Practices in Education and Training for Direct Care Workers

Prepared for the Legislative Task Force on House Memorial 37

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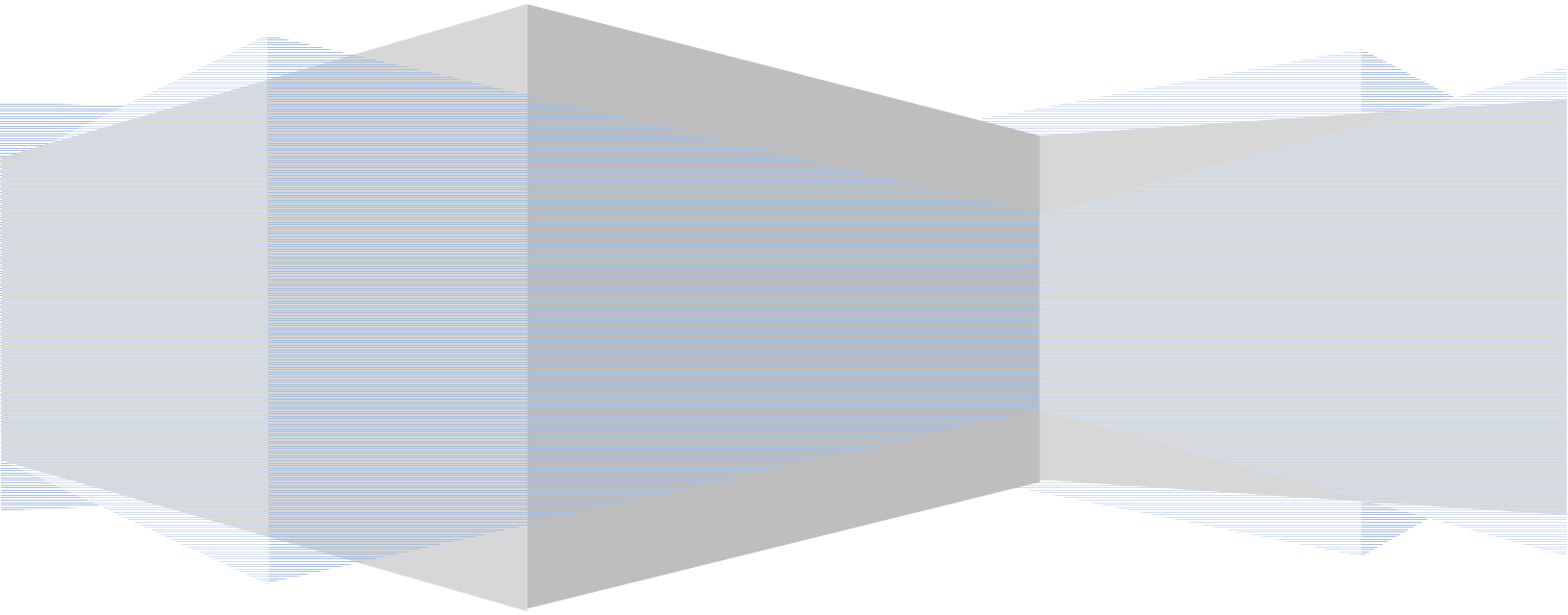

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Education and Training

Cooperative Home Care Associates: Integrated model for recruitment, training, and retention

Description	Cooperative Home Care Associates (CHCA) uses a model for recruitment, training, and retention that encompasses five primary elements: targeted recruitment, enhanced entry-level training, supportive services, opportunities for advancement, and wage and benefit enhancements.
Sponsoring Organization	Cooperative Home Care Associates is a worker-owned home care agency in the South Bronx (NY), which employs 800 direct-care workers. CHCA has developed its recruitment, training, and retention program in cooperation with the Paraprofessional Healthcare Institute (PHI), a not-for-profit health care employment and advocacy organization in the South Bronx.
Setting	CHCA provide services to elderly and non-elderly people living with disabilities in the Bronx and upper Manhattan.
Target Group	CHCA targets public assistance recipients and other low-income individuals who may be seeking more secure or meaningful employment to participate in its direct-care training and employment programs.
Start Date	CHCA was founded in 1985 and has worked to refine its recruitment, training, and retention program since that time. The agency has done all its own training since 1987.
Objectives	To create high-quality jobs for home care workers by offering enhanced training, a supportive work environment, and opportunities for personal and professional growth. To improve the quality of care delivered to people living with disabilities by creating a more stable workforce.
Key Components	To recruit new workers, CHCA targets candidates likely to succeed in direct-care work and provides them with a learner-centered environment, supportive services, and guaranteed employment for those who graduate. To retain staff, CHCA offers enhanced wages and benefits, opportunities for professional growth, and ongoing support from both supervisors and peers. Assessment and selection. Rather than accepting large numbers of trainees, CHCA uses a layered assessment and selection process to identify the candidates most likely to succeed as caregivers. Recruiters look for people with some formal or informal caregiving experience who express compassion for other human beings and demonstrate an ability to set priorities and resolve problems. Only about 35 percent of those who interview are enrolled in the training program. Of these, over 80 percent graduate and become CHCA employees. Recruitment partnerships. To enhance its ability to recruit appropriate candidates, CHCA has built strategic relationships with the public welfare department as well as a range of public and private human service organizations, most of which assist low-income individuals in securing employment. Though it takes time to cultivate these relationships, they have contributed to agency's rapid growth over the last five years. CHCA's challenge is first to target agencies that serve populations

who are likely to include prospective direct-care workers and then to communicate clearly to agency staff the qualities that make a successful home health aide, so they recommend people who fit the profile.

Learner-centered training. CHCA invests significant resources in its training program. Entry-level training runs for four weeks, significantly longer than the 75-hour minimum required for home health aides. Instructors strive to create a safe but challenging learning environment for trainees who may have had little formal education or work experience. Rather than using traditional lecture methods, they emphasize active learning techniques such as role-plays, case studies, and team discussions to make the direct-care job 'come alive' in the classroom. In addition, team teaching, often with senior aides participating as peer educators, allows for individualized attention and support.

Communication and problem solving. In addition to teaching clinical skills, the curriculum includes modules on non-technical skills that are critical to success on the job, such as team-building and respecting differences. It also includes modules that focus on helping participants enhance their communications, problem-solving, and critical-thinking skills. The *4P Communication and Problem-Solving Curriculum*, which was developed by Home Care Associates of Philadelphia and is now used by CHCA, breaks problem solving down into four concrete skills: paraphrase, pull back, present options, and pass it on. Trainees practice each skill, learning how to think objectively about an interpersonal conflict, communicate clearly, and find solutions without allowing emotions to overwhelm rational thinking.

On-the-job training. CHCA provides three months of on-the-job training. During this time, new employees receive peer support from mentors, close oversight from supervisors, and frequent opportunities to gather for peer exchanges, problem-solving sessions, and additional clinical skills training as required.

Employment counseling. CHCA employs an employment counselor to help trainees and employees overcome obstacles to success on the job; for example, lack of reliable childcare or transportation or an unstable housing situation. The employment counselor meets with each new trainee to discuss his or her situation and to assist in accessing any public support services for which the trainee is eligible. This service is also available to employees.

Coaching supervision. CHCA has trained its supervisory and management staff in a coaching style of management, which offers support in resolving performance issues while holding employees accountable for their actions. This management style is used often with professional employees but rarely with entry-level staff. When a problem arises that affects performance, coaches try to understand the employee's perspective and works with him or her to analyze the problem and come up with a solution, always ensuring that the employee takes responsibility for solving the problem. The coach then follows up to ensure that progress is being made. This method often resolves problems that would otherwise lead to an employee being disciplined, or even being terminated or quitting in frustration.

Worker participation in agency decisions. As a worker-owned agency, CHCA wants its employees to be knowledgeable about the home care industry and influence agency decisions. Geographically based worker councils meet to discuss important issues facing the agency, to air concerns and grievances, and to contribute to management decisions. In addition, worker-owners elect

	representatives to the board of directors. Career advancement. CHCA home health aides have moved into training positions and into the patient services department, where they have become patient service coordinators. CHCA has also developed a career ladder to train senior aides in peer mentoring skills. Leadership development. CHCA aides participate each year in PHI's Paraprofessional Assembly, which brings together aides from all Cooperative Healthcare Network agencies. Attendees celebrate their role as caregivers and learn advocacy and leadership skills. Some aides also develop these skills at work by participating in CHCA's policy action group, which has sponsored voter registration drives, met with local legislators to discuss policies that impact home care workers, and provided speakers at statewide conferences and other events. Base wages. CHCA rewards longevity by using a tiered pay scale that ranges from $6.40 to $8 per hour. Although still low for a region with a high cost of living, these wages are $2 an hour higher than average for New York home care agencies. Guaranteed hours. Aides who have been with the agency at least three years are paid for at least for 30 hours a week, even if they work less than this threshold amount, if they agree to accept case assignments on alternating weekends and any substitute assignments offered. Since aides typically work 36 hours per week, CHCA rarely pays for hours not worked, but this arrangement guarantees senior aides a stable income. Wage differentials. Aides who take weekend assignments or work with clients with complex care needs earn an additional 50 cents an hour. Benefits. CHCA pays 100 percent of the premium cost for full-time employees' health insurance and prorates the payment for part time employees. In addition, it provides a 401(k) retirement fund, five paid vacation days, and annual dividends for all worker-owners.
Results, Outcomes, Evaluation	Of the aides CHCA trained between July 2001 and June 2002, 87 percent were employed with the agency after 90 days and 72 percent were still there after one year. The agency's turnover rate between August 2001 and August 2002 was just 22 percent. (To calculate turnover, the agency divides the number of terminations by the average number of employees. Employees hired 90 days prior to the end of the year are not included in the calculation of terminations. The average number of employees is estimated by adding the number employed at the beginning of the year to the number employed at the end, then dividing by two). Furthermore, more than 25 percent of its workforce has been with the agency for more than five years. This is extraordinary when growth is taken into account: the agency has doubled in size over the past five years. Informal information shows that many workers have stayed with CHCA for years because CHCA is not just a workplace but also a community. Workers often talk about how important it is for them to feel that their employer truly respects them and the value of their work. In addition, clients often request aides from the agency because the service is reliable, client-centered, and compassionate. The quality of CHCA's service is recognized by the New York Visiting Nurse Service, which has made CHCA a preferred provider.

Lessons Learned	For CHCA, the first step toward creating a stable workforce is finding the right people for the job. The next step is offering an extended training program that provides opportunities for new workers to learn not just clinical skills but also things such as how to function in a work environment, how to be a team player, and how to resolve personal problems that interfere with work performance. How these things are taught is almost as important as what is taught. Instructors must respect the trainees and draw on their life experiences to build knowledge and understanding. CHCA notes that an employee doesn't make a single transition into the workforce. Instead, there are a series of small transitions, some predictable, some not. An agency that assists employees through these transitions is less likely to lose them along the way. To avoid turning into a social service agency, CHCA has arranged a structured support system that includes employment counselors, supportive supervision, and peer mentors. Because the quality of direct-care workers' experience is heavily influenced by their interactions with their immediate supervisors, CHCA has found it pays to invest in training supervisory staff. Its coaching supervision method has improved relationships between frontline workers and supervisors and decreased the need for disciplinary actions. PHI shares the lessons learned at CHCA with a group of direct-care staffing agencies and training programs known as the Cooperative Healthcare Network (CHN). Although they operate in geographically diverse areas, and although some are worker-owned while others are more traditionally structured, each CHN site has successfully adapted several of the recruitment, retention, and training strategies outlined above. As a result, all five report successes in helping people with limited education and skills enter the workplace and provide high-quality service. CHCA's greater success, as measured by its rapid growth and above-average worker retention rates, is probably due primarily to market conditions. However, other factors also contribute. One CHN site, for example, has had retention problems because it places aides in facilities where it has no control over the quality of the job, creating a gap between the values and sense of community nurtured by the agency and the aides' actual working environments. In addition, not all of the agencies provide the wage enhancements and guaranteed hours offered by CHCA.
Costs and Funding	It costs CHCA approximately $3,500 to train and employ a home health aide. CHCA receives funds from private foundations and public welfare-to-work contracts to defray these costs. In addition, PHI provides CHCA with development assistance and works with the agency to refine its recruitment and training programs.
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Other Resources	Clark, Peggy, and Steven L. Dawson with Amy J. Kays, Frieda Molina, and Rick Surpin. 1995. *Jobs and the urban poor: Privately initiated sectoral strategies.* Washington, DC: The Aspen Institute together with the Charles Stewart Mott Foundation. Paraprofessional Healthcare Institute. 2000. *Recruiting quality health care professionals.* Bronx, NY: Paraprofessional Healthcare Institute. Paraprofessional Healthcare Institute. 2001. *Creating a culture of retention: A coaching approach to paraprofessional supervision.* Bronx, NY: Paraprofessional Healthcare Institute. Inserra, Ann, Maureen Conway, and John Rodat. 2002. *Cooperative Home Care Associates: A case study of a sectoral employment development approach.* Washington, DC: Aspen Institute. Glasser, Ruth, and Jeremy Brecher. 2002. *We are the roots: The organizational culture of a home care cooperative.* Davis, CA: Center for Cooperatives, University of California.

Direct CareGiver Association: Comprehensive model training program for caregivers

Description	Direct CareGiver Association (DCGA) has developed a comprehensive model for recruiting, training, and retaining caregivers. The model has five major components: community-wide recruitment; intensive screening; comprehensive, portable training leading to CNA certification; job placement; and the provision of ongoing supports. DCGA implements this model through development of local Caregiver Resource Centers.
Sponsoring Organization	Located in Tucson, Arizona, Direct CareGiver Association is a nonprofit organization dedicated to 'recognizing, honoring, valuing and training Direct Caregivers, [and] thus assuring that those who need care are treated with dignity, compassion, and skill.' DCGA is a membership organization of caregivers, consumers, providers, professional counsel, researchers, and policymakers, working together to solve the problems facing long-term care. DCGA seeks to address caregiver issues systemically, by 1) providing opportunities for caregivers to pursue training, certification, and continuing education, and 2) by improving the system in which caregivers work through developing standards, educating the public, and working with providers to enhance recruitment, screening, and retention.
Setting	DCGA operates a Caregiver Resource Center in Tucson, Arizona, serving caregivers, consumers, and providers in southern Arizona.
Target Group	DCGA targets caring people throughout the community who seek to enter or advance in the caregiving field. Trainees to date, almost all of whom are low-income, have tended to fall into three groups: young, single, largely Hispanic mothers currently unemployed or employed in minimum wage service jobs; older, displaced homemakers, seeking to enter or re-enter the labor market after a long absence; and current caregivers who are severely underemployed and have received little or inadequate training.
Start Date	DCGA began operations in late 2000, and began its training program in March 2002.
Objectives	To improve the quality of long-term care by: increasing the number of highly trained and skilled caregivers qualified to work across the spectrum of long-term care settings through comprehensive recruitment, screening, and training. improving caregiver retention through carefully matching individual caregiver needs and preferences to job characteristics and providing ongoing support.
Key Components	DCGA's **CareGiver Resource Center** provides a 'one-stop' center for communitywide recruitment of caregivers; screening, training, and introduction to the workforce; job placement; and continuing education, mentoring, and support. *Recruitment*: DCGA recruits extensively throughout the community to attract candidates from

both traditional and nontraditional labor pools. Regular orientation sessions are scheduled through the city-county library system and other community-based venues, and free provider tours are organized for potential recruits so that they can see for themselves what various levels of caregiving entail and the various kinds of facilities in which they might work. A recruitment video is currently being produced.

Screening: In order to screen for appropriate candidates DCGA administers psychological and literacy tests, collects screening references, and conducts two personal interviews with each potential trainee to collect background information and determine individual skills, interests, motivations, career aspirations, and barriers. Those who are not accepted into the training program are referred to other appropriate programs in the community.

Training: The curriculum includes 203 hours of training, exceeding Arizona's 120-hour requirement. Training begins with the 'Know Me' game, which establishes each person as an individual first and creates a sense of community among trainees. Trainees learn about traditional training topics (personal care issues - bathing, dressing, feeding, ambulation assistance - the aging process, chronic diseases and treatments, communication, ethics and boundaries, and professionalism) and receive additional instruction in life/employability skills areas such as cooking, home management, house cleaning, interpersonal communication skills, conflict resolution, problem behaviors, stress management skills, time management skills, and healthy lifestyle choices. The curriculum reflects adult-learning principles and emphasizes active learning that addresses multiple learning styles. As needed, case management and/or emergency assistance is provided to enable trainees to complete their training.

Unlike many traditional on-the-job training programs, trainees have ample time to practice their skills *before* being asked to care for actual patients. Trainees are given clinical experience in both geriatric and acute care, so that they can identify their interests and preferences and match them to the jobs for which they will apply.

Job Placement: Once trainees have completed the 12-week training, an employment specialist works to place them in positions with one of DCGA's member-providers. (As of May 2003 DCGA had 13 member-providers that employ a total of 350 caregivers.) Individual trainees' needs are matched with particular job openings. Employment specialists meet with employers during the training session to determine current job needs and openings. They meet with trainees about two weeks before graduation to discuss in detail their job preferences regarding location, duties, hours, and type of facility, in order to make an appropriate match.

Ongoing Support: DCGA 'checks in' with trainees frequently during the training and provides individual direct assistance and/or appropriate referrals to help meet emergency needs for child care and transportation, food and shelter, counseling, and the like. Monthly in-person follow-up meetings are conducted with trainees for the first three months after graduation, and quarterly telephone follow-ups for at least one year.

To facilitate ongoing communication, a bi-monthly caregiver newsletter is produced that goes to all caregivers working for member-providers. DCGA's advisory board of direct caregivers is convened every six months to provide feedback about program and caregiver needs. Ten different continuing education courses are offered each month for caregivers to upgrade their skills. In addition DCGA has offered a training workshop on effective supervision for supervisors of caregivers.

Results, Outcomes, Evaluation	During the training program's first full year of operation, a database was developed with the names of 650 people who made inquiries or attended an orientation. The 193 individuals who applied to the program were screened, and 66 were accepted into the program. Of the 66 trainees in the four training classes: 60 completed the training, a 90% training retention rate; 49 (82%) have passed the Certified Nursing Assistant state certification test. (The rest are Certified Caregivers.) 53 are currently employed as caregivers - an 88% employment rate. 25 percent have indicated interest in pursuing nursing degrees, and DCGA has worked to place these trainees in positions with facilities that offer tuition reimbursements and other incentives for additional education. Immediate post-training wages now average 139% of pre-training wages (from an average of $6.73 to $9.37). A survey of the first two graduating classes (who have been in the workforce from 9-12 months) reveals that almost all are still working in the caregiving field, and a large majority have held the same job for the entire time.
Lessons Learned	*Recruitment*: To attract enough suitable applicants, sufficient funds need to be budgeted to create a variety of recruiting materials in different media that can be presented in different venues. Recruitment in December for winter training classes is especially difficult. Orientations and provider/facility tours are invaluable to help potential trainees understand caregiving work and settings; these are especially important for those referred from other agencies (for example, the One-Stop Center). *Screening*: Potential trainees need to be evaluated for their physical stamina to work in the industry. Although recruiting older trainees definitely expands the labor pool, they may require additional accommodations and/or more careful placement if they are to actually work in the industry. At a minimum, trainees need to read at an 8th grade level. Potential trainees are referred to entities that provide adult basic language education, ESL, and computer-assisted language instruction. However, DCGA now believes that adding a formal ESL component to the training program may be essential to significantly expand the qualified applicant pool. *Training*: While some trainees may need life skills instruction and some may not, almost all trainees benefit from employability skills instruction. For example, training needs to include information and discussion about the long-term care industry itself: how long-term care is delivered and where, how reimbursement works, and how to partner with other staff, administration, families, and consumers in the delivery of care. Other employability skills focus on time and stress management, communication and team-building, and caring for the caregiver. For a substantial subset of trainees, social support services, including case management and emergency assistance, are required for trainees to successfully complete training. *Job Placement and Follow-Up*: Matching trainees to individual positions needs to take into account a variety of factors: location; work hours, pace, and responsibilities; types of clients; physical requirements of the job; trainees' life circumstances. Multiple follow-up sessions with past trainees over time are desirable as the content of such meetings shifts from a discussion of the new job

	itself to subsequent consideration of various work situations and how to handle them. *Employer Involvement*: DCGA has found that it takes a lot of effort to keep employers actively involved in addressing caregiver issues; employers will often cite time and resource constraints as significant barriers to their ongoing involvement. However, employers are willing to pay placement fees for trainees who successfully complete probationary employment periods. Extending case management/social services support to all caregivers in the employ of member-providers (not just DCGA trainees placed with member-providers) may increase the visibility and value of DCGA to employers, which will in turn stimulate their active and substantive involvement. DCGA also sees a need to create one- to three-month paid internships for trainees to facilitate their successful transition into the caregiving workforce.
Costs and Funding	The direct costs of the actual training currently average $838/trainee. Costs for the comprehensive program (recruitment, screening, training, job placement, follow-up support, and continuing education) at the current level of activity (70 trainees/year) as well as the DCGA organizational infrastructure to support this range of activities works out to approximately $3500/trainee. DCGA expects this latter cost to decrease as the number of trainees in the program is expanded. Funding comes from membership dues, job placement fees, tuition (sliding scale), modest foundation grants and individual donations, and modest job training funds. DCGA reports that is has proved difficult to secure local WIA/One-Stop funding for the program.
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Golden Care Academy

Description	Golden Care Academy, via its Golden Hill Health Careers Academy program, administers training programs to primarily low-income, minority people in San Diego, California. Current programs enable trainees to obtain entry-level jobs as nursing assistants and home health aides. Special features of the Academy include a dual certification program preparing workers to be both nursing assistants and home health aides, a program to reach the hardest-to-serve welfare recipients, strategic partnerships with government, and community agencies and health care providers.
Sponsoring Organization	Golden Care Academy (GCA), founded in 2002. As the new home of the Golden Hill Health Careers Academy program, GCA received official non-profit status on October 31, 2003 and began operating independently of its founder, the Greater Golden Hill Community Development Corporation on January 1, 2005.
Setting	Classroom training takes place at Golden Care Academy. Clinical training takes place at two long-term care facilities, one in the community, and a second nearby in the San Diego area.
Target Group	The Academy serves primarily low-income, ethnically diverse people who live in San Diego County and who are interested in working as direct-care workers. Program selection is on a first come, first served basis and contingent on applicants successfully completing the admissions process.
Start Date	Golden Hill Health Careers Academy, 1996; Golden Care Academy, 2004
Objectives	Provide students with a high-quality education that qualifies them to work in a variety of healthcare settings; Link potential workers with potential employers to fill direct-care jobs; Provide career ladders to participants that will lead to careers in nursing and allied health professions; Increase the number of direct care workers in California to provide services to the growing number of elderly, disabled, homebound, and other people needing assistance.
Key Components	The core part of GCA's mission is to promote care giving as a vocation. GCA screens, tests, and interviews applicants for the Academy program. All classes are limited to 30 students. The agency is fully approved by the California Bureau for Private Postsecondary Vocational Education to provide the following trainings: *Certified Nurse Aid (CNA)* The CNA certification program prepares individuals to provide personal care services, also known as 'hands-on' care, to the client/patient. CNA's assist clients in getting in and out of bed, with bathing, dressing, grooming, and eating. They check vital signs, help with simple prescribed exercises, and assist with medication routines (CNAs cannot actually administer medication). This

	course requires 255 hours of training composed of 100 hours of theory, 105 hours of clinical and 50 hours of work preparation. *Home Health Aide (CHHA)* This certification prepares students for employment as a home health aide, also known as homemaker, home health aides or home attendants. This course requires 56 hours of training with 36 hours of theory, work preparation and 20 hours of clinical training. This training is offered as funding allows. A 40-hour, certified home health aide conversion class is also offered to CNAs who desire this additional training. *Acute Care Certified Nurse Aid (CNA)* This certification prepares students for jobs in acute care settings. The course requires 120 hours for completion including classroom instruction, laboratory instruction and practice and clinical experience in an acute care (hospital) setting. This training is offered as funding allows. In addition to these training courses, every year since 2003 the GCWI has sponsored The Golden Caregiver Awards, which serves to recognize caregiving as an essential vocation and bring awareness to the people and programs that serve the elderly, disabled and homebound. **Strategic Partnerships.** GCA entered into a strategic partnership with the San Diego Community College District Regional Occupations Program to create a multi-tiered system of continuing education partners. Through this partnership, potential program participants can access adult basic education vocational English as a second language classes. These classes are offered to applicants if they do not meet the requirements for enrollment on their first attempt. GCA also collaborates with local partners to address the shortage of long-term care workers and devise solutions to systemic problems. Among the organizations that GCA has worked with are the San Diego Workforce Partnership, the San Diego/Imperial Counties Labor Council, the California Wellness Foundation, and the United Domestic Workers Union. **Recruitment.** Employers in the area are permitted to come onsite and recruit trainees. They make presentations to trainees in the weeks prior to graduation, highlighting their wages, benefits, and staffing needs. Onsite recruitment has enhanced placement ratios because it allowing trainees to make contact with providers who may be able to offer them employment upon graduation. **Resources.** GCA has a store onsite that sells items that trainees need. All items are at or below market prices. To support program participants after graduation, GCA offers job placement assistance and access to a computer lab to all program alumni. GCA also offers onsite continuing education unit (CEU) classes and CPR certification classes, both of which are required to maintain certification.
Results, Outcomes, Evaluation	Since 1996, the Academy has trained 647 direct-care workers and currently trains a minimum of 100 additional direct-care workers each year. The Academy has an overall program completion rate of 85 percent and the average GPA of CNA program students is 87 percent. The most recent classes (2003-2005) maintained a 99 percent passing rate on the state certification exam. Graduates often recommend the certification training programs to coworkers, friends and families,

	resulting in an overflow of applicants for the each of the four CNA classes offered each year.
Lessons Learned	In September 2004 GCA closed its Golden Care Cooperative program, founded as a means to employ graduates of its Academy program. Rising workmen's compensation costs combined with increasing competition in the long-term care marketplace made it impossible for this program to thrive. GCWI's board of directors, together with the staff, decided to renew the focus on the Academy program. Their goal of closing the Golden Care Cooperative program was to reorganize and expand existing programs to train more people and add additional programs to better serve the community. Expansion plans are currently underway through the Academy program/training activities.
Costs and Funding	The cost of the Golden Hill Health Careers Academy's CNA certification program is $2,800 per participant. The cost of the certified home health aide conversion program is $250 per participant An endowment covers approximately one fifth of GCA's operating costs. The San Diego Community College District covers the cost of instructor salaries ($50,000 per year) and 10 percent of direct overhead costs. Remaining expenses are covered with a blend of private and public sources including foundation funding, donations and fundraising activities.
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Home Care Associates: The 4Ps

Description	The 4Ps curriculum is used to teach problem solving and communication skills to direct-care workers.
Sponsoring Organization	Home Care Associates (HCA) of Philadelphia
Setting	Home Care Associates (HCA) of Philadelphia, a home care agency founded in 1993. In July 2002, the agency employed approximately 125 home health aides and personal care assistants, many of whom were former welfare recipients. HCA is a member of the Cooperative Healthcare Network, a group of paraprofessional staffing agencies and training programs affiliated with the Paraprofessional Healthcare Institute.
Target Group	Home health aides and personal care assistants
Start Date	1997
Objectives	To increase problem-solving capabilities, especially for home care workers assisting clients in the field, where supervision is not immediately available; To help workers develop self-awareness; To create a framework and language for providing feedback to direct-care workers
Key Components	HCA's in-house, 4-week entry-level training program lasts approximately 130 hours. More than 15 of those hours are devoted to the 4Ps curriculum. The 4Ps is also taught as part of orientation to any home health aides and certified nursing assistants who have received training prior to their employment at HCA. *Defining the 4Ps.* The 4Ps curriculum breaks down the problem-solving process into these four steps: *Paraphrase*: Listening actively and asking questions to ensure full understanding of a problem *Pull back*: Gaining emotional control in a stressful situation *Present options*: Identifying critical facts, brainstorming solutions, considering consequences, and presenting options to a client or supervisor *Pass it on*: Passing on important information to a supervisor or to others involved in a situation, either verbally or in writing *Teaching the 4Ps.* Following a general introduction to the concept, each step is taught in a three-hour session. The instructors use a variety of activities, especially role-plays, to develop and practice each specific skill and to build overall confidence and competence. Before the last step is taught, an additional three-hour session is devoted to a summary of the first three steps. During

	this session, trainees, who as part of their training have visited a home care client with a peer mentor, discuss their observations of their mentors' clinical and problem-solving skills. HCA staff identified several critical components to a successful program: *Adult-learning techniques.* These techniques are built on the assumption that trainees learn in different ways (visual, audio, experiential) and that most have had limited or negative experiences with formal schooling. In lieu of a textbook, training incorporates role-plays, case studies, small group discussions, hands-on training, and interactive lectures. To teach the 'Pull Back' step, for example, the instructor introduces a role-play with a surprise element that forces trainees to practice pulling back and assessing a situation. During the first 30 minutes of the 'Pass It On' session, participants discuss agency policies, examining what does and does not need to be passed on. In addition, trainees practice documentation skills by using time sheets and other agency forms. *Seasoned instructors.* Instructors are selected because they are skilled at adult learner-centered teaching techniques and have demonstrated natural teaching ability. They are also fluent and comfortable with all sections of the 4Ps curriculum. For example, one of the current 4P instructors is a former senior aide and peer mentor with eight years of experience at HCA. Others were recruited without health care experience because of their experience in adult learner-centered methods and began teaching the 4Ps after teaching other components of the curriculum. *Peer mentors in the classroom.* Senior direct-care workers help teach the curriculum and offer examples from their experiences for role-plays. *Constant reinforcement of the language and concepts.* This reinforcement continues throughout the training, not just in the section devoted to teaching the 4Ps curriculum. Also, the language and concepts are reinforced by other staff throughout the agency. If an employee runs into difficulties with a client, for example, her supervisor might ask, 'Did you pull back? What options did you present?'
Results, Outcomes, Evaluation	This practice has not been formally evaluated. However, staff who were at the agency before 1997 have noted fewer phone calls from the field regarding problems and a decrease in the number of call-outs and no-shows since the problem-solving curriculum was introduced. The culture of the agency has also changed, they say. Staff are more apt to help each other solve problems, and they use language and behaviors learned in the 4Ps curriculum. Workers are also more inclined to take responsibility for their actions, rather than blaming others or attributing problems to external causes (for example, blaming public transportation for an inability to get to cases on time).
Lessons Learned	In order to be fully effective, HCA staff emphasize that the 4Ps must be integrated not just into training but also into everyday interactions between agency staff. HCA staff also believe it is vital that home health aides provide the 'real-life' situations for role-plays and act as models and mentors for trainees. HCA found that the curriculum is most effective when taught by someone familiar with the overall training program and the trainees rather than a guest instructor. It was also important to find trainers who could work through each step with conviction, although some steps might initially feel contrived.

	Initially, after each training session, instructors talked over the curriculum with trainees. That feedback, they say, helped them amend the curriculum to improve future training sessions. Because accurate self-assessment is an important part of learning the 4Ps, trainers find it important to set ground rules such as respecting confidentiality and other people's opinions at an early stage of the training (generally on the first day). This makes it easier for trainees to share their thoughts and feelings.
Costs and Funding	The curriculum is included in Home Care Associates' training. The annual budget for training is $871,000 a year, or about $4,300 per trainee. Foundation support and Temporary Assistance to Needy Families (TANF) reauthorization funds cover some training costs.
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Other Resources	Paraprofessional Healthcare Institute. 2002. *Relational Skills Curriculum: Teaching problem solving and communication skills.* Bronx, NY: Paraprofessional Healthcare Institute. This curriculum is made available with PHI consulting services. Please contact the number above for more information.

Linking Employment, Abilities, and Potential (LEAP) of Cuyahoga County: Personal care attendant and state tested nurse aide training

Description	A program that trains people with disabilities to become personal care attendants (PCAs), home health aides, and state tested nurse aides (STNAs), Ohio's term for certified nursing assistants. The program assesses trainees' abilities and matches them with community needs.
Sponsoring Organization	Linking Employment, Abilities, and Potential (LEAP) of Cuyahoga County [Ohio] is a not-for-profit organization whose goal is to improve and expand independent living and employment options for people with disabilities. The personal care attendant and STNA training is one of the agency's programs.
Setting	LEAP's training programs operate out of a satellite office in an accessible apartment complex for people with physical disabilities in Cleveland, Ohio (Cuyahoga County).
Target Group	People with disabilities. Initially the program targeted only those with mental retardation (both high- and low-functioning), but it quickly expanded to include others, including those with learning disabilities, depression and other forms of mental illness, all levels of hearing loss, and/or vision impairments. Many trainees have dual diagnoses (e.g., a learning disability and clinically diagnosed depression).
Start Date	Teaching/placement staff were hired in 1989 after a year of planning. The first personal care attendant class was held in January 1990. The first class for STNA training was held in July 2002.
Objectives	To address the lack of trained, reliable, caring, and available direct-care workers and expand employment opportunities for people with disabilities.
Key Components	LEAP has two training programs: a basic personal care attendant and home health aide training program, and an advanced STNA license program that leads to state licensure. Each program is held five times a year and consists of three steps: screening, training, and placement. *Basic Attendant Training.* This four-week, 100-hour course uses hands-on and classroom experiences to train students as personal care attendants or home health aides. Screening. The attendant must demonstrate the ability to work in one-on-one situations and be safe to him or herself and others. In addition, candidates must be responsible, reliable, and able to follow directions. Each attendant is tested for these skills; for example, a candidate might be given directions to be at a specific address by a specific time. Each candidate must also provide proof of a negative TB test and pass a criminal background check. Training. Training is tailored to accommodate each trainee's disability. Trainees identify issues that might affect their employment and develop means to accommodate or overcome them. The four-

	week course covers such topics as universal precautions and other safety issues; bathing, bowel and bladder care; disease and disability processes; transfer techniques and body mechanics; positioning and range of motion; bed making; housekeeping; documentation; temperature, pressure, and respiration; and CPR and first aid. LEAP also offers classes in communication, stress management skills, and abuse prevention. After basic caregiving skills and safety issues have been covered, 'consumer consultants' provide hands-on training experience. Consumer consultants are residents of the apartment building where the training is held who have used personal assistance for years and are used to giving direction. They help trainees learn skills that would typically be performed during a morning routine, such as bathing, showering, dressing, transfers, meal preparation, and feeding. LEAP pays consumer consultants for their work. Placement and follow-up. LEAP instructors work closely with their graduates to identify strengths, abilities, preferences, and accommodations needed to make their employment successful. Graduates may work either full-time or part-time for community-based home health agencies, private-pay clients, or group homes. Once a student is placed in a job, LEAP conducts 90 days of intense follow-up to make sure they feel properly trained and ready to handle the job. This may include field visits by the case manger, office visits, or assigned supervision. In addition, trainees may request a hands-on demonstration about any procedure that may be unclear. After the first 90 days, follow-up is provided by phone for a year. LEAP also helps trainees find social supports and referrals, such as affordable childcare or transportation, as needed, for as long as the attendant or employer requests such services. *State Tested Nurses Aide (STNA) License Program.* This 4-week, 85-hour advanced employment skills program is available only to people who have completed the basic attendant training program. At the end of this program, participants are prepared to sit for Ohio's State Tested Nurse Aide licensing exam. Screening. The prerequisites for this program are that each attendant must be able to read and write English and lift, push, and pull 100 pounds twice within a six-hour period. In addition, candidates must have no felonies on their record, and they must have had a negative TB test within the last six months. Training. The training curriculum covers 10 hours more than the state-mandated minimum. As required by the state, it includes basic nurse aide skills, basic restorative skills, residents' rights and psychosocial issues, care of the confused or withdrawn, and 16 hours of clinical training, which is completed at a local nursing home. Also covered are communication and interpersonal skills, infection control, signs and symptoms of common diseases, care of the dying, sexuality in aging, caring for special needs populations, and rest and relaxation. Instructors also help trainees prepare for the state-licensing test. Placement. LEAP instructors help trainees find jobs after graduation, taking into account each trainee's interests, skills, and abilities. Placement options include working in long-term care facilities, home health agencies, or hospitals.
Results, Outcomes, Evaluation	LEAP has trained approximately 25 to 40 direct-care workers a year. Of its graduates, 80 to 85 percent are placed in direct-care jobs, where their retention rate is 90 percent after 90 days.

Lessons Learned	This program shows that people with disabilities can work as personal care attendants, home health aides, and nursing assistants. Program managers believe the key to the program's success is the hands-on training component. Also important are the emphasis on communication and interpersonal skills; the help given workers in accessing childcare, transportation, and other needed supports; and the follow-up support offered to both trainees and employers. It is difficult for most home health agencies and nursing facilities to use this model because most do not have the time or the expertise (vocational rehabilitation, independent living) to help trainees develop needed life skills.
Costs and Funding	The cost of this program is approximately $6,000 per trainee. The Rehabilitation Services Commission (RSC) and the Cleveland Foundation funded the start-up. LEAP has a fee-for-service arrangement with RSC, the Veterans Administration, and the Cuyahoga County Board of Mental Retardation and Developmental Disabilities.
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Martin Luther King Economic Development Corporation: Maximizing Opportunity in a Restructuring Economy (MORE)

Description	This program provides assessment and job-readiness services to identify low-income individuals who are interested in becoming certified nursing assistants (CNAs).
Sponsoring Organization	The MORE Project is sponsored by the Martin Luther King Economic Development Corporation, which works to improve the job prospects of low-income residents of Harambee, a neighborhood located in northeastern Milwaukee. The Martin Luther King Economic Development Corporation promotes all of its programs–including the MORE Project–by working with a wide range of organizations within Harambee, including churches, block associations, tenants groups, and other non-profit organizations.
Setting	The assessment and initial job-readiness training occurs in the headquarters of the Martin Luther King Economic Development Corporation. Qualified individuals are placed in nursing assistant training programs in area facilities.
Target Group	Unemployed and low-income residents of the Harambee neighborhood and surrounding communities.
Start Date	1996
Objectives	The MORE Project was created to help low-income individuals - especially those transitioning from public assistance - obtain CNA positions.
Key Components	*Assessment.* The program begins with an in-depth interview, in which applicants are asked about their employment history, family composition, education, health, alcohol or drug abuse, housing, and prior criminal convictions. While these subjects are often difficult for people to discuss, staff emphasize the importance of truthful answers, which enable staff to refer those with severe employment barriers to social service agencies. After these interviews, suitable participants attend a group orientation, where MORE project staff evaluated their ability to interact with others. *Initial Job-Readiness Training.* Selected participants attend a two-week job-readiness training program. This begins with a goal-setting exercise in which participants identify their aspirations and celebrate their achievements, especially those that involved overcoming hardships or adversities. The training then introduces conflict-resolution and team-building techniques, which provide a framework for conquering challenges encountered during employment as CNAs. Next, the curriculum teaches job-search skills. Participants learn basic interview techniques, conduct mock interviews with each other, and prepare resumes and references. Volunteers call references so participants can learn if they supply negative comments, in which case they select someone else. *Referrals to Employer-Based Training Programs.* The program ends with a referral to an employer-

	based nursing assistant training program, usually one administered by a Milwaukee affiliate of the Mount Carmel or Covenant systems.
Results, Outcomes, Evaluation	Each year, the program serves approximately 100 low-income individuals, of whom 66 are employed as CNAs.
Lessons Learned	The MORE project quickly learned the importance of being responsive to the needs of health care employers, who need help in assessing candidates for CNA training and teaching job-readiness skills. To learn more about what local employers needed and to raise their awareness of its services, the program joined the Wisconsin Workforce Coalition, a subsidiary of the Wisconsin Hospital Association, and developed a strong relationship with the Wisconsin Association of Homes and Services for the Aging. After interviewing CNA supervisors within the Mount Carmel and Covenant Health Systems, MORE staff learned that graduates rarely lose their jobs because of their clinical skills, but many leave because of an inability to work with their supervisors. This illustrates a gap between the supportive nature of the project's assessment and job-readiness services and the more task-oriented approach of supervisors in long-term care facilities.
Costs and Funding	The program costs $50,000 in the form of staff salaries. The primary funding source is a Community Development Block Grant administered by the City of Milwaukee.
Contact Information	Betty Speed The MORE Project Director 2745 North Dr. Martin Luther King Jr. Drive Milwaukee, WI 53212 t: (414) 264-5000 e: bettys@mlkedc.com
Other Resources	Wallace, Amy, Kimberly Tarr, and Cindy Marano. February 2002. Putting the pieces together: Connecting industries, workers and communities to strengthen traditionally low-wage sectors. National Network of Sectoral Partners.

Mennonite Manor: Manor Care Attendant (MCA) program

Description	The MCA program is a recruitment and retention effort developed to hire people ages 16 and older in the community with no prior training in health care and to expose them to working in long-term care. Using a process of extended support and training, Mennonite Manor works to 'grow its own staff' through this program.
Sponsoring Organization	Mennonite Manor, a freestanding nonprofit provider of independent living, home care, and skilled nursing in rural South Hutchinson, Kansas.
Setting	Mennonite Manor skilled nursing facility
Target Group	People with no prior training in long-term care and an interest in becoming certified nursing assistants (CNAs)
Start Date	January 2001
Objectives	To reduce the use of agency workers; To develop a paid position for people not previously trained in long-term care; To provide more time and support to CNAs in training.
Key Components	*Hiring.* MCAs go through Mennonite Manor's standard hiring process. In addition, either a unit manager nurse or the director of nursing interviews applicants briefly. All applicants also undergo drug testing and background and reference checks. *Orientation.* MCAs attend two sessions: *MCA I orientation.* On their first day, they receive four hours of general orientation, which is led by the education coordinator. They are given handouts and a tour of Mennonite Manor, and they review the MCA orientation book and various forms they will use on the job. *MCA II orientation.* The second, more detailed orientation period acquaints MCAs with products used at Mennonite Manor, teaches them how to fill out sample forms, and covers communication and policies and procedures. MCAs who will work in the special care unit watch videotapes on Alzheimer's care, and all MCAs are assigned to a CNA team. *Supervised Work.* CNAs mentor the MCAs on their team as they learn duties such as making beds, transporting and visiting residents, emptying and cleaning commodes and urinals, filling water glasses and pitchers, assisting with mechanical lifts, and charting food intake. MCAs earn $5.80 an hour. *CNA Training.* MCAs who demonstrate a commitment and ability to progress, as determined by their CNA team members and nurse supervisors, are given the title of nurse assistant-in-training (NAT I) and receive payment upfront for the cost of CNA training which includes tuition,

	books, CPR training, and the cost of the state certification exam. The training is sponsored by the local junior college and may be provided either by Mennonite Manor or by another facility, depending on the employee's schedule and preference. The NAT I continues to perform MCA duties and does not receive a pay increase. After 40 hours of CNA class, the MCA becomes a nursing assistant-in-training II (NAT II). Under the supervision of a nurse or CNA, the NAT II learns to perform CNA tasks, including taking vital signs and charting various activities. NAT IIs also answer written questions to review what they are learning. State regulations allow the NAT II to provide the same direct care as the CNA within four months of the date of CNA training. The pay of those who achieve NAT II status is increased to $7.45 an hour. After completing the training and becoming certified as a CNA, workers earn another raise, to $7.80 an hour.
Results, Outcomes, Evaluation	The cost of agency workers for Mennonite Manor was $108,000 in 1999 and $168,000 in 2000. From January to August 2001 (the year the MCA program was implemented), Mennonite Manor paid almost $103,000 in agency-related expenses, but by September 1, Mennonite had eliminated its agency spending. No formal evaluation of the MCA program has been conducted. However, approximately two-thirds (29) of the 43 people who joined Mennonite as MCAs in 2001 were still at the facility at the end of the year. By comparison, during the same time period less than half (11) of the 25 CNAs hired by the facility who did not go through the MCA training were still there on December 31. The following year (between January and September 2002) the retention rates of MCAs who became CNAs and those who did not go through the MCA program were almost equal: 78 percent for new MCAs (4 were asked to leave due to poor performance; 14 remained), and 79 percent among new CNAs (3 voluntarily resigned; 11 remained). The increased retention rate among CNAs who did not go through MCA training can be attributed to Mennonite Manor's ability to be more selective in hiring already trained CNAs. Applications were rejected from 88 CNA applicants with poor references, falsified application material, or who did poorly in their interviews.
Lessons Learned	According to Mennonite management, CNAs perceive MCAs differently than newly hired CNAs. They are more willing to teach them, rather than expecting them to know how to do things already, and they take pride in helping them. Management also finds MCAs less defensive than newly hired CNAs when given instruction, and more willing to work as part of a team and to follow staff requests and facility procedures. Because their orientation to the facility, residents, and staff is completed before they start CNA training, MCAs are better able than those with no exposure to long-term care to understand the importance of material presented in class. Teachers say test scores are generally higher for the MCAs than for CNAs who do not go through the MCA program.

	CNAs who started as MCAs appreciated that the program allowed them to become oriented to the facility, residents, and staff before taking total responsibility for resident care. By the time that happened, they said, they were comfortable about knowing who to go to for help, which helped relieve their stress. Initially, Mennonite Manor recruited only students for the MCA program, but the facility found that people at many different stages of their lives made good candidates. Mennonite has now recruited young mothers, people with grown children, retirees, and people who did not have the resources to pay for CNA training, or were reluctant to spend the money without knowing whether they would like the work.
Costs and Funding	The cost of the CNA training class is $222.35 per person, including tuition, books, CPR training and the fee for the state exam. The facility paid for the training of 40 MCAs in 2001 and 14 in 2002. Mennonite Manor budgets 85 hours of MCA time every two weeks; these hours are usually divided between three or four part-time workers. The CNA staff has not been reduced as a result of the hours budgeted for MCA time. Rather, a cost saving is achieved because there is a full staff. The time that MCAs spend performing certain tasks frees up time for CNAs to attend to other duties. As a result, cost savings have accrued from less overtime, fewer bonuses, and the reduced number of call-outs.
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OHI: Comprehensive retention program for direct support professionals

Description	OHI provides extensive orientation and training, employee recognition, continuing education and certification opportunities, and an employee assistance program for all direct support professionals. In addition, the agency has implemented a program of regular feedback and merit-based raises for its mental health division, which it plans to make permanent and agency-wide.
Sponsoring Organization	OHI is a nonprofit private agency with 325 employees located in Hermon, ME. It provides supportive services and housing to over 200 people with mental retardation, developmental disabilities, or mental health needs who are living in the community.
Setting	OHI's 63 community homes and day treatment programs in 24 Maine communities
Target Group	Direct support professionals working with people with mental retardation, developmental disabilities, or mental health needs
Start Date	Development began with the inception of the Mental Health Quality Improvement Team in 1996. The employee recognition program was started in February 1998. The merit-based wage increase demonstration project was initiated in 2001.
Objectives	Maintain a high level of employee morale; Provide responsive service to disabled individuals within the framework of self-determination; Continuously assess and improve employee-related practices; Ensure that direct support professional have input into the lives of the people they support, their work, and the overall functioning of the agency
Key Components	*Orientation and Training.* New hires attend a paid, two-week intensive training and orientation session before beginning work. The program is grounded in the Direct Support Professionals Code of Ethics. Topics covered include sexuality awareness, understanding and dealing with difficult behavior, improving communication, and mentor shadowing, in which a new employee is paired with an experienced and exemplary aide for the first two weeks on the job. Trainers use adult learning techniques such as role-plays, scenarios, and interactive discussions. Each employee develops a professional plan that sets goals for the next six months, year, and two years. Plans are included in both the human resource department's employee files and employee-managed portfolios. *Evaluation and Merit-Based Wage Increases.* This demonstration program, which was implemented in the mental health division, requires employees to maintain a portfolio of certificates, achievements, resumes, and other information pertinent to their work. Each employee meets monthly with his/her supervisor for a supervisory session called a fireside chat, where they discuss the portfolio and any work-related problems that may have arisen. In addition, employees participate in yearly 360-degree feedback groups where colleagues give each other feedback on their work. Every worker earns a yearly salary increase of 2 to 7 percent. The amount is based on

	evaluations made in fireside chats and feedback groups, attendance and discipline records, and supervisory input. *Continuing Education.* OHI often pays for continuing education and gives employees paid time off to attend classes. A division of professional development, which handles training and certification, offers 40 to 80 hours of annual training to all employees, not including orientation. *Employee Recognition.* OHI recognizes an employee of the month, team of the quarter, and employee of the year. All may be nominated by a consumer, worker, supervisor, or a family member and are chosen by a majority vote of the quality improvement team. Recipients receive a plaque or certificate and a letter from the CEO, and their names are added to a 'Perpetual Plaque' in the main office. Employees receive 'atta-boy letters,' informal acknowledgments of exemplary accomplishments, when applicable. OHI also uses employee recognition boards, sends each employee a birthday card every year, and holds an annual employee recognition dinner. *Benefits.* OHI offers medical, dental, retirement, life and long-term care insurance to each worker, with small employee contributions based on hours worked. Its employee assistance program is staffed full time. The program offers counseling services, information about and referrals for additional therapy, and connections to practical supports such as food stamps, childcare, and transportation.
Results, Outcomes, Evaluation	According to management, OHI has a low turnover rate and receives a constant stream of applicants through word of mouth, making newspaper advertising unnecessary. Exit interviews conducted with each staff member who leaves OHI show that the main reasons for leaving are moving out of town or going to school full-time.
Lessons Learned	The quality improvement team played a key role in making many of OHI's initiatives work, ensuring that they were implemented consistently and supported the agency's mission and values.
Costs and Funding	OHI primarily relies on Medicaid for funding. The organization also generates income by inviting outside agencies to participate in its training programs for a fee.
Contact Information	Bonnie Jean Brooks, CEO Sue Phillip, Director of Quality Improvement Deb Smith, Director of Training and Professional Development 25 Freedom Parkway Hermon, ME 04401 t: (207) 848-5804 Website: www.ohimaine.org

The Care Advantage Nurse Aide Academy: Certified nursing assistant training program

Description	The Academy was founded by an alliance between a health care agency, a local housing authority, and a YMCA to train public housing residents as certified nursing assistants (CNAs).
Sponsoring Organization	The Richmond Redevelopment and Housing Authority (RRHA), in partnership with Care Advantage Healthcare Agency and the YMCA of Greater Richmond, in Virginia.
Setting	YMCA and public housing in Richmond, Virginia.
Target Group	Public housing residents interested in working as CNAs who are transitioning from welfare to work or are unemployed or underemployed.
Start Date	The first class was held in August 2001.
Objectives	To address the chronic shortage of nurse aides and to help public housing residents achieve self-sufficiency and economic independence.
Key Components	The initial curriculum, which was developed by a registered nurse consultant, was amended by the instructor, a former director of nursing in a nursing home, who diluted the focus on clinical skills to devote more time to such topics as preventing neglect and abuse and acting compassionately. The downtown YMCA donated space to house the program. *Building relationships with sponsors and potential employers.* The program coordinator finds nursing homes and medical center staff willing to sponsor the program by giving trainees a place to do their clinical training. In addition, in response to specific requests, the agency recruits trainees for two nursing homes. These recruits receive their training at the facility where they will work upon graduation. *Enrolling students.* All RRHA residents are asked if they are interested in the program. Everyone who expresses interest is invited to enroll and told how to get a drug test, background check, and TB test. Those who pass the tests attend a weeklong professional development program designed by the housing authority. The coordinator places the students who complete this phase in an appropriate training program, either at Care Advantage Academy or at one of the two nursing homes. *Training and placement.* The training program lasts six weeks. For the first three weeks, students attend class six hours a day for four days a week. The next two weeks are spent in clinical training, which lasts eight hours a day, four days a week. This is considerably more clinical training than the minimum state requirement of 40 hours. During the last week, students take their final exam, evaluate the instructor and the program, and meet with recruiters from participating facilities. Students also tour facilities that are offering employment. *Boosting retention rates.* To encourage CNAs to stay on the job, the housing authority developed two programs: the RRHA Family Self-Sufficiency Program and the HOPE VI Self-Sufficiency

	Training Program. Both provide incentives for residents to work by escrowing rent or excluding income from rent calculation while residents establish careers. These programs span from three to five years, allowing participants ample time to achieve self-sufficiency.
Results, Outcomes, Evaluation	Of the 85 people who initially expressed interest in the CNA training program, 40 came to the initial general session and 30 completed the tests required for acceptance in the program. Of those, 25 attended the professional development session and were signed up for training. As of spring 2002, the program had graduated 60 CNAs, 51 of whom were working in the medical or long-term care field. A spring 2002 waiting list of 85 applicants suggests that there is considerable interest in the program.
Lessons Learned	Motivating residents to take advantage of the program has been a challenge. So has operating without a full-time coordinator or employees, since everyone who works for the program also works full-time with the RRHA.
Costs and Funding	The project's main funding sources are the Richmond Redevelopment Housing Authority and Care Advantage. The budget for a 10-student class is $6,750, broken down as follows: transportation, $600 ($100/week); uniforms, $1,000; TB tests, $70; drug tests, $280; background checks, $150; textbooks, $350; instructor, $3,500; certification exam, $800.
Contact Information	Joan Seldon Program Manager and Coordinator, HOPE VI Richmond Redevelopment Housing Authority, c/o RRHA University 210 Hospital Street Richmond, VA 23220 t: (804) 780-8805 Website: www.rrha.org
Other Resources	Seldon, Joan. 2002. *Hope for health care: An overview of the Care Advantage Nurse Aide Academy.* Richmond, VA: Richmond Redevelopment Housing Authority.

The Good Faith Fund: Careers in Health Care

Description	Careers in Health Care is an employment training and support initiative designed to help low-income adults access quality jobs and career advancement opportunities in the health care sector.
Sponsoring Organization	The program is sponsored by the Good Faith Fund in Pine Bluff, Arkansas. The Good Faith Fund is a non-profit affiliate of the Southern Development Bancorporation, whose mission is to increase the income and assets of low-income and low-skilled residents of the Delta in Arkansas and Mississippi. The Good Faith Fund offers a combination of workforce training and asset development for low-income clients, while also engaging in public policy activities.
Setting	The original program is in Pine Bluff, Arkansas, with replication sites in Stuttgart and Helena.
Target Group	Low-income people, many transitioning from welfare to work and/or without a high school diploma, and recent graduates of the training program who are working as home health aides and nursing assistants.
Start Date	November 1996
Objectives	Train high-quality, reliable nursing assistants for work in long- term facilities and home health care settings; Enhance the lives of low-income people, including those transitioning from welfare to work
Key Components	The program helps workers access training and needed supports. *Recruitment.* Because Careers in Health Care is well known in the community, most trainees are referred through word of mouth. The program also has a good relationship with the local Department of Human Services and the Department of Labor workforce centers. *Screening.* Each applicant must pass a background check and must show that they are at an eighth-grade educational level before they are admitted to the program. *Training.* The training program is 8 weeks long (260 hours), providing many more hours than the mandated federal minimum of 75. The first 140 hours are spent in the classroom; the curriculum integrates problem-solving, communication and employability skills with more standard health care content and clinical skill development. This is followed by 120 hours of clinical experience in local hospitals and nursing homes. *Support Services.* A Careers in Health Care counselor helps trainees arrange for subsidized child care, transportation, food stamps, Medicaid-sponsored health care insurance for their children, and other public benefits or community services as needed. Counselors maintain contact with the instructors, assist if an instructor becomes aware of a problem involving a trainee, provide emotional support, and refer trainees to additional counseling if necessary. They also connect

	alumnae to further opportunities for education and training and follow up with them on an ad hoc basis, helping if a problem arises. *Alumnae Association.* Alumnae meet monthly to share stories, provide peer support and feedback, network about job openings, and plan service projects. 'Step Up' awards are given at meetings to alumnae who make progress in their careers, such as securing a job, going from part time to full time, completing hospice training, or completing a licensed practical nursing degree. The alumnae association is also involved in political advocacy. *Advisory Council.* The advisory council meets bimonthly to seek jobs for program graduates, discuss plans for the training program, and promote communication between service providers. Members also discuss the progress of recently trained graduates in order to improve the training curriculum, solve problems, and provide feedback to the alumnae association.
Results, Outcomes, Evaluation	As of spring 2002, 90 percent of CHC's 400 graduates had been placed in direct-care jobs, with an overall retention rate of 49 percent from November 1996 through the end of 2001. In 2002, 133 students graduated; of these graduates, 103 (77.3%) were placed in jobs at an average wage of $7.48 an hour, and 88 were still employed after three months. Several graduates have taken steps to become licensed practical nurses or registered nurses. Twenty active alumnae attend the association meetings regularly.
Lessons Learned	The coordinators of the program stress the importance of a multifaceted approach to address the complexity of the workers' lives. Access to needed community supports and ongoing communication between program staff and the employers of program graduates is vital, as is follow-up with graduates of the training program through the alumnae association. They also caution against judging the success of a program solely by the number of workers graduated, as numbers do not reflect the quality of the training.
Costs and Funding	Good Faith Fund estimates its training cost to be approximately $5,000 per trainee, including staff time, materials, supplies, and building space. The Good Faith Fund and Careers in Health Care employ a fund development specialist to solicit private and public funding, in order to provide services to trainees at no cost.
Contact Information	Lyric Seymore Director - Careers in Health Care 2304 West 29th St. Pine Bluff, AR 71603 t: (870) 535-6233 e: Lseymour@goodfaithfund.org Website: www.goodfaithfund.org/index.html

Career Advancement and Peer Mentoring

Center for Nursing and Rehabilitation—Peer Mentoring Program

Description	The Center for Nursing and Rehabilitation (CNR) developed an eighteen-month program to train certified nursing assistants (CNAs) as "CNA Person Centered Care (PCC) Mentors." The PCC mentors have since gone on to orient and mentor new employees as well as share person-centered skills with other staff.
Sponsoring Organization	The Center for Nursing and Rehabilitation is a member of the Beth Abraham Family of Health Services, a voluntary, nonprofit organization delivering a range of continuing care services throughout New York City. These include adult day health care, long term home health care, short-term rehabilitation, and nursing home care.
Setting	Nursing aides were selected from the Penthouse Gardens, an 80-resident neighborhood focused on caring for residents with dementia, at the Center for Nursing & Rehabilitation. The Penthouse Gardens has been the site of workplace and environmental changes since 1999. Since the training has been implemented, aides have been deployed to other resident neighborhoods throughout the facility.
Target Group	A cadre of certified nursing assistants was selected from within the Penthouse Gardens suite of CNR.
Start Date	Training began in October 2003; the CNA Person-Centered Care Mentor job title was instituted in August 2005.
Objectives	The primary objectives of the program were 1) to train a core of CNAs in person-centered care, with a focus on dementia care; and 2) for that core of CNAs to mentor new employees and provide leadership on their floors with other CNAs.
Key Components	**Selection:** Of twenty applicants, thirteen CNAs were selected for an 18-month training to become mentors. To qualify for the position, nursing aides were required to have a high school diploma or equivalent, a current CNA certification, above average performance assessments, a minimum of two years of employment at CNR, and no history of disciplinary action within the past year. The selection process included a group interview and submission of writing samples. CNAs were also expected to understand and articulate the principles of "culture change." **Training:** The training content was divided into two components. One was a formal training conducted by a project manager and the Paraprofessional Healthcare Institute, which covered 1) increased knowledge and skill in caring for residents with dementia; 2) mentoring skills with newly-hired staff; and 3) leadership skills related to "culture change" activities throughout the organization. The second was an informal training conducted by the project manager in conjunction with CNR nurses and directors. This part of the training developed the aides' clinical skills and preparation for grief and bereavement.

	The role of the CNA person-centered care mentor: The PCC mentors assist in the hiring and orientation of new CNAs, serve as a resource for other staff, and provide leadership to select projects relating to person-centered care. Each new CNA is paired with a mentor for two to three weeks. The mentors teach routines, skills, time management, and also serve as a liaison between the nurse or neighborhood director and the new CNAs. While the mentors are not supervisors, they do assist in the identification and reporting of the skills performance of CNAs in their departments. PCC mentors participate in constructing care plans and in teaching bathing, nutrition, feeding, and communication skills. In particular, they have enhanced the process of bathing dementia residents. They also give a lead in developing person-centered changes, such as a welcoming committee, which was revitalized after the program was implemented, and changes to the decor of the bathrooms and resident rooms. The mentors have three days of regular assignments, and usually work two days a week as mentors. The PCC mentors are now dispersed in all neighborhoods and floors of the facility.
Results, Outcomes, Evaluation	Surveys taken in 2003 and 2005 (before and after the program's implementation) showed signs of improvement in staff satisfaction and turnover rates. During this time, while all nursing staff turnover decreased from 10.5% to 7.6%, the staff at the "Penthouse Gardens" site, where the program was implemented, decreased from 5.6% to 0%. Furthermore, all PCC mentors still work at the facility. Job satisfaction and commitment also increased. For instance, the 2005 survey found that 37% of staff felt they had an opportunity to participate in decision-making in their "neighborhood" based worksite, as opposed to 20% in 2003. 61% agreed or strongly agreed with the statement: "Being involved in decisions about my neighborhood and choices of uniform gives me a sense of pride and loyalty," up from 43% in 2003. Anecdotally, residents, families, and staff have all expressed increased satisfaction with environmental changes since the program's implementation. These include redesigned spas for bathing and a dining room that supports restaurant-style dining. Peer mentors also developed and implemented other projects—adding heat lamps in bathrooms, decorations in residents' living spaces, using shadow boxes, and creating welcome baskets—that were well received by residents and families. The most dramatic changes, according to the program participants, occured in relation to staff team building and communication. Mentors and administrators alike agree that the hierarchy of the nursing department broke down significantly as a result of the program. There is now a direct line of communication between CNAs and the administration as well as between PCC mentors and other staffing departments (building operations, dietary department, director of environmental services, etc.). Administrators find that the mentors consistently offer insight and useful suggestions about how care ought to be implemented, and they are able to react quickly and directly when there are problems or suggestions. The mentors also express an increased confidence in their own knowledge of dementia, feel invested in the process of developing person-centered care, and feel they are better at problem-solving and communicating with co-workers and residents. According to the Penthouse Gardens' neighborhood director: "The mentors feel empowered, feel

	they are making a difference. They ask to do more now that they are not stuck in a box. They speak well, they have knowledge, make suggestions, are intelligent... they are a plain asset."
Lessons Learned	Administrators and mentors discussed three main challenges in the program: 1) recruiting CNAs to submit applications for the program, 2) initial suspicion on the part of other CNAs to the new mentor roles, and 3) hitting a plateau in translating knowledge from mentors across to other CNAs. One of the main reasons cited by the mentors as to why they were initially hesitant to join the program was that they had seen many programs come and go and were not convinced that this was a serious initiative. Administrators felt they had to market the program and provide incentives in order to recruit CNAs to apply. Work needed to be done to clarify to other CNAs what the new mentor roles were. According to the mentors, some CNAs initially saw them as supervisors or even "spies." This initial suspicion broke down over time as mentors were able to share skills that other CNAs saw work in practice. Now staff regularly seek out mentors for help needed. Mentors overwhelmingly expressed a need for patience and periodic check-ins with each other in order to weather the difficulties in adjusting to their new roles. The challenge now is to translate the knowledge learned by the mentors to other CNAs. Mentors and administrators expressed a dynamic in which PCC mentors do more of the work than they are able to effectively share.
Costs and Funding	The program was developed out of a grant from the Department of Health that was to address educating staff on Dementia and improving the environments for residents with dementia. They spent $108,000 on staff replacement during the training period; $202,000 on consultant and trainers fees; and approximately $30,000 on program supplies, mentors' travels to seminars and conferences, and other staff development costs. The grant started on 1 July 2003 and ended on 31 October 2005. Any costs incurred after the life of the grant are CNR's responsibility. These include $1.50/hr raises for PCC mentors upon completion of the training and any new policies and systems implemented.
Contact Information	Joyce Lusan Director of Certification, Education, Research, and Training (CERT) CNR Health Care Network 520 Prospect Place Brooklyn, NY 11238 t: 718-636-1000, ext. 313 f: 718-789-9212 e: jlusan@cnrhealthcare.org Website: www.cnrhealthcare.org

Other Resources	
	Bathing without a battle: Creating a better bathing experience for persons with alzheimers disease and related disorders, Barrick, Ann Louise, Phil Sloane and Joanne Rader, 2003, University of North Carolina at Chapel Hill. *Peer Mentoring: A Workshop Series for Direct-Care Workers in Home and Residential Care*, Paraprofessional Healthcare Institute, April 2006. *Introducing Peer Mentoring in Long-Term Care Settings*, Paraprofessional Healthcare Institute, May 2003, Workforce Strategies, No. 2.

Cooperative Home Care Associates: Integrated model for recruitment, training, and retention

See page 5.

Green House Project

Description	The Green House project creates small, intentional communities for eight to ten elders who need assistance with their daily activities and the staff who assist them. Green Houses are intended to de-institutionalize long-term care by eliminating large nursing facilities and creating habilitative, social settings that provide elders with support in activities of daily living and clinical care that meets skilled nursing requirements without allowing that assistance and care to become the focus of their existence. Because the model recognizes how essential the relationship between direct-care workers and the elders they support is to achieving that goal, considerable attention is given in all aspects of the program's design to the training and support of direct-care workers.
Sponsoring Organization	The Green House project is sponsored by the Center for Growing and Becoming, a non- profit organization in New York that grew out of the Eden Alternative.
Setting	The first four Green Houses were implemented at Methodist Senior Services in Tupelo, Mississippi. As of late 2005, additional replications were underway in Arizona, Michigan, North Carolina, Ohio, Pennsylvania, New York, Kansas, and Nebraska.
Target Group	Elderly, frail, and disabled people with a high level of need, and the certified direct-care staff, known as Shahbazim (the plural of Shahbaz), who support them.
Start Date	The Methodist Senior Services Green Houses in Tupelo opened in 2003.
Objectives	The goal of the Green House project is to create living environments for the elderly, frail, and disabled that are rich in meaning, vitality, and joy. The focus is on autonomy, dignity, choice, and keeping the locus of decision making as close to the elder as possible. In order to keep the decision-making close to residents, the project includes a strong emphasis on direct-care worker supports, training, and empowerment.
Key Components	**Overview of the Program** Each Green House is designed to be a home for eight to ten elders who require a skilled nursing level of care. Each elder has a private living space with a private bathroom. There is a central hearth or living room with an adjacent open kitchen and dining area. All meals are cooked by the Shahbazim in the Green House and are eaten at one long dining table that acts as a focal point for a 'convivium', or communal meal. The Center for Knowing and Becoming requires each Green House to adhere to a set of standards. In addition, a sponsoring health care organization must supply administrative, fiscal and 'back office' services, and each Green House must maintain specified clinical and team staffing requirements. One licensed nurse is available to provide skilled nursing care for two to three houses, depending on the clinical needs of the elders. Clinical staff specializing in speech therapy, recreation, diet,

occupational, and physical therapy also visit as required by the care plan. There is no nursing station. Nurses visit the houses frequently throughout each day taking notes via a wireless handheld device or laptop computer.

The Role of Direct-Care Workers

The majority of the care is provided by two Shahbazim on the day and evening shifts and one assigned to night duty. Only the Shahbazim and the elders have direct entry access to the house. All others must ring the bell to request entry.

Shahbazim receive 120 hours of training. The first 40 are administered by Green House staff and include information about the Green House philosophy and the role of the Shahbaz, empowerment, teamwork, Green House policies and procedures, and dementia care techniques. The other 80 are administered by contracted facilitators who teach classes on first aid, CPR, culinary skills, food safety, and home repairs.

Shabahzim who are not certified nursing assistants (CNAs) upon hire must undergo training and become state certified. Program administrators are developing a continuing education module for Shahbazim, which is expected to be available online in the spring of 2006.

Although they are CNAs, Shahbazim do more than traditional CNA duties. In addition to clinical tasks and assisting residents with activities of daily living, they are responsible for cooking, recreational activities, laundry, and light housekeeping.

Each replication site sets its own pay scale. When the Tupelo site opened, the Shahbazim earned a starting salary of $11 an hour, $4 more than CNAs who continued to work in Methodist Senior Services' traditional nursing home units.

Shahbazim do not report to nursing staff. Instead, they form self-managed work teams to operate each house. Each team has five rotating coordinator positions that are held by a Shahbaz: team coordinator, housekeeping coordinator, scheduling coordinator, food coordinator, and care coordinator.

Shahbazim are supervised by a guide who works as a liaison between Shahbaz and other staff. In addition a house sage, who is an individual from the community, volunteers to visit the house regularly to provide guidance and support to elders and staff.

In case of an emergency, all Shahbazim are equipped with two-way radios, with which they can contact the nurse on duty and other emergency medical response professionals.

The Green House Project does not have defined protocols on how to recruit and retain workers. They allow each facility to determine their own criteria. It does, however, suggest that when converting an existing facility, administrators should allow CNAs to decide whether the new role would be right for them and apply for the job on a voluntary basis.

The Shahbazim who work in Tupelo, Mississippi wrote a code of ethics, which Shahbazim at other replication sites are encouraged to rewrite.

Results, Outcomes, Evaluation	A formal evaluation of the Green House project in Mississippi was conducted by Dr. Rosalie Kane of the University of Minnesota. A series of studies of residents, primary family caregivers, and Shahbazim as well as two control groups showed that Green House elders reported a better quality of life and greater satisfaction, and their family members were more satisfied with their relatives' care and with how they themselves were treated. There was less of a decline in the ability to do activities of daily living, a lower prevalence of depression, less incontinence without a toileting plan, and less use of anti-psychotic drugs without a diagnosis among residents of the Green House homes. Green House staff reported that they felt more empowered to assist residents, they knew residents better, and they experienced greater intrinsic and extrinsic job satisfaction. They were also more likely to say they planned to remain in their jobs. To view the complete results of the Tupelo, Mississippi Green House evaluation, click here.
Lessons Learned	Green House project designers have had to revise the training curriculum and staffing patterns to better fit the facilities that used the original model and critiqued it. In addition, they report that some experienced CNAs find it difficult to switch to the Shahbaz model, since the daily responsibilities of a Shahbaz are, at times, significantly different than those of a traditional CNA.
Costs and Funding	Project administrators have found that the general costs associated with running a Green House are similar to the costs incurred by a traditional nursing home facility. For example, in Tupelo, the Green House was able to operate at the Medicaid daily rate of $117 a day when it opened in 2003. While certain economies of scale are lost when operating a small residence, the Green House model is designed to shift resources away from institutional overhead towards supporting the direct care needs of residents. For example, many of the costs of conducting regular house maintenance and cooking are transferred to the daily operations of the direct-care worker. Funding for evaluation, replication costs and general administrative support have been provided by the Robert Wood Johnson Foundation, the Samuels Foundation, and the Commonwealth Fund.
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Ohio PATHS: In-depth skills training and certification for direct support professionals

Description	The Ohio PATHS (Professional Advancement through Training and Education in Human Services) program is an employer-directed professional skills training and certificate program for entry- and mid- level workers who provide direct support to people with developmental disabilities in the state of Ohio.
Sponsoring Organization	Ohio PATHS is an initiative of the Ohio Alliance for Direct Support Professionals, begun in collaboration with the Ohio Private Resource Association (OPRA) and the Human Services Research Institute (HSRI) as part of a six-year initiative to strengthen the human services direct support workforce. Project management, fiscal coordination, grant-writing and reporting are supported through OPRA. Technical, evaluation and educational expertise is provided by HSRI. Ongoing funding is provided by The Ohio Developmental Disabilities Council. Additional funding has been provided by The Ohio State Apprenticeship Council, the Ohio Department of Mental Retardation and Developmental Disabilities. Participating agencies have also used significant in kind and financial contributions.
Setting	The pilot was initiated by regional councils in Cincinnati, Cleveland and Toledo. To date, thirty-two agencies that provide residential, and community based services to people with disabilities, and two family advocates have participated in the program. To be eligible for the pilot program, agencies interested in the program must offer peer mentors and leave time to workers for training.
Target Group	Direct support professionals (DSPs) work independently in a variety of residential and community settings assisting people with development disabilities to lead self-directed lives. This program targets workers who are currently employed by agencies.
Start Date	Planning and development for the pilot project began in 2001. The Cleveland, Cincinnati, and Toledo regions launched pilots of the Certificate of Initial Proficiency (CIP) level in 2003. Expansion to a fourth pilot region is planned for January of 2005. The statewide PATHS Council is planning to test the Certificate of Advanced Proficiency (CAP) in 2005. It is intended that the voluntary credential will be established throughout Ohio by 2006.
Objectives	To create clear and desirable career paths both within the direct support profession and from direct support to other human services positions. To create a community of learning and practice that collaboratively designs and tests a framework for the development and certification of direct support staff using nationally validated skill, knowledge and ethical standards.
Key Components	*Key stakeholders* (consumers, employers, direct support staff, policy makers) on statewide and regional councils designed the framework and directed the operation of regional pilots. Program guidelines assure consistent implementation and coherence of vision across multiple locations. The educational plan requires that effective adult education methods be used. It includes an

	assessment plan through which local sites can compare their results with others across the state. *Planning* In planning the certification curriculum, the team used nationally validated skill, knowledge and ethical sets called community support skill standards that reinforce the care givers competency in key areas. They reflect the skills, knowledge and attitudes of an experienced worker who is recognized by peers and supervisors as skilled and competent. Competencies include: facilitation of services, participant empowerment, communication, assessment, community and service networking, community living skills and supports, education, training and self-development, advocacy, vocational, educational and career support, crisis intervention, organization participation, documentation. (For more information on these standards visit the: NADSP *Credential Framework* PATHS includes four levels of certification that are aligned with the U.S. Department of Labor's apprenticeship for the occupation of direct support specialist and include both on-the-job learning and classroom instruction: The Registration level is achieved upon submission of a complete application packet by employees in good standing after 320 hours of employment and 40 hours of classroom instruction. The Certificate of Initial Proficiency (CIP)- is earned by people who have completed the registration level, have an additional 1000 hours of work experience, have completed 60 hours of related instruction and are able to demonstrate mastery of CIP learner outcomes. The Certificate of Advanced Proficiency(CAP) can be earned by CIP awardees who have completed an additional 1680 of work experience, 110 hours of classroom instruction and can demonstrate mastery of CAP learner outcomes. As of January 2005 specialization levels are still at the design stage. *Operations* The Statewide Council oversees the project and approves candidates for credentialing. Regional Councils oversee local training. Individual agency employers pay their employees while they participate in the classroom training. Each candidate is supported by a skill mentor.
Results, Outcomes, Evaluation	During the first year of classes, thirty-one agencies participated. Among those agencies, forty-eight people graduated and received the Certificate of Initial Proficiency (CIP). Forty-three were grandfathered in and completed the Certificate of Advanced Proficiency (CAP). During the second year of classes there were fifty CIP graduates and twenty CAP graduates. *Professional development.* The project has had a positive effect on candidate's commitment to their work and their view of their work conditions. Significant transfer of learning is occurring, particularly in the areas of communication, interpersonal skills, documentation and empathy. Candidates report a growing sense of professionalism and pride in their work that is a result of taking perspective on their role and its skill set as it is taught in the PATHS program. In addition, all candidates have received one-time bonuses or wage increases, and many have been promoted. *Leadership.* Several candidates have become performance and thought leaders at work, teaching others who are not in the program how to improve practices and significantly transforming workplace practices.

	Quality. The vast majority of candidates are highly satisfied with the program, saying that the instructors are excellent, the material is highly relevant, and the methods have retained their interest. They report a sufficient level of challenge without being overwhelmed, resulting in high motivation to complete the course and continue to the next level. The PATHS initiative has received the 2004 Moving Mountains Best Practices Award from the National Alliance for Direct Support Professionals click here to visit the site.
Lessons Learned	Participating agencies must take an active role in the regional council or their commitment to the program diminishes and their employees do not fare as well in the training. Skills mentors require good training and the opportunity to connect on a regular basis Frequent contact between skills mentors and candidates used to assure favorable outcomes Self-directed learning did not work well Meeting others doing the same job was a very important feature to candidates
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San Francisco In-Home Supportive Services Public Authority: Improving the quality of direct-care workers' jobs

Description	The In-Home Supportive Services (IHSS) Public Authority of San Francisco is an agency through which consumers with disabilities hire independent providers. To help consumers find and keep qualified workers, IHSS has substantially improved the quality of the independent providers' jobs. IHSS serves as the employer of record. It administers pay and benefits, which are relatively generous, and provides supports including a central registry.
Sponsoring Organization	The IHSS Public Authority of San Francisco, which was created under the authorization of a bill passed by the California legislative in 1992. The IHSS governing board consists of three San Francisco Commissioners from Human Services, Aging, and Public Health; one member recommended by the Mayor's Disability Council; six current or past users of personal assistance services; and one home care worker.
Setting	IHSS employs 8,000 workers, who provide services to 9,689 consumers in the San Francisco County.
Target Group	Independent providers (the IHSS public authority's term for the personal assistance workers who deliver care and services to IHSS consumers)
Start Date	The ordinance to create the IHSS Public Authority was passed in May 1995. The executive director was hired and the office opened in July 1996. In May 1996, the workers voted to be represented by Service Employee International Union Local 250. The central registry began operation later that year. The City College training course began in 1998. The Healthy Workers healthcare insurance initiative was launched in March 1999, and dental benefits were added in January 2000.
Objectives	Help IHSS consumers find qualified help by creating and operating a central registry of screened workers Provide for or arrange training and supportive services for IHSS workers as well as consumers Become employer of record for independent providers, to ease administrative burdens for consumers and to give workers a base from which to access needed supports Provide formal leadership opportunities for consumer and workers in program and policy development Improve the quality and consistency of personal assistance services delivered to IHSS consumers.
Key Components	Five components of IHSS help create a stable and qualified workforce and ensure that consumers will be able to find the help they need:

	Payment to Friends and Relatives. IHSS allows consumers to hire family members (about half do) or friends (about 25 percent do) as caregivers. This significantly expands the pool of eligible workers. *Central Registry and On-Call Services.* The registry provides lists of screened workers. Those with at least two positive references for home care are identified as 'experienced.' To join the registry, workers must fill out job applications and be approved by an interviewer, who also obtains background information. The on-call program, which operates outside regular business hours, is a service for consumers who urgently need replacement workers on short notice. Consumers leave a message on a voice mail service. Staff members check regularly for messages and dispatch experienced providers from the public authority's pool of replacement workers. *Orientation and Training.* IHSS offers educational programs for workers. Before being listed in central registry, workers learn universal precautions regarding health hazards and are given a manual covering a range of topics from 'wheelchair safety' to 'effective communication' and 'caring for a friend or relative.' Workers are also encouraged to attend a free Home Care Worker Training course offered by City College of San Francisco, which consists of five five-hour sessions covering such topics as health and safety, lifting, special diets, nutrition, communication skills, and job readiness. In addition, IHSS educates consumers about the importance of the consumer-worker relationship. *Wages.* In March 1997, independent providers earned $5.29 an hour. Since that time, wages have increased significantly. By July 1, 2000, the minimum wage was $9.70. On-call employees (those who fill in as needed for workers who miss work unexpectedly) earn $15 an hour, with a two-hour minimum and a transportation subsidy of $5 per visit. *Benefits.* In 1999, the public authority instituted Healthy Workers, a health insurance plan for independent providers. A contract between the public authority and San Francisco Health Plan, a not-for-profit health plan offering affordable health coverage to lower-income San Franciscans, provides health care services through the county's network of providers. Benefits include doctor visits, hospitalization, pharmacy services, and vision care with few co-pays. Workers are qualified to participate if they have worked for at least two months in IHSS with a minimum of 25 hours in one of those two months. Workers pay $3 a month toward the cost of the premium, with IHSS covering the rest (approximately $150 per enrollee). In January 2000, IHSS added a dental benefit. This proved very popular but prohibitively costly, and was being reworked as of 2002.
Results, Outcomes, Evaluation	The IHSS public authority appears to be satisfying both consumers and workers within the consumer-directed model of care. The registry has proven popular among both groups. As of summer 2002, it had helped more than 1,700 consumers find assistants, and it helped more than 1,250 workers find employment as of December 2000. Raising wages and providing affordable healthcare for independent providers achieved the hoped-for effect of attracting more candidates, says Executive Director Donna Calame, who notes that 'it's kind of a no-brainer [that] more people are interested in doing the job as it improves.' IHSS also found that allowing consumers to hire friends or family members as caregivers greatly widens the pool of available workers. Meanwhile, of 364 randomly selected IHSS consumers surveyed in

	1998, more than 94 percent rated their services as either good or excellent. The main weaknesses identified related to the number of hours of service received.
Lessons Learned	The negotiations to improve wages and benefits for independent providers were lengthy and difficult. They could not have succeeded without a strong and continuing effort by all three constituencies on the IHSS public authority board (consumers, workers, and county board of supervisors), who agreed that improving pay and benefits was a key part of improving the quality of care within the IHSS program. The board's collaboration with the union was also crucial. Still needed, according to Calame, is a central meeting place where workers could drop by and get support, as independent providers are 'a scattered workforce that could use support.' In addition, she says, workers 'express wanting more training.' For example, 'Some of them, when they lose a consumer, would like ideas on [processing] grief.'
Costs and Funding	In fiscal year 2000, the cost of operating the public authority was over $6.5 million, of which approximately 90 percent covered wages and benefits for independent providers. The rest went to the registry; worker benefit management, education, and advocacy; program development; and general management costs. Funding for the San Francisco IHSS comes from federal, state, and local revenues. More than three-quarters of its consumers qualify for Medicaid's Personal Care Services program. All others are covered by a combination of state and local funds. During FY 2000, the state paid up to $6.25 an hour in wages, with a number of counties contributing the additional funding needed to increase wages to the then-current rate. For FY 2001, the state contributed an additional 60 cents an hour toward health benefits.
Contact Information	Luis Calderon, Program Manager IHSS Public Authority of San Francisco 939 Market Street, Suite 550 San Francisco, CA 94103 t: (415) 243-4477 Website: www.sfihsspa.org
Other Resources	Heinritz-Canterbury, Janet. 2002. Collaborating to improve In-Home Supportive Services: Stakeholder perspectives on implementing California's public authorities. Paraprofessional Healthcare Institute. San Francisco IHSS Public Authority. 1998. The first report: Activities from the first meeting of the In-Home Supportive Services public authority governing body in October 1995 through June 30, 1997. San Francisco IHSS Public Authority. San Francisco IHSS Public Authority. 2001. Report at five years: Activities and accomplishments through December 2000. San Francisco IHSS Public Authority

WIN A STEP UP: Improving job quality and increasing retention

Description	This project, whose name stands for Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance, works to increase job satisfaction and retention rates by giving nursing assistants financial incentives in exchange for completing training modules and staying with an employer for a specified period. Nursing homes are also paid incentives for their participation.
Sponsoring Organization	The project is a partnership between the North Carolina Department of Health and Human Services and the Institute on Aging of the University of North Carolina at Chapel Hill.
Setting	As of November 2003, the program was active in 38 North Carolina nursing homes. By July 2005, 80 nursing homes are expected to be involved. While several home care agencies and adult care homes were involved in the pilot, the program operates solely in nursing homes, largely because it is funded by civil monetary penalty (CMP) fines collected from nursing homes, which the state has earmarked for use in improving nursing home quality.
Target Group	At present, the program involves only nursing assistants in nursing homes.
Start Date	The pilot program began in March 1998 with a comprehensive study of the nursing assistant workforce in North Carolina. The pilot education and incentive program was implemented and evaluated by January 2002. Planning began that year on Phase Two, a rollout version developed from the pilot. In 2003 planning began on Phase Three, in which licensed nurses responsible for managing CNAs will receive help in becoming better supervisors.
Objectives	Upgrade nursing assistants' skills Increase nursing assistants' career commitment and job satisfaction Reward nursing assistants for their dedication and commitment to the job Increase retention rates for nursing assistants
Key Components	*Selection.* Any nursing home in North Carolina may choose to participate. Homes may participate as many times and for as long as they choose. Each home designs its own method of selecting nursing assistants and decides how many will participate, although they are encouraged to keep classes small (usually 10 members) and to select participants by drawing names from a lottery. *Educational Program.* This consists of 27 hours of education divided into 7 modules, which are supported by detailed participant and instructor training manuals and overheads for the trainer, all supplied free of charge by WIN A STEP UP. Instructor manuals include lesson plans, teaching strategies, and evaluation tools for each topic. Facilities may choose to provide their own qualified instructor. Those who cannot or who opt not to are provided an instructor free of charge. In

	addition, the program offers a course on the principles of adult education for facility-based instructors, since modules must be taught through a variety of methods including mental imagery, simulation and class discussion. Nursing assistants are evaluated for their participation based on attendance, participation and passing a 'closed book' written test with a minimum grade of 80. The modules cover a mix of clinical and interpersonal/communication skills: Infection control (1 session). Participants study an infection control vocabulary, complete a crossword puzzle, and conduct a confidential self-assessment of their infection control practices. Fecal impaction and hydration (1 session). This covers how to identify and prevent fecal impaction and poor hydration, including causes and risk factors for both. Pressure ulcers (1 session). This module reviews the causes, identification, risk factors, prevention and treatment of pressure ulcers, using clinical photographs, clinical practice sheets and a crossword puzzle to help memory. A more empathetic you (2 sessions). This fosters the development of empathetic skills to help nursing assistants better understand the feelings and fears experienced by most nursing home residents. It also covers beliefs and myths about aging. Teaching methods include mental imagery and role plays. Me, myself and I (1 session). The focus of this module is coping with challenges faced both on and off the job, including stress, self-image, conflict, and differing needs and values. Being part of a team (1 session). This module uses role play and class discussion in addition to lectures to convey the knowledge, skills, and effort required to create effective teams. Advanced communication (2 sessions). This addresses both verbal and non-verbal communication, including listening skills and sensitivity to cultural differences. It also explores ways of communicating with residents who face problems such as anxiety and depression. *Incentives.* Participating nursing assistants and facilities are given financial rewards. These include: Training session incentives. Nursing assistants receive $70 for each session they attend. Retention incentives. Nursing assistants who compete at least 70 percent of the sessions and stay at their facility for at least three months after completing the sessions receive a one-time bonus of $75 from WIN A STEP UP. In addition, they receive an incentive from the facility. The facility incentive may be a one-time bonus of at least $75, a wage increase of at least 25 cents an hour, or both. Facility incentives. WIN A STEP UP provides an incentive to the facility of $250 (to those who offer participants a bonus), $1,000 (to those that offer a pay raise), or $1,250 (to those that offer both). In addition, facilities are encouraged to provide graduation ceremonies and provide pins for graduates of the educational program.
Results,	*Pilot Phase Evaluation.* A formal evaluation of the pilot program was conducted by the University

Outcomes, Evaluation	of North Carolina's Institute of Aging. More than 80 percent of the participants reported that they applied the skills and ideas they learned in their daily work, and annual turnover rates were lower (15 percent) for nursing assistants who participated in the program than for those in matched comparison groups (32 percent.) In addition, 60 percent of the participants reported increases in job satisfaction, although that increase may have been due at least partly to other factors, since 44 percent of those in the comparison groups also reported increased satisfaction. *Phase Two Evaluation.* The University of North Carolina has received a research grant from the Better Jobs Better Care program to evaluate the program's performance.
Lessons Learned	According to program administrator Leigh-Anne Royster, WIN A STEP UP cannot succeed in facilities whose administrators don't understand the link between investing in a facility's nursing assistants and investing in its quality of care. The educational program should not be stretched over too much time or squeezed into too short a period. Facilities that have completed the classes in as little as two weeks have found that the classes failed to create a lasting impression. Others have found that taking as long as 18 months causes the monetary reward to lose its appeal and turnover to take its toll. The ideal time period, says Royster, is about six months. Some facilities enroll only nursing assistants who have already demonstrated outstanding dedication to the profession, using the program to reward their dedication, but WIN A STEP UP works best when groups combine some outstanding workers with some who are not as highly motivated or who are struggling with certain aspects of the job. Royster recommends drawing names of prospective participants from a lottery to keep a balance in the group, and to avoid the appearance of favoritism. Royster believes that raises, either alone or in combination with one-time bonuses, work better than bonuses alone as retention incentives, although there is no data to prove or disprove that belief. In addition, she says, giving raises in recognition of this special achievement encourages facility administrators to think of CNA work as a career and to consider giving systematic raises to those who demonstrate a commitment to it. The positive response to the pilot led to recommendations that the program be expanded to all nursing homes in the state, that it be expanded to other long-term care settings as well, and that a more explicit career ladder be developed for nursing assistants.
Costs and Funding	WIN A STEP UP supplies all training materials - and trainers, if requested - at no charge, so the only cost to facilities is the bonus and/or wage increase they provide to participants. That expense is partially covered by the incentives they receive from the program. For WIN A STEP UP, the program costs about $10,000 for each class of 10, including the $70 per participant per module, the $75 for each graduate who stays through the end of the retention period, and the incentive paid to the facility. The cost of developing the pilot program was funded by a grant from the Kate B. Reynolds

	Charitable Trust. Phase Two is funded by the State of North Carolina's CMP fines.
Contact Information	Ally Woodside WIN A STEP UP UNC Institute on Aging 720 Airport Road, CB# 1030 Chapel Hill, NC 27599-1030 t: (919) 218-1192 e: awoodside@schsr.unc.edu Website: www.aging.unc.edu/research/winastepup
Other Resources	Konrad, Thomas R. and Jennifer Craft *Morgan Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance* http://www.aging.unc.edu/research/winastepup/pilot.html State of North Carolina Department of Health and Human Services (2000): *Continuing Education Modules for Nurse Aides* http://facility-services.state.nc.us/hcprcd.htm ** These training materials were developed by the North Carolina Division of Facility Services. As such, these materials are in the public domain and may not be altered without approval from the Division of Facility Services nor may these materials be reproduced for sale.*

Recruitment

Catalina In-Home Services: Recruitment and screening of caregivers for consumer-directed home care

Description	This program enables individuals to directly hire a home health aide or personal assistant using the professional personnel services of an established home care agency. The program reduces the cost to a client while ensuring that caregivers earn a reasonable wage and adequate benefits.
Sponsoring Organization	Catalina In-Home Services, a for-profit home care agency located in Tucson, Arizona.
Setting	Catalina In-Home Services
Target Group	Home care workers seeking employment and private-pay clients who wish to directly employ and supervise a home health aide or personal assistant.
Start Date	1988
Objectives	To reduce the cost of home care services to private-pay clients while ensuring that caregivers receive above-average wages and benefits.
Key Components	*Initial Assessment.* Catalina conducts an initial assessment of the home care client, sending a registered nurse to the client's home to evaluate the client's clinical needs and ability to effectively manage an employee. The process ends if the nurse determines that a client appears confused, combative, or otherwise unable to properly supervise a caregiver, or if the client is unwilling or unable to pay the minimum required salary, including benefits and Social Security contributions. The client then receives an information packet explaining the legal, ethical, and managerial responsibilities of being an employer, including tips on achieving a good working relationship with home care employees and instructions on how to ensure that the client and employee have the same expectations concerning duties, schedules, and compensation. Catalina requires clients to pay at least $9 an hour to home health aides and personal assistants, including benefits and Social Security contributions. For a fee, Catalina can handle the financial management aspects of hiring a direct-care worker on behalf of clients, such as withholding the proper Social Security contributions. *Recruitment.* Catalina advertises for caregivers in local newspapers. The agency selects one candidate it considers the 'most appropriate choice' and two others who may be 'suitable' for the particular client. After this selection process, Catalina arranges an interview between the client and 'most appropriate' caregiver. If the client chooses not to hire that caregiver, they can interview the two others. If the client rejects all three candidates, Catalina negotiates for an additional fee to continue advertising for caregivers or cancels the contract, refunding all fees less direct costs. Interviews are usually conducted in a client's home or in a neutral setting. If clients are not satisfied with a home health aide or personal assistant during the first 30 days of employment, Catalina will identify other caregivers. If these individuals are not accepted, one final group is sent.

	Screening. After a client identifies a 'suitable' caregiver, the caregiver enrolls in an eight-hour orientation/skills-inventory program through Catalina and completes both a criminal background check and drug test. Additionally Catalina encourages placed caregivers to participate in its in-service training seminars. *Additional Services.* Catalina provides two additional services to clients for whom it recruits home care providers, and one to workers: When a caregiver is unable to get to work, Catalina provides a back-up worker at its standard rate of $18.25 an hour. Catalina provides one year's worth of monthly nursing visits. RNs typically set up medication boxes, check vital signs, and look for early signs of developing health problems. Catalina also ensures that caregivers receive benefits and Social Security contributions.
Results, Outcomes, Evaluation	Catalina In-Home Services has placed more than 300 caregivers with private-pay clients. Using the personnel services of an established agency, clients avoid the stress and time demands of recruiting and interviewing a caregiver off the street. Moreover, the screening provides some assurance that they will receive quality care. Catalina has had to replace only one worker since it first offered the service in 1988. The agency attributes that success to its screening of applicants and assessment of the client's ability to manage a caregiver.
Lessons Learned	Through this program, Catalina has learned that it can help consumers privately hire home care workers without sacrificing quality of care, at a lower cost than using agency staff. Catalina found that the program's most important component is its initial assessment to ensure that clients are capable of supervising a caregiver and can offer a decent-quality job.
Costs and Funding	$1,500 for a part-time home health aide or personal assistant; $3,000 for a full-time or live-in worker ; $5,000 for two workers. Clients quickly recoup this expense because they pay considerably less than standard agency rates, which run about $230 per day.
Contact Information	Judy Clinco, RN BS, President and CEO Catalina In-Home Services 1602 E. Fort Lowell Road Tucson, AZ 85719 t: (520) 327-6351 e: JBClinco@theriver.com

Retention

Leelanau Memorial Health Center: Strategies to Reduce Turnover

Description	Strategies to Reduce Turnover (SRT) is a set of programs and practices developed to reduce the high rate of turnover. After a 1997 mission statement change and an assessment of workplace practices, culture, and values, the facility developed a strategic plan that focused on customer satisfaction, team building, quality and process improvement, empowering employees, and enhancing employees' decision-making skills. Using the Eden Alternative approach to culture change and development, Leelanau minimized or eliminated traditional management practices and adopted participatory management techniques. It also began cross-training all staff as CNAs.
Sponsoring Organization	Leelanau Health Care Center is part of Munson Healthcare System, a non-profit, multi-site health care organization. In addition to a long-term care unit, Leelanau contains acute-care inpatient services, an emergency room and outpatient clinic, a pool and fitness center, and a childcare center. The long-term care unit was established in 1971 and has 72 beds.
Setting	SRT was implemented in the long-term care unit of Leelanau Health Care Center, in Northport, Michigan.
Target Group	Certified nursing assistants (CNAs).
Start Date	The development plan was adopted in 1997 and fully incorporated by 1999. Eden recognized the facility in 1998.
Objectives	To create and maintain a homelike environment for residents; To foster a sense of belonging among staff and residents; To create a culture of retention and maintain a low level of turnover; To provide high-quality, rewarding jobs to CNAs and high-quality, compassionate care to residents.
Key Components	Leelanau used Maslow's hierarchy of needs, a psychological theory about the levels of need all people strive to fill in order to function well, as a framework to organize its turnover reduction strategies: *Physiological needs (basic body needs such as food)* are met via wage increases. All certified nursing assistants start at $9 an hour (this includes activity aides and housekeepers, as they are cross-trained as CNAs). Yearly raises are based on market increases and cost of living. To provide this increased wage, Leelenau reduced the number of full-time equivalent workers, including both direct-care workers and licensed or managerial staff. To compensate for having fewer full-time equivalent CNAs, the facility adopted an 'all-hands on deck' approach, cross-training every staff member to be a nursing assistant. CNAs provide the bulk of the care, but all staff members assist during meals and help with transportation and group activities. *Safety and security needs (the need for order and security)* are met through concise job descriptions, education on the management structure, and maintenance of a stable and predictable work environment. Each applicant gets an accurate job description and a recruitment letter detailing

	what is expected of Leelanau employees, which help prepare interested candidates for the job and screen out those who would not mesh with the company culture. In-house training further acquaints trainees with the facility and its values. The facility's culture and work environment is continuously monitored to ensure that job descriptions and working conditions maintain predictability. *Love and social needs (the need for belonging)* are met through a commitment to teamwork and meaningful interaction between all employees, including management. Each new frontline employee is assigned to an interdisciplinary decision-making team related to his or her work area. These teams serve as support groups, an informal form of orientation, and a resource to help members solve job-related problems. No team leaders are assigned. Communication between staff members is fostered through the following: Monthly staff meetings Twice-monthly head coach meetings (administrators at Leelanau are referred to as coaches) Daily rounds by the head coach to check in with every employee and ensure their satisfaction with the work Action-oriented process improvement teams that improve processes that are large in scope and involve long-standing policy or procedure Ad hoc 'do-it' teams that handle and address smaller problems in a timely manner Quarterly 'culture' meetings The facility also recognizes the relationships between staff and residents in various ways, including bereavement support. When a resident passes away, the facility holds a memorial service for staff, residents, and families in the spot where the resident spent most of his or her time. In addition, a Coping with Life Losses class meets regularly. *Esteem (feeling of self-worth)* is addressed through self-managing of assignments, scheduling, and problem solving. The facility also places a strong emphasis on both formal and informal training, through in-services and at the monthly staff meetings held on each shift. Adult learner-centered teaching techniques (interactive lectures, role plays, scenarios, etc.) are used to facilitate learning. All staff and residents are included in 'process improvement' and 'do-it' groups, where they make joint decisions that bolster their sense of responsibility and accountability. *Self-actualization (growth)* is achieved through organization-wide recognition events throughout the year, recognition of teams for their accomplishments, educational opportunities, and opportunities for advancement. CNAs help interview prospective employees.
Results, Outcomes, Evaluation	The yearly turnover rate for Leelenau employees in 1997 was 72 percent. That dropped to 17 percent in 2001 and 9.8 percent as of summer 2002. The number of on-the-job injuries has also been significantly reduced and residents' infection rates have been extremely low since inception of the plan. Formal customer and worker satisfaction scales have shown higher levels of satisfaction each year since 1997. In addition, Leelanau has a waiting list for people who want to work as

	nursing assistants.
Lessons Learned	The first step in the change process was to see the unit as a community where people live and prosper. The managers and staff stayed focused on the Eden Alternative's goal of reducing loneliness, helplessness, and boredom. All staff had to be on board with the changes. Coaches (administrators) had to give up the traditional hierarchical style of management and commit to the idea of improvement, continually asking, 'What's working?' and 'What's a challenge?' Every staff member had to take responsibility for asking questions and working towards solutions. Furthermore, as soon as a need was acknowledged, a process for dealing with it had to be established soon, if none was already in place. The reduction in high-level staff positions also placed more responsibility on teams, which became the 'go to' source for solving many types of problems. Pay differences between front line workers in dietary, recreation, and nursing were eliminated when workers in the other departments were cross-trained to do CNA work.
Costs and Funding	The long-term care unit is operating at a break-even level. To maintain a balanced budget, the facility continually eliminates what is unnecessary or redundant. Since SRT was implemented, many higher-level staff positions were eliminated through attrition and the facility was able to hire fewer full-time equivalent direct-care workers.
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WIN A STEP UP: Improving job quality and increasing retention
See page 48.

Recognition & Advancement

Cooperative Care: A worker-owned cooperative of caregivers

Description	OHI provides extensive orientation and training, employee recognition, continuing education and certification opportunities, and an employee assistance program for all direct support professionals. In addition, the agency has implemented a program of regular feedback and merit-based raises for its mental health division, which it plans to make permanent and agency-wide.
Sponsoring Organization	OHI is a nonprofit private agency with 325 employees located in Hermon, ME. It provides supportive services and housing to over 200 people with mental retardation, developmental disabilities, or mental health needs who are living in the community.
Setting	OHI's 63 community homes and day treatment programs in 24 Maine communities
Target Group	Direct support professionals working with people with mental retardation, developmental disabilities, or mental health needs
Start Date	Development began with the inception of the Mental Health Quality Improvement Team in 1996. The employee recognition program was started in February 1998. The merit-based wage increase demonstration project was initiated in 2001.
Objectives	Maintain a high level of employee morale; Provide responsive service to disabled individuals within the framework of self-determination; Continuously assess and improve employee-related practices; Ensure that direct support professional have input into the lives of the people they support, their work, and the overall functioning of the agency
Key Components	*Orientation and Training.* New hires attend a paid, two-week intensive training and orientation session before beginning work. The program is grounded in the Direct Support Professionals Code of Ethics. Topics covered include sexuality awareness, understanding and dealing with difficult behavior, improving communication, and mentor shadowing, in which a new employee is paired with an experienced and exemplary aide for the first two weeks on the job. Trainers use adult learning techniques such as role-plays, scenarios, and interactive discussions. Each employee develops a professional plan that sets goals for the next six months, year, and two years. Plans are included in both the human resource department's employee files and employee-managed portfolios. *Evaluation and Merit-Based Wage Increases.* This demonstration program, which was implemented in the mental health division, requires employees to maintain a portfolio of certificates, achievements, resumes, and other information pertinent to their work. Each employee meets monthly with his/her supervisor for a supervisory session called a fireside chat, where they discuss the portfolio and any work-related problems that may have arisen. In addition, employees participate in yearly 360-degree feedback groups where colleagues give each other feedback on their work. Every worker earns a yearly salary increase of 2 to 7 percent. The amount is based on evaluations made in fireside chats and feedback groups, attendance and discipline records, and supervisory input.

	Continuing Education. OHI often pays for continuing education and gives employees paid time off to attend classes. A division of professional development, which handles training and certification, offers 40 to 80 hours of annual training to all employees, not including orientation. *Employee Recognition.* OHI recognizes an employee of the month, team of the quarter, and employee of the year. All may be nominated by a consumer, worker, supervisor, or a family member and are chosen by a majority vote of the quality improvement team. Recipients receive a plaque or certificate and a letter from the CEO, and their names are added to a 'Perpetual Plaque' in the main office. Employees receive 'atta-boy letters,' informal acknowledgments of exemplary accomplishments, when applicable. OHI also uses employee recognition boards, sends each employee a birthday card every year, and holds an annual employee recognition dinner. *Benefits.* OHI offers medical, dental, retirement, life and long-term care insurance to each worker, with small employee contributions based on hours worked. Its employee assistance program is staffed full time. The program offers counseling services, information about and referrals for additional therapy, and connections to practical supports such as food stamps, childcare, and transportation.
Results, Outcomes, Evaluation	According to management, OHI has a low turnover rate and receives a constant stream of applicants through word of mouth, making newspaper advertising unnecessary. Exit interviews conducted with each staff member who leaves OHI show that the main reasons for leaving are moving out of town or going to school full-time.
Lessons Learned	The quality improvement team played a key role in making many of OHI's initiatives work, ensuring that they were implemented consistently and supported the agency's mission and values.
Costs and Funding	OHI primarily relies on Medicaid for funding. The organization also generates income by inviting outside agencies to participate in its training programs for a fee.
Contact Information	Bonnie Jean Brooks, CEO Sue Phillip, Director of Quality Improvement Deb Smith, Director of Training and Professional Development 25 Freedom Parkway Hermon, ME 04401 t: (207) 848-5804 Website: www.ohimaine.org

Sisters of Bon Secours Nursing Care Center: Wage Parity Initiative

Description	This initiative increased the wages and benefits of certified nursing assistants (CNAs) in order to reduce turnover and dependence on temporary agency staff.
Sponsoring Organization	The Bon Secours Health System, Inc., a non-profit health system that includes 24 acute-care hospitals, one psychiatric hospital, and 9 long-term care facilities, along with numerous ambulatory sites, 8 assisted living facilities, 2 retirement communities, home health care services, and hospices. It is based in Mariottsville, MD.
Setting	The Sisters of Bon Secours Nursing Care Center, a 250-bed long-term care facility in St. Clair Shores, MI.
Target Group	Certified nursing assistants (CNAs)
Start Date	1998
Objectives	To increase the wages and benefits of CNAs at the Sisters of Bon Secours Nursing Center in order to reduce the disparity in compensation between the nursing facility's CNAs and those who work in hospitals in the Bon Secours Health System; To reduce turnover among CNAs at the nursing center; To reduce reliance on agency staffing.
Key Components	In 1995, a new administrator joined Sisters of Bon Secours Nursing Care Center in St. Clair Shores and found high staff turnover and use of temporary staffing. Sporadic wage increases were implemented to address the situation, but after a year the facility's turnover rate had only marginally improved, and it still spent nearly $1 million a year to hire agency staff. The facility then implemented a comprehensive wage parity initiative that included the following components: A new pay scale with 14 levels. Pay is based on experience and ranges from $9 to $13 per hour. In the program's first year, most CNAs already on staff received raises of between 10 and 15 percent Annual merit raises. These average 3 percent annually but range from 2.1 to 6 percent An annual market survey of local CNA wages to ensure that the facility's compensation remains at or above the 90th percentile Increased contributions to health plans for CNAs, who now rarely pay more than $25 per week for coverage A 403(b) pension plan with a three percent employer contribution A $25 attendance bonus paid monthly to CNAs who do not arrive late or call out

Results, Outcomes, Evaluation	During the first year of the parity initiative, the facility reduced its spending on agency staff by 60 percent. As of halfway through the second year, the facility was spending 70 percent less on temporary workers. In addition, residents reported enhanced levels of satisfaction in a biannual survey administered by the Healthcare Association of Michigan. The facility achieved a quality-of-care rating of 93 percent in 2000, compared with 87.5 percent in 1998 before the initiative's implementation.
Lessons Learned	Bon Secours learned that nursing home residents and their families will support initiatives that enhance quality of care even if it means paying higher prices. The costs incurred through the Wage Parity Initiative required Bon Secours to raise daily room and board rates for private-pay residents (see Costs and Funding). Family members received a detailed explanation that this increase would fund the wage parity initiative. While family members had complained in the past after routine inflation-based rate hikes, no complaints were registered about this increase.
Costs and Funding	The initiative cost approximately $1.5 million. Most of this cost was offset by the decreased use of temporary agency staff. The remainder was funded by an increase of 4.5 percent in private-pay residents' daily room and board rate. Private-pay residents account for about half of the facility's client base.
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Catalina In-Home Services: Recruitment and screening of caregivers for consumer-directed home care

See page 53.

Cooperative Home Care Associates: Integrated model for recruitment, training, and retention

See page 5.

Direct CareGiver Association: Comprehensive model training program for caregivers

See page 10.

OHI: Comprehensive retention program for direct support professionals

See page 28.

Quality Improvement

Leelanau Memorial Health Center: Strategies to Reduce Turnover

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Northern Pines Community: Culture change initiative

Description	A comprehensive culture change initiative that incorporates three innovations affecting direct-care workers: blended workforce, team decision-making, and career ladders.
Sponsoring Organization	The Northern Itasca Healthcare Center, a government-owned hospital district that contains a 20-bed hospital, a 5-physician clinic, a 40-resident nursing home, 30 units of senior housing that provide supportive service, an adult-day care center, and a home health agency. The Northern Itasca Healthcare Center is located in Bigfork, Minnesota, a rural community, whose service area has a population density of approximately 2.2 people per square mile.
Setting	Northern Pines is a licensed long-term care facility with 40 residents divided into three communities: Spruce Lodge, a community of 16 residents who are able to provide some of their own care Balsam Lane, a community of 16 residents with cognitive challenges Cedar Grove, a community of 8 residents who require extensive care
Target Group	All frontline workers, including direct caregivers, housekeeping, and dietary staff.
Start Date	1999
Objectives	To transform the facility into a resident-centered and resident-driven community.
Key Components	Northern Pines embarked upon a culture change initiative that was described as being more like a three-year journey then simply implementing a specific long-term project. Northern Pines extensively researched culture change initiatives successfully implemented by other providers by sending 150 'stakeholders' from the facility (including administrators, nurses, frontline staff, and the spouses of residents) to visit 17 other long-term care providers. This helped generate support and enthusiasm for the project within Northern Pines. From this research, the Northern Pines community designed key components of its culture change model, which requires that residents, employees, families, volunteers and the community become actively involved in the creation of a healthy climate for living and learning. The model includes physical renovation to create home-like environments, organizational re-design to remove department silos and to bring decisions closer to the elder, and the personal transformation of all through involvement in all aspects of design and implementation and ongoing learning. This change process as implemented in Northern Pines also encompassed three innovative practices affecting direct-care workers: 1) a blended workforce, 2) team decision-making meetings, and 3) career ladders.

	Eighteen months into developing this culture change project, Northern Pines hired LaVrene Norton from Action Pact as a consultant. Through Norton's efforts, Northern Pines: 1) refined its culture change initiatives, 2) linked together various components within a theoretical framework, and 3) enacted an effective implementation strategy. As Linda Bump, Northern Pine's Administrator at the time, recalled: Norton brought skill-sets, processes and trainings to a journey that Northern Pines was already on and while Northern Pines was 'talking the talk,' Norton's efforts were essential in enabling Northern Pines to 'walk the walk.' The three workforce development components of Northern Pine's culture change initiative are detailed below: *Blended workforce*: Northern Pines ensured that all frontline staff received training as certified nursing assistants, including housekeepers and dietary staff, who then spent approximately 20 percent of their time working with residents. Simultaneously, CNAs devoted approximately 20 percent of their time to cleaning rooms and cooking meals for their residents. This resulted in more varied and less monotonous work and reduced divisions within the staff. This approach allows frontline workers time for the conversations and other social interactions that increase the job's emotional rewards and boost resident satisfaction. *Team decision-making meetings*: Each community within Northern Pines pays its frontline workers to attend weekly decision-making meetings. While all frontline workers are invited (and receive pay) for attending these meetings, Northern Pines concedes that it is difficult for individuals who work the night shift to often attend these meetings. Workers who do attend these meetings discuss a wide range of topics including the food served to residents for the week and activities in which residents will participate. Although scheduling and resident assignment are not currently within the purview of team decision-making meetings, workers facing challenging situations can use this time to receive support and advice from their peers. Additionally, Northern Pines concedes that team decision-making meetings are labor intensive for small facilities. However, they believe it is worth the expense because paraprofessionals feel more invested in their work and understand they have an ownership stake in the facility's activities. *Career ladders*: For each area of cross-training completed, frontline workers can receive raises of 5 cents per hour. Additionally, all CNAs must learn ten caregiving skills, which are taught by the facility, and upon completing this training, workers receive a raise of 10 cents an hour. Those interested in advancing further may then become a medication aide, dispensing medication to residents, which is authorized under Minnesota's Nurse Practice Act. After completing the required training, designated medication aides receive a raise of 10 cents per hour. Northern Pines also offers an 'Advanced CNA' training course, which confers a raise of 10 cents upon completion. Additionally, in each of the three communities (Spruce Lodge, Balsam Lane, and Cedar Grove) one frontline worker serves as a LEAD Care Assistant, a liaison to the Community's leadership team, which typically includes the Director of Activities, Director of Nursing, Social Worker, Registered Nurse, and Community Coordinators from each community. The 'LEAD Care Assistants' ensure that the opinions and needs of frontline staff are considered during leadership team discussions and receive an additional 25 cents per hour raise for their efforts. Finally, Northern Pines provides scholarships to frontline staff interested in completing LPN or RN programs.

Results, Outcomes, Evaluation	There has been no formal evaluation of this program. Staff turnover, which averaged 85 percent before the changes began, decreased to 20 percent in 1999 and 13 percent in 2000. Management believes that a dramatic improvement in the quality of care as measured by the following indicators can be attributed at least in part to the culture change initiative: Medication error rates fell from 5 percent to 0.5 percent; Infection rates fell from 22 percent to 12 percent; Resident and family satisfaction increased by 10 percent. Even better than the statistics, staff say, are the individual stories. Some residents started walking again, while others began to play musical instruments they had long neglected. In the community for residents with cognitive impairments, the staff noted a significant reduction in disruptive behaviors. 'People aren't hollering for attention because they know the staff is always there,' says activities director Laurel Laudert.
Lessons Learned	The greatest challenge Northern Pines encountered in implementing this program was encouraging its frontline staff to embrace the changes. When the idea was first proposed, staff responded that Northern Pines was already an excellent facility and questioned why such a drastic change was necessary. LaVrene Norton from Action Pact was instrumental in educating the frontline staff about the culture change process and why it was needed. Even so, staff members were not convinced of the value of the initiative until they saw how positively residents reacted to it.
Costs and Funding	The physical renovation cost Northern Pines approximately $300,000, which was funded through adroit management of depreciation funds and capital account money. In developing the workforce development initiatives, Northern Pines required that the changes, in their entirety, be budget-neutral. In team meetings at the community level, frontline staff together with management developed adjustments that would enable Northern Pines to defray the costs of these workforce development initiatives. As one example, in Spruce Lodge, it was recognized that residents were sleeping later then 7 a.m., so there did not need to be a full complement of frontline staff until a few hours later. Implementing that scheduling change reduced costs so that money became available to finance other aspects of their workforce development initiatives.
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Visiting Nurse Service of New York: Recognizing Home Health Aides As Vital Partners in Quality Improvement

Description	The Visiting Nurse Service of New York (VNSNY) used the breakthrough collaborative model developed by the Institute for Healthcare Improvement (IHI) to foster a better understanding of the role of home health aides (HHAs) in the delivery of care and to engage HHAs in identifying and disseminating related best practices and new approaches. The initiative -the Home Health Aide Partnering Collaborative- involved working intensively with a small number of high-performing teams.
Sponsoring Organization	VNSNY, a New York City-based organization with a long history of addressing the needs of direct-care workers, is the largest freestanding not-for-profit provider of home health care in the United States. Its other HHA job improvement initiatives include a 2004 agreement to bring thousands of HHAs to a $10-per-hour starting wage by 2007, provision of pension benefits and health insurance with family coverage at no cost to those employed by Partners in Care, and opportunities for advanced skill training accompanied by related wage increases.
Setting	VNSNY delivers the entire range of home health care services including nursing care, rehabilitation therapy, nutrition counseling, social work services, and allied professional services as well as home health aide, home attendant, and housekeeping services. These services are provided through a range of short-and long-term care and specialty programs. VNSNY serves the greater New York City area including Manhattan, Bronx, Brooklyn, Queens, Staten Island, Nassau County and Westchester County. VNSNY caregivers see an average of 25,000 patients each day. To provide these services, VNSNY contracts with a number of home health agencies.
Target Group	The HHA Partnering Collaborative and a number of earlier related initiatives have focused on the role of HHAs, nurses and other members of the service delivery team in providing quality patient care and addressing related challenges. Partners In Care, a licensed agency that is a for-profit subsidiary of VNSNY, employs over 4,000 HHAs. Home health aide service is also provided on behalf of VNSNY by HHAs employed by several outside licensed home care service agency 'partners.'
Start Date	June 2003
Objectives	Objectives of the HHA Partnering Collaborative are: To optimize the role of the home health aide as a member of the VNSNY care team. To improve patients' functional independence and self-management capabilities. To improve field support of HHAs. To facilitate partnering between licensed agencies that supply VNSNY with paraprofessionals. To increase the satisfaction of patients, HHAs, and other direct-care staff.

Key Components	*Collaboration* The collaborative was launched with the help of a panel of experts, who identified challenges and discussed solutions. They included representatives from three licensed home health agencies and seven acute and congregate care teams. Participants included HHAs, nurses, rehabilitation specialists, managers, and senior leaders from VNSNY and licensed agencies. About 20 VNSNY clinical directors and quality-management staff acted as collaborative leaders, or faculty. Teams varied in the number of members, with at least three HHAs serving on each. *A structured approach* The learning collaborative followed the 'plan, do, study, act' model set out by IHI. An initial learning session for VNSNY and licensed agency staff set the stage, teaching participants about a rapid-cycle approach to quality improvement. Two subsequent learning sessions allowed teams to share data gathered during action periods. HHAs and other team members had opportunities to voice their concerns and opinions and to present data in these highly interactive sessions. During action periods, team members used conference calls, e-mails, and listservs to enhance communication. *A relatively short period of intensive focus on change* The HHA Partnering Collaborative ran from June 2003 through May 2004. During this time, teams tested ways to make HHAs integral players on the care team. 'Change concepts' were identified, implemented, and tested. During these 12 months, HHAs also received special training for diabetes and other conditions. Together, the teams considered ways to address four key themes related to the initiative's objectives: How to better match workforce to patient needs ; How to improve field support for HHAs; How to increase functional health care; How to bolster patients' self-management skills. The ideas tested included the following: Licensed agencies assigned fewer home health aides to a team, assigning more hours to each, to better match workforce to patient needs. Supervising clinicians and HHAs communicated via cell phones, providing HHAs with more field support. A functional improvement tracing and reporting tool was used to support patients' self-management abilities and shift the role of the HHA from 'doer' to 'supporter.'
Results, Outcomes, Evaluation	VNSNY has not released a formal report on the findings of the collaborative, although the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation has indicated its intent to grant VNSNY a contract to conduct an evaluation. In the meantime, VNSNY has reported several preliminary findings. A pilot test of a tool created to document progress in activities of daily living (ADLs) over a four-week period with 114 patients demonstrated a decrease in the degree of assistance and support HHAs provided to patients in the activities of bathing, ambulation, and transferring. These results were correlated on those patients' aggregate functional status scores, as measured by the OASIS assessment instrument. Improvement in all three ADL areas between two assessment time points during which the ADL tool was used indicated a decrease in patient dependence. There was an increase in HHA

	satisfaction, with a greater percentage of the participating HHAs strongly agreeing that they were treated as members of the care team (59 percent after participation in the collaboration, compared to 45 percent before.) In addition, the percent of participating HHAs who strongly agreed that their opinions were heard and appreciated by team members rose from 45 percent to 65 percent over the course of six months. Another significant finding was the percent of professional staff who strongly agreed that the primary partnering licensed agency was responsive to services concerns and issues, which increased from 69 percent to 97 percent.
Lessons Learned	Though the collaborative has led to gains in HHA satisfaction and care outcomes, it has also underscored the complexity of the problems facing the nation's largest home health care provider, according to a collaborative co-director. The broad challenge remaining is how VNSNY can best meet the sometimes conflicting scheduling and staffing needs of the many licensed agencies it contracts with while delivering care seamlessly to patients. As it works toward that goal, VNSNY will continue to eye its success in continuity of scheduling for HHAs (that is, assigning an aide to a certain team or group of teams so he or she gets to know visiting nurses and patients), scheduling HHAs for a consistent number of hours each week, and improving overall team and HHA satisfaction.
Costs and Funding	VNSNY funded collaborative planning, learning session planning, coordination and delivery as well as faculty support and staff participation. Each licensed agency involved funded the participation of its own administrative and supervisory staff. A Health Workforce Retraining Initiative grant from the New York State Department of Health supported the participation of HHAs.
Contact Information	Sally Sobolewski Director of practice improvement and collaborative co-director 107 East 70th Street New York, NY 10021 t: 888-867-1225 Website: www.vnsny.org
Other Resources	For more information on the Breakthrough Collaborative Model, contact: Institute for Healthcare Improvement 375 Longwood Avenue, 4th Floor Boston, MA 02215 USA Phone: (617) 754-4800 www.ihi.org

Wellspring Innovative Solutions, Inc.: The Wellspring model of quality improvement

Description	Wellspring is a multi-faceted quality improvement initiative originally undertaken by an alliance of 11 freestanding, nonprofit nursing homes (the Charter group). This model is based on the premise that improving quality of clinical care and better clinical outcomes for residents requires organizational culture change, including staff empowerment.
Sponsoring Organization	Wellspring Innovative Solutions, Inc., an alliance of freestanding, nonprofit nursing homes.
Setting	In addition to the Charter group, there are 45 Wellspring organizations nation wide currently licensed to use the Wellspring model. Current alliance members are in Illinois, Wisconsin and Maryland. There are two alliances in Wisconsin, and two in Illinois, and one alliance in Maryland.
Target Group	All staff, including administrators, registered nurses, licensed practical nurses, social workers, certified nursing assistants (CNAs), and staff from the dietary, housekeeping, and activities departments. CNAs are *especially* targeted, given that they are the key to the successful implementation of this model.
Start Date	Founded in 1994, the Wellspring Charter Group became fully operational in 1998. Wellspring has since added five Alliances, which include 46 additional nursing homes. Each of these newer alliances is in the early implementation stages of the Wellspring model.
Objectives	To improve the quality of clinical care and quality of life for residents. To change the organizational culture by flattening the hierarchy that is generally found in nursing homes. To create a more positive work environment, empower staff, and reduce staff turnover.
Key Components	*An Alliance Superstructure.* The Alliance is a joint body composed of one person from each of the member facilities. It both performs the practical functions associated with cost savings and serves as an open forum for a discussion of quality improvement in the individual facilities. The Alliance provides opportunities for staff at many levels, from CEOs to the front line, to meet and interact at quarterly meetings and module trainings. *Clinical Training Modules.* The modules are vehicles for the acquisition of 'best practices' in clinical care. Each facility sends several staff members, including both CNAs and non-nursing staff, to learn about best practices and new developments in clinical practice across a variety of care areas. The teams attending these trainings are then expected to return to the facility and lead the effort to incorporate these practices into its normal care routine. These training sessions are a means of initiating culture change both within and among alliance member facilities. *A Shared Geriatric Nurse Practitioner (GNP).* The primary source of knowledge and advice about best practices and adherence to regulatory requirements, the GNP is hired by the Alliance to work with the member facilities, teach module trainings, communicate with coordinators, collect and

	analyze data, solve problems, and visit member facilities. *Wellspring Coordinators.* Each facility has a Wellspring Coordinator who links all Wellspring components together. The Coordinator serves as a conduit between the facility and the Wellspring Alliance and between the management and the front line staff, as well as overseeing the reporting of clinical data (number of incontinent episodes, number of falls, weight loss, etc.) to ensure consistency and accuracy. Because of the range of clinical issues with which the Coordinator is involved, Wellspring requires that the Coordinator be a nurse. *Care Resource Teams (CRTs).* These non-hierarchical, interdisciplinary teams of nursing assistants and other staff members learn about best practices and new developments in clinical practice. They then lead the effort to incorporate the practices into normal care routines at their facilities. CRTs are the main engines of quality improvement within facilities, viewed by other facility staff as change agents and experts. Membership is voluntary, and members are recruited by the Wellspring Coordinator. CRTs plan ways to implement Wellspring strategies, monitor their success, and intervene when implementation is thwarted. Along with the Wellspring Coordinator, these teams are the glue that holds the Wellspring model together as the modules are implemented in the facilities and mature into routine care protocols. *Systematic Collection and Use of Outcomes Data.* Each facility collects data related to targeted clinical areas on each resident, noting prevalence and trends in clinical areas such as the number of incontinent episodes and the number of falls. Data are processed centrally, to give each facility a record of where it stands on quality indicators over time and in relation to each other facility. At quarterly meetings, facility directors of nursing and Wellspring Coordinators compare data, noting where progress is being made and where further improvements are needed. The data are aggregated and analyzed by the group to explore facility differences in outcomes and practices that promote better outcomes. *Non-Hierarchical, 'Staff Empowerment' Management Philosophy.* The Wellspring model calls for the administrative staff of each nursing home to create a receptive environment by empowering front-line staff to gain clinical skills, collaborative skills, and authority for decision-making. As a result, managers must learn new ways of interacting with staff and new strategies for ensuring accountability.
Results, Outcomes, Evaluation	A 15-month study of the Charter Group of Wellspring facilities completed in 2001 assessed the impact of the Wellspring model on facilities, employees, and residents. Wellspring facilities were found to have a retention rate of 71 percent for nursing assistants in 1999, compared to 62 percent in non-Wellspring facilities in Wisconsin. Wellspring facilities also experienced smaller increases in turnover rates than Wisconsin nursing homes in general. Wellspring facilities improved their performance over time and performed better on three measures of survey deficiencies than non-Wellspring comparison groups.
Lessons Learned	The most dramatic changes seen through the Wellspring model are related to staff excitement, empowerment, and turnover. A host of strategies must be implemented to achieve staff empowerment within facilities. Without these additional strategies, empowerment often did not occur or was not sustained.

	The charge nurses who supervise nursing assistants are extremely important in the implementation of this model. In the facilities where the model was not successful, the charge nurses were often the obstacle. Where the model did work, charge nurses were key to its success. Organizations that remained hierarchical had great difficulty implementing and/or sustaining Wellspring. The desire to change was not sufficient in these facilities. In order to manage collaboratively, charge nurses and other managers need to learn more skills for delegating, coaching, and managing staff.
Costs and Funding	Each facility incurs costs associated with the program, including equipment, administrative and coordinator time, monthly dues, time for employees to participate in trainings, care resource team meetings, and in-services. However, Medicaid cost report data analysis and interviews with administrative staff showed that Wellspring did not increase total costs for the facilities, indicating that savings in other operational areas made up for the additional costs.
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