to partnerships that continue to work together to raise awareness and influence policymakers.

Endnotes

1. Leadership, Education and Advocacy for Direct Care and Support
2. A call out (sometimes called a call off) is an unplanned absence from work where the employee informs their place of employment ahead of time of their absence, but with less than 24 hours notice.
3. Leadership, Education and Advocacy for Direct Care and Support
4. R. Moos and P. Insel. "Work Environment Scale Manual." CPP, Inc. Palo Alto, California, 1994.
5. With the LEADS pre- and post-data, we ran factor analysis and reliability tests, revealing most items to load on three factors with Cronbach's alpha of .90, .86, and .89. Cronbach's alpha is a reliability measure that checks for internal consistency—the correlation among variables comprising a set.
6. For one home care organization, state partners administered the survey on-site to administrative/office staff and mailed the survey to a random sample of direct-care workers.
7. Kendal Guthrie et al. *The Challenge of Assessing Policy and Advocacy Activities Part II—Moving Theory to Practice*, 2006.
8. Coffman, J., Hendricks, A., Masters, B., Williams Kaye, J. Kelly, T. *The Composite Logic Model*, 2007.
9. Maine Department of Health and Human Services, March 2007.
10. For those comfortable with statistical terminology, these Standard Scores have a mean of 50 and a Standard Deviation of 10. That means that about 68% of all scores for the work comparison group fall between 40 and 60 and about 98% of all scores fall between 30 and 70 (the dotted lines on these charts).
11. The statistical tests performed on these data examine all responses, not just affirmative responses.
12. This call out ratio is calculated by dividing the total number of call outs for the year by the average number of direct-care workers employed during the year.
13. Based on PHI lessons learned discussions.

Appendix A

LEADS Job Satisfaction Survey

1. Job Title: _____ | LEAVE BLANK: | | | | | | | | | |

2. Name of Organization: _____

How long have you been employed here? ____ years ____ months

3. What is your hourly wage? \$_____ per hour.
Dollars cents

Please indicate whether you agree or disagree with the following statements by circling the appropriate letters. There are no right or wrong answers, so please answer truthfully.

	(1) Strongly Disagree	(2) Disagree	(3) No Opinion	(4) Agree	(5) Strongly Agree
4. I am satisfied with my wages.	SD	D	N	A	SA
5. Management informs me about issues that are important.	SD	D	N	A	SA
6. Policies and procedures are explained adequately.	SD	D	N	A	SA
7. I am satisfied with my total benefits package.	SD	D	N	A	SA
8. I often feel frustrated at work.	SD	D	N	A	SA
9. I feel a strong sense of loyalty towards this organization.	SD	D	N	A	SA
10. This organization provides enough opportunity for me to upgrade my skills.	SD	D	N	A	SA
11. I am very satisfied with my job.	SD	D	N	A	SA
12. I trust the leadership of this company.	SD	D	N	A	SA
13. Management treats front line staff with respect.	SD	D	N	A	SA
14. I am treated fairly by my supervisor.	SD	D	N	A	SA
15. I have enough opportunity to let management know how I feel.	SD	D	N	A	SA
16. I would recommend this organization to others as a good place to work.	SD	D	N	A	SA
17. My work gives me a feeling of personal accomplishment.	SD	D	N	A	SA
18. My supervisor provides adequate supervision.	SD	D	N	A	SA
19. I am satisfied with the career development opportunities at this organization.	SD	D	N	A	SA
20. I am satisfied with the number of hours I work each week.	SD	D	N	A	SA
21. I would like to continue to do this job for the next two years.	SD	D	N	A	SA
22. I am satisfied with the support I receive from my co-workers and/or peer mentors.	SD	D	N	A	SA
23. I am satisfied with the opportunities for ongoing or advanced training.	SD	D	N	A	SA
24. If you could change one thing here—other than salary—that would make you happier in your job, what would it be? Say what you would change here: _____					

Appendix B

Newspaper Articles and Other Media Coverage about LEADS, or LEADS Public Policy/Education Activities

Date	Title	Publisher
General Articles on LEADS		
April 2006	<i>Northern New England LEADS Institute: A regional strategy to ensure quality care and quality jobs</i> http://phinational.org/publications/GIHbulletin_4_17_06.pdf	Grant Makers in Health Bulletin
Labor Market Reports		
March 2006	<i>Eldercare in New Hampshire: Labor market trends and their implications</i> http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=203010	New Hampshire Economic and Labor Market Information Bureau
March 2007	<i>Study of Maine's direct care workforce: Wages, health coverage, and a worker registry</i> http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=236010	Maine Department of Health and Human Services
March 2008	<i>Legislative Study of the Direct Care Workforce in Vermont</i> http://dail.vt.gov/dail-whats-new/legislative-study-dcw-vt	Disabilities, Aging and Independent Living Vermont Agency of Human Services
Articles/Publications		
Maine		
June 2005	<i>Maine groups part of effort to improve care for elderly</i> http://nl.newsbank.com/nl-search/we/Archives?p_product=ME&p_theme=me&p_action=search&p_maxdocs=200&p_topdoc=1&p_text_direct-0=10AC635DC2748FD9&p_field_direct-0=document_id&p_perpage=10&p_sort=YMD_date:D&s_trackval=GooglePM	Portland Press Herald
February 2006	<i>Where will direct care come from?*</i> <i>Many of Maine's direct care workers do not have health insurance.</i> http://www.hchcw.org/docs/HCHCW_ME_FactSheet.Final.pdf	Portland Press Herald Health Care for Health Care Workers and Maine's Direct Care Worker Coalition
April 2007	<i>Crisis nears for society's vulnerable</i> http://209.85.165.104/search?q=cache:f0P_LmaETYEJ:bangordailynews.com/news/t/viewpoints.aspx%3Farticleid%3D149175%26zoneid%3D35+Joyce+Gagnon+%22bangor+daily+news%22&hl=en&ct=clnk&cd=1&gl=us	Bangor Daily
July 2007	<i>Leadership stories from Maine: The voices of direct-care workers in culture change</i> http://www.directcareclearinghouse.org/download/LEADS7-07.pdf	Northern New England LEADS Institute, PHI

* Not available online

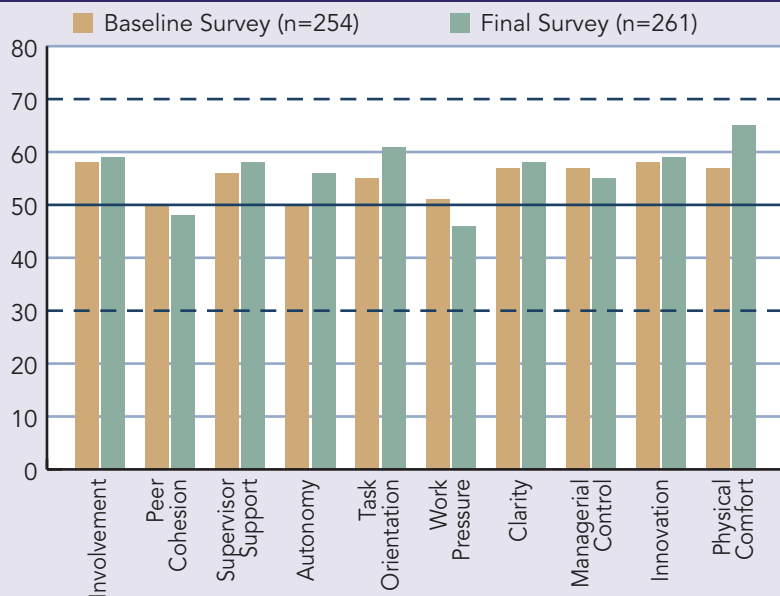
Date	Title	Publisher
Articles/Publications (continued)		
New Hampshire		
March 2005	<i>Wages in N.H. under debate*</i>	Nashua Telegraph
Winter 2006-07	<i>Home alone in New Hampshire</i>	New Hampshire Community Loan Fund
	http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=225610	
March 2007	<i>Numbers don't add up to meet direct care needs</i>	New Hampshire Business Review
	http://findarticles.com/p/articles/mi_qa5283/is_200703/ai_n21234099	
June 2007	<i>Women care workers behind curve in wages</i>	New Hampshire Union Leader
	http://www.unionleader.com/pda-article.aspx?articleId=583d19b2-9c65-494d-b686-59c76371564b	
Summer 2007	<i>Family caregiver: Balancing home and work: Communities and banking</i>	The Federal Reserve Bank of Boston
	http://www.bos.frb.org/commdev/c&b/2007/summer/Lochhead_home_health.pdf	
December 2007	<i>Disabled care to cost state millions more</i>	Concord Monitor
	http://www.concordmonitor.com/apps/pbcs.dll/article?AID=/20071214/NEWS01/712140359/1043/NEWS01%20	
Vermont		
February 2008	<i>Direct-care workers are key</i>	Times Argus Online
	http://www.timesargus.com/apps/pbcs.dll/article?AID=/20080229/OPINION02/802290400/1022/OPINION02	
March 2008	<i>Vermonters Get Fired Up at Town Meeting</i>	PHI Blog
	http://phinational.org/archives/vermonters-get-fired-up-at-town-meeting/#more-201	
April 2008	<i>Study: Direct care workers need boost</i>	Times Argus Online
	http://www.timesargus.com/apps/pbcs.dll/article?AID=/20080401/NEWS01/804010400/1002/NEWS01	
April 2008	<i>Care worker numbers fall as aging population rises*</i>	St Albans Messenger
April 2008	<i>State shortage of home care providers seen*</i>	Brattleboro Reformer
April 2008	<i>Sixty Plus: Attention must be paid to direct care workers</i>	Burlington Free Press
	http://www.burlingtonfreepress.com/apps/pbcs.dll/article?AID=/20080421/LIVING/804210305/1004/NEWS05	

* Not available online

Appendix C

Work Environment Scale (WES) Results

LEADS Home Care Sites Standard Scores for All Staff



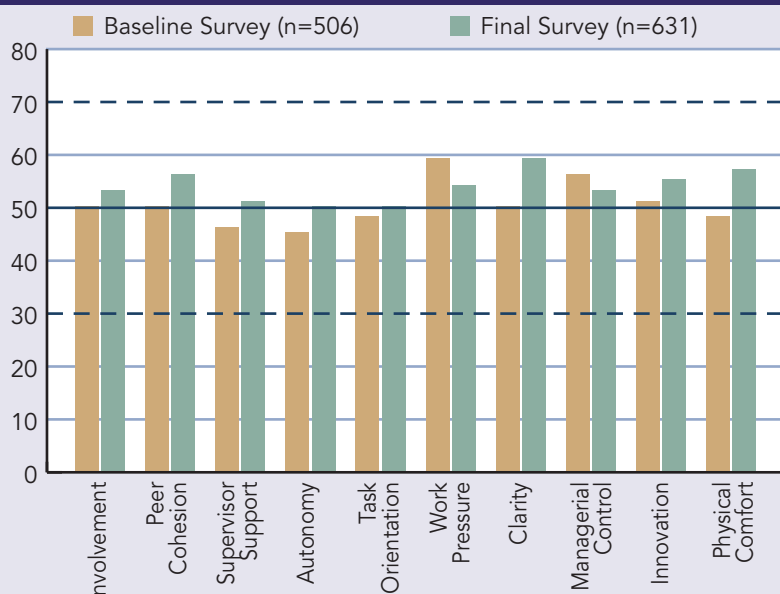
All Staff Scores

Home Care

Changes in the standard score points recorded by All Staff in the home care setting (5 sites) were small between both rounds of data collection.

Supervisor Support increased by 2 points to 58, Involvement and Clarity both increased by 1 point (to 59 and 58 respectively) and a decrease of 5 points to 46 was recorded in Work Pressure. Peer Cohesion decreased by 2 points from 50 in the baseline survey to 48 in the final survey.

LEADS Nursing Home Sites Standard Scores for All Staff



Nursing Homes

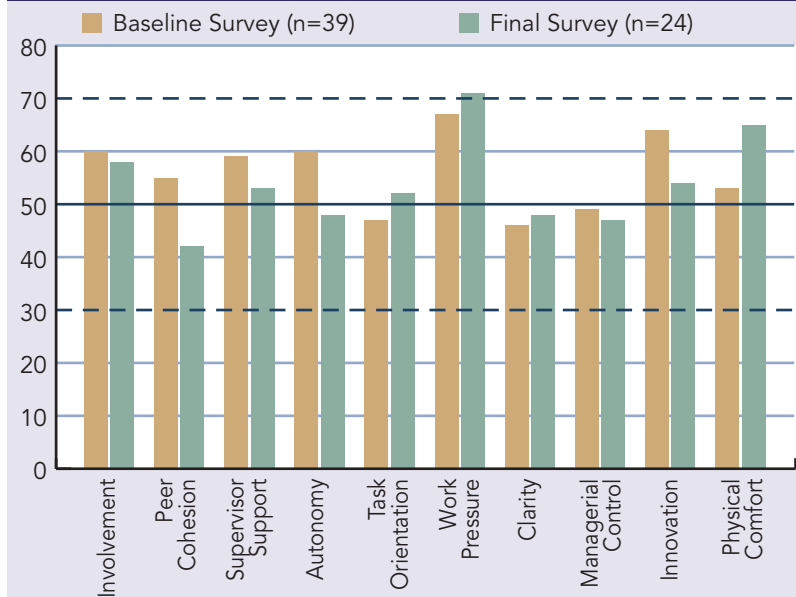
All staff aggregated in the nursing home setting (7 sites) recorded a notable 9 point increase in Clarity from 50 in the baseline survey to 59 in the final survey. Improvements were also noted in Peer Cohesion (50 to 56 points), Supervisor Support (46 to 51 points) and Involvement (by 3 points to 53). A decrease in Work Pressure was also recorded from 59 in the baseline survey to 54 in the final survey.

Nursing Staff Scores

Home Care

Overall Nursing Staff in home care did not show many improvements in the areas LEADS interventions targeted. There was a small increase in Clarity from 46 points to 48 points in the final survey. Decreases were noted in Involvement (by two points to 58), Supervisor Support (by six points to 53) and Peer Cohesion (by 13 points to 42 in the final survey). Nursing Staff also recorded an increase in Work Pressure by 4 points to 71 in the final survey.

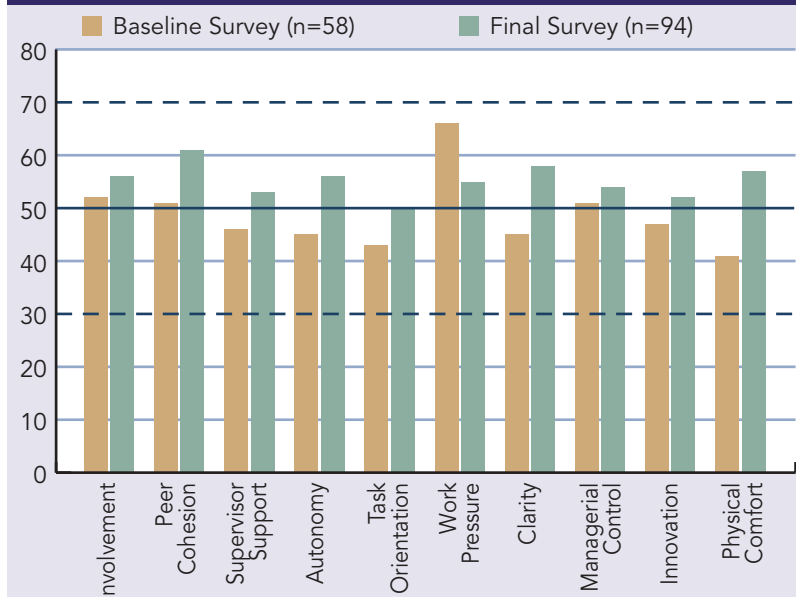
LEADS Home Care Sites Standard Scores for Nursing Staff



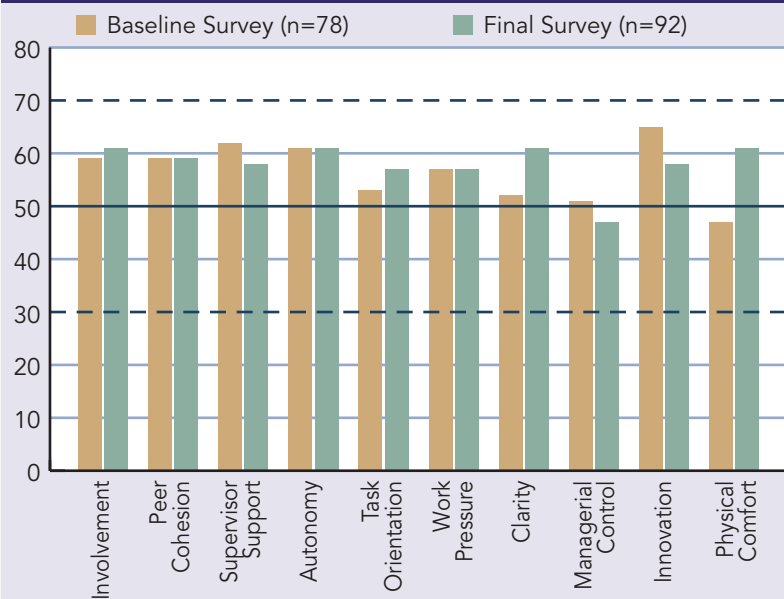
Nursing Homes

Nursing Staff at Nursing Homes recorded many large changes between both rounds of data collection. Clarity increased by 13 points to 58, Peer Cohesion increased by 10 points to 61, and Work Pressure decreased by 11 points to 55 in the final survey. Smaller increases were noted in Supervisor Support (46 to 53 in the final survey) and a 4 point increase in Involvement to 56 in the final survey.

LEADS Nursing Home Sites Standard Scores for Nursing Staff



LEADS Home Care Sites Standard Scores for Other Staff

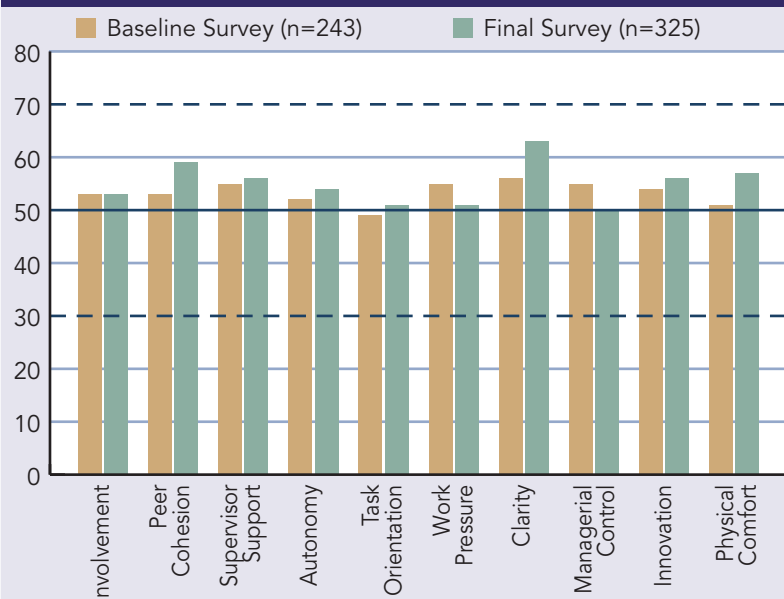


Other Staff Scores

Home Care

The results for Other Staff in Home Care settings are mixed. There was a marked increase in Clarity from 52 points to 61 points in the final survey and a small increase of 3 points in Involvement to 61 in the final survey. There were no score point changes in Peer Cohesion (59 points) and Work Pressure (57 points). A small decrease was recorded in Supervisor Support from 62 in the baseline survey to 58 in the final survey.

LEADS Nursing Home Sites Standard Scores for Other Staff



Nursing Homes

Results among Other Staff in Nursing Homes were also mixed. Clarity increased by 7 points to 63, Peer Cohesion increased by 6 points to 59, Supervisor Support increased by 1 point to 56 and Work Pressure decreased by 4 points to 51. There was no change in the recorded score point for Involvement between the two rounds of data collection (53 points).

The following tables summarize, by job title, the baseline and final WES standard scores for home care and nursing home employees for those scales the LEADS interventions were expected to influence.

WES Standard Scores for Home Care Employees at Baseline and Final Survey*

Scale	DCW baseline	DCW final	Nursing baseline	Nursing final	Other baseline	Other final	All baseline	All final
Clarity	61	76	46	48	52	61	57	58
Supervisor Support	53	59	59	53	62	58	56	58
Involvement	57	58	60	58	59	61	58	59
Peer Cohesion	52	42	55	42	59	59	50	48
Work Pressure	42	35	67	71	57	57	51	46

WES Standard Scores for Nursing Home Employees at Baseline and Final Survey*

Scale	DCW baseline	DCW final	Nursing baseline	Nursing final	Other baseline	Other final	All baseline	All final
Clarity	46	57	45	58	56	63	50	59
Supervisor Support	36	41	46	53	55	56	46	51
Involvement	46	52	52	56	53	53	50	53
Peer Cohesion	46	51	51	61	53	59	50	56
Work Pressure	62	58	66	55	55	51	59	54

* scores in gold cells represent improvements

Appendix D

Results from the Job Satisfaction Survey

Interpreting the JSS Results

The charts on the following pages present a summary of survey items for which respondents agree or strongly agree. Improvements from baseline to final survey are highlighted in gold, and those showing a decline in staff satisfaction are highlighted in light blue. When analyzing changes between the two rounds of data collection a Mann-Whitney U test of statistical significance (p-value) was also calculated. Percentages with a single green asterisk (*) indicate a p-value of $<.05$ and percentages with two green asterisks (**) indicate a p-value of $p <.10$.

Nursing Staff

Home Care

Nursing Staff in the home care setting recorded a statistically significant improvement in the percentage of nurses who feel their supervisor provides adequate supervision. A larger percentage of nurses in Round 2 also agreed that their organization provides adequate supervision and that they are satisfied with ongoing opportunities for advanced training. Nursing staff also recorded a statistically significant decrease in those who believe their work gives them a feeling of personal accomplishment.

Home Care

Statement	Nursing Staff	
	Round 1 (n= 34)	Round 2 (n = 33)
My supervisor provides adequate supervision	68%	82%**
This organization provides enough opportunity for me to upgrade my skills	55%	70%
I am satisfied with the opportunities for ongoing or advanced training	47%	55%
My work gives me a feeling of personal accomplishment	100%	88%**
I trust the leadership of this company	70%	64%
I would recommend this organization to others as a good place to work	82%	70%
I am satisfied with the career development opportunities at this organization	65%	58%
I would like to continue to do this job for the next two years	82%	76%

* $p < .05$ ** $p < .10$

Nursing Homes

In the nursing home setting, Nursing Staff recorded statistically significant improvements in their desire to continue to do this job for the next two years, their satisfaction with opportunities for ongoing or advanced training, and their level of frustration at work.

Nursing Homes

Statement	Nursing Staff	
	Round 1 (n= 57)	Round 2 (n = 109)
I would like to continue to do this job for the next two years	56%	76%*
I often feel frustrated at work	67%	50%**
I am satisfied with the opportunities for ongoing or advanced training	37%	57%**
Policies and procedures are explained adequately	60%	67%
I am satisfied with the career development opportunities at this organization	45%	57%
This organization provides enough opportunity for me to upgrade my skills	45%	62%
My work gives me a feeling of personal accomplishment	79%	92%
I am very satisfied with my job	61%	69%
I trust the leadership of this company	52%	59%
I have enough opportunity to let management know how I feel	68%	77%
I am satisfied with the support I receive from my co-workers and/or peer mentors	77%	85%
I would recommend this organization to others as a good place to work	73%	80%
My supervisor provides adequate supervision	60%	70%
Management treats frontline staff with respect	57%	73%

* p < .05 **p < .10

Other Staff

Home Care

Other Staff recorded statistically significant decreases in their satisfaction with career development opportunities at their organization and their trust of the leadership at their organization. However, they recorded improvements (albeit not statistically significant) in the percent agreeing that they have enough opportunity to let management know how they feel; expressing satisfaction with the support they receive from their co-workers and/or peer mentors; expressing the belief that management informs them about issues that are important; and, agreeing that they would like to continue to do this job for the next two years.

Home Care

Statement	Other Staff	
	Round 1 (n= 115)	Round 2 (n = 113)
I have enough opportunity to let management know how I feel	81%	91%
I am satisfied with the support I receive from my co-workers and/or peer mentors	84%	91%
Management informs me about issues that are important	76%	87%
I would like to continue to do this job for the next two years	76%	87%
I am satisfied with the career development opportunities at this organization	66%	52%*
I trust the leadership of this company	86%	74%**
I am very satisfied with my job	84%	74%
My work gives me a feeling of personal accomplishment	94%	87%
I am satisfied with the opportunities for ongoing or advanced training	70%	61%

* p < .05 **p < .10

Nursing Home

Other Staff in the nursing home setting recorded a statistically significant decrease in their belief that their work gives them a feeling of personal accomplishment. However, a smaller percentage of Other Staff in the final survey reported often feeling frustrated at work than at baseline.

Nursing Homes

Statement	Other Staff	
	Round 1 (n= 236)	Round 2 (n = 279)
I often feel frustrated at work	51%	41%
My work gives me a feeling of personal accomplishment	86%	82%**

* p < .05 **p < .10





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