Promoting Work-Based Learning for Quality Community-Based Care: An evaluation of the Portland Community College Jobs-to-Careers Project

Jobs to Careers Research Project
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Diana White, David Cadiz, Cynthia Lopez
Portland State University
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Executive Summary

This report describes evaluation findings from the Portland Community College Jobs to Careers (JTC) project which focused on frontline workers in five assisted living (AL) facilities. Portland State University (PSU) conducted the research. The ALFs varied by size, target population served (e.g., frail elders, those with dementia, those with chronic mental illness), geographical location (i.e., urban, rural, suburban), and profit and nonprofit status. Through the JTC project, frontline workers (referred to in this report as Direct Care Workers – DCWs) participated in work-based learning by completing 27 competency-based care modules. The JTC-AL training modules were based on a systematic job analysis of caregiver tasks and the knowledge, skills, and abilities needed to perform them. The modules were delivered by assisted living staff who had completed a train-the-trainer program. Composition of training teams varied across settings, but included supervisors (including nurses, managers, administrators), and/or experienced DCWs. Most modules contained entry level and more advanced content. Those completing the first level of content became a “Resident Assistant I (RA I),” while those completing all content achieved a “Resident Assistant II (RA II)” certificate. Completers were eligible for 2 or 3 academic credits respectively through the Gerontology Program at Portland Community College. Wilson and Goldberg (2010) have described the context of assisted living in Oregon and the five participating facilities were described in detail by Craft Morgan and her colleagues (2010) in their final evaluation report. The Jobs to Careers initiative was funded by the Robert Wood Johnson and Hitachi Foundations.

The PSU evaluation addressed three research questions:
1. What is the impact of work-based learning on workers, the organization, and resident care?
2. What are the facilitators and barriers to career advancement through work-based learning from the perspectives of direct care workers and their supervisors/managers?
3. What cost and benefit criteria are used by assisted living employers to make decisions about implementing work-based learning programs?

A person-environment fit conceptual framework guided this research and a symbolic interactionism perspective aided in qualitative analysis. Training theories developed through the discipline of industrial and organizational psychology guided the selection of measures used in the surveys. This report describes findings from focus group and survey data. DCWs and managers/supervisors participated in separate focus groups early in the implementation of the training program and again toward the end of funding when most of the DCWs had completed all
27 modules. Focus group data addressed research questions 1 and 2. Time 1 focus group data were used to develop surveys which were completed by DCWs when, on average, DCWs had completed one third of the modules and again at the end of the project. Survey data were used to address research question 1. Discussions held with facility-based long-term care providers who were not JTC participants were held to address research question 3. Additional data were collected during this project, including observational data of DCW and resident interactions, family surveys, and resident interviews. Findings from these data will be described in a separate report.

Impact of JTC-AL. Focus group data revealed positive benefits of the JTC-AL curriculum; these benefits emerged early in implementation and strengthened over time. New or enhanced identities as trainers become apparent from comments by both DCWs and managers/supervisors. Trainers had opportunities to develop their own leadership skills, help English language learners understand content, develop different kinds of relationships with staff, and identify and address issues before they became problems. Among trainers, as well as other focus group participants, DCWs and managers/supervisors reported increased self-confidence and improved job performance. For the most part, focus group data also suggested an improved work environment. Training was more systematic, more thorough, and more predictable. Many focus group participants described enhanced team work and better DCW-supervisor relationships. However, other DCWs identified areas where the work environment needed improvement, such as recognizing and addressing issues related to a heavy work load. Focus groups, especially the Time 2 groups provided evidence that the JTC-AL program contributed to enhanced career aspirations. These included interest in continuing to enhance RA skills as well as interest in enrolling in community college courses. Part of the emerging identity of supervisors and managers was that of career coach, which involved helping workers achieve career goals.

Survey data confirmed many of the focus group findings. Between Time 1 and Time 2, DCWs reported increases in self-efficacy (a measure of self confidence and job performance) that was statistically significant. We did not find significant increases in measures of a supportive work environment or in satisfaction with management. This may be because some DCWs found workload was increasingly demanding due to increasing acuity of residents. Increasing acuity is part of the evolution of care in assisted living, but part is also due to the increased capacity of organizations to care for these residents because of the training program. Increasing skill in caring for dependent residents, in the view of some DCWs, did not preclude increasing staffing levels. In addition, low pay and benefits were noted in the DCW focus groups, which may keep workers from feeling supported by the management and organization. From Time 1 to Time 2, however, we found that satisfaction with the training program did contribute in significant ways to job satisfaction, performing the job as taught by the training program, and enhanced career aspirations. Turnover intentions did not change in either a positive or negative direction, though we should note that intentions to leave the job were relatively low for this workforce. It may be that the timing of our surveys limited our abilities to assess actual impact of the JTC-AL program. The focus group data suggest that positive benefit had occurred prior to our entry into the field. Therefore, it is likely that findings from survey data underestimate the impact of the program.
Facilitators and barriers. The design of the program facilitated implementation of the JTC-AL curriculum, beginning with the participants’ judgments that the content was relevant to their work. Focus group participants consistently described the benefits associated with learning in small groups or one-on-one with the trainer. This enabled workers to ask questions in a safe environment and “get on the same page” as everyone else and helped the trainer understand learner needs and level of understanding. Other important facilitators included the train-the-trainer program and having modules that were already developed and ready to teach. The AL facilities that developed training teams composed of both experienced DCWs and managers and where training teams met regularly to assess progress and continue planning appeared most effective in integrating the training program into their organizations. Being part of a grant project and having the opportunity to meet with other staff engaged in implementing and conducting the project was also beneficial.

Focus groups also identified barriers to JTC-AL. By far the biggest barriers involved time and scheduling; these issues were particularly difficult at Time 1. Another barrier at Time 1 involved motivating some staff to participate in the program. By Time 2, motivation no longer was a problem and, although time to conduct training remained a challenge, each organization had identified solutions that helped make scheduling manageable. Concerns with time and scheduling were major concerns of the ALF providers not participating in this program. Lessons learned by the JTC-AL sites are of great importance in helping to spread JTC-AL to other organizations. Other barriers remain. DCWs, even those motivated to pursue additional education, identified continuing barriers to career advancement related to costs of education beyond tuition, the need of many to work two full-time jobs, and concerns with work and family balance. These barriers remain for low wage workers in spite of the participating ALFs willingness to provide tuition advancement.

In spite of workload issues and barriers to continued career development, by the end of the project, focus group participants were nearly unanimous in their support for the program. Barriers of time and scheduling had been overcome and judged to be worth the effort. As reflected in the Time 2 focus group data, all five organizations were committed to continue the program and had institutionalized many aspects of it. As they shifted from training all incumbent workers, to needing to train only new hires, focus group participants viewed the training program to be manageable and an effective way to integrate new workers into their workforce. As a further indication of success, those facilities that were part of corporations had seen the program expand to other ALFs within their companies.

Cost-benefit concerns. Providers participating in discussion groups about implementing the JTC-AL program in their facilities expressed concerns about time and scheduling and the costs of freeing staff to do the training. Concerns also were expressed about how the program would fit into existing corporate training policies and state regulations regarding training. Several were interested in an online version of the program, although such an approach would limit the benefits of the one-on-one training identified through this evaluation.

Conclusions. The JTC-AL program was successful in preparing workers to care for residents in an assisted living setting. The evaluation provided evidence that the training program generally contributed to a better person-environmental fit for workers. The JTC-AL modules
provided stimulation that workers enjoyed, which may have buffered some of the work load issues revealed in the focus groups. As a group, DCWs valued the modules because they helped them learn and increase their skills. For the first time, many also began to explore career options. New learning in these circumstances likely added positive environmental press because it kept the work interesting and engaging, workers felt competent to perform well, and, according to focus group data, contributed to a sense of teamwork. The JTC-AL contributed to workers’ well-being with respect to self-confidence, performance ability, job satisfaction, and career aspirations. More work is needed to foster organizational commitment by addressing the complex contextual issues such as compensation. As LTC continues to face workforce shortages over the next several decades, effective training programs such as JTC-AL are needed to help these workers to continue their careers, whether as well-trained and experienced caregivers or as the next generation of nurses, administrators, and other critical players in the long-term care workforce. We expect that the JTC-AL program has laid a good foundation in which participating ALFs will continue to nurture these workers.

Introduction

Portland Community College received funding through the Jobs to Careers (JTC) Initiative to implement a work-based learning curriculum for frontline workers in assisted living facilities (ALF). Portland State University (PSU) received a grant to evaluate that project. This report describes components of the PSU evaluation that focused on the perspectives of assisted living staff, including frontline workers (referred to in this paper as Direct Care Workers – DCWs) and members of the management team (e.g., supervisors, managers, administrators). The JTC training program was conducted in five ALFs. They represented both non-profit and for-profit organizations, and were located in urban, suburban, and rural communities. The ALFs varied with respect to the populations served and the levels of physical and cognitive disabilities experienced by residents. One ALF served the chronically mentally ill and another only those with dementia. In some ALFs, all residents paid privately for their care and in another most residents received support from Medicaid; the rest served a mix of Medicaid and private pay residents. Wilson and Goldberg (2010) have described the context of assisted living in Oregon and the five participating facilities were described in detail by Craft Morgan and her colleagues (2010) in their final evaluation report. The Jobs to Careers initiative was funded by the Robert Wood Johnson and Hitachi Foundations.

The competency-based curriculum that became the Jobs to Careers Assisted Living (JTC-AL) curriculum was developed prior to the JTC initiative. First, WorkKeys was used to conduct a systematic job analysis. WorkKeys is a comprehensive employability skills assessment tool developed by ACT, an independent, not-for-profit organization that provides a broad array of assessment, research, information, and program management solutions in the areas of education and workforce development. DCWs from in-home care, residential care, and assisted living served as subject matter experts in developing occupational profiles. Specific job tasks were categorized into personal care, emotional care, health related, verbal communication and problem solving, written communication, and safety. Required skill levels to perform these tasks were identified in areas of locating information, observation, reading for information, and writing.
Second, the gap between required and existing worker competencies was used to develop the curriculum. The JTC-AL curriculum consists of 27 modules that address the tasks identified in the job analysis. Each module is comprised of a short written text and supplementary materials (e.g., diagram of the skin; nutrition pyramid for older adults), a list of tasks required to do the job, and a competency checklist. Training is delivered one-on-one or in small groups providing opportunities for the trainee to ask questions, for the trainer to determine which training approach works best for the individual, and for the trainee to practice skills. Competency testing is conducted one-on-one at the end of each module providing immediate feedback to the trainee. If trainees do not meet the competency, they have opportunities to try again at a later time. This is aligned with principles of programmed instruction, a specific training approach in which trainees need to demonstrate successful mastery before moving on. Most modules have both entry (Resident Assistant I) and advanced level (Resident Assistant II) content.

The role of trainer was critical to delivery of the curriculum. Each organization designated a team of trainers who completed a train-the-trainer program described below. Teams included human relations staff, administrators, supervisors, nurses, and experienced DCWs. Only one organization hired a new staff person to coordinate and conduct most of the training; an experienced DCW was the backup trainer, mostly training the night shift DCWs. This organization was the only one consistently to train housekeeping and kitchen staff as well as DCWs. The remaining four organizations selected 5-7 staff who were already employees at their facilities to be trainers (e.g., administrators; managers—nurses, human resources, residential care managers, training coordinators; experienced DCWs). Two of the four organizations included 3 or more DCWs on their training team, trainers in the other two organizations were mostly managers.

All trainers attended a 3-day program totaling 24 hours and included instruction on adult learning, adapting teaching approaches to meet trainee learning styles and prior learning, providing feedback, and teaching English language learners. Participants had opportunities to practice teaching and begin to develop implementation plans specific to their organizations. Several train-the-trainer sessions were held during the course of the grant. This provided an opportunity to add additional trainers or to replace those who left the workforce.

The work-based training design required that teaching be done on the job, during regularly-scheduled work hours, one-on-one or in small groups of six or fewer trainees. Competency demonstrations were required by the trainee at the end of each module; these were to be done only one-on-one. Thus, the JTC-AL curriculum was designed to enhance trainee knowledge, skills, and self-confidence. One-on-one time with a trainer was designed to help to reduce fear of education, build supportive relationships between trainer and trainee, and provide opportunities for success. Those completing the basic content in all modules received a certificate identifying them as “Resident Assistant (RA) I.” RA I staff hold different titles in the various ALFs, such as service partner or caregiver. Those completing the more advanced content achieved “Resident Assistant (RA) II.” RA IIs typically hold job titles such as “lead caregiver” or “med aide.”

The intent of the JTC program was that academic credits be awarded to program completers. By the end of the project, the mechanism for awarding transcriptable credits was in
place at Portland Community College through the Gerontology Program. Those completing the RA I level earned 2 credits and those earning RA II received 3 credits. These credits can be applied to several certificate programs and the associate degree within the Gerontology Program.

**Conceptual and Theoretical Frameworks**

This project used a person-environment fit conceptual model drawing from management/organizational research as well as gerontological inquiry. Person-environment fit models have explained motivation and job satisfaction among workers. Ton and Hansen (2001), for example, found that congruence between organizational and personal values resulted in greater worker motivation and job satisfaction. Lawton (1980) explored issues of environmental press and optimal functioning that can be used to explore both worker and resident experiences. In this framework, environments need enough “press” to make life and work interesting, challenging, and supportive, but not so much that the environment becomes overwhelmingly stressful.

As PSU began the focus group analysis, we also found that a symbolic interactionist framework was useful in understanding the evolution and impact of JTC on DCWs, managers, and administrators as a new understanding of what it means to be a DCW in assisted living emerged (Lopez, 2009). Symbolic interactionism emphasizes how communication with others (both verbal and nonverbal) in the social environment (e.g., coworkers, supervisors, residents, family members in ALF settings) leads to the creation of meaning and personal identity. For symbolic interactionists, the various perspectives being communicated in a given interaction are important to study to understand how situations, such as worker and trainer identity, are socially constructed and what that means to issues such as job satisfaction and the functioning of the organization as a whole (Lopez, 2009).

The PSU evaluation addressed three research questions:

1. What is the impact of work-based learning on workers, the organization, and resident care?
2. What are the facilitators and barriers to career advancement through work-based learning from the perspectives of direct care workers and their supervisors/managers?
3. What cost and benefit criteria are used by assisted living employers to make decisions about implementing work-based learning programs?

**Methods**

Both qualitative and quantitative methods were used to address the three research questions. Qualitative methods included 1) focus groups with DCWs, 2) focus groups with managers and supervisors, 3) discussion with providers at professional meetings, 4) comments emerging during structured interviews with residents, and 5) observations of DCWs providing care. Quantitative methods included 1) surveys of DCWs, 2) closed-ended responses to a resident interview, and 3) surveys of family members of residents living in the ALFs. This report presents data only from the staff focus groups, DCW surveys, and discussion with providers at professional meetings.
Focus Groups

Participants. Two sets of formal focus groups were conducted with participants in the JTC project to address the three research questions. One set involved DCWs and the other set was composed of managers and administrators. Focus groups were held shortly after implementation of the JTC curriculum, and again toward the end of the project. During the Time 1 focus groups, DCWs had completed, on average, about one third of the modules. By the time the second focus groups were held approximately one year later, over half of the DCWs had completed all modules, and most others were nearing completion. Four ALFs participated in both sets of focus groups. A fifth ALF formally joined JTC after the first round of focus groups were completed; managers from that ALF participated in one focus group at the end of the project.

Two additional informal discussion groups were completed with long-term care providers interested in the JTC program at the end of the project. These discussion groups contributed data used to address research question 3. One discussion group was conducted as part of a presentation of the JTC-AL evaluation results to the Oregon Health Care Association, a professional membership organization of long-term care providers. The second involved delivery of similar content to ALF providers who are managed by the company, Concepts in Community Living (CCL). CCL manages one of the ALFs participating in the JTC project and is interested in expanding the program to their other facilities.

Procedures. Focus group protocols were approved by Portland State University’s Institutional Review Board. Focus group questions for both Time 1 and Time 2 are presented in Appendix A. Questions were developed in accordance to the structure and processes outlined by Morgan (1998). An English Language Learner consultant assisted in framing focus group questions for discussion with nonnative English speakers. The project site coordinators from each of the participating ALFs recruited participants. Each participant was given an information sheet and assured confidentiality in reporting findings at the time of the focus groups. The Principal Investigator conducted all focus group interviews at the ALFs during working hours. The PI explored additional issues and topics as they emerged in the discussion. Focus group attendance ranged from 4-7 for DCWs, and 1-9 for managers and supervisors (at Time 1, a single manager was interviewed at one site). Each lasted approximately one hour. Participants were paid for their time by the ALFs and each received a $10 gift card to a local grocery/department store. All focus groups were recorded by permission of group members and transcribed verbatim. Tapes and transcripts were reviewed by research assistants for verification, and transcripts were corrected as needed.

Analysis. In Year 1, transcripts were reviewed for themes regarding the impact of the JTC curriculum and satisfaction with the curriculum. As described below, this information was used in constructing measures regarding the impact of the JTC curriculum and satisfaction with the modules and used in surveys of all direct care workers. (See Appendix B for measures developed from the Time 1 focus group data.) More in depth analysis was done with both sets of focus group data to compare responses at Time 1 to those at Time 2. Initial line-by-line coding was done with transcripts. Codes were grouped together thematically.
Staff Surveys

Participants. Surveys were conducted with DCWs employed at the five ALFs. The numbers of DCWs employed at each ALF ranged from 15 and 40 at Time 1, and between 16 and 37 at Time 2. Two levels of DCWs were included in the training. The frontline DCWs went by many different job titles such as caregivers, service partners, and resident assistants. Housekeepers, maintenance staff, and activities directors were included if they currently provided personal care services (e.g., dining services, grooming, transfers, showers) or expected to participate in the JTC-AL training program. The more advanced level DCWs had greater responsibilities (e.g., administering medications) and went by job titles such as medication aides, lead caregivers, or lead service partners. Most of the 27 modules included both basic information for the first level of DCW and more advanced content for the second level. Those completing modules earned the title of Resident Assistant (RA) I or RA II depending upon the level of training they completed. At one facility, all DCWs completed RA II training; the remaining four facilities trained a mix of RA I and RA II staff.

At Time 1, close to 90% (n=109) of the staff completed surveys. This declined to a 76% (n=72) participation rate at Time 2. The biggest decline, nearly 50% of the overall decline, occurred in one ALF that had experienced an administrative change and had also lost the bilingual administrative staff person who had assisted many participants in completing the surveys at Time 1. To maintain anonymity, we asked each participant to generate their own identity code by providing the first letter of the town they were born in, the first letter of their mother’s name, and the month in which the participant was born. The self-identification codes were of limited success. Although we knew that turnover was minimal at most of the sites, we could verify only 45 matched surveys. The analyses presented in this report were conducted with the matched sample unless otherwise indicated.

Data collection procedures. Staff completed Time 1 surveys during work hours after the JTC-AL training program was implemented and after the first set of focus groups and preliminary analysis was completed. At the time of the first survey, DCWs had finished an average of 11 of the 27 modules. Time 2 surveys were conducted approximately one year later. At Time 2, more than half of the participants had completed all of the 27 modules and the median number of modules completed by the remaining DCWs was 17 (63% of modules).

DCWs also completed Time 2 surveys during staff meetings or during scheduled in-service meetings for DCWs. At both time points the research team was present to provide snacks, answer questions, and collect the completed forms. In addition, research team members went to the ALFs during all shifts to reach those who did not attend meetings. At both at Time 1 and Time 2, each person who completed a survey received a $10 gift card to a large grocery/department store.

Measures. Three measures were created for the evaluation based on the Time 1 focus group data. Two measures were specific to the DCW’s experiences with the JTC-AL modules. The measures developed for this project are presented in Appendix A. The items in these measures were based on focus group data held separately with DCWs and managers two to four months prior to the surveys. The first measure focused on the impact of the training in three
areas: caregiving self-efficacy (e.g., “confidence in my ability to provide good care”), satisfaction with management (e.g., “my relationship with my supervisor”), and perceptions of support (e.g., “how comfortable I feel asking for help”). Because we were not able to collect data prior to implementation, we asked respondents to score these items in two ways: before taking the modules and now after taking the modules. At Time 2, we ask only about their current experience with the modules.

The second measure created for this study addressed participants’ satisfaction with the modules. The 12 items in this scale focused on the level of agreement with descriptions of the training modules (e.g., they are practical, understandable, and deal with topics relevant to the job). A four-point response scale ranged from strongly disagree to strongly agree. After analysis of Time 1 data, three negatively worded items that did not contribute to the measure were deleted. An example is “the modules take too much time.” Because the desired goal of the Jobs to Careers initiative was to assist DCWs to advance in their careers, we developed a third measure composed of three items to assess career development aspirations (e.g., “career development is important to me”).

We also used established measures. The Direct Care Worker Job Satisfaction Scale was used to measure job satisfaction (Ejaz, Noelker, Menne, & Bagaka, 2008). Turnover intention was measured with three items from Hom, Griffeth, and Sellaro (1984). Two measures were added at Time 2 to tap the impact of the training program at both individual and organizational levels. Self-rated training transfer items were adapted from Facteau, Dobbins, Russell, Ladd, and Kudisch (1995). An adapted version of the 6-item affective commitment scale (Meyer, Allen, and Smith (1993) was also used. Finally, participants were asked to complete information about their job (title, length of time on the job, hours and shift worked, number of residents cared for, previous experience) and answer demographic questions related to race and ethnicity, primary language, and education.

Data Analysis. Descriptive statistics, including frequencies, mean scores, and standard deviations were calculated to describe the sample and survey responses. Cronbach’s alpha was calculated to determine reliabilities for each measure. Correlations among key variables were calculated. Paired t-tests were used to examine change over time and hierarchical linear regressions were computed to understand how key variables contributed to outcomes including job satisfaction, career development aspirations, organizational commitment, training transfer, and turnover intentions. Additional details about quantitative methods and data analyses are reported in White and Cadiz (manuscript in preparation).

Discussion Groups with Providers

As described above, findings from the focus groups and surveys were presented to two provider audiences. We posed several questions to the participants, including whether they viewed the training curriculum as a resource for their organization and what factors they would consider in a making a decision about implementation. We specifically asked about their concerns and potential barriers. Notes were kept on chart paper and field notes were written after each session. Notes were content analyzed.
Results

Results are presented below by research question. Both focus group and survey data were used to address question 1. Focus group data are presented first followed by survey data. Questions 2 and 3 were addressed by focus group data only.

1. What is the impact of work-based learning on workers, the organization, and resident care?

Focus Group Results

The JTC initiative had an impact on both individuals and the organizations they worked for. Themes emerging from the data are described below. Included were worker identity, resident care, work environment, and career aspirations. Specific design features of the program contributed to these outcomes and are described first.

Impact of the JTC-AL Curriculum Delivery Design

Many benefits related to the training design were noted, including trainee engagement with the material and improved relationships between trainers and trainees. DCWs and managers had similar responses in describing the direct impact of the program design. Several additional benefits contributed to the overall work environment and are described below in a separate section.

DCWs—Benefits. At both the Time 1 and Time 2 focus groups, DCWs reported that the one-on-one and small group delivery made it easier for them to ask questions and to receive information. Almost all preferred this delivery approach to the traditional inservice education, which they found inconvenient and boring.

It’s when you get in the really, really big groups when people don’t really want to open their mouth.

I wish we could do the group [3-6 people] more . . . because that way we can share our experiences together.

Both DCW trainers and trainees made comments about the training being adapted in ways that fit their learning styles. For example:

One thing I really liked was the one-on-one that you got, [and] everything being on paper, because I’m visual. So, I liked have the papers to refer to and information that I could still have to look at if I had any thoughts on the matter.

This small group/individual instruction design also made it easier to help DCWs connect the content of the modules with the needs of specific residents. For example, one DCW described it this way at time 2:
. . . when you’d go over [the modules with medical conditions] . . . it was really easy to talk to [the nurse] . . . and apply it to residents we have here, and sort of problem-solve through that.

The process of talking about residents during the training session also contributed to building relationships with the trainers (both DCW and manager/administrator trainers) by providing opportunities to share previous related experiences and getting to know each other better. Because of the relationship, trainees felt comfortable going to trainers outside of the training sessions when they had questions about resident care. Because all of the DCWs were participating in this program, there was a sense of shared experience.

*I think what I liked about it was the fact that it wasn’t so much about whether you got something right or wrong, it’s just that you were all learning together as a group.*

As the program transitioned from one focusing on incumbent workers to new employees, benefits continued to be noted by DCWs: *It’s a good way of training new employees that come in.*

Managers/administrators—Benefits. Like the DCWs, managers noted during the first focus groups that the delivery design made it easier for DCWs to ask questions and for manager trainers to help them understand the content. This was especially important for DCWs whose English language proficiency was limited. For example, managers and administrators reported that they sometimes read materials to trainees with low literacy skills or spent extra time with them to make sure they understood the material.

Managers and administrators also stressed the relationship that developed between trainers and trainees.

*As a trainer, the opportunity to talk one-on-one with [DCW] staff members, whether it is a med-aide or the RA is really invaluable because it’s relationship building, and it’s an opportunity to build their confidence.*

*I see that it [the one-on-one] validates the employee as we sit down and talk . . . they find out in a hurry that what they already know is exactly perfect for the job and they already know a lot.*

*I just really enjoy that one-on-one time, talking about our modules of course, but also just an opportunity to build a relationship. So, I just feel that connection when I seem them in the hall after we’ve had a training. We just light up and talk to each other and are on a different level than we were before.*

The emphasis of the training was on supporting DCWs and helping them learn, not on finding fault. These relationships also eased anxiety of DCWs.

*Training] is not rushed time . . . however long it takes. They don’t feel rushed, they don’t feel pressured, [they feel] it’s a calm, safe environment
It’s not like a test. Even though you are asking them to in turn demonstrate, it doesn’t feel like . . . if they show that they’re struggling with a certain module, we just do more training until they get it.

Managers also viewed the training program as a way to better assess the capabilities of their staff, especially those who were new to the facility. By doing so they could prevent personnel problems later. For example,

*We find out sooner rather than later about obstacles to their assimilation into the work team, the department, the process of providing services, so that we can identify and help address those issues much earlier.*

The flexibility built into the training program for delivering the content was also beneficial, allowing each organization to adapt it to their needs. Each organization determined the order the modules would be delivered. One organization was systematic in making this choice; they divided the modules into thirds based on their organization’s priorities. They taught the first group of modules to all DCWs, and then moved onto the second set, and finally the third. Some organizations supplemented the training with videotapes, and added materials they located on their own to the modules. For example, one trainer created a game to illustrate the chain of infection and located a food pyramid specifically for older adults to add to the module on special diets. Most organizations identified a subset of modules that became part of their orientation program for new employees. Most organizations made training on all modules mandatory for all DCWs. One organization, however, decided that they would train all employees only on modules they selected for their orientation program (e.g., personal care, hand washing). The remaining modules were delivered to workers only if workers requested them. However, this facility also made the commitment to train all workers on all modules if requested.

Worker Identity

**DCW Identity.** Most of the DCWs participating in the Time 1 focus groups valued their role as caregiver and enjoyed caring for residents. (*I like taking care of people; I like the feeling I get from helping these people, who seem to be pretty much forgotten by society.*) Some came into their current positions with several years of caregiving experience and others were new to the field. Several talked about their family-like role in the lives of residents: *This is our family, because we do everything for them every day.* Many also saw their role as distinct from those of DCWs working in nursing home settings where residents are more impaired. The ALF setting allowed them a greater scope of work and they viewed work in ALF as being more varied. Some participants commented that it was easier to develop a relationship with those living in ALF, compared to those residing in nursing homes. The JTC-AL appeared to support and reinforce this existing identity of caregiver. Toward the end of the JTC project, at the Time 2 focus groups, worker identity as caregivers was as strong or stronger. Below are some typical comments:

*I have a goal, my career. And I love working here. I love the residents, and I love the work I do.*
I enjoy working here. Staff are nice, residents are very nice. Families, same thing. . . . And it’s good experience for me working in the med room. It’s challenging every day. . . . this is what I wanted to do.

Even early in implementation of the JTC-AL curriculum, the role of “trainer” was a new identity emerging in the DCWs who were JTC trainers. As trainers, they found their roles expanding. Many realized they had the tools to hold coworkers accountable and could take advantage of “teachable moments.” They took their responsibilities very seriously, working to develop teaching skills and thoroughly learning the content they would teach others.

I’ve had to go back and learn things the right way, because you don’t want to teach things the wrong way, especially when you are being held to a certain standard or responsibility. You definitely don’t want to be doing something wrong, so having to go back and ask for the extra help, or really do the extra studying on a module to make sure you’ve got it right. Because it’s all stuff we do every day, and it’s all stuff I’ve already been doing, or done. It’s a matter of, am I doing it right? So I’m teaching myself before I teach anybody else.

. . . if I see somebody doing something I’ll go back and say, “What did we just go over the other day?” and it could have been a module, I think I did it with you, and she says, “Oh, yeah, yeah, I remember."

I had a body mechanics situation where one person [not a trainer] was teaching another person. And when I was watching them doing it, it was scary. I thought they were going to break their ankles. [laughs] And so that’s when I jumped in and I went, “Okay, this is how you got to do it,” and I explained all the reasons why, and you could literally see on their face that the light bulb went on. Like, “Oh, well, that’s much easier.”

Manager/administrator identity. Managers also had evolving work identities influenced by JTC-AL. By the first focus group, one manager in particular began to see her role in a new way. In addition to helping workers learn role responsibilities as DCWs, she reported being more aware of the need of educating people. During hiring interviews she began asking DCWs what their career goals were and how she could help them achieve them. She also saw the ALF and the JTC program as the best place to mentor future RNs. Another manager reported, I’m learning how to help the [caregivers] and that’s huge. . . . learning how to communicate with them and how to help them communicate with others. Still other managers talked about being role models for DCWs in how to be compassionate and be a guest in residents’ homes.

These new identities as supportive managers were stronger by the end of the project. As one manager reported, JTC was putting me in a more of a coaching role versus a managing role; it’s been fun. She also reflected that when you are doing a one-on-one with the person, you’re a peer versus somebody of authority. So you just become more approachable to people. Another manager reflected that being a trainer,
It’s kind of like there is an informal mentoring – and it wasn’t even really put into place. The staff has just taken it upon themselves to come to me and ask me questions if they don’t understand something.

Still another manager/trainer reported, We have learned a lot from the learning that is taking place . . . we didn’t remain unchanged as trainers. Similarly, many of the managers felt their abilities to implement and manage new programs was enhanced through their involvement in JTC: I think project management skills is something that was acquired through the training project and at these [project practice] meetings that were held at the sites.

Impact of the Curriculum Content on Resident Care

Both DCWs and managers/administrators reported enhanced performance ability among DCWs, particularly increased self-confidence. As with identity, these results were apparent to both groups at Time 1, growing in strength by Time 2.

DCW experiences. At the Time 1 focus groups, nearly all of the DCWs participating in focus groups felt the information provided through the modules was relevant to their work. Even experienced caregivers, including CNAs, were positive about the content, typically reporting that the modules were a good refresher of information they already knew. For example,

I did this for nine years as a CNA, and worked at facilities and through an agency, and at homes, and just reviewing it is really good, because sometimes even though you know what you are supposed to do, you just don’t always do it . .

Several of the experienced DCWs reported learning new things, such as

I learned things I didn’t know. It should have been this way and not the way that I was doing it. So it does help.

DCWs, both new and experienced, felt the training program put them all “on the same page” so that everyone provided care in the same way and met the same standards of care. This was viewed as an improvement to the previous less structured and unsystematic approaches to training that had been the practice in all five sites.

Like when they first come onto the floor we say, you know, when you’re taking someone’s garbage out, you don’t hold it with your bare hands. But when you go into detail with that chain of infection [module #4], I’ve seen a lot of the girls go, ”wow, I didn’t realize it’s just that small little thing that can make everybody in the building sick.” And so it just makes it easier—again, another backup way for training that makes it easier for us to train them and know that they know it, and they can get the job done.

I knock first to see if I’m allowed in their room, because it is their room. And then I ask them how they’re doing, then I go through what I need to go through with them, and at the end I say, “Is there anything else I can do for you?” in case there’s something we forgot, and then leave.
At Time 2, DCWs were equally positive about the content of JTC, reiterating the importance of learning the content, how it reinforced good practice, and all being on the same page. Compared to Time 1, comments at Time 2 were more specific about ways they had learned to support residents and the rationale behind the practice. They spoke about knowing more and being more confident in their abilities. For example, one DCW said that the training had made a difference in the way he approached residents:

... because that can make a big difference. If you approach them wrong, if the resident is having a bad day, and then you approach them in the wrong way, it just gets things really complicated for the resident—for yourself, too.

Many DCWs had a better understanding of what was important for providing good care. Comments below reflect growing skills in working effectively with residents, including what they needed to be watching for to keep residents healthy, relate better to residents, and greater confidence in abilities to work without depending so much on the nurse.

When the resident is different than the day before, I report what happened. When I go to the bathroom and see their pee is different, I report that. When the residents don’t eat very well, I report it. When they’re not sleeping, not eating, roaming around and around asking to go home, I report that.

It’s helpful a little bit because you can learn better on how to treat a resident and how to be patient with them.

... we learned that at the classes, so we know how to do it... just some simple things you don’t have to look for her [nurse], wait for her.

Manager/administrator observations—DCW knowledge, performance ability. Managers consistently described the increased confidence they saw in DCWs soon after implementation of the curriculum began.

I am pleasantly surprised at how empowering this has been to staff; they feel better about themselves.

I think [workers] have more pride in their jobs

I think their sensitivity has been raised.

I think there is a lot of learning and growth going on.

Managers also found their own confidence in the workers was increasing:

They are more confident with doing their jobs, so it’s not like they’re so stressed out. They know exactly what to do and how to deal with it, and if they don’t have ideas, they go to somebody else.
Managers made similar comments at Time 2, with most again emphasizing the increased confidence of the DCWs. This time they provided more specific examples of how knowledge and confidence contributed to improved care. One manager described care at the end of life:

... before I felt like I had to keep on top of people for [care of people who were actively dying]. . . [a resident] was dying and she looked beautiful. Her mouth was clean, she just looked really clean and nice. I was really happy. I went home and I wasn’t worried about [resident].

Some of them, they grabbed the book with some of the modules in it, to help a new hire recently, several times. New things came up that they’ve had training on, and they knew in their mind that was in the modules and they went to it and looked for it.

The whole project related to getting to know a person sooner has made us be able to serve people who come in at a higher acuity level. And I have confidence that our staff can [take care of them]. As much as two years ago I would not have screened somebody in because of our inability to meet their needs. I would tend toward screening them in now.

Impact on Work Environment

In addition to stronger relationships among trainers and trainees, other changes occurred in the work environment following training. These included changes in the work climate and changes in various organizational policies. Importantly, both Managers and DCWs described how JTC made their training more systematic, more thorough, and more predictable. At the same time, focus group participants, especially DCWs, identified additional areas where improvement in the work environment was needed.

DCW perspectives. DCWs at all sites expressed pride in the quality of care they and their organization provided. Prior to JTC, training had been limited and inconsistently delivered, as described by this DCW during the first focus group:

We had employees who couldn’t tell you what a service plan was or any of the methods or steps to doing a certain procedure, and going through the modules, they can tell you all of it now.

By the Time 2 focus groups, comments like this were common:

I think there’s more continuity amongst staff . . . [we] seem to be more on the same page as far as medical conditions and how things should be handled.

DCWs across settings generally described working well as a team. Although many indicated that positive work relationships predated JTC, several made comments indicating that the JTC program contributed to continued or improved relationships. For example, one DCW trainer described working relationships at Time 1 this way:
I think generally we are close enough to each other that if we catch each other doing something wrong anyway, we will say, you know, “Hey, I think there’s a better way to do that,” because we’re constantly watching out for each other to make it easier and safer for each other and the residents. So I don’t think any of us would let something like that go by without trying to talk to the person to help them.

At Time 2, some of the DCWs remarked on improved teamwork attributed to JTC:

_When I came in, there was a kind of attitude of “you better do the work up on your neighborhood because we’re not going to help you do it.” . . . and people didn’t go around and check on the other ones and see if something needed to be done. Now people do._

_It’s a good environment here. And I think that makes it easier to come to work, even when you’re stretched thin._

At the same time, DCWs discussed the ongoing challenges of their work, including the increasing acuity of residents and, at times, the lack of acknowledgement from managers and nurses.

_We’ve been down beds, so technically we shouldn’t be overwhelmed. But our acuity level for most residents here is continuing to increase. So the residents that we still have need a lot more care and attention. So we tend to be a little understaffed and overworked. It’s been real stressful, especially in the last two months._

DCWs in some settings, mostly those with higher acuity, felt that although managers recognized their workload, they _turn a blind eye to it._

Although generally very complimentary about the workplace and management, several DCWs commented at both Time 1 and Time 2 that they are underpaid for the work they do. The comments of one DCW trainer, suggests that good training alone will not keep many people on the job.

_I know I don’t want to be a caregiver in five years . . . I mean it’s a rewarding job, but it’s a lot of hard work and very little pay . . . I could take ten other careers out there and say that I work 10 times harder than those people and get paid $15 an hour less to do it and its unfair._

Manager/administrator perspectives. The ALFs that agreed to participate in this project did so because they were not happy with their current training process. According to one manager at Time 1, JTC improved orientation for new employees. Before JTC,

_It wasn’t organized. It was however good the person [DCW] was who was doing the training [orientation]._
At Time 1, organizations were changing some policies in support of their workers. This included revising job descriptions to connect them better to the actual job tasks. All facilities moved from a tuition reimbursement system to tuition advancement, allowing many more workers to take advantage of education benefits. Managers and administrators also reported being more selective in their hiring practices, such as checking for literacy and writing skills during the interview process. All of these changes were attributed to participation in JTC.

At Time 2, managers and administrators at all 5 sites indicated that the training program had been integrated into their organizations and would be maintained. Four organizations reported significant decreases in turnover; one of these sites reported no turnover in DCWs in the prior year. All sites indicated that staff remained engaged in and motivated to complete the modules. All continued to refine HR policies in support of training and education.

Impact on Career Aspirations

Helping advance career development for frontline workers was a major goal of the JTC initiative. Part of the JTC project included career development workshops held for DCWs as well as for managers at the AL site. Workshops had taken place in some of the assisted living sites, but not all, at the time of the first focus groups.

DCW perspectives. Some of the DCWs had been pursuing career advancement prior to the JTC project. One or two DCWs from most sites were taking classes at community colleges. Fields of study included information technology in health care, nursing, and emergency medical technician training. The JTC project contributed to some additional DCWs thinking about the next steps in their careers. Some intended to stay in the field as DCWs. Others, particularly those working in corporate organizations, indicated interest in becoming CNAs, administrators, or nurses within their current organization. During the Time 1 focus group discussions, it was clear that many DCW participants were not familiar with the educational benefits that were available to them through work. Similarly, not all DCWs knew that the JTC-AL program was seeking college credits for completion of the modules. Those who were aware of the plan viewed the opportunity for college credits positively, finding it to be an additional incentive to complete the modules. Some felt it would help them find better jobs, you have your certificate and the people say, “Oh, she knows because she’s had training.”

At the same time, however, several DCWs expressed skepticism about the emphasis on career development. Many barriers to training and education were identified even if tuition would be paid by the employer. Concerns were expressed about strings attached to the tuition, such as commitment to continue working for the organization for a specified amount of time (the policy in some, but not all, organizations). Others noted that expenses required in addition to tuition placed further education out of reach, including costs for child care. Finally, many felt the time required to attend classes was a major barrier given other family responsibilities. One worker said,

I haven’t really thought of it much. I want the outcome, but I don’t really have the oomph to go to school to get there.
When the Time 2 focus groups were convened, more participants than those at Time 1 expressed interest in additional training and education. It appears that the JTC project resulted in more DCWs developing long-term career goals. At one site, all of the DCWs in the focus group expressed an interest in becoming CNAs. None of these DCWs wanted to work in nursing homes; they just wanted more information on how to do their work better. In this and in other organizations, some of the staff had taken advantage of CNA training offered through the organization and had moved on to CNA positions in the affiliated nursing homes. Higher pay was one incentive reported for taking these new positions. Several DCWs reported nursing careers was part of their long term goals. More focus group participants reported enrolling in classes or described coworkers who were taking community college classes. However, as revealed in the Time 1 focus groups, DCWs identified many barriers to achieving education goals, including their limited time (sometimes because of working two full-time jobs), family obligations, and expenses beyond tuition. A major theme emerging from Time 2 focus group data was the barrier to education related to language. English language learners indicated more time and effort was needed because of their need to learn new vocabulary and their difficulty in communicating because of their accents. English language classes on site were identified by these workers as a desired benefit from their employers. In spite of these barriers, however, most of the workers in the focus groups expressed interest in and desire for further education.

Manager/administrator perspectives. Managers and administrators, beginning with the Time 1 focus groups found that JTC-AL was making an impact on DCW career aspirations. They observed more interest among DCWs in education beyond the JTC modules and reported that workers valued the college credits that were planned from completing the modules and that the idea of receiving college credits had become a motivator for staff. Managers also saw awarding credits as a way for workers to “get their foot in the door” for further education. Managers reported hearing discussion among their staff about going on to school and that was never the case before. Furthermore, managers/administrators also identified DCWs in their organizations who had enrolled in or had sought information from Portland Community College. One manager was critical of the career exploration workshops that had been offered by PCC, finding them not specific or practical enough for her staff. Her recommendation was that the workshops focus on why go to college, the questions they might consider in making the decision, and who at the college to go to for more information.

The Time 2 focus groups resulted in more specific descriptions of staff enrollment in CNA and college classes. Several DCWs had obtained their CNA certification. One manager credited the JTC modules with giving one of their valued employees, who had previously been unsuccessful in a CNA training program at the community college, more confidence.

She could be a very good CNA. She is one of the best employees we have in the nursing department. She just can’t get through the [community college] program.

Managers at all sites described workers who had enrolled in community college health professions programs and attributed their enrollment to JTC. In addition to CNA courses, DCWs were enrolled in pharmacy tech, nursing, and a general associate degree program.
One person had taken the initiative to enroll in an English language class prior to accepting a promotion.

Survey Results

Below is a summary of survey results. More detail about the statistical analysis is presented in White and Cadiz (manuscript in development). Based on the Time 1 focus group data, we developed several hypotheses regarding the impact of the program. First, we hypothesized that the JTC-AL training program would have a direct positive impact on caregiving self-efficacy, perceptions of support, and satisfaction with management. Our self-efficacy measures included five items related to self-confidence, knowledge about resident needs, and abilities to provide care and solve problems. A supportive work environment was measured by three items that addressed team work, openness of others to suggestions, and comfort in asking for help. Management satisfaction included two items regarding relationships with supervisors and with administrators. Because we were not able to gather baseline information, we asked participants at Time 1 to rate these items in two ways: how they would have rated them prior to the beginning of JTC and how they rated them now after participating in the JTC-AL program. Paired t-tests on these self-reported pre- and post-tests were all statistically significant. In the Time 2 survey, we asked only for participants’ current ratings of the items. Paired t-tests were once again used to determine whether the Time 2 ratings on these items were significantly different than retrospective ratings they had given at Time 1. Using paired t-tests, we found a significant increase in the ratings on self-efficacy from Time 1 to Time 2. We did not find significant increases in measures of a supportive work environment or in satisfaction with management.

We also hypothesized that self-efficacy would be a predictor of career development aspirations, measured by three items related to career development and support from the organization. Although caregiving self-efficacy was significantly correlated with career aspirations at both Time 1 and at Time 2, we did not find support for this hypothesis using hierarchical multiple regression. This may be due to the fact that career development aspirations were very high at both Time 1 and at Time 2, leaving little room for change. We examined each of the items that composed our career aspirations scale. Most of the participants expected to take community college courses in the next year or so, increasing from 69% at Time 1 to 76% at Time 2. About 60% of the participants at both Time 1 and Time 2, indicated they planned to continue working with older adults in poor health, but not as DCWs, suggesting that participants may have long-term goals to advance in their careers while staying in the long-term care field.

Our third hypothesis addressed satisfaction with the JTC-AL training program. We hypothesized that satisfaction with the JTC-AL training program would be positively related to overall job satisfaction, organizational commitment, training transfer, and career development aspirations. As with our measure on the impact of the training program, items reflecting satisfaction with the training program emerged from the Time 1 focus groups. Items included nine descriptors of the training modules, such as they are understandable, practical, are taught well, and deal with topics relevant to the job. We found statistical support that satisfaction with the training program contributed to overall job satisfaction, training transfer (which involves performing the job as taught in the training program), and career aspirations. We did not find
support for our hypothesis that satisfaction with the training program would predict organizational commitment.

Finally, we hypothesized that satisfaction with the JTC-AL training program would be negatively related to turnover intentions. We did not find support for this hypothesis. There was virtually no change in reports of intention to quit between Time 1 and Time 2, with approximately 25% of the sample indicating they agreed or strongly agreed with one or more of the following statements: “I frequently think of quitting this job,” “I will probably look for a new job in the next year,” and “There is a good chance that I will leave this job in the next year or so.”

2. What are the facilitators and barriers to career advancement through work-based learning from the perspective of direct care workers and their supervisors and managers?

As described, above, focus group data indicate that DCWs, administrators, and managers liked the JTC-AL program and felt it contributed to DCWs plans and actions regarding career advancement. This was supported through survey data that found satisfaction with the JTC-AL program predicted increased career aspirations. In analyzing focus group data we found several facilitators and barriers to the work-based learning program, and these are presented below.

Facilitators.

The design of the JTC-AL program itself facilitated career advancement of DCWs. First, the train-the-trainer component of the program prepared trainers to deliver the modules at their own workplace. Discussion about different learning styles and teaching English language learners, and opportunities to practice teaching skills was a critical first step in preparing trainers. According to one manager, I think training them to be trainers was really key. Most comments about the train-the-trainer programs were positive, though some DCWs wished they had had more opportunity to practice teaching before they began training in their facilities.

Second, having ready-to-use modules made it easier for staff to assume teaching roles. Basing the curriculum on the occupational analysis likely contributed to participants’ reports that the module content was relevant to their work. As a result, those responsible for staff development felt the program was comprehensive. According to one nurse,

It takes the burden off trying to put something in play . . . it’s already there, you don’t need to start researching, find stuff, and pulling all the information together. It’s done. And that’s a time saver and money saver for the facilities, because the nurse has to spend time to put that all together.

Third, the composition of the training team at each site contributed to success of the program. The sites most successful in implementing and sustaining their programs included a combination of administrators, managers, and DCWs as trainers. Administrator trainers demonstrated to their organization their commitment to and knowledge of the program by teaching one or two of the modules. DCWs who were trainers were positive role models for
other DCWs and, as described earlier in this report, developed new identities as trainers. Managers similarly developed an expanded view of their role to include that of trainer and career coach. As described previously the one-on-one training clearly enhanced worker and worker-management/supervisor relationships. Enhanced relationships made it easier for DCWs to talk with managers and supervisors about career plans.

Fourth, management of the training team or training process was key. Most training teams met regularly, often in conjunction with other staff meetings. At first teams planned for implementation, identified modifications of modules based on organizational policies and procedures, identified which trainers would train on which modules, and prioritized the order of the modules. Once training began, teams continued to meet to monitor progress in training, identify challenges, and determine responses to those challenges. As described below under “barriers,” scheduling was a major issue at all sites. Therefore, all training teams identified a staff person who would be responsible for scheduling and coordinating training times. All organizations also developed a system to track both individual and organizational progress toward completing the JTC program.

Finally, being part of a grant project likely contributed to success. The training teams or representatives from teams across all organizations met monthly. At first they revised modules to comply with new state regulations. In the Time 2 focus groups, managers and administrators in particular were reflective about the process of implementing the program and participating in a grant project. Participants appreciated opportunities to meet with peers in other assisted living settings.

Just kind of bouncing ideas off each other; that was nice because you’d get ideas or you’d give somebody else ideas about what helped, what worked, what didn’t work.

As one example, following the lead of one organization, all developed a large charting system listing each worker and the modules they had completed. In addition to keeping the training on track, the chart proved to be a motivational tool. Some workers who had been reluctant participants became more competitive and were more active in scheduling and completing modules.

. . . we put a board [chart listing DCWs and modules completed] upstairs; you can’t miss it. Now there’s kind of a lot of competitiveness to get it done, so you can see that a lot of them are really wanting to start, more than they did before.

Barriers

By far, the major barrier to implementing the program was time and the related issue of scheduling. Providing 30 hours or more of training for each incumbent DCW was extraordinarily challenging, particularly at the beginning of the project. Schedules had to fit the needs of the trainers, trainees, and the general work demands of resident care. This was particularly difficult when staff missed work, whether because of planned vacation days or illnesses. During the first focus groups, time and scheduling were reported to be significant barriers, though some of the workers and managers were already developing strategies to address them. For example, one
DCW trainer made sure she learned her modules well and was not dependent on the printed materials to deliver the content. That way she was always prepared.

*If it’s looking like we’re going to have 15 or 20 minutes of down time, we say, ‘hey, [worker’s name], come over here for a minute, I want to talk to you about this.’*

Both DCWs and managers reported that training night shift workers was especially difficult due to time and scheduling. In some facilities trainers provided training during the night shift.

By the Time 2 focus groups, most of the incumbent workers had completed all or were nearing completion of modules. All remarked that time and scheduling had continued to be somewhat challenging, but that they had figured out how to make it work. One DCW said, *it’s a little easier now, it’s kind of working.* Managers provided a little more detail:

*Timewise we knew that [scheduling] was going to be a struggle. But, I think we figured out a system... we got into the routine.*

*I think a lot of people are actually into it. At the beginning it was a lot harder. It was harder for me, too, though because I had to try to implement it, get everybody into it. And now it’s just kind of like a day-to-day thing.*

*It was a struggle to get the thing set up, but I think that we’ve finally found ways to do the scheduling, to pull people off the floor without additional hours, to fit it into our schedules and not freak out if we have to postpone it.*

*We had to think about how we were going to do this and we really thought about it a lot. . . . we’re making the modules work for us instead of, ‘oh, my God, this is so much training.’*

Other barriers were also identified, though they generally were of less concern to participants. For example, a few of the DCWs in the Time 1 focus groups commented that some of the modules were repetitive, particularly those related to hand washing, chain of infection, and disinfection and cleaning. However, the repetition was viewed positively by others. For example, one DCW said,

*I learn things by repeating... and because there was overlap in that way, I got it again and again and again. So, it got ingrained in my mind much better.*

Motivating some DCW to participate in the training was a challenge early in the program, though by Time 2, this did not appear to be an issue. Tracking module completers on a large chart posted in the staff room was one motivator. More importantly, however, as DCWs began to experience the benefits of the training and as it became integrated into the weekly routine, most DCWs seemed to value the training. Indeed, the managers who had reported they had DCWs with motivational issues at Time 1, confirmed it was no longer a problem at Time 2.
Finally, language barriers were difficult for some DCWs and for their trainers. Sometimes a DCW would translate for another worker. Those with the most language difficulties tended to hold positions in the dietary and housekeeping departments rather than in direct care. However, at least some managers reported that the one-on-one training design addressed this issue and was beneficial in training and mentoring nonnative English speakers. Trainers would read the content to the DCWs, explain difficult words or concepts. For example, some staff from other countries did not understand what was meant by the “Patient’s Bill of Rights” because they were unfamiliar with the Bill of Rights that is part of the constitution of the United States.

3. **What cost and benefit criteria are used by assisted living employers to make decisions about implementing work-based learning programs?**

   This research question was addressed by asking DCWs and managers whether other assisted living facilities should adopt the JTC-AL program and, if so, what advice would they give and how they would the “sell” the program. Data from discussions with providers who were not part of the JTC project also provided data to explore this question.

**DCW perspective**

As part of the Time 2 focus groups, all participants felt strongly that other ALF should implement the program, identifying several of the benefits described above. Mostly, these involved learning the right way to do caregiving tasks and the right way to treat people. One focus group noted that staff who are trained on the JTC modules can make a good impression on families that are considering the ALF, making the program good for business. When asked what advice they would give those implementing the program, some of the responses included:

   *The only thing I will say is, ‘Take it. Study. Learn it. It will help a lot.’*

   *It will make a difference in your care.*

   *Take it seriously . . . it’s for our own good, our own benefit. So if we take it serious we’re going to get knowledge and skills. And if we don’t, then we’re not going to get a good job.*

**Manager/administrator perspectives**

All of the managers and administrators felt the program had been successful in their facilities and all were committed to continuing to provide the training to new workers. When asked about “selling” the program to others, one participant said simply, *it works.* Specific areas of success included resident care, staff development, and marketing.

With respect to resident care, many participants again emphasized the increased self-confidence of workers and increased knowledge and skills they obtained in working with residents. Enhanced skills led to a higher standard of care and greater peace of mind among managers that residents were well cared for. One nurse said she was able to admit residents with greater care needs because the staff was now able to meet those needs. This ability to admit
residents with greater levels of physical and cognitive impairment had helped the facility weather the impact of the recession. Census was down because older adults were stretching their resources or having difficulty selling their homes to seek residence in assisted living. It was helpful to the organization to draw from a larger pool of applicants. Other managers and administrators described improved satisfaction surveys from both families and residents, connecting these results to the JTC training program.

Other benefits included increased capacity of the organization to train and retain staff. For example, having a curriculum that addressed job requirements and was ready to use, saved time and expense for facilities. One person emphasized the benefit of being proactive with training. She provided examples of how the training program prepared caregivers to address problems prior to encountering a particular issue or concern with a resident. Managers across facilities reported that turnover had declined since beginning the program. Most emphasized that retention rates were only partially explained by the poor economy and credited the training program for most of this change. Focus group participants also emphasized that once the training program is up and running, the actual training goes smoothly.

Finally, several managers reported that they were using the training program to differentiate their facility from others. Participants from these facilities valued being on the cutting edge of developing better long term care services. One assistant administrator, responsible for marketing and who taught some of the modules, described a conversation with a resident’s family member who had selected the facility for his parent:

\[\ldots \text{one of the deciding factors was walking down the hall on our tour. The staff greeted my tours, but everyone of them said, ‘well, hi, how are you doing?’ That personal connection he felt was special. He felt that respect—they respected me and I showed respect to them. He thought that was really a deciding factor.}\]

Finally, an administrator described the value of JTC this way:

\[\text{The big pay-off is lower turnover, that capacity building, the ability to take care of people longer \ldots the employees feel respected. All of those things are real and huge.}\]

**Other provider perspectives**

The facilities participating in JTC were early adopters and based on the data presented above, the program was successful. We were interested in learning about concerns of administrators of other facilities who might consider adopting the program as a way to identify potential barriers to widespread implementation. We presented information about the JTC training modules and evaluation results to two groups of providers, asking each what would keep them from making the decision to adopt the program. Not surprisingly, the major concerns were about time and costs. Even though we presented data indicating these barriers could be overcome, issues of time and scheduling remained major concerns for providers during the group discussions. They also wanted to know more about how the training program was integrated into daily routine and what it would take to sustain the program.
Another concern raised at one of the groups was how the JTC training program fit into the overall corporate view of training and whether the JTC approach would be supported at the corporate level. It is clear that corporate buy in and commitment is vitally important in implementing and sustaining the program. These commitments were present in all JTC pilot sites. Non JTC providers expressed concerns about how this program would fit into existing training programs used. As an example, online education is increasingly being used in LTC settings and some providers wondered if this training program could be offered through online education, a method that appears to be of lower cost than the one-on-one training.

Finally, participants wondered whether the JTC training program was consistent with new state regulations. Training issues are consistently in the top three areas of deficiency in state surveys of assisted living. None of the facilities participating in the JTC-AL program received any deficiencies related to training or resident care. In fact, the training program served as a basis for the development of orientation programs that met new state requirements. JTC participants simply selected modules that they would use with newly hired DCWs within the first 30 days of employment.

In summary, criteria for making decisions about whether to implement the JTC-AL curriculum in assisted living includes whether time and financial resources are available and whether results will be worth these costs. Results desired included staff retention, quality resident care, ability to market to prospective clients, and ability to meet state regulations. Providers will need to know how this approach builds on or enhances current training activities and receive specific guidelines for implementation.

**Discussion**

The Jobs to Careers-AL training program developed by Portland Community College and put into practice in five assisted living facilities contributed to workforce development and job satisfaction. Consistent with a symbolic interactionist perspective, workers and management contributed to developing the program through mutually negotiated roles and responsibilities regarding training and learning within these settings. Both DCWs and manager/administrators expanded their roles to include new identities as trainers. Further, management in each setting developed unique ways of implementing the program that met the needs of the organization and in ways that were consistent with its culture.

The combined results from the focus groups and surveys illustrate the benefit of a mixed-method approach to evaluation. The focus groups provided preliminary evidence of the benefit of the JTC-AL program on worker performance and self-confidence. Survey data, using a measure of self-efficacy based on focus group data, supported this benefit across a larger sample of workers. Focus groups also provided support for improved team work and relationships with coworkers, supervisors, and administrators. This was not supported by the survey data using measures of a supportive work environment and management support. Two issues with the survey sample may have contributed to the contradictory findings. First, because the program already was in process at Time 1, the surveys may not have captured real change with respect to these variables. Second, the sample may not have been large enough to detect modest changes if
they were present. The significant correlations among variables suggest that sample size may be a factor.

At the same time, careful examination of the focus group data suggest additional explanations for the lack of significance between Time 1 and Time 2 survey results with respect to the impact of the JTC-AL curriculum on perceptions of a supportive workplace and supervisor support. On the one hand, a majority of DCW comments in focus groups were complimentary toward co-workers and management during focus groups. These focus group participants reported they were more likely after JTC-AL to share information with others, which contributed to a common knowledge base and a work-based support system. These workers said they felt more comfortable in asking questions or seeking help from others, including their managers and coworkers. On the other hand, a number of workers talked about the heavy work load, increasing acuity of care, poor compensation, and lack of recognition by some supervisors to these issues. Therefore, while JTC-AL clearly contributed to self-efficacy, some workers experienced little improvement in organizational support. An explanation may lie in the focus group data from managers and administrators. They consistently reported that a major benefit of the JTC-AL program was the staff and organization’s increased capacity to care for residents with ever greater care needs. Yet workers reported that staffing levels had remained the same in spite of caring for residents with greater needs. Thus, greater skill and ability may have contributed to a greater and more complex workload, which perhaps added too much environmental press. Similarly, although managers and administrators formally recognized staff accomplishments in completing the modules through formal celebrations, compensation with respect to salary did not change commensurately. Although supportive of the JTC-AL curriculum and pleased with their experiences with it, the DCW focus group data suggest a potential for increased job dissatisfaction if other aspects of the environment do not change as well. This may explain why survey findings did not find significant improvements in scores on measures of perceptions of support, organizational commitment, satisfaction with management.

These same factors might explain why turnover intentions remained stable over the two data collection points. Although participants in all of the manager/supervisor focus groups reported decreased actual turnover following implementation of the JTC-AL curriculum, about 25% of the workforce at both Time 1 and Time 2 indicated they had intentions to leave their jobs. This is a relatively low level for turnover intentions for this workforce; these numbers may reflect the generally positive work environments present in these early adopter organizations. As discussed above with respect to measures of career aspirations, the JTC-AL implementation may have had an early and significant positive impact on turnover intentions that could not be captured through this evaluation.

The lack of congruence between focus group data related to improved self-efficacy and increased career aspirations and the lack of statistical significance found in the survey data may also be a result of the timing of Time 1 data collection. Focus group data indicated a growing interest and enthusiasm for education across the two time periods. Survey results, consistent with the Time 1 focus groups, indicated high levels of career aspiration at Time 1. These aspirations may have been present prior to JTC, though focus group data suggest that they were likely inspired early in the implementation of the JTC-AL program. Without baseline data, we can not know with certainty at this time. In addition, the small matched sample again may make it
difficult to identify modest effects if they were present. The DCW focus group data suggest further explanations about other factors that might serve as barriers to education, even among those who wish career advancement. These findings suggest that increased self-efficacy without additional resources will not be sufficient for workers to achieve their educational goals. Although facilities are now paying tuition up front rather than reimbursing workers, DCWs must still consider several expenses when making the decision to pursue education beyond JTC. These include child care expenses, lost time with families, and whether to give up a second job to pursue schooling. These issues are particularly difficult for those without a high school diploma or those who are English language learners. More support is needed to help potential students identify resources, including help to develop proficiency in basic reading and writing skills. Although the AL organizations participating in this project provided considerable support to their direct care workforce, many challenges clearly remain.

The vast majority of DCW and manager/supervisor focus group participants were very enthusiastic about the JTC-AL curriculum. Basing the curriculum on a thorough job analysis likely contributed to participants’ views that the content of the modules was relevant to the job and appropriate for DCW training. According to survey data, DCWs generally reported that the provided care the way they had been taught through the JTC-AL program, an indicator of successful integration of the content into practice. The design of the program also appeared to contribute to the positive views of the training program held by DCWs and supervisors/managers. This included use of a train-the-trainer model where employees, including DCWs and licensed staff, provided the training. The competency-based curriculum delivered one-on-one or in small groups was instrumental in building personal and professional relationships among staff. Online training is increasingly being used in long-term care settings. As reported above, several providers expressed interest in conducting the modules through online education. We suspect this approach may be of limited value to this workforce which is comprised of many who are English language learners and/or have low literacy skills. Our response to the providers was that strengths of the JTC-AL program include the relationship that develops between the trainer and the worker, the ability of the worker to ask questions within a safe environment, the connection that can be made between curriculum content and specific residents the DCW supports, and the ability of the trainer to recognize when the worker needs additional information or whether the content needs to be presented in a different way. Replication of these benefits through an online only approach would be difficult. However, future research could explore ways that online education can supplement the work-based learning approach in assisted living.

Barriers to implementing the JTC-AL were significant and real. Implementation required careful planning and commitment from all levels of the organization. Finding time to schedule and train so many workers was challenging; it took several months for all workers to complete the training. Multiple strategies and approaches were used through trial and error before each organization identified the scheduling methods that would work best for them. All solutions involved assigning at least one staff person the responsibility for scheduling and tracking progress. Management and staff had to be flexible as well as persistent. They had to be willing to reschedule when workload, outside events (e.g., ice storms), or absenteeism interfered with the schedule. A key learning, however, was to reschedule immediately and continually recommit to the process; regular meetings of the team of trainers contributed to the process.
In spite of workload issues and barriers to continued career development, by the end of the project, focus group participants were nearly unanimous in their support for the program. Barriers of time and scheduling had been overcome and judged to be worth the effort. As reflected in the Time 2 focus group data, all five organizations were committed to continuing the program and had institutionalized many aspects of it. As they shifted from training all incumbent workers, to needing only to train new hires, focus group participants viewed the training program to be manageable and an effective way to integrate new workers into their workforce. As a further indication of success, those facilities that were part of corporations had seen the program expand to other ALFs within their companies.

Administrators of the participating ALFs were early adopters of new practices. Most had a history of innovation and willingness to participate in demonstration projects. To expand this program to additional ALFs, it will be necessary to provide detailed information about the time required, to plan and implement the program. New adopters will need concrete information about how to schedule the training, particularly for incumbent workers, so that staffing requirements are met during training and overtime costs are minimized. They need tools that will help them in this process. Providers considering the program also want to know how the program may fit with their current practice. We found that the program is adaptable and that the work-based approach could be used to augment existing programs. What is unique about the JTC-AL training program that was tested in this project is that it addresses competencies related to the job and so the content “made sense” to both learners and trainers. As providers adapt the content to their organizations, they are encouraged to review the modules, enhance them in any way through their own training materials, but to maintain the basic curriculum and competency testing components of the program.

As indicated throughout this discussion, the evaluation had important limitations. The most serious was the lack of baseline data gathered prior to implementation of the Jobs to Careers project. The work-based learning project had been in the planning stages for a year prior to the beginning of the research project and by the time we began data collection, implementation was well underway at all sites. A second limitation was the small sample size. In part this reflects the relatively small numbers of DCW staff that work in these settings compared to nursing homes or other health settings. The sample size was further reduced because of the faulty identification codes used to help maintain anonymity of the data. A related issue involved the large number of nonnative English speakers who completed surveys. They were more likely to generate a different code for each survey. In the future, we recommend beginning the research project in conjunction with the intervention project. A different, more standard approach for generating participant identification numbers should be used with this population, one that will protect confidentiality but allow researchers to track participants. Finally, interpreters who are not employees are needed in the data collection process. In spite of these limitations, we feel this research contributes in important ways to identifying the impact of the JTC-AL curriculum at the five assisted living facilities and suggesting future directions for the program. The use of both survey and focus group methodology contributed to this result.

In conclusion, the JTC-AL program was successful in preparing workers to care for residents in an assisted living setting. This evaluation provided evidence that the training
program generally contributed to a better person-environmental fit for workers. The education provided through the modules provided stimulation that workers enjoyed which may have buffered some of the work load issues revealed in the focus groups. As a group, DCWs valued the modules because they helped them learn and increase their skills. For the first time, many also began to explore career options. New learning in these circumstances likely added positive environmental press because it kept the work interesting and engaging, they felt competent to perform well, and, according to focus group data, contributed to build a sense of teamwork. The JTC-AL contributed to workers’ well-being with respect to self-confidence, performance ability, job satisfaction, and career aspirations. More work is needed to foster organizational commitment by addressing the complex contextual issues such as compensation. As LTC continues to face workforce shortages over the next several decades, effective training programs such as JTC-AL are needed to help these workers to continue their careers, whether as well-trained and experienced caregivers or as the next generation of nurses, administrators, and other critical players in the long-term care workforce. We expect that the JTC-AL program has laid a good foundation in which participating ALFs will continue to nurture these workers.

References


Wilson, R., & Goldberg, C. (2010) *Jobs to Careers in Community-Based Care: Case Study of an Oregon Project to Improve the Quality of Elder Caregiving*. Boston: Jobs for the Future.
Appendix A

Focus Group Questions – Time 1

Direct care worker

General questions about work in an ALF
We would like to start with introductions. Please tell us your first name, your job title, how long you have worked here, and a few of your primary responsibilities here
1. Why did you decide to work here?
2. How prepared were you to do this job when you first started here? (transition question)

Work based learning
3. This ALF is participating in a project called “Jobs to Careers” – What is your understanding about the project?
4. How has the Jobs to Careers project changed the way you learn how to do your job? (probe for positive/negative; more information, etc)
5. Jobs to Careers is using a work-based learning approach. This means that specific modules are taught to workers while on the job.
   a. What is your experience with these modules?
   b. What makes it hard to participate in the modules?
   c. Have the modules made a difference in how you relate to residents? In what ways?
   d. Have the modules changed the way you provide care? How?

What can be done to improve working conditions and support your learning?
We would like to know more about how this organization supports you.
6. How aware are managers and administrators about your work here?
7. What things does the administration do now to help you with your job?
8. What additional training or skills would help you with your job?
9. What things could the administration do differently to help you with your job?

Career Plans
As part of this project, Portland Community College hopes to provide college credits for completing all of the modules.
10. How will this affect your career choices? Do you expect to pursue a certificate or degree from Portland Community College?
11. What kind of work do you hope to be doing in about 5 years?

Final
12. Jobs to Careers has almost a year and a half to go. What changes would you recommend to the project?

Manager/Supervisor

General questions about work in an ALF
1. Let’s start with introductions. Please tell us your first name, your job title, how long you have worked here, and a few of your primary responsibilities.
2. Why did you decide to work here? How prepared were you to do this job when you first started here? (transition question)

Work based learning
3. As many of you know, this ALF is participating in a project called “Jobs to Careers.” What is your understanding about this project?
4. How has the Jobs to Careers project changed the way you prepare caregivers for their jobs?
   a. How has the Jobs to Careers project changed the way staff learn?
   b. What about the ways they interact with one another and residents?
   c. What other changes have you seen? (in staff or residents)
5. Think about the best employee you ever had.
a. What traits did they possess?
b. How do you think the Jobs to Careers project will contribute to developing employees with these traits?
c. What else could you do to help develop employees such as the ones you described?

6. What are your hopes for this project? Fears?
7. What are the barriers to implementing Jobs to Careers?

As part of this project, Portland Community College hopes to provide college credits for completing all of the modules.

8. How will this affect your staff? Do you expect any staff to pursue a certificate or degree from Portland Community College?
9. What kind of staff do you expect in 5 years?

Final questions
10. How will you know if the Jobs to Careers project is successful?
11. Jobs to Careers has almost a year and a half to go. What changes would you recommend to the project?

Focus Group Questions – Time 2

Direct Care Worker

General questions about work in an ALF
13. We would like to start with introductions. Please tell us your first name, your job title, how long you have worked here, and a few of your primary responsibilities here
14. Why did you decide to work here?
15. How prepared were you to do this job when you first started here? (transition question)

Work based learning
16. As you know, this facility has participated in a project called “Jobs to Careers” – How many modules have you completed? Have you completed the program? If not, when do you expect to finish the program?
17. What has been your overall experience with Jobs to Careers?
   a. What do you like about this kind of training?
   b. What changes do you think should be made in the training? What content should be added?
   c. Have the modules made a difference in how you relate to residents? In what ways?
   d. Have the modules made a difference in how you relate to your coworkers?
   e. Have the modules changed the way you provide care? How? (PROBE: impact on medication errors, injuries)
   f. Have the modules changed the way you relate to coworkers? Supervisors or administrators? How?
   g. Impact on turnover, absenteeism?
18. Last year, these are some of the things that a group of workers here said about working here and about their experiences with the modules. Is anything different this year? What is the same?

Career Plans
As part of this project, Portland Community College is providing 2-3 academic credits for completion of the modules?
19. Has this project sparked your interest in attending college?
20. What kind of work do you hope to be doing in about 5 years?
21. What would keep you from achieving this goal?

Final
22. Although the Jobs to Careers grant will be ending soon, facilities can continue to offer this training to staff. What is your recommendation?
a. Would you recommend this program to other assisted living facilities?
b. What advice would you give them?

**Administrator & Manager**

**General questions about work in an ALF (10 minutes)**

12. Let’s start with introductions. Please tell us your first name, your job title, how long you have worked here, and a few of your primary responsibilities.

13. As you know, the project called “Jobs to Careers” is ending. We want to know, from your perspective, what has happened over the past year. (transition question)
   a. About how many staff have completed the training?
   b. How many are near completion?
   c. Are new staff receiving the training?

**Work based learning (30-35 minutes)**

14. What is your overall experience with this project and the approach to training?
   c. How has the Jobs to Careers project changed the way staff learn?
   d. What about the ways they interact with one another and residents?
   e. What other changes have you seen? (in staff or residents) (Absenteism, injuries, Med or other errors, trainer turnover, staff turnover)

15. Were there any unexpected outcomes? If so, what were they? (Probe: negative & positive)

16. Do you expect to continue this training program beyond September? Why or why not?

17. What are the barriers/challenges to continuing Jobs to Careers?

18. Last time, the focus group made these points (distribute 1-page bulleted points):
   How well does this reflect your experience this year?

**Career Development. (5-10 minutes)** As part of this project, Portland Community College was successful in obtaining 2-3 college credits for completing the modules.

19. How will this affect your staff?

20. Do you expect staff to pursue, or are staff currently pursuing a certificate or degree from Portland Community College? Are staff involved with any other professional degree programs (e.g., PSU, OHSU, trade school)

21. How has the economy affected your workforce?

22. What kind of staff do you expect in 5 years?

**Outcomes (5-10)**

23. From your perspective, has the Jobs to Careers project been successful?

24. Here is a list of indicators of success that was generated at one of the practice meetings early in Jobs to Careers. Have any of these things (not already mentioned) happened in your organization?

**Final questions (5 minutes)**

25. If you were asked to “sell” this program to other assisted living facilities, what would be the key points you would make?

26. Other facilities are now in the early stages of implementing the Jobs to Careers program and others are considering the program. What recommendations would you give to them?
Appendix B – Survey Measures

Impact of Jobs to Careers Modules

After taking the modules: (response categories: poor, fair, good, very good, excellent.)

Self-efficacy
My confidence in my ability to provide good care is
My knowledge of how to provide good care is
My confidence in my coworkers to provide good care is
My understanding of resident needs is
The care that residents get from me is
My ability to solve problems on the job is

Supportive work environment
How comfortable I feel asking for help is
The openness of others to my suggestions is
How we work as a team is

Management satisfaction
My relationship with my supervisor is
My relationship with the administrator is

Satisfaction with Training Modules

The Jobs to Careers modules: (response categories: strongly disagree, disagree, agree, strongly agree.)

are understandable.
are practical.
are something I hope my employer continues.
are taught well by the trainers.
are something I would recommend to my coworkers.
deal with topics relevant to my day-to-day job.
prepared me for the test (return demonstration) at the end of the module.
are good because they are taught one-one-one or in small groups.
are taught in a way that helps me learn.

Career Development Aspirations

(Response categories: strongly disagree, disagree, agree, strongly agree.)

Career development is important to me
My employer provides me with opportunities for career development
My supervisor supports my career development