Global Ageing Network:
Workforce Summit Summary

September 17, 2019
Toronto, Canada

With support from PointClickCare

Introduction

The Global Ageing Network, with support from PointClickCare, convened the Global Ageing Network Workforce Summit on September 17, 2019 in Toronto, Canada. This is the third summit convened by the Global Ageing Network.

Global Ageing Network Workforce Summit

During the 2019 Global Ageing Network Workforce Summit, providers and researchers shared their perspectives on the aging services workforce shortage as a global issue and discussed efforts underway to define the needs and develop solutions as well as best practices to improve the recruitment and retention of long-term services and supports workers. The presentations and discussions focused on recruitment strategies, models of training in home care and the residential setting, engagement with the workforce, retention strategies, and the role of technology and the workforce.

DEFINITION OF TERMS "Long-term services and supports," or LTSS, or long-term care refers to a range of health and social services that support older adults and persons with disabilities who have a reduced degree of physical or cognitive functioning and need help with daily living tasks.

"Nurses" are licensed professionals who provide nursing services directly to care recipients, either in the home or in a nursing home/residential care setting. They include Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).

"Direct care workers" help older adults carry out basic activities of daily living. These workers provide most of the care that LTSS clients or residents receive. Direct care workers are not licensed, and do not have any recognized qualifications or certification in nursing. They may also be referred to as "caregivers," "personal care assistants," "personal support workers," and "aides."

Acknowledgements

This report synthesizes themes from the presentations made during the 2019 Global Ageing Network Workforce Summit. See appendices for more detailed descriptions of the provider best practices and research based practices, which are summarized in the report, practices from the field among a provider and technology vendor, the summit's agenda and specific PowerPoint presentations.

Global Ageing Network acknowledges the contributions of the researchers, providers, and business sponsors:

- **Robyn I. Stone, DrPh,** Senior Vice President, Research and Co-Director, LeadingAge LTSS Center @UMass Boston
- **Robert Espinoza MPA,** VP of Policy, PHI
- **Kathy McGilton, RN, PHD, FAAN,** Senior Scientist, Toronto Rehabilitation Institute-UHN; Professor, Lawrence S Bloomberg Faculty of Nursing
- **Imja Choi, MS,** Founder & CEO, Penn Asian Senior Services
- **Jiri Horecky, MBA, PhD,** President, European Ageing Network; Vice President, Federation of European Social Employers
- **Bill Dillane,** President, Responsive Group Inc.
- **Stephen Cornelissen, MHA,** Adjunct Professor; Group Chief Executive Officer, Mercy Health
- **Veronique Boscart, RN, PhD,** Executive Director, School of Health & Life Sciences; CIHR/Shlegel Industrial Research Chair for Colleges in Senior Care; Executive Director, Schlegel Centre for Advancing Seniors Care
- **Majd Alwan, PhD,** Senior Vice President of Technology and Executive Director, LeadingAge Center for Aging Services Technologies
- **Denise Rabidoux,** CEO Emeritus, Evangelical Homes of Michigan
- **Heath Odom,** Vice President of Business Development and Strategic Alliances, PointClickCare
- **Stuart Feldman,** General Manager, PointClickCare

Executive Summary

Aging services providers cannot have a quality organization without a quality workforce. Countries across the globe face significant challenges in the recruitment and retention of long-term services and supports (LTSS) workers. An increasingly aging population and fewer workers to care for them has created a workforce crisis. Several trends have impacted the aging services workforce including a shrinking ratio of workers and caregivers to older adults, low compensation and poor benefits for workers, high turnover among workers, and lack of public awareness and support to create policy reform to fix the systematic issues. In addition, the influx of foreign-born workers can create ethical issues and challenges both in sending and receiving countries.

The direct care workers provide the majority of hands-on care to assist older adults and people with disabilities. Direct care workers provide daily support to people living in the community and in the nursing home setting and they can be independent providers employed directly by consumers in state and publicly-funded programs. The workforce is predominately female, diverse, and often receive low wages and can have irregular hours for the work. Aging services providers face challenges recruiting and retaining these critical workers.

Given the shortage of available workers, new workers are needed to join the workforce. We need to think about new pipelines of workers such as:

- Older workers who may require flexible scheduling, ergonomics, and job sharing.
- Immigrants or foreign-born workers, who already make-up a significant percentage of the LTSS workforce.
- New graduates who require peer support to feel embedded in their work environment and to promote the development of peer and supervisory relationships.
- Informal caregivers who cared for a family member who passed away or no longer needs the service.
- Younger workers who may require rethinking of the job design as they want more freedom and flexibility.

A challenge for LTSS workers is the quality of training and lack of competencies for the various positions. Countries across the world have variations in the identified competencies for the workforce and policymakers are not investing in the LTSS workforce. Workers are not equipped with the skills, knowledge or confidence they need to succeed in their roles caring for people with acute, chronic conditions and there is a lack of gerontological training. Direct care workers need stronger, standardized training requirement and better-quality training. Training should be didactic and should incorporate e-learning models and assessments to test workers on their skills.

Workers also lack career advancement opportunities to enhance their basic skills. Direct care workers need career paths and growth opportunities through advanced roles. These opportunities enable workers to take on more expansive and satisfying roles, which can reduce turnover and make the job more competitive with other comparable industries. This also can result in optimal clinical health, reduced hospitalizations, and emergency room visits.

A key position within the LTSS workforce is the nurse and the relationship between the nurse supervisor and aide. Poor supervision negatively impacts quality of care for residents and causes frontline workers to leave the organization. The quality and quantity of supervisory relationships has a central role in shaping the effectiveness of supervision. Effective supervisory support is characterized by frequent and high-quality supervisor-staff interactions. This includes an awareness of the interdependence of the roles of the supervisor and aide and a supervisor having a flexible approach and fostering fluid teams to respond to residents' needs.

The four key dimensions of the nursing role include clinical work, supervisory work, team support and managerial work. The role of the charge nurse is in flux, lacking clear boundaries and standardization within and across nursing homes. The time spent on each dimension depends on the shift worked and the organizational, staffing and resident factors. Aging services providers would benefit from increasing recognition of the role according to the range of tasks performed by and the responsibilities of the nurses. These should be taken into consideration when recruiting for the charge nurse position. Charge nurses should be adequately trained and supported for the four dimensions involved in their role.

One innovative model to attract new nurses and nursing assistants and prepare new graduates incorporates gerontological content into the educational program and create a learning lab. The Living Classroom training program is delivered within the context of the long-term setting with team members (faculty, students, residents, family members, and volunteers) engaging within a cultural of interactive learning. Students learn in a real environment and have opportunities to practice their skills and interact with staff and residents in the nursing home.

Staff can feel supported when they work efficiently within high functioning teams. This is the basis for a neighborhood team development program where a neighborhood coordinator forms teams across disciplines that learn how to cross-functionally work together to serve the residents. The teams discuss challenges, attend trainings, and develop initiatives to improve the workplace environment and/or care provided to the residents.

Providers have implemented strategies to address the workforce crisis. The summit highlighted the promising practices of three providers to improve the recruitment, training and retention of staff:

1. A home care agency in the United States, Penn Asian Senior Services, developed a cultural competency training to train its bilingual/bicultural caregivers. The training is

provided by a bilingual RN and taught in the language of the caregiver. The agency also employs bilingual/bicultural community coordinators to educate clients on the role of the home care aides and mediate any disputes or issues that arise between the client and aide. They also help with recruitment of aides as they can tap into different communities and inform recruitment strategies.

2. Responsive Group Inc., an organization that oversees the operations of long-term care homes and retirement communities in Ontario, Canada, embarked on a multi-year journey to advance the talent management and development of its staff. The talent management strategy involved development of core competencies across five levels, revised position summaries and job task inventories based on the competencies, performance management and personal improvement plans, and individual development plan process for employees at all levels. The organization also took measures to mitigate the loss of staff members in the executive director and director through leadership modules, a leadership coach, and team development.
3. Mercy Health, a large Catholic aging services and hospital system in Australia, established a learning framework for staff starting at orientation through continuing professional development. It also established a leadership capability framework to set the leadership expectations required of staff at all levels and allows management to asses cultural fit and alignment during the recruitment and selection process and identify gaps for individual development and career progression.

Technology and artificial intelligence can support the workforce and should be considered within the context of how the workforce is structured. Electronic Health Records, telehealth, activity monitoring and social connectedness have shown potential to improve resident quality of life and quality of care and improvements in the workforce. The summit highlighted one provider who uses technology to serve clients remotely and the technology allows caregivers to manage a cohort of individuals to create and monitor the health and well-being in a greater way. PointClickCare, the largest provider of Electronic Health Records in the United States and Canada, discussed how technology can be used to engage workers, particularly remote workers, can improve processes, and has a good return on investment for both the workforce and management. It is important for the technology vendor to be a partner with the provider organization and be open to individualize the products and have staff who will use the technology vet the products. In addition, staff should be engaged in the process and organizations should assess the competencies of staff and make sure they have appropriate training to effectively use the technology.

Countries across the globe face similar workforce challenges. The summit highlighted not only the challenges but the potential solutions that can help improve the recruitment and retention of workers. Expanding the pool of workers can help aging service providers address the workforce shortage. However, it is not just bringing in warm bodies to the organizations. The LTSS sector requires adequately trained and high-quality workers. The workers need a living

wage and career advancement opportunities. The nurse supervisor is a key role within the organization and effective supervision influences whether the frontline workers stay on the job and quality of care provided to residents. Nursing schools should be incorporating gerontological content into the education of nurses and teaching them effective supervisory practices. Aging services providers must have high-quality and effective clinical placements to provide mentorship and guided preceptorship for nursing students. This also provides opportunities for the students to see the challenging situations and opportunities for working in the LTSS sector. In addition, innovative educational and workplace development models that immerse nursing students into the long-term care setting through a collaboration of the long-term care home and educational institution should be replicated. Aging services providers are implementing promising practices to recruit and retain workers. They are providing cultural competency training, rethinking how to develop the staff and have continuous learning and leadership development for all workers at the organization. Finally, technology can play a role in addressing the workforce crisis. Aging services providers should use the best practices on technology training and staffing practices for evaluating the technology and implementing the new technology at the organization.

The Workforce Issue Overview

Aging service providers cannot have a quality organization and system without a quality workforce. While countries may have differences in their regulatory requirements and environment, many face significant challenges in the recruitment and retention of long-term services and supports (LTSS) workers. One issue is the reduction in the supply of workers and demand for LTSS services. The workforce is shrinking at the same time the older adult population is growing. Ageism impacts the ability to recruit and retain workers as well as an undervaluing of the workforce. Countries also face political issues, such as immigration, that can create barriers in finding new workers.

Trends Impacting Aging Services Workforce

Public Spending on LTSS

Countries overall are not publicly investing in the LTSS sector, including both the health and social components. The Nordic countries are the strongest in their investment of dollars in LTSS, with the Netherlands having the highest percentage (4.3%). These countries have high taxes and investment that society pays for the formal system of care. On the other hand, the United Kingdom, Canada, Germany, and United States spend some of the lowest percentages of Gross Domestic Product (GDP) on long-term care and less than the average for the OECD countries (1.4%). Greece and the Slovak Republic do not have any public spending on LTSS as a percentage of GDP.

Old Age Dependency Ratio

The Old Age Dependency Ratio measures the relationship between the number of older adults in a country and the number of working-age people available to provide services and supports to those older citizens. The lower a country's ratio of workers/caregivers to older adults, the more challenges that country is likely to encounter as it attempts to ensure that older people have access to the services and supports, they will need as their level of frailty, chronic illness and disability increases with age. Almost all countries, except for a few, are experiencing a shrinking of that ratio. There are fewer people available per 100 people 65 and older to provide the services for individuals who need it. The shrinking of the dependency ratio is the biggest challenge around the elder care system internationally. Demographics will be driving what is going on over the next 20 to 25 years. It raises the questions of whether there are enough people, who are skilled and qualified, to work in LTSS and how to support the human capital to make this work.

Low compensation

In the United States, approximately 40% to 50% of the workers are near poverty level and one in five is at poverty level. The median hourly wage is $11.03, and the median income is $15,000.

The low wages and irregular schedule make it difficult to retain and recruit workers in this sector. In 2016, five European countries the LTSS workers were at poverty level and had a second job to make a living (according EASPD survey from 2016).

Turnover

Turnover is costly and disruptive to both workers and residents/clients. It is significant in most countries as providers face a shortage of staff and high turnover. A tight labor market reduces turnover although the systematic issues—low wages, poor working conditions, physically and mentally demanding work, few opportunities for career progression, and precarious work conditions—that contribute to the recruitment and retention challenges continue to exist at the provider organizations.

Limited Traction of Person-Centered Care in the LTSS System

Person-centered care supports that acknowledge and affirm the person in his or her setting have not gained enough traction in the LTSS system. Many employers don't create person-centered workplaces. Workers are not trained in person-centered approaches and don't always encourage it for their residents or clients.

Marginal Data on Direct Care Workforce

The United States and other countries have limited data on the LTSS workforce. For example, the United States lacks state level data on direct care workers, including the number of workers, stability and compensation. Direct support professionals don't have a federal occupation code and data doesn't exist on the number of workers. This prevents leaders from identifying and targeting the high-need workforce areas with appropriate interventions.

Under-Resourced System of Long-Term Care

State Medicaid budgets, that funds most of long-term care in the United States, are tight and have few dedicated dollars for labor costs. Reimbursement rates are often inadequate and can't be used to improve jobs through higher wages and training.

Lack of Public Awareness and Support

Policy reform often requires a shift in public awareness and support, yet the infrastructure to educate the public remains limited. Little awareness about LTSS workforce crisis and much less on the solutions. Thought leaders become invested in the LTSS workforce when they are personally affected by the issue. There are few resourced public education and advocacy initiatives. And, inadequate media coverage on LTSS workforce.

Job Migration

Job migration can raise ethical issues. Wealthier European countries are bringing in nurses and direct care workers from poorer countries and those countries have fewer workers left to care for the older adults.

According to a statement from the European Commission from 2019:
Due to unbalanced growth of emerging long-term care systems, additional demand for labor force in some countries has created pull-factors for labor migration within the European Union (EU), but recruiting strategies also went far beyond the EU – with related challenges both in sending and receiving countries.

In practice, the long-term care sector represents a gateway for migrant workers from countries with low-wages and high unemployment to get access to the formal labor market in receiving countries. A classical trajectory consists of (often undocumented) live-in care in private households as a first step even for trained care professionals, but in many cases the transition to the formal care market and professional integration remains barred due to a lack of support mechanisms (Bednarik et al., 2013). Another trajectory for health care professionals is based on direct recruiting by receiving countries, whereby despite various attempts to establish internationally agreed 'codes of conduct', 'ethical nurse recruitment' (www.icn.ch) or bilateral agreements to address health workers migration or fair international recruitment in general, much needs to be done in the area of long-term care. From a European perspective this entails mutually agreed standards of cross-border recruitment, social security, the role of 'posted workers' in long-term care, and the monitoring of social consequences of significant labor force emigration in sending countries.

Characteristics of LTSS and the Workforce

Private sector versus public sector

In Europe the private sector is increasing rapidly. Western European countries have almost no public sector investment in LTSS. For example, the United Kingdom and Germany have less than 10% public sector investments and France, Spain, Belgium, and Italy have between 20% to 35%. One exception is the Nordic countries where demand is from the public sector more so than the private sector. The Netherlands has 80% public sector investment, followed by Sweden and Slovakia. One advantage of the private sector is its ability to react to the LTSS demand more rapidly than the public sector.

Distribution of Beneficiaries

In the European Union, most of the care is provided through cash benefits with or without informal care (approximately 40%), followed by home care (30%), and those who live in residential settings (20%). The Southern European countries rely more on informal care, though

there is less reliance on cash benefits in the Central and Eastern European countries. Residential care is high in the Nordic countries.

Informal Care

Long-term services and supports in European countries rely heavily on the care provided by informal caregivers, mainly spouses and children of the care-dependent person. This is also true in the United States. In most cases, the caregivers are women. Countries vary greatly to the extent to which the informal caregiver is supported by public policies.

Live-In Migrant Workers

Data on live-in migrant caregivers working in European countries are fragmentary, but for some of the major receiving countries it is possible to retrieve partly estimated numbers. For instance, there are about 70,000 registered "personal care assistants" in Austria, an estimated 300,000-400,000 in Germany, and more than 500,000 in Italy. According to the German Services Trade, Union Federation Verdi, between 115,000 and 300,000 migrants from Eastern Europe are working in the home care sector for older adults. Some European countries regulate live-in migrant workers. One example is a requirement in Austria's regulations that the live-in migrant workers receive time off after working for two weeks.

Characteristics of the Personal Care Assistant Workforce

Direct care workers, who provide most of the hands-on care to assist older adults and people with disabilities, numbered 4.4 million workers in the United States (2017). Direct care workers have a variety of occupations and work in different types of settings. These occupations include the following:

- Personal care aides (1.4 million): Provide daily support to older adults and people with disabilities.
- Home health aides (704,000): In addition to daily support provide clinical support and assistance with motion exercises to people living in the community.
- Nursing assistants (594,000): Provide similar tasks as home health aides but work in nursing homes.
- Independent providers (325,000): Employed directly by consumers in states with publicly-funded programs.
- Direct support professionals (1.3 million): Support people with intellectual and emotional disabilities.

The home care workforce in the United States is predominately female and increasingly diverse. The typical worker is a female in her 40s. Many are immigrants (29%) and/or women of color (60%). From 2005 to 2015, Black/African American workers consistently made up approximately 30% of the direct care workforce. Research shows profound disparities within

the home care workforce as white men have the highest median family income ($60,800), followed by men of color ($56,300), white women ($52,900), and women of color ($43,400).

Recruitment of Workers

The workforce itself is aging and new workers are needed to join the workforce. Given the shortage of workers, we need to think about new pipelines of workers—older workers, high school students, younger workers, and immigrants.

Older Workers

The average age of an LTSS worker is relatively high and more than half of Australian caregivers enter LTSS after the age of 40. It raises the question of the role of older workers and how to prepare the workforce and environment to allow older workers to enter and remain in the workforce. Some considerations are flexible scheduling, ergonomics, and job sharing.

Immigrants

Many countries use immigrants to help with the workforce shortage. In the United States, about one-third of home care workers and one-quarters of certified nursing assistants are immigrants. We see a similar pattern in other parts of the world in the use of immigrants for LTSS jobs. Italy has an over-representation of foreign-born workers and Israel has a guest worker program. Japan, who in the past was reluctant to accept immigrants, now has bilateral agreements with Indonesia to bring in workers. The United Kingdom and countries in the European Union have benefitted from porous borders. The workers come through managed migration and unmanaged migration. Most of the immigrant workers in the United States come through family reunification.

Immigration and migration patterns globally raise ethical issues and implications for the host and source countries. What about remittances? In the Philippines a huge proportion of the economy is through remittances, but not from LTSS workers alone. What about the draining of professionals to care for people in their home country? Finally, the tightening of immigration policies in many countries can have grave implications for the workforce.

New Graduates

New graduates require peer support to feel embedded in their work environment and to promote the development of peer and supervisory relationships. This can help assimilate them into their role. They require a resident program so new nurses are not just placed in a nursing home. In addition to providing support, providers should have opportunities for growth such as early career ladder programs and directing tuition assistance for leadership and gerontological courses and acquiring the essential knowledge for decision making. Finally, there should be incentives for staff such as time off for education and differentials for educational attainment.

Awareness

We need to create awareness about and raise the profile of the job opportunities in LTSS. The Czech Republic government created a public awareness campaign about nursing as a profession that was aimed at students and their parents. In four years, there was a 10% increase in the number of people entering the nursing profession.

Recruitment Abroad

One challenge is the lack of recognition for the qualifications of workers from other countries. In some situations, providers have trained doctors working as nurses and trained nurses working as direct care workers. The European Union is engaged in discussions on how to rectify the problem.

Recognition of Informal Caregivers

Informal caregivers caring for family members may be potential future workers when the family member passes away or no longer needs the service. These caregivers may be ready and willing to work in the social sector. However, a process isn't in place to make these connections for informal caregivers who want to enter the field.

Younger Workers

The challenges to attract younger workers to the field are they want more freedom and flexibility, don't want jobs with the physical and mental stress, want to make more money, and don't want to work night or weekend shifts.

Quality Training and Career Advancement Opportunities for LTSS to Retain Workers

Concerns on Training and Competencies of Workers

How do we train staff? What are the training and competencies needed for staff to do a quality job? Countries across the world have variations in the identified competencies for the workforce. Policymakers are not investing in the LTSS workforce. Most of the formal care (60 to 80%) is provided by direct care workers—aides, certified nursing assistants, and personal care aides. Clinicians, managerial staff, and C-Suite are critical to the infrastructure as well. Attention needs to be paid to the competencies for each of these jobs.

The insufficient training standards and their infrastructure doesn't equip direct care workers with the skills, knowledge, or confidence they need to succeed in their roles caring for people with acute, chronic conditions. In the United States, the training requirements for personal care aides vary by state and that is a challenge. Direct care workers also lack specialty training to

care for a complex and more diverse clientele. In addition, many training programs are didactic, not high quality, and don't abide by adult learning concepts.

In the United Kingdom, employer and staff engagement in training and development is highly variable across the sector, and there are some indications that investment in training is falling. Individuals are uncertain about the most appropriate training and qualifications, evidenced by the inconsistencies in training undertaken. In some cases, this results in staff leaving the sector.

Few LTSS providers offer cultural and linguistic services and workplace supports that are culturally and linguistically appropriate for their population. Lack of cultural and linguistic competence among workers and a need for training and incorporation of cultural competency into provider policies.

Direct care workers can benefit from career advancement opportunities and enhance their basic skills. Upskilled workers can be trained to report and manage clients on issues such as health conditions, risk factors, care plans, stressors in the home, social connections, and more. This can result in optimal client health, reduced hospitalizations, and emergency room visits. Direct care workers also need more advanced roles and increased compensation.

Training and Career Advancement Solutions

Direct care workers need stronger, standardized training requirements and better-quality training. The training requirements should be across occupations, be portable, and identify the competencies for workers. Training should not be didactic and should incorporate e-learning models and assessments to test workers on their skills. We need to support and disseminate effective e-learning models and test them, so we equip workers with the right skills.

Washington State increased the training hours required for a personal care aide and built a training infrastructure. Currently, Washington has the most rigorous requirement for its 60,000-home care and personal care aides—a minimum of 75 hours of entry-level training and 12 hours of continuing education. Competency-based in-person and online training teaches aides the skills needed to safely deliver personal care and instrumental activities of daily living assistance (including a special focus on tailored, nutritious meals preparation); person-first and cultural competency skills to help aides tailor service delivery; applied learning techniques around mental illness, dementia and chronic disease; professionalism, communication, problem-solving and relationship-building skills; and the knowledge and skills required to measure, identify and communicate to a care team significant changes in patients' health and function. Washington also developed the nation's first competency-based Advanced Home Care Aide Apprenticeship program that adds 70 hours of advanced on-the-job training to the basic 75-hour core curriculum.

Direct care workers need career paths and growth opportunities through advanced roles. These opportunities enable workers to take on more expansive and satisfying roles, which can reduce turnover and make the job more competitive with other comparable industries. Advanced roles can be created to: assist clients with care coordination and transitions; support clients with complex chronic conditions; assist with clinical observation and reporting; educate clients on health promotion and medication adherence; mentor newly hired aides; and help with entry-level training. A variety of interventions have demonstrated that when personal care aides take on advanced roles, they improve care for clients, reduce unnecessary emergency room visits, and potentially save health care costs.

The European Ageing Network (EAN), a group of more than 10,000 providers across the European continent, developed a training certificate for home directors. The training consists of 3 levels: basic (280 lessons), advanced (520 lessons), and professional (800 lessons). The basic certificate covers the following topics:

- The structures of long-term care.
- Care concepts, dementia, palliative care.
- Professional ethics and awareness of elder issues.
- The legal basis for the management of care facilities.
- Human resources management and leadership.
- Business and financial management and fundraising.
- Strategic and project management.
- Quality and process management in elderly care.
- Facility management.
- Risk, stress, time and case management.
- Digitalization and technologies.
- Communication, public relations, marketing.
- Country-specific topics.

Nurses: Recruitment and Retention Strategies

Overview of Problem of Nurse Supervision

Nurses in Canada, and other countries such as the U.S., are not taught in school and prepared to supervise and lead properly in the complex work environments of long-term services and support settings. Poor supervision negatively impacts quality of care for residents and causes frontline workers to leave the organization. Despite the importance of good supervision, there is limited knowledge on what factors affect supervisory practices. This limits our capacity to effectively improve them and raise the quality of care in long-term service and supports organizations.

RNs can be asked to supervise 30 aides in a nursing home and home care is often worse with the level of staff for supervision. In addition, some home care agencies are going digital which eliminates the need to visit the central office to collect schedules and talk to supervisors. This has removed one of the few opportunities that home care workers used to have to communicate with peers and supervisors.

Effective Supervisory Practices

Research examined what factors contribute to supervisory performance in long-term care settings. The study found that the quality and quantity of supervisory relationships had a central role in shaping the effectiveness of supervision. In the nursing homes with low supervisory scores the nurses and aides had infrequent connections that were driven primarily by the need to monitor and correct infractions of policies and procedures. The management style was rigid and the roles compartmentalized. The supervisory processes and structures were problematic for both quality of work life and quality of care.

The nursing homes with high supervisory scores had created frequent and high-quality interactions between supervisors and aides in trusting and supportive environments. Supervisor and aide awareness of the interdependence of their roles enhanced relationships and promoted communication and collaboration. Supervisors were flexible in their approach, cultivated fluid teams focused on responsiveness to residents' needs, and often pitched in to support other caregivers. Consistent use of these behaviors fostered improved work environments and facilitated staff's self-organization that was required to respond to residents' needs in a timely, effective and compassionate manner.

Dimensions of the Supervisory Role

Another challenge is that nurses work in highly regulated environments that create a problematic structure as nurses are paralyzed by forms and can easily go into a monitoring role and look for what is wrong because that is how they are judged. Nurses juggle many roles and the amount of time on each task or dimension of their responsibilities changes depending on the day and the shift. A research study was conducted to unpack the role of supervisors and understand the dimensions of the charge nurse role as a central figure in the nursing home setting. The study found that charge nurses have high variability in their role. The four key dimensions of their responsibilities are:

- Clinical work that involves direct work with the resident and indirect work such as supervising and auditing the health care provided by others.
- Supervisory work which is not limited to overseeing the quality and efficiency of the nursing staff but also encompasses leading teams, mentoring and educating colleagues.
- Team support work to support teams to deliver resident-centered care and maintain optimal levels of staffing.
- Managerial work and being in charge of the nursing home at large.

The high degree of variability in each shift to which tasks are required and the level of responsibility these tasks involve is dependent upon organizational, staffing, and resident factors. The role of the charge nurse is in flux, lacking clear boundaries and standardization within and across nursing homes. In addition to their clinical and supervisory work, charge nurses perform a variable amount of managerial and team support work which are not formally recognized.

Nurses in a charge nurse role would be more successful in provider organizations if they were adequately trained for the four dimensions involved in the role. For nursing home leaders seeking to attract and retain nurses, it is essential to be clear on what the charge nurse role entails, and to support staff to learn how to prioritize.

Attracting Nurses to the LTSS Field: Living Classroom Interactive Learning Program

Canada, similar to other countries, has a growing older adult population and shortage of nursing staff. It is difficult to attract new workers to the field and retain the workers. Schools have not done a great job preparing nurses to work for and care for clients with complex needs. This raises the questions of how to attract new nurses and nursing assistants to long-term care and how to prepare new graduates to care for older people when there is limited gerontological content in educational programs. Gerontological education should be a priority expectation. Nursing students are more likely to be attracted to settings where they have positive learning experiences in clinical placements.

This was the impetus for the Living Classroom (LC), a partnership between Schlegel Villages, College of Waterloo and Research Institute of Aging, to engage the next generation of workers. The program is an inter-professional approach whereby the training program is delivered within the context of a long-term care setting with team members (faculty, students, residents, family members, and volunteers) engaging within a culture of interactive learning. It provides a real environment for the students to practice new skills in the real world. The LC consists of classroom and clinical teaching for direct care workers and LPN students so they can apply gerontological content learned in class and interact with staff and residents in the nursing home as well as gain insight into the daily occurrences and work conducted in long-term care and residential facilities. The students learn about the culture, workload, and have conversations with family members that aren't easy. The program integrates the challenging situations into the learning because this is what pushes people out of the field.

Neighborhood Team Development

Another issue is retention of staff at long-term care organizations. Nursing assistants report they want to feel respected for their work and have supervisors make them feel part of a team. They seek flexible hours, job advancement opportunities, and overtime income.

Staff can feel supported when they work efficiently within high-functioning teams. LTSS needs to optimize the roles of people and to have a team-based approach where staff members have flexibility to take on tasks that are beyond their role or job as this impacts the quality of care and life for residents.

A neighborhood team development program was implemented at household model homes and at some traditional nursing homes. A neighborhood coordinator formed teams to serve residents and improve the quality of life. The teams examined the roles of each team member and how to cross-functionally work (e.g., the nurses, physical therapy, occupational therapy, etc.) to serve the residents. The team members met at least three times per year to discuss challenges in the neighborhood. They also attended trainings on topics such as conflict resolution and team culture in the neighborhood. Teams developed initiatives to improve the workplace environment or care for residents, such as moving to independent scheduling, implementing consistent assignment, creating their own budgets, and doing their own hires.

To improve the recruitment and retention of LTSS workers, it is key to find the right people and train them in a way that prepares them for the realities of the job and not just a two-week visit to “measure blood pressures.” This method prepares students for what the job will be like at the organization. The two programs have improved recruitment and retention of workers. Creating a positive learning experience in clinical environments, such as the Living Classroom, can motivate students to pursue careers in long-term services and support. Then creating supportive teams enhances retention, increases engagement, and increases person-centeredness. If people have meaningful jobs then they will give meaning to the residents and inspire the next generation.

Compensation and Value of the Workforce: Recruitment and Retention Solution

It is widely acknowledged that the LTSS sector needs to pay higher wages and a living wage for all workers, including direct care workers, and offer financial literacy and counseling programs. The financial literacy and counseling programs can help workers understand complex job-related benefits and supports (including health insurance options), navigate difficult financial situations, and plan for their short- and long-term financial futures. There is a need to account for benefit cliffs and benefit plateaus when crafting strategies that increase wages for direct care workers. These cliffs and plateaus occur when, as low-wage workers’ wages and hours

increase, their total compensation drops or remains the same due to corresponding decrease in public benefits.

One example of improving renumeration is the Czech Republic put pressure on the government to provide long-term services and supports sector with more money so the sector wouldn't collapse. The government increased the money provided to both the public and private sectors and salaries were raised by 33% in one year.

Data Solutions to Improve the LTSS Workforce

Better Data

Better and reliable data on the workforce can inform stakeholders on the most critical workforce shortages and track other workforce-related characteristics and trends. Some key opportunities and considerations are:

- Establish an infrastructure to systematically collect employer-level data on the direct care workforce and ensure consistent and public reporting of the data.
- Centralize training and certification records of direct care workers in a database made available to key stakeholders, such as current and potential employers, with safeguards to protect the privacy of workers.
- Fund original studies on the direct care workforce. These can include studies that measure workforce size and composition, and workers' experiences and needs, among other workforce indicators.

Data Infrastructure Project

A consortium of researchers in medicine, nursing, behavioral and social sciences from 21 countries have launched the WE-THRIVE initiative to develop a common data infrastructure. The goal is to identify measurement domains that are internationally relevant, prioritize concepts to operationalize domains, and specify a set of data elements that can be used across studies for data sharing and comparisons. The four domains identified for long-term services and support measurement that are salient internationally are:

- Organizational context, external and internal to the residential care setting.
- Workforce and staffing.
- Person-centered care.
- Care outcomes.

The five top concepts to measure within the workforce and staffing domain are:

- Staff skills, attitudes, and knowledge in relation to residents' needs.
- Staff collaboration and teamwork, including supervisory control and feeling supported.
- Training and self-efficacy of staff, including educational opportunities.

- Staff retention and turnover, including staff's sense of feeling valued, wage competitiveness, and the desire to stay on the job.
- Leadership and supervisory effectiveness, including delegation and task allocation.

Role of Technology and the LTSS Workforce

Why Focus on Technology

Long-term services and support work is labor intensive. Technology and artificial intelligence can support the workforce, but it is not a solution. The role of technology must be considered within the context of how the workforce is structured.

Technology has transformed every aspect of people's lives, and the older adult population is no exception. Need to think about ways that we can leverage technology to better deliver care and services. Technology can support independence and enable supportive services from monitoring technologies to Electronic Health Records. It has a positive impact on quality of life.

We are seeing an explosion of products coming on the market for social connectedness and engagement technologies fueled by human interfaces that have improved significantly with the latest addition of voice that makes these kinds of interfaces really easy to use. We are starting to see the positive impact on the quality of life of the residents. For providers, technology is imperative. The increasing demands for documented quality for regulatory reasons was the primary driver for the use of technology. We are seeing increasing pressures for improved communication and coordination to reduce hospital rate admission and value-based purchasing.

Use of Technology

Electronic Health Records

In the U.S. about less than 50% of providers have Electronic Health Records (EHRs). Not all EHRs are created equally or used meaningfully. LeadingAge Center for Aging Services Technologies has created an adoption model to reclassify functionalities of the EHRs and is collecting a few case studies on their impact. Some of the positive impacts are: 1) The Aloha Nursing Rehab Center freed up 1 FTE through EHR's Quality Assurance and Performance Improvement Reporting and Quality Dashboards and 2) Christian Health Care Center reduced staffing hours by 2% by reducing paper-based tasks and nursing overtime decreased by 80 hours per month as a result of eliminating end of month recaps.

Telehealth

A telehealth nurse can manage up to 200 patients in their own homes. It is not a replacement for the home health nurse or aide going to the person's home to deliver the care. It collects biometric and other data, so the nurse or aide has information about the health status and the

context about the individual. A case study of New Jewish Home that managed frequent flier group of patients with congestive heart failure had a hospital readmission rate of 29%. With the utilization of telehealth, they were able to reduce the rate to 16%. When the medication adherence monitoring device was added to the telehealth program the readmission rate went from 16% down to 5%.

Activity Monitoring

Activity monitoring is a behavioral monitoring system that monitors restlessness out of bed, time out of bed, and frequency of bathroom visits. The monitoring technology was piloted at two Volunteers of America assisted living facilities: One served as the intervention site and used the monitoring system and the other facility did not use the technology and served as the control site. The impact was the technology reduced billable intervention by 75% compared to the beginning of the pilot and compared to the control site. In addition, the perceived workload of the frontline caregivers at the control site was much higher than the perceived workload of the caregivers who used the technology. When you factor in the higher resident to staff ratio at the intervention site, you realize the intervention had a much more significant impact.

Social Connectedness

The Asbury Group nursing home recently deployed a portal for engaging residents with staff and giving information about activities throughout the community to their residents. Almost all the residents used the platform. One benefit was a 40% savings in staff time regarding preparing and inputting information in different parts of the system or delivering information to residents. In addition, there was increased communication between residents and staff and families that had a positive impact on perceived quality of life, resident engagement and resident satisfaction.

Is Technology a Threat to Staff?

Technology can be a perceived threat to staff especially among staff members who are less familiar with the technology and less competent or comfortable in the use of the technology. When staff is not engaged in technology visioning, planning, selection, standardization of data and process, workflow design, implementation, and training this can be problematic. Staff can also perceive threats when leadership doesn't address staff concerns and fears and doesn't reassure them early on how technology will assist them and not replace them.

Technology and Lessons Learned

Lessons learned over the past few years regarding staffing practices are:

- Leadership should understand and address staff technology concerns and fears, reassuring them of employment early on.
- Assess staff technology competencies and have basic technology training early on: they need these skills and will appreciate them.

- Familiarize staff with technology.
- Engage staff, including and especially frontline staff, in technology visioning, planning, selection, standardization of data and processes, workflow redesign, implementation, and training. Frontline staff will be using the technology and they should be part of the technology demonstrations on design use and test cases to evaluate the technology themselves and ask about the support and training modalities.

Technology Training Best Practices

Some best practices for providers regarding technology training are:

- Work with vendors to create customized and detailed training materials. Sometimes the vendor's training materials are not appropriate for the population and the end users.
- Employ training by peers or train-the-trainer for what is known as a group of "super-users," especially when it comes to Electronic Health Record training. The "super-user" should be on each shift and staff should be aware of the super-users for resolving any issues.
- Utilize different modalities: Hands-on, in-person, facilitator-led, online, and in-service refresher. Develop the training materials through apps on mobile devices.
- Training should be an ongoing endeavor that starts from new staff onboarding and orientation and continues on. It is a journey rather than a destination.

Technology and Staffing Research

Research conducted by University of California, San Francisco looked at the implications of health information technology on the nursing home worker, primarily the nurses, and why staff resisted technology. The study found that staff sometimes resisted the use technology, particularly nurses with longer tenure. They generally resisted the new ways things were being done because of the technology. However, staff members were interested in learning Health IT systems. Newer nurses tended to have more interest and learned the technology faster. The new nurses' age, not years of experience or tenure, determined their ability to adapt to the Health IT system.

Can Technology be a Solution in Support of Workforce?

Appropriate technologies can be an efficiency tool. They can make aging services a lot more attractive and fun work environments, especially in rural areas. This can be especially true for telehealth and telemedicine applications. They also can be used to attract, engage, and retain new, and especially younger, staff. Younger staff can be the largest potential pool in aging services, and they cannot live without their smart phones or tablets. They also have challenges to meaningfully engage or communicate without technology. It is difficult to expect them to work the whole day without it.

Technology is a "must" component in addressing the workforce shortage. Technologies should be included in strategies to attract, prescreen, shorten the hiring cycle, engage, and retain staff, especially millennials. This can be done by:

- Adopting technology and best practices, including training practices.
- Adopting appropriate policies and procedures to make communities more mobile friendly, such as exploring Bring Your Own Device if and when appropriate.
- Showcasing technology and efficiency tools, including mobile apps that support staff, in job fairs, recruitment ads/campaigns, and job postings.
- Encouraging Technology Ambassadors, at all levels, to also be recruitment ambassadors.

Provider Best Practices

PASSi: Cultural Competency Training and Retention Strategies

Penn Asian Senior Services (PASSi), a home care agency in the United States, serves a primarily Asian population and addresses language and cultural barriers faced by Asian older adults. The agency cares for people who have limited English language proficiency. PASSi has 600 home health aides who serve older clients in 17 different Asian languages. Approximately 70% of the PASSi clientele is served by family members due to a law in the state that allows older adults to have family members provide the care. The agency has a 70% retention rate among its aides.

PASSi opened a state licensed vocational training program (Penn Asian Vocational Institute) to address the gap in a trained bicultural/bilingual workforce. All instructors are bilingual RNs with experience working with the geriatric population in clinical settings and a special license to teach the course. The training is 80 hours and is offered in 4 different Asian languages. Caregivers are trained in their ethnic language and examination materials are also translated.

PASSi also provides all their caregivers in-service training every other month to improve their skills and knowledge. The continuing training supports caregivers confidence in their work and provides networking opportunities with peers. The training covers topics such as medication management, dementia and other specialty topics. The sessions are conducted in multiple languages with on-site translation from bilingual RNs.

PASSi employs 6 bilingual/bicultural community coordinators who are specialists in the local community and work with the home health aides. They have a vital role in the home care agency and mediate any disputes or issues that arise between the client and aide. They also educate clients to help them understand the role of the home health aide and the scope of their work. The coordinators and supervisors each visit clients two times per year. They also help with recruitment of aides as they can tap into different communities and inform

recruitment strategies. Immigrant communities are ideal to hiring direct care workers as these individuals have native language proficiency and can help address the employment gap.

Responsive Group Inc.: Talent Management and Development

Responsive Group Inc., an organization that oversees the operations of long-term care homes and retirement communities in Ontario, Canada, embarked on a multi-year journey to advance the talent management and development of its staff. The impetus was that the organization couldn't retain and grow workers if they were constantly hiring more people because of staff turnover. The talent management strategy involved development of core competencies across five levels, revised position summaries and job task inventories, performance management and personal improvement plans, and individual development plan process for employees at all levels.

The management team identified 11 core competencies across five levels of staff tied to the mission, values and vision of the organization and the skills management felt staff need to be successful at the organization. The competencies are grouped into tasks and tie into accountability, evaluations, and key performance metrics. Based on the competencies, position summaries and job task inventories were created. The position summaries clarify the role, identify the core competencies required for the role, and identify specific qualifications and education. The job task inventories group similar tasks regarding the role and provide further clarity of accountability and expectations.

The leadership team also recognized that the evaluation process wasn't effective because it lacked consistency and didn't help staff make improvements. The organization decided to move away from disciplinary conversations and focus on the individual and positive/constructive feedback. They developed a duality of performance improvement plan and individual development plan. The performance improvement plan is around a specific problem and an agreement between the supervisor and supervisee on how the behavior will change. The annual or bi-annual individual development plan focuses on the individual and what he or she wants to achieve. Each year the conversation between the staff and manager focuses on a different area. The advantage of this process is the ability to identify and track the core competencies of individuals and the areas they need to improve. In addition, staff with a high level of performance in a number of areas can work with their managers to focus on their advancement opportunities based on their areas of interest and the organization's interest. The overall talent management strategy has broadened the base of engagement and created a culture of mentoring, coaching and growth of individuals. It has helped improve recruitment and retention by advancing people who are more skilled, have more personal capacity and life skills.

Mercy Health: Learning Framework

Mercy Health is a large Catholic aging services and hospital system in Australia that offers a range of long-term care services from residential living and nursing care to independent living and home and community-based services. The organization employs over 10,000 people and operates in five out of eight states in Australia.

Mercy Health introduced a small, household model in seven of its 35 nursing homes and redefined the worker. The care companion is a universal worker who cares for eight to 15 people in one home. The organization instituted the consistent assignment model—the caregiver works with the same residents every day—in its household model and is rolling this out in all of its nursing homes. Mercy Health is evaluating the new model to assess the impact on nursing and care practices and on resident care outcomes.

The organization has developed a workforce plan that maps out the rules for an efficient workforce in the management team. The philosophy is that training and education should be embedded into the way an organization plans its whole business. Mercy Health established a learning framework that is a five-step framework starting at orientation through continuing professional development. The interactive training covers the heritage, values and philosophy of care and ethics and is designed to be personally informative. The goal at Mercy Health is to reorient staff so they become lifelong learners and self-developers.

In addition, Mercy Health has a leadership capability framework with the belief that every person at each level within the organization is a leader and can influence leadership. The framework has six core leadership capability clusters and articulates the behaviors that current and emerging leaders should aspire to exhibit at each stage of their career journey at Mercy Health. The framework sets the leadership expectations required of staff and allows management to assess cultural fit and alignment during the recruitment and selection process, assess leadership capability and identify gaps, which inform opportunities for individual development and career progression, and align leaders to mission, vision and values of the organization.

CONCLUSION

Many countries are experiencing a workforce crisis. This is due to the growing older adult population, fewer available workers, low investment in the LTSS workforce, low compensation, and poor working conditions. As the workforce ages and the traditional LTSS workforce decreases, providers should consider new pipelines of workers, including older workers, high school students, younger workers, and immigrants.

LTSS workers, including direct care workers who provide most of the hands-on care, are not adequately trained to care for the complex residents and clients and have few advancement opportunities. LTSS workers need stronger, standardized, high-quality training and career paths to take on more expansive, advanced roles. Nurses often are not prepared to supervise and lead in the complex LTSS workplace environments. It is important to include long-term care nursing in the curricula for nursing students, improve the preparation and competency of RNs entering the chare nurse role and those currently working within them, train nurses on effective supervision, and recognize the high level of responsibility taken up by charge nurses. In addition, nursing students and potential LTSS workers should have meaningful clinical placements and be able to apply and practice their new skills in a real-world environment that integrates the challenging situations. Technology can the support the workforce. Staff should be engaged in technology planning, selection, workflow design, implementation and training. Leadership should assure staff how the technology will assist them and make sure staff is adequately trained on the new technology. Finally, providers are implementing promising practices to improve training and to develop and engage staff.

APPENDIX

Examples of Provider Best Practices from Around the Globe Detailed Descriptions

PASSi: Cultural Competency Training and Retention Strategies

Penn Asian Senior Services (PASSi), a home care agency in the United States, serves a primarily Asian population and addresses language and cultural barriers faced by Asian older adults. It was started by Imai Choi in 2004 because her mother required assistance after cancer surgery, and she recognized a dearth of caregivers to care for seniors with language barriers. The agency cares for people who have limited English language proficiency. PASSi has 600 home health aides who serve older clients in 17 different Asian languages. Approximately 70% of the PASSi clientele is served by family members due to a law in the state that allows older adults to have family members provide the care. The agency has a 70% retention rate among its aides.

PASSi Training

A common constraint to serving a diverse consumer population is the lack of trained bilingual/bicultural healthcare professionals. PASSi opened a state licensed vocational training program (Penn Asian Vocational Institute) to address the gap in a trained bicultural/bilingual workforce. All instructors are bilingual RNs with experience working with the geriatric population in clinical settings and a special license to teach the course. The training is 80 hours and is offered in 4 different Asian languages (Mandarin or Cantonese Chinese, Vietnamese, Khmer Korean, and Hindi) and English. The caregivers are trained in their ethnic language and the training and examination materials are translated. The trainings are free to PASSi's field caregivers.

PASSi also offers Certified Nursing Assistant training for employment in nursing homes and hospitals. The training is conducted in English as the state exam is offered only in English. Bilingual/bicultural instructors provide an added cultural lens to the curriculum. PASSi offers competitive training tuition through income-based discounts when grants are available and installed payment plans for students.

Retention Strategies

PASSi utilizes several strategies to retain its workers. These include:

- Competitive pay and benefits to validate the value of the worker and support their livelihood. Well compensated family and paid caregivers help alleviate the family's financial stress.
- Client education to help them understand the role of the home health aide and non-duty items so clients do not make requests beyond the scope of work for the aide. The

agency also employs community coordinators to resolve issues between clients and the aides and explain to the clients the rights and obligations, so they understand the system.

- Provide all their caregivers in-service training every other month to improve their skills and knowledge. The continuing training supports caregiver's confidence in their work and provides networking opportunities with peers. The training covers topics such as medication management, dementia and other specialty topics. The sessions are conducted in multiple languages with on-site translation from bilingual RNs. The trainings are presented by experts in the field. Attendees are encouraged to network and build connection with fellow caregivers, which can be a great support for those who work in isolated environments. PASSi pays all employees who attend the 2-hour session, plus the worker gets bonus points at the end of the year for added income.

PASSi employs 6 bilingual/bicultural community coordinators who are specialists in the local community and work with the home health aides. They have a vital role in the home care agency and mediate any disputes or issues that arise between the client and aide. The coordinators and supervisors each visit clients two times per year. They also help with recruitment of aides as they can tap into different communities and inform recruitment strategies. Immigrant communities are ideal to hiring direct care workers as these individuals have native language proficiency and can help address the employment gap.

Responsive Group Inc.: Talent Management and Development

Responsive Group Inc., an organization that oversees the operations of long-term care homes and retirement communities in Ontario, Canada, embarked on a multi-year journey to advance the talent management and development of its staff. The impetus was that the organization couldn't retain and grow workers if they were constantly hiring more people because of staff turnover. The talent management strategy involved development of core competencies across five levels, revised position summaries and job task inventories, performance management and personal improvement plans, and individual development plan process for employees at all levels.

Core Competencies, Position Summaries and Job Task Inventories

The management team identified 11 core competencies across five levels of staff tied to the mission, values and vision of the organization and the skills management felt staff need to be successful at the organization. The competencies for Level 1 are the most hands-on and for people who are focused on what they are going to do in the next eight hours. At the other end of the spectrum is Level 5, which is for staff who are responsible for planning over a two to three-year period and coordinate resources beyond the provider site. The competencies are grouped into tasks and tie into accountability, evaluations, and key performance metrics. The 11 core competencies also include life skills and help staff with running, managing and developing a family. The core competencies are:

- Teamwork and collaboration.
- Developing others.
- Service and quality focused.
- Interpersonal sensitivity.
- Leadership presence.
- Holding self and others accountable.
- Conflict management.
- Strategic orientation.
- Integrity.
- Resource management.
- Planning, coordination and implementation.

Based on the competencies, position summaries and job task inventories were created. The position summaries clarify the role, identify the core competencies required for the role, and identify specific qualifications and education. The job task inventories group similar tasks regarding the role and provide further clarity of accountability and expectations.

Performance Management and Personal Improvement Plans

The leadership team recognized that the evaluation process wasn't effective because it lacked consistency and didn't help staff make improvements. The performance evaluation combined

managing problems with career advancement. The staffing ratios in the nursing and personal care departments are high and many staff hadn't talked with their supervisor about their performance for several years. Responsive Group Inc. wanted to move away from disciplinary conversations and focus on the individual and positive/constructive feedback. When the disciplinary process is required, the managers work with staff to develop performance improvement plans.

They put aside the process and developed a duality of performance improvement plan and individual development plan. The performance improvement plan is around a specific problem and an agreement between the supervisor and supervisee on how the behavior will change. The annual or bi-annual individual development plan focuses on the individual and what he or she wants to achieve. Each year the conversation between the staff and manager focuses on a different area. The topic last year was on resources and support staff seek from managers. Staff and manager report the lessons learned during the process, including what went well and what didn't work.

The advantage of this process is the ability to identify and track the core competencies of individuals and the areas they need to improve. In addition, staff with a high level of performance in several areas can work with their managers to focus on their advancement opportunities based on their areas of interest and the organization's interest.

The program was difficult to implement. Not all the supervisors and managers embraced the new approach, even those who initially supported it. Some of the longer-term employees had a hard time with the new model.

The organization has received positive feedback on the individual development plan program.

- The process is faster and more personal.
- Frontline staff perceive the program as beneficial.
- Managers can get to know their staff better, both professionally and personally. It allows for good conversations and shows staff that managers recognize what they are doing.
- It is powerful for engagement with staff when they have an opportunity to discuss their needs.

Career Advancement: Executive Director and Director of Care Positions

In Ontario, the executive director and director of care positions are difficult to fill. When providers hire for these positions externally, the retention is low. However, when promote from within find that the averages for retention are high. Responsive Group Inc. implemented a performance and risk retention strategy by identifying people they didn't want to lose through a competitor because they didn't create a career path for them. They concentrated on these

individuals for career advancement and to mitigate the risk of losing the staff member. This was accomplished through leadership modules, a leadership coach, and team development.

Training

The organization utilizes a Learning Management System (LMS) for the regulatory components of 10 required training sessions each year for managers. The training includes clinical training and compliance training. The LMS has an annual training calendar and staff can track and follow-up for completion of the training. All the platforms are available on the cloud and accessible 24/7.

Leadership assessment

In addition to experience, skills, and good references, leaders require self-awareness. If leaders don't understand themselves and have sensitivity to understand people, then they will have a tough time being a leader. The organization uses three leadership assessment tools—360 Reviews, Behavioral assessments, and Strength-based leadership. The 360 Review is basic. Responsive Group Inc. doesn't us it frequently and it is self-directed. The behavioral assessment tool is a predictive index and facilitates conversations leaders can have with themselves and with their coworkers. It is low cost and time efficient. The strength-based leadership assessment tool is designed to find the strengths of the leaders. The tool has 32 strengths and focuses on the five strengths of the individual. When used and shared as an organization, you can see the collective strengths of the organizational staff. You begin to see patterns in the different departments and where people have strengths outside of their job responsibilities. Collectively this adds to the depth and capacity of the organization. It demonstrates where each person can be a contributor to the organization beyond their role and function.

Leadership Coach

A leadership coach is a full-time position and responds to requests from management teams and homes and offers specific training programs (e.g., understanding organizations, emotional intelligence, and crucial conversations). Responsive Group Inc. felt that the topic on crucial conversations was critical because these conversations occur every day between caregivers and residents, between staff and family, between different professionals, and between management and staff. Staff need to develop life skills around these types of conversations that are difficult to execute.

Team Development

In 2016, leadership discussed the heavy workload of the executive directors and director of care. The organization created an artificial bottleneck within leadership around these positions. They identified areas where executive directors and directors of care have capacity and interest but lack time. Responsive Group Inc. reorganized resources to create new roles—Clinical Practice Coordinator, Director/Talent Management, and Employee Engagement Specialist. The

Employee Engagement Specialist focuses on absenteeism, recruitment, IDP and administrative support, development of staff, and wellness. Responsive Group Inc. hires people for the position with talent in labor management, industrial relations, and talent development. The reallocation of resources to create the position has resulted in reduced absenteeism, overtime, agency costs and turnover and has more than paid for the position. It also has freed up the directors of care and other directors on their primary aspects of the job and not worrying about whether have staff at the home for the weekend.

The overall talent management strategy has broadened the base of engagement and created a culture of mentoring, coaching and growth of individuals. It has helped improve recruitment and retention by advancing people who are more skilled, have more personal capacity and life skills.

Mercy Health: Learning Framework

Mercy Health is a large Catholic aging services and hospital system in Australia that offers a range of long-term care services from residential living and nursing care to independent living and home and community-based services. The organization employs over 10,000 people and operates in five out of eight states in Australia.

The demographics of the workforce at Mercy Health in Australia is like other countries. The majority is female, half work part-time and about one-third work casually. The average age of the caregiver is 45 years. Mercy Health believes it is important to know the demographics of your workforce, so you know who you are developing, teaching, training, and retaining.

Mercy Health's Learning Framework and Care Companion Worker

One solution Mercy Health embarked on to address the workforce shortage is an innovative model to define the vision. Mercy Health introduced a small, household model in seven of its 35 nursing homes and redefined the worker. The care companion is a universal worker who cares for eight to 15 people in one home. The organization instituted the consistent assignment model—the caregiver works with the same residents every day—in its household model and is rolling this out in all of its nursing homes. Mercy Health is evaluating the new model to assess the impact on nursing and care practices and on resident care outcomes.

Mercy Health's mission and values define every aspect of its operations. Mercy Health employs, trains and educates, and reviews staff in accordance with the mission and values. It also lives its values in the position descriptions, advertisements and annual performance development reviews. The organization has developed a workforce plan that maps out the rules for an efficient workforce in the management team. The philosophy is that training and education should be embedded into the way an organization plans its whole business.

Recruitment is the first part of education and getting the right people employed at the organization each time. Each person who applies for a job at Mercy Health is psychometrically tested to make sure they have the psychometric care components, attitude, and emotional intelligence for the position. The individual then moves through the system of the training centers to obtain the skills and competencies necessary for the job.

Mercy Health established a learning framework that is a five-step framework starting at orientation through continuing professional development. The interactive training covers the heritage, values and philosophy of care and ethics and is designed to be personally informative. The goal at Mercy Health is to reorient staff so they become lifelong learners and self-developers.

In addition, Mercy Health has a leadership capability framework with the belief that every person at each level within the organization is a leader and can influence leadership. The framework has six core leadership capability clusters and articulates the behaviors that current and emerging leaders should aspire to exhibit at each stage of their career journey at Mercy Health. The framework sets the leadership expectations required of staff and allows management to assess cultural fit and alignment during the recruitment and selection process, assess leadership capability and identify gaps, which inform opportunities for individual development and career progression, and align leaders to mission, vision and values of the organization.

Outcomes

Mercy Health has seen positive, early outcomes with the household model and care companion positions. It has resulted in:

- Lower levels of depression scores.
- 170% reduction in the use of psychotropic medication. Staff are more equipped to deal with behavior and are more able to predict mood.
- Decreased requirement for food supplements and completely eliminated in four homes.
- Increased engagement in lifestyle activities. The care companions know the individual resident preferences.
- Increased food satisfaction. Among resident's staff wanted to gain weight, 95% of them have weight gain. Food costs are down because there is no wastage.
- Reduction in staff sick leave from 4% to 2%.
- Lower staff turnover—1 turnover in 12 months and 97% retention rate among caregiver at small, household model compared to 85% retention rate in other, more traditional nursing homes.
- No worker injuries in 12 months.
- Higher engagement and staff satisfaction rates.

Practices from the Field among a Provider and Technology Vendor: Implications of the Workforce and Technology

The perspectives are based on a panel discussion with a provider, Evangelical Homes of Michigan, and a technology vendor, PointClickCare.

Evangelical Homes of Michigan

Provider Perspective: Value Proposition of Workforce and Embracement of Technology

Evangelical Homes of Michigan (EHM) had an opportunity to embark on a different track on innovations using technology to enhance the care provided to clients. Approximately ten years ago, EHM along with 10 other US providers started to develop continuing care at home model. It is a long-term service and supports model in the private sector where consumers pay a one-time fee and then are guaranteed care for life. EHM had to deploy individuals into the home at distances of more than 4 hours in the car from the organization. Technology was key to keep older adults safe, happy and well in the home.

When look at the value proposition, technology allows the employees the concept of high tech and high touch. Technology enables them to be stronger caregivers of clients. For example, staff don't have to worry about the home care client and whether he or she is taking medications. The sensor technology lets staff know if the client has taken the medication. Another example is the technology allows staff to know that the diabetic resident has taken his or her insulin. If not done, staff will call the resident to remind them. The value proposition is the speed of trust of the caregiver/nursing assistant managing a cohort of individuals to create and monitor the client's health and well-being in greater way and trust as a valued partner.

EHM initially served 600 clients and then went to 5,500 clients over 10 years. Approximately 1,500 clients are being monitored and served through wireless technology apps employees have on their own devices that are password-protected. Each nursing assistant has a cohort of 20 or 30 clients. Staff is aware of any concerns or issues with the clients through wireless technology.

Lessons Learned

Need to think about how deliver service with a geography that has up to a two to three-hour distance in driving. It is challenging to deploy a workforce who is punching in one place and leaving to deliver care in another environment or waking up in the morning before they even punch in and being responsible for taking care of 20 people in their home. EHM used employees from the communities who could be deployed to install technology devices in a client's home, such as Lifeline (a medical alert system) or a sensor, during their workday with

permission from the supervisor. While this could be a logistical nightmare, it caused major engagement of employees toward technology and innovation. The organization trusted them to leave the workforce to install the technology and explain it to the client. The worker became the client's person: checked in on them and became ambassador for the adoption with the older adult as well. It took some logistics and letting teams work through the processes. The biggest "aha" moment for the CEO was the use of technology and innovation as an enabler to create a work environment that became fun for everyone. Staff talked about it at orientation to new workers and promoted EHM in the community. The benefit was retention increased, workforce turnover decreased and ability to recruit became stronger.

One key to the success is EHM works with technology providers who partner with the organization to deliver the service into the home and understand that the staff vet the product and not a CFO in an office. EHM also works with technology providers that are newer, not seasoned technology developers, because they are open to individualize the product. They will change it, write a new code and make revisions if the technology isn't working and change the parameters. The technology developers also have to commit to delivering a piece of technology, based on the assessed client needs, within 24 hours of the visit in the home. This is due to the cash flow in long-term care. EHM has maintained a group of about 25 or 30 technology providers that are true partners.

Impact and Return on Investment

EHM was a 1,200-person workforce at that time—home care, skilled nursing, long-term supports, some senior living, and dementia care. It had a small vacancy factor. At the time CEO left, EHM had 80 vacancies out of 1,200-person workforce.

Return on investment (ROI) can be defined in multiple ways. Workforce engagement is not valued enough by executives in long-term services and supports—engagement, retention, and ability to recruit and get new employees interested in the LTSS sector is very important. There are tangible ROI for EHM—readmission for hospital rates are in the five to six percent range. Factor of trust is important. When EHM tests technology to be delivered to the consumer in the home by a caregiver or family member, the organization is committed that nobody is terminated based on the data in the backroom platform that leadership can see, including call light answering, falls not detected by the emergency response, failure to get up in the morning and check sensor data on the app. The staff believe there is a partner in the journey to test new ways to deliver services. Those are important ROIs and that the LTSS sector needs to be better at monitoring and evaluating its value.

Advice for Providers Embarking on Strategy Using Technology as Relates to Workforce

The United States has very little reimbursement other than telehealth and telemonitoring world. Look at ROI in different way to enhance workforce and be that recruitment technique or retention tool. Continue to look at future because there will be a point where it will be common for all of us to distantly monitor an older adult and help them live a healthier life. We can be that influencer to changing their lifestyle.

PointClickCare: How PointClickCare Leverages Technology?

PointClickCare (PCC) is the largest provider of Electronic Health Records in North America. Over 17,000 providers use the cloud-based software for skilled, senior living and home care. PCC has over 1,600 employees today and 500 to 600 are remote employees. This raises the question about how to keep the remote workers engaged with the company.

Technology is a big piece for the remote workforce and staff need constant training and education. PCC has four or five internal applications that promote and work to get training onboard. Training isn't just on the developer programs and customer support, but it is nursing home 101. The programmers may only get the nursing home 101 but people implementing the systems need to understand Medicare, Medicaid and all the finite details.

PCC also has a rewards and recognition software in-house so they can publish the good works of employees and the managers affected by the good works. The employees can earn points and PCC gamifies things to that effect.

PCC has online training for their products and often run competitions among staff. Going through implementation of a new technology is not easy for providers. The employees need to understand the basics, stop and address issues. It is not a cookie cutter approach.

PCC Education of Staff: Minimize Issues at Product Design or End User/Customer Training Materials and Support Programs

It is easy to get away from the industry as a company grows. PCC focuses on being a technology company and a long-term care/post-acute care company. The company believes you can't get away from the provider side or industry piece. If something goes wrong with the technologies, it is a big deal and it is important to keep the focus. The leaders and executives of PCC are constantly in the field. This is particularly important for people who are hired and not from the industry. Think about how to set them up with executive sponsors from the provider side so they are constantly engaged with them.

PCC has a customer advisory board with representatives from all different segments of the sector: home care, senior living, skilled, multi-chain, independent and all the different groups. They drive the product development, education tools and learning tools.

Use of Technology to Measure and Improve Employee Engagement and Retention

Regardless of whether you are a software technology company or provider, without proper trust employee engagement survey products won't mean much. You really need to have trust and have the organization in order before using the tools. PCC uses employee engagement solution twice a year to measure the different statistics. It is used as a coaching tool. It is important to act when you get the feedback from the survey tools and not just publish the stats. Everyone knows the good and bad managers and the question is what the organization does about it. What are we doing to act: Are we coaching people out of organization as sometimes we have to do that or are, we coaching people up?

The provider side has great acceptance of the employee engagement tools. Workforce management is a huge deal and comes in as one of the top three issues. Providers are moving ahead with workforce management. Typically, in assisted living see 30% turnover and skilled see 50% turnover—anything can do to keep employees in place is a positive.

PCC also has a developer program that allows other third-party products to connect with the technology. For example, a vendor may want the acuity data to help improve staff scheduling. They also use employee engagement software. One of the top items among providers is how to help them address these workforce issues.

Technology and Return on Investment

For PCC, the ROI is easy. Staff can chart faster, have more time with residents and improve patient care. Fewer pharmacy errors are easy to document that show up in ROI. From workforce and management standpoint there are lots of good ROI features. It costs 60% of a skilled employee first annual salary to recruit, hire and bring up to speed and make practical as a new employee. If you can put any tool to get them in place and retain them, it is easy to justify. Need good foundation to start with and grow from there.

Advice for Providers Embarking on Strategy Using Technology as Relates to Workforce

Providers should be early adopters of technology. It is important to make sure the technology is affordable, and the organization can justify the ROI. Make sure you partner—lots of organizations that will embrace you. Leverage associations, whether it is the national or sister associations, that have platforms to look at and evaluate different types of technologies.

Research Based Practices Detailed Descriptions

The Role and Importance of Nurses and Effective Supervision: Retention Strategy

Overview of Problem

Nurses in Canada, and other countries such as the U.S., are not taught in school and prepared to supervise and lead properly in the complex work environments of long-term services and support settings. Poor supervision negatively impacts quality of care for residents and causes frontline workers to leave the organization. Despite the importance of good supervision, there is limited knowledge on what factors affect supervisory practices. This limits our capacity to effectively improve them and raise the quality of care in long-term service and supports organizations.

RNs can be asked to supervise 30 aides in a nursing home and home care is often worse with the level of staff for supervision. In addition, some home care agencies are going digital which eliminates the need to visit the central office to collect schedules and talk to supervisors. This has removed one of the few opportunities that home care workers used to have to communicate with peers and supervisors.

Effective Supervisory Practices

Research examined how to enhance the relationship between nurses and aides through a survey of 400 nursing homes in Canada. The goal of the project was to describe how different patterns of interactions between nurse supervisors and personal support workers contribute to the supervisory performance of nurses. The research team examined the five nursing homes rated highest for supervisory effectiveness and the five nursing homes with the lowest supervisory ratings.

The common theme among the nursing homes with low supervisory scores was the nurses and aides had infrequent connections that were driven primarily by the need to monitor and correct infractions of policies and procedures. The nurses only spoke to the aides when they were doing something wrong. The management style was rigid, and the roles compartmentalized. The supervisory processes and structures were problematic for both quality of work life and quality of care.

The nursing homes with high supervisory scores had created frequent interactions between supervisors and aides in trusting and supportive environments. The nurses and aides were “in it together” and nurses listened to the frontline staff. Supervision was carried out flexibly, by

fostering fluid teams focused on responding to the needs of the residents. The supervisory processes and structures enhanced resident-centered care approach and teamwork.

The two major behavioral factors in the nursing homes with high supervisory scores that stood out were:

- A common understanding of interdependence among staff. Nurses provided frontline staff with space to get what they needed done. Both supervisors and personal care assistants were aware of the interdependence of their roles in caring for residents and it enhanced their relationships and promoted communication and collaboration.
- Effective nurse supervisors acknowledged self-organization and worked in environments that encouraged fluidity of roles. Supervisors were able to continuously adapt their strategies to the needs of the organization and the characteristics of their units and supervisees. This approach allowed staff to effectively self-organize and to respond to residents' needs in a fluid and creative way. When staff worked collaboratively to meet the needs of residents, regardless of whether a task could be performed by a staff member with less training or whether the task was assigned to a peer, it created a more cohesive, healthy work environment.

Consistent use of these behaviors fostered improved work environments and facilitated staff's self-organization that was required to respond to residents' needs in a timely, effective and compassionate manner.

Dimensions of the Supervisory Role

Another challenge is that nurses work in highly regulated environments that create a problematic structure as nurses are paralyzed by forms and can easily go into a monitoring role and look for what is wrong because that is how they are judged. Nurses juggle many roles and the amount of time on each task or dimension of their responsibility's changes depending on the day and the shift. A research study was conducted to unpack the role of supervisors. The study was conducted in five nursing homes with 10 supervisors/charge nurses.

Charge nurses have high variability in their role. There are different dimensions of the supervisory role and charge nurses spend varying amounts of time on each dimension depending on the part of the day.

- *Dimension 1: Clinical Work.* Charge nurses play a key role in assessing and treating residents' health, including medication administration, assessments, and treatments. The clinical work involves direct work with the resident and indirect work such as supervising and auditing the health care provided by others.
- *Dimension 2: Supervisory Work.* Supervisory work is not limited to overseeing the quality and efficiency of the nursing staff. It encompasses leading teams, mentoring, and educating colleagues. The organization's structure, number of beds, and model of care

are amongst the factors that determine the charge nurse's direct line of supervision and number of staff they supervise. The charge nurse's supervisory skills and approach have a direct impact on the team dynamics and relationships.

- *Dimension 3: Team Support Work.* Maintaining optimal levels of staffing at long-term care organizations is a common struggle and there are often permanent or occasional low staff to resident ratios. At some organizations, team members decide whether to fill in for co-workers when they are busy and for others it is engrained in the culture and expected by all.
- *Dimension 4: Managerial Work.* Overseeing the facility at large.

Charge nurses differed in their regard for paperwork and administration in general, and they all shared a concern with the increased administrative burden they have experienced related to the different dimensions of their role. The administrative tasks that charge nurses perform were highly variable, based on the facility and the shift.

There is a high degree of variability in each shift to which tasks are required and the level of responsibility these tasks involve, and this is dependent upon organizational, staffing, and resident factors. The role of the charge nurse is in flux, lacking clear boundaries and standardization within and across nursing homes. In addition to their clinical and supervisory work, charge nurses perform a variable amount of managerial and team support work which are not formally recognized.

Preparation and Workplace Practices for Nurses

The nursing home environment is complex and difficult place for people to work. We haven't scaled up the workforce for the client's nurses care for in the nursing home. Some recommendations are:

- Early inclusion of long-term care nursing within the curricula, along with focus on leadership development and creating opportunities for nursing students to gain meaningful experiences in long-term services and supports settings.
- Improve the preparation and competency of RNs entering the charge nurse role and those currently working within them. A multi-faceted approach could be to set some standards: some experience in acute care to account for the clinical decision making needed in long-term care facing an increase in resident complexity, and some experience in long-term care to account for the knowledge of the sector needed for their supervisory and managerial work.
- The same way that a graduate in business administration is not offered a middle management or supervisor position at a company right out of school, similar practices should exist for RNs in long-term care.
- Formal and appropriate acknowledgement of the complex role and the adequate education and experience required from the long-term services and supports by the

administrators may increase job satisfaction, as well as help with recruitment and retention of RNs in these charge nurse roles.
- The conceptual framework proposed can be used to map and assess charge nurses' workloads and responsibilities, in order to enhance quality of care and resident-centered care in provider organizations.
- RNs in a charge nurse role would be more successful in provider organizations if they were adequately trained for the four dimensions involved in the role. For nursing home leaders seeking to attract and retain RNs, it is essential to be clear on what the charge nurse role entails, and to support staff to learn how to prioritize.
- A recognition of the high level of responsibility taken up by charge nurses could increase staff satisfaction, and in turn reduce staff turnover and burnout.

We may be setting charge nurses up for failure and jeopardizing their health by recruiting new graduates for this role, which may lead to deleterious effects on resident outcomes, the work environment, and staff outcomes.

Recruitment and Retention in Long-Term Care: Living Classroom and Neighborhood Team Development

Overview of the Problem

The number of older adults in Canada is growing, increasing from 14.4% in 2011 to 17.2% in 2018. At the same time few LPNs (38.1%) and RNs (8.9%) choose to work in long-term care or retirement homes. It is not a first choice for graduating nurses. The need for care providers in long-term services and supports continues to be a challenge. It is a burden to attract new workers to the field and retention is difficult. LTSS is viewed as a challenging work environment. Direct care providers have a significant impact on residents' quality of life. Unmet needs of residents are linked with adverse outcomes, such as emergency department visits. When link these outcomes with the person providing the care, this creates a bigger stigma for the caregiver. The nurse can be solely responsible for the outcomes of the resident reinforcing the responsibility of the job in the field.

Schools have not done a great job preparing nurses to work for and care for clients with complex needs.
- The undergraduate education among RNs is criticized for missing opportunities and disorganized approach for supporting gerontological content.
- Direct care workers and LPNs have persistent deficits in gerontological content in their education.
- Few leaders are teaching gerontology classes.
- Nurses lack training on leadership, dementia, person-centered care, and communication, all important capabilities. T

- The educational system sets up students that long-term care is easy, and this has done a disservice for nurses.

These raise the questions of how we can attract new nurses and nursing assistants to long-term care and how we can prepare new graduates to care for older people when there is limited gerontological content in educational programs. Gerontological education should be a priority expectation. Nursing students are more likely to be attracted to settings where they have positive learning experiences in clinical placements.

Living Classroom to Recruit Staff

This was the impetus for the Living Classroom (LC), a partnership between Schlegel Villages, College of Waterloo and Research Institute of Aging, to engage the next generation of workers. The program is an inter-professional approach whereby the training program is delivered within the context of a long-term care setting with team members (faculty, students, residents, family members, and volunteers) engaging within a culture of interactive learning. It provides a real environment for the students to practice new skills in the real world. The LC consists of classroom and clinical teaching for direct care workers and LPN students so they can apply gerontological content learned in class and interact with staff and residents in the nursing home as well as gain insight into the daily occurrences and work conducted in long-term care and residential facilities. The students learn about the culture, workload, and have conversations with family members that aren't easy. The program integrates the challenging situations into the learning because this is what pushes people out of the field.

Residents interview the students and adopt a student to help them understand what it is like to live in a retirement home. Students have their gerontological curriculum enhanced by adding modules that were designed to achieve: 1) increased knowledge of the social needs of older adults; 2) understand aging as a continuum with varying needs; and 3) develop the ability to recognize an older person within a social context. The focus is on wellbeing and living with dementia, which is often lacking from curricula.

Outcomes of the Program

Students give high marks for the program. The students and residents formed strong bonds. Student participation in the long-term care or residential community progressed from observational and friendly visits to participation in care with older adults and active participation in the care team. This allows for immediate application of and reflection on classroom learning. Among a cohort of graduates, most of the students indicated that they want to work in long-term services and supports: 65.2% indicated LTSS as a preference for a workplace. Students in a traditional classroom generally prefer to work in other sectors of healthcare and not LTSS (typically 2% of students in the traditional classroom prefer LTSS workplace).

It is difficult to compare the program to students taught in the traditional classroom. Students in the LC environment haven't been in traditional classroom and don't know the difference. Regular college students don't know what it is like to be in the LC environment.

This model also influenced the faculty as to how they can look differently at their educational program and integrate this type of learning for other disciplines. They are incorporating resident-student interactions into the teaching program for occupational therapy, physical therapy, social work, paramedics, and other disciplines.

Neighborhood Team Development to Address Retention

Another issue is retention of staff at long-term care organizations. Turnover is high, ranging from 55% to over 100%, and many staff experience stress and high levels of burnout. The cost of replacing a direct care worker is $4,500 (including indirect costs) and for RN it is over $7,000.

Nursing assistants report they want to feel respected for their work and have supervisors make them feel part of a team. They seek flexible hours, job advancement opportunities, and overtime income.

Staff can feel supported when they work efficiently within high-functioning teams. LTSS needs to optimize the roles of people and to have a team-based approach. The current "norm" for teams are hierarchical and task-oriented, and they lack communication and supportive leadership ability. There is a need to optimize the roles and staff member flexibility to take on tasks that are beyond their role or job as this impacts the quality of care and life for residents. The culture won't improve by having courses at one level or another if the team cohesion isn't in place.

A neighborhood team development program was implemented at household model homes and at some traditional nursing homes. A neighborhood coordinator formed teams to serve residents and improve the quality of life. The neighborhood coordinator was not always the physician or nurse but the staff person who had leadership skills. The teams examined the roles of each team member and how to cross-functionally work (e.g., the nurses, physical therapy, occupational therapy, etc.) to serve the residents. The team members met at least three times per year to discuss challenges in the neighborhood. They also attended trainings on topics such as conflict resolution and team culture in the neighborhood. Teams developed initiatives to improve the workplace environment or care for residents, such as moving to independent scheduling, implementing consistent assignment, creating their own budgets, and doing their own hires.

Outcomes

Program is being evaluated and some of the findings are:

- Increased engagement scores and strong staff engagement.
- Two of the four homes are working towards high scores of person-centeredness.
- Improved quality indicators.
- Increased transformational leadership scores.
- In the beginning, the homes had increased turnover rates because the new culture wasn't a fit for some of the workers. People had to make decisions on whether they wanted to be part of the model. The turnover rate has since decreased to 15 staff members leaving in one year and a reduction in nursing staff and direct care worker staff terminations.
- Increased sense of "team." Teams developed strong sense of belonging to discuss their roles and responsibilities and their participation.

To improve the recruitment and retention of LTSS workers, it is key to find the right people and train them in a way that prepares them for the realities of the job and not just a two-week visit to "measure blood pressures." This method prepares students for what the job will be like at the organization. The two programs have improved recruitment and retention of workers. Creating a positive learning experience in clinical environments, such as the Living Classroom, can motivate students to pursue careers in long-term services and support. Then creating supportive teams enhances retention, increases engagement, and increases person-centeredness. If people have meaningful jobs, then they will give meaning to the residents and inspire the next generation.

Wrap-Up Points from the Summit

Stuart Feldman
General Manager, PointClickCare

The term used internally at PointClickCare is the force multiplier as it relates to technology. It can be on the caregiving community or relate to employee retention. As look at opportunities to improve processes everything should be designed with it being a force multiplier. Whatever you do today, you have a more efficient way of getting to the goal. One example in the technology world is improving the process for a product to go from five clicks to two clicks to meet the goal or it can be a more complicated process. Look at platforms for knowledge, dissemination and sharing. Centralizing these for organizations, depending on whether large or small, is an opportunity. No one person ever has authority for great ideas. Those often come from working with frontline staff and getting them engaged with management staff and executives. Ensuring there is an opportunity for people to come forward and share their ideas on a singular platform is essential to success of being able to direct change.

Be the change that you want to be. The industry is very challenging, and it is easy to have downer conversation. The statistics on the industry takes the wind out of sails in many ways. We have ability to change the narrative. Giving people the ability to give back to the community by working in healthcare is far more rewarding than stocking shelves at Amazon. Make sure we change how talk about the industry and to be passionate about it. The concept of giving people the actual experience of what they are going to encounter before they walk in the door is beneficial. Give people the opportunity to look and see under the cover of what long-term care is about is how to change the conversation.

Apple is cool and people think that Apple products and computers are cool even though expensive. If you are an organization that is looking at investing in hardware on what will attract and maintain talent, having something that is at least at minimum on parity of what receive in acute care environment is important in terms of what they look at in the enablement of technology in the long-term services and supports environment. It should be fun and cool. Training shouldn't be an exercise. Gamification is something that adults respond to and should introduce that concept in learning. There are a lot of studies from Canada in relation to impact of gamification on training versus someone being in the traditional learning environment in a classroom. It doesn't work.

Technology shouldn't create a negative disruption when brought into the market as it relates to managing workforce and the delivery of care and services. If bringing technology to the forefront and it is making it more difficult for staff, then it is the wrong technology. Technology shouldn't be disruptive.

Robyn Stone
SVP and LTSS Director, LeadingAge

Thanked participants for attending the summit, speakers for their presentation, and PointClickCare for sponsoring the event. We started with the conversation that it is about people. We ended with conversation that it is about the people.

Global Ageing Network would like to get workgroup going around this issue. Global Ageing Network is trying to generate and keep energy and to move it forward. Our goal, and particularly with the Global Ageing Network, is to make it clear from the provider perspective, elder care and the workforce issues are paramount. How can we influence the quality of the development of that workforce over the next 20 to 25 years?

I think it is wonderful closed with technology piece and tried to demonstrate the relationship between technology and the workforce. Unless they are together this will not work. We have a lot more to do about this issue. We need more research on what technologies produce on productivity. OECD in latest report indicated that we have very little evidence base about what is the productivity around the various interventions that are being used with the workforce. The next step is to get more evidence behind this so we can help people make better decisions.

Help us by providing feedback on what are the most burning issues around workforce. The learning laboratory for the students is a fantastic concept and believe should have them all over the world. We have learning laboratories for researchers in provider organizations. We don't have the same models of a learning laboratory for students to get them engaged beyond the one awful placement they tend to get at aging service providers. If had these all over the world, think we would be making a significant contribution to getting people into the field.