Needs Assessment of Long Term Care, North Dakota: 2002

Initial Report and Policy Recommendations

North Dakota State Data Center at North Dakota State University, Fargo, ND

Needs Assessment of Long Term Care, North Dakota: 2002

Initial Report and Policy Recommendations

Issued November 2002

Forward

This report is part of the 2002 North Dakota Needs Assessment of Long Term Care. The Long Term Care project was funded by a grant through the North Dakota Department of Human Services. The purpose of the project was to assess the current and future long term care needs of residents in North Dakota. This particular report is a summary of the activities contributed by North Dakota State University and the University of North Dakota.

Contributors

North Dakota State University	University of North Dakota
North Dakota State Data Center	*Center for Rural Health*
Dr. Richard Rathge, Professor	Dr. Richard L. Ludtke, Professor
Ramona Danielson	Lene Vallestad
Mandy Clemenson	Kathy Williams
Jordyn Nikle	
Steph Noehl	
Lindsey Bergeron	
Tammy Karlgaard	

Table of Contents

RECRUITMENT AND RETENTION

PERCEPTIONS OF LONG TERM CARE ADMINISTRATORS

University of North Dakota
School of Medicine and Health Sciences

A report based on collaboration including

Center for Rural Health
UND School of Medicine and Health Sciences

The North Dakota Long Term Care Association

November 2002

Forward

This report is part of the 2002 North Dakota Needs Assessment for Long-Term Care. This part of the Long-Term Care project was supported by the North Dakota Long Term Care Association with professional assistance from the North Dakota Department of Human Services and the Center for Rural Health. This particular report addresses the perceptions of long-term care administrators with respect to their perception of recruitment and retention issues. Analysis and writing were a collaborative effort.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

RECRUITMENT AND RETENTION:

PERCEPTIONS OF LONG TERM CARE ADMINISTRATORS

INTRODUCTION

The 2001/2002 survey of North Dakota long term care administrators was undertaken by

the North Dakota Long Term Care Association with the collaborative assistance of the Center for

Rural Health at the UND School of Medicine and Health Sciences and the North Dakota

Department of Human Services. The purpose of the survey was to assess administrator

perceptions of the level of difficulty in recruiting and retaining staff for their facilities and to

identify strategies that administrators define as effective for recruiting and retaining staff.

Comparisons of these strategies for urban and rural facilities and for facilities containing nursing

care, assisted living, basic care and independent apartments were also included in the objectives

of the study.

The data were collected by and belong to the North Dakota Long Term Care

Association. This working relationship was crafted in response to budget reductions in the

statewide long term care study that were required to accommodate the costs of financial

analyses. In this project, the Long Term Care Association solicited responses to a survey from

all of the long term care administrators in the state. Data were collected during the fall and early

winter 2001-2002 using a combination of Internet based surveys and paper copies of the same

instrument for those unable to respond using the internet. The survey instrument is attached.

Response rates were high with 95.3% (81 of 85) of the nursing facilities responding and

84.2% (32 of 38) of the basic care facilities belonging to the North Dakota Long Term Care

Association. The Department of Human Services reports 46 basic care facilities in the state.

Apparently 8 are not members of the North Dakota Long Term Care Association. Responses

were also received from 17 facilities offering assisted living and 28 offering independent

apartments. Many of the respondents represented multiple levels of care. The data, once

collected by the Long Term Care Association, were entered into computer readable format at

UND. The electronic data files, once created, were shared with the research staff at the

Department of Human Services and the North Dakota Long Term Care Association. The

analysis was conducted as a joint activity of the Department of Human Services and UND.

The number and distribution of Long Term Care Facilities in North Dakota Counties is

presented in a map of facilities per county (see Figure 1).

A second map (Figure 2) presents the ratio of population over age 55 to long-term care

facilities by county. Each of these maps are presented to display the distribution of long term

care facilities in the state.
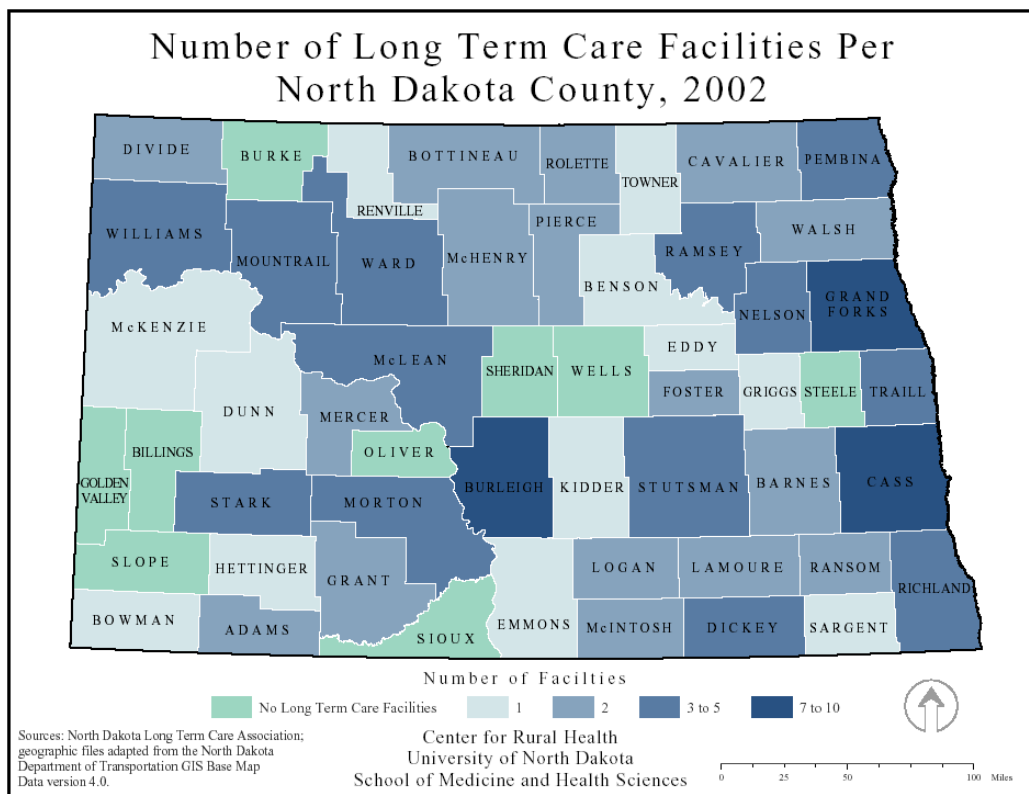
Figure 1. Number of Long Term Care Facilities Per North Dakota County, 2002

Figure 2. Ration of 2000 Population Age 55 and Over to the Number of Long Term Care Facilities for North Dakota Counties

INITIAL DESCRIPTIVE FINDINGS

In this section descriptive frequencies are presented for key variables in the survey. These descriptive findings establish a foundation for examining other questions about relationships and that address questions as to what seems to work under different conditions with respect to the key issues of recruitment and retention.

Facility Characteristics

The facilities responding to this survey are described in Table 1. Eighty-one of the 85 facilities with nursing homes responded, as did 17 operating assisted living units. Seventy-three percent of all facilities contained nursing beds while 15.3% contained beds defined as assisted living. Facilities were least likely to possess assisted living bends as they represent a relatively new configuration for care. Thirty two of a possible 38 facilities with basic care beds were represented and 29 facilities operating independent living apartments. This represents 92% of the facilities with nursing beds and basic care beds. While we lack precise data on the total number of assisted living facilities and independent apartment facilities, these are also thought to be high in terms of participation.

Table 1. Characteristics of Facilities*.

Characteristics	Number	Percent
Nursing Beds	81	73.0%
Assisted Living Beds	17	15.3%
Basic Care Beds	32	28.8%
Independent Apts.	29	26.1%

* This table is based on multiple responses, consequently the percents total more than 100%. Two respondents failed had missing data.

Average numbers of beds by type are presented in Table 2. Nursing home beds remain the most common and represent the largest facility sizes as well. While this mix is changing, this provides a picture of the distribution at this point in time.

4

Table 2. Total and Average Number of Beds by Type.

	Nursing Beds	Assisted Living	Basic Care	Independent Apts.
Number	6,446	718	1,132	732
Average size	80	42	35	25

Overall, the occupancy rate reported for all types of facilities was 89.2%. The most common ownership pattern was "private non-profit" with 78.6% of the facilities in that classification.

Ownership patterns found private for-profit facilities accounting for 14.3% of the facilities and public facilities accounted for 7.1%. Most of the facilities were free standing (80.9%) with the remaining being attached to hospitals.

Staff Vacancies

Vacancies were reported for a variety of staff positions. The results in Table 3 are based on the administrators reporting of vacancies as of the date of their responses. The timing of this data collection, late fall and winter, in all likelihood occurred during the season of lowest turnover. Changes in employment should be expected to peak during graduation and the start of school terms. Much higher reports of staff vacancies were found in August of 2000 and this difference may in part be due to the time of year in which data were collected. It is likely that the vacancies reported in this data represent low estimates for vacancy rates. Reports of part time vacancies were counted as .5 positions. It should be noted that this snapshot in time represents a highly variable element of the data. As an example, one administrator reported that the day before he filled out the survey, he considered his facility fully staffed with stable personnel. However, his survey responses reflected three vacancies, all of which surfaced in a 24 hour period. The largest volume of vacancies was for CNAs, followed by RNs and LPNs.

Table 3. Number of Vacancies by Type of Position.

RN	LPN	CAN	Dietitian	Dietary Aid	Housekeeping	Total
55.5	26	136	2	23.25	10	247.75

Recruitment

Administrators were asked to rate the degree of difficulty they experienced in recruiting staff for their facilities on a scale of 1 to 5 with one representing no difficulty and 5 representing great difficultly. The average rating was 3.18 – very near the scales midpoint or neutral value. This suggests that, on average, administrators across the state were not experiencing acute recruiting difficulties at this time. It is important to note, however, that 38% of the administrators did rate recruiting with a score of 4 or 5, suggesting some difficulties in recruiting staff continue to exist. A similar question was asked in a separate survey of staff regarding the difficulty of recruiting for their facilities, yielding results suggesting a slightly more severe view of recruiting difficulties from the staff viewpoint. They scored an average of 3.28 and 42.8% scored this item with either a 4 or 5.

Questions soliciting perceptions of effective recruitment strategies were also asked. Table 4 contains the results represented as the mean score on items rated from 1 to 5 with 1 indicating "not effective" and 5 indicating "very effective". The percentage using each strategy is also reported. Long term care administrators appear to gravitate to neutral responses, regarding most strategies as neither particularly effective or ineffective. Word of mouth was used universally and was the most highly regarded recruitment method. Nearly all used newspapers, but without great confidence and a majority used continuing education as a recruitment tool, but again without confidence in its effectiveness. It appears that administrators are not optimistic regarding the array of tools at their disposal for recruitment.

Table 4. Perceived Effectiveness and Use of Specific Recruitment Strategies.

Recruitment Strategies	Mean Score	Percent Using
Word of Mouth	3.96	100%
Newspaper	3.19	99.1
Radio	2.39	46
Television	2.67	24.8
Newsletter/Journal	2.35	46.9
Personal Letter	3.00	42.5
Sign on Bonus	3.14	45.1
Relocation Assistance	2.48	21.4
Continuing Education	2.93	61.9
Child Care	2.88	22.1
Paid Licensure	3.14	34.5

Additional strategies were suggested by some of the respondents as tools for recruiting. Bonuses to current staff who recruit new personnel, personal telephone calls, a sign in front of the facility, personal visits, website listings, loan repayment, tuition assistance, better salaries and benefits were all listed as additional suggestions that have potential.

Lastly, a count of the number of strategies employed by each facility was computed. The average number was 5.47 strategies from the 11 potential strategies listed. Clearly many of these carry costs, but some do not. Administrators seeking t bolster their recruitment efforts might consider extending the array of activities employed and increasing financial incentives to the recruit and recruiter.

Retention

Retention strategies are also important for developing and maintaining stable and high quality staff. When asked to rate their facilities problems in retaining staff, again an item asked them to relate their level of difficulty on a 5 point scale with a score of one indicating no difficulty and 5 indicating great difficulty. The average score on this item was a 2.75, just

slightly below the neutral midpoint. This rating suggests that retention is slightly less difficult than recruitment, and that it is not dire.

Again, a series of specific strategies were rated and assessed in terms of whether facilities employed them. These are presented in Table 5. The range of scores on specific strategies was from 2.92 to 3.45. The ratings of the specific retention strategies scored relatively high, apparently leading to the sense of low difficulty in overall retention efforts. The most effective strategy (according to the mean scores) was flexible scheduling, yet it was not the most used. Health, dental insurance and retirement plans were also rated highly in terms of effectiveness and were used widely.

Table 5. Ratings of Specific Retention Strategies and Proportion Using Each.

Retention Strategies	Mean Score	Proportion Using
Career Ladders	3.19	62.8%
Continuing Education	3.11	91.3%
Tuition Reimbursement	3.42	59.3%
Flexible Scheduling	3.95	89.4%
Education Based Wage Differentials	3.39	40.7%
Certification Based Wage Differentials	3.32	51.9%
Child Care Services	3.17	22.1%
Maternity Leave	3.02	92.9%
Health Insurance	3.90	96.5%
Dental Insurance	3.59	74.3%
Retirement Plans	3.48	89.4%
Shift Rotation	2.92	69.0%

A count of the strategies employed was constructed for this variable as well yielding an average of 8.37 strategies employed per facility from this list of 12 potential strategies. This appears to represent a substantial effort on the part of each facility.

Additional suggestions were also made regarding strategies for retention. The list of potential additional strategies included employee appreciation events, good communication,

mentoring programs, shared governance, meals, improved staff relationships, improved pay, loan reimbursements, short term disability coverage and improved corporate culture.

Access to Distance Learning

Facility administrators reported on their access to distance learning opportunities for their staff to receive certification, recertification or continuing education. A slight majority (53.4%) reported that they did not have access to these opportunities. This was somewhat surprising in that the list of distance learning programs reported by respondents was very long and varied, including on-line training and testing, corporate programs in leadership or for career advancement, Med Star, Web conferencing, and general use of proximal college campuses. Many types of technologies were employed in distance learning, including computers, satellite broadcasts, interactive TV, correspondence, teleconferencing, and video tapes. Given the array of options, the opportunity for enabling staff to learn new skills and information should be increasingly attractive. Perhaps incentives for continuing education would enhance access to and use of distance learning.

Barriers to Recruitment

A list of 15 potential barriers to recruitment were presented to the respondents, which they were to rate each on a scale of 1 to 5, with 1 being "not a barrier" and 5 representing "major barrier". The results of these items are summarized in Table 6. The competition for workers and occupational opportunities for spouses were the highest rated barriers, followed closely by the physical and psychological demands of long term care work. Pay and shift work were also rated somewhat higher than other factors and in the context of the total workforce in long term care, the role of benefits was not viewed as a significant hindrance. While this analysis assists in delineating problems for recruiting, it does not identify issues that reside within the capacities of

the facilities. Rather, it suggests that matters of the local economy are important obstacles to

overcome as are some of the difficulties inherent in providing care to the residents of long term

care facilities. Creative efforts to mitigate these barriers may be derived from the suggestions on

retention, such as providing greater recognition and psychological rewards for the service

providers.

Table 6. Ratings of Potential Barriers to Recruitment.

Issue	Average Rating
Undesirable amount of work hours	2.68
Shift work	3.21
Training requirements	2.39
Pay	3.33
Benefits	2.81
Working conditions	2.62
Psychological stress of LTC work	3.45
Physical demands of LTC work	3.66
Overwork as result of short staffing	3.17
Health hazards	2.11
Medical liability concerns	2.03
Size of this community	3.04
Competition for workers	3.76
Local employment opportunities for spouses	3.41
Geographic isolation	2.96

Rural/Urban Comparisons

        Are there concentrations of issues unique to or more common among urban and rural

facilities? In this section we examine differences that exist between the facilities classified as

urban and all other facilities. Urban facilities for present purposes include those located in Grand

Forks, Fargo, Minot, Bismarck and Mandan. The distribution of facilities responding to this

survey is presented in Table 7. Since most of the state is rural, the bulk of facilities are located in

rural places. The exception is with assisted living facilities, which are relatively new and

continue to experience changing definitions and status. The majority of Assisted Living facilities

are in the urban areas. It should be noted that this is a growth sector for the long term care

industry and models for smaller scale Assisted Living facilities in smaller communities are

emerging.

Table 7. Distribution of Facilities/Urban and Rural.

Distribution	Rural	Urban	Total
Nursing Beds	64	17	81
Assisted Living Beds	8	9	17
Basic Care Beds	28	4	32
Independent Apts.	23	6	29

The size of facilities also varies by location, with urban facilities generally being much

larger. The range in total number of units runs from a low of 11 beds to a high of 378. Rural

locations may be more likely to experience limits on the size of their facilities. Economies of

scale may be difficult in these smaller facilities for matters such as purchasing, training staff or

having depth in their staff, while the relative contribution of these smaller facilities to their local

economies is great.

Table 8. Average Number of Beds Licensed by Type: Rural and Urban.

Type of Beds	Rural	Urban	Total
Nursing Beds	69.3	118.1	79.6
Assisted Living	20.2	61.8	42.2
Basic Care	35.6	33.5	35.4
Independent Apts.	20.7	42.7	25.2

Occupancy rates also vary significantly by location with rural occupancy rates generally

average well below those of the urban facilities. Occupancy rates are displayed by county in the

map found in Figure 3. The lowest average occupancy rate is for Assisted Living in rural

locations. This low occupancy does not appear to reflect recent construction. The average age

of buildings for North Dakota long term care facilities by county is presented in Figure 4.
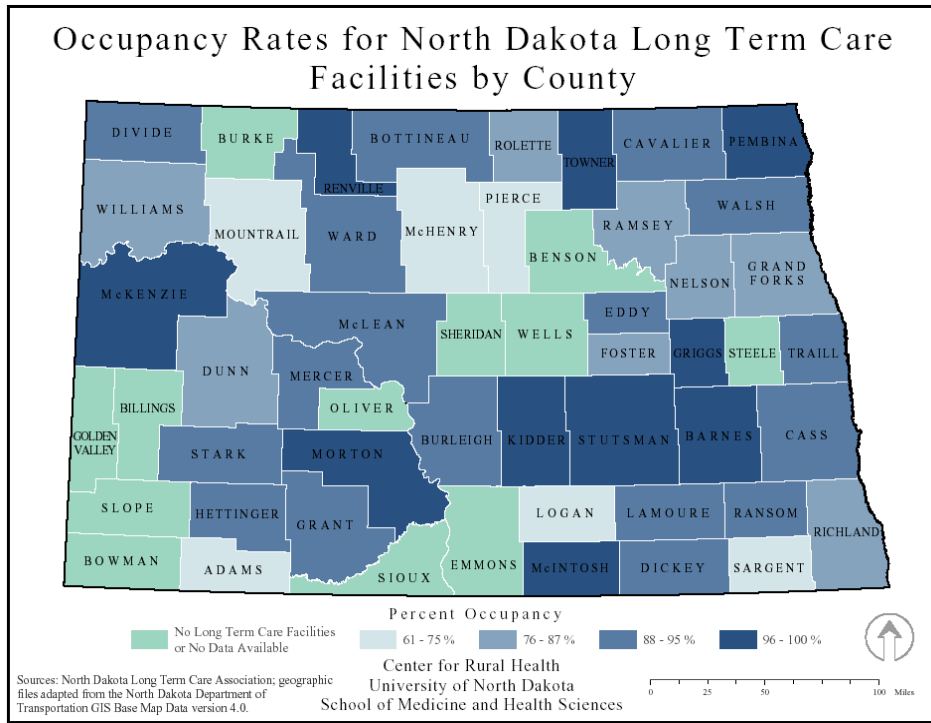
Figure 3. Occupancy Rates for North Dakota Long Term Care Facilities by County
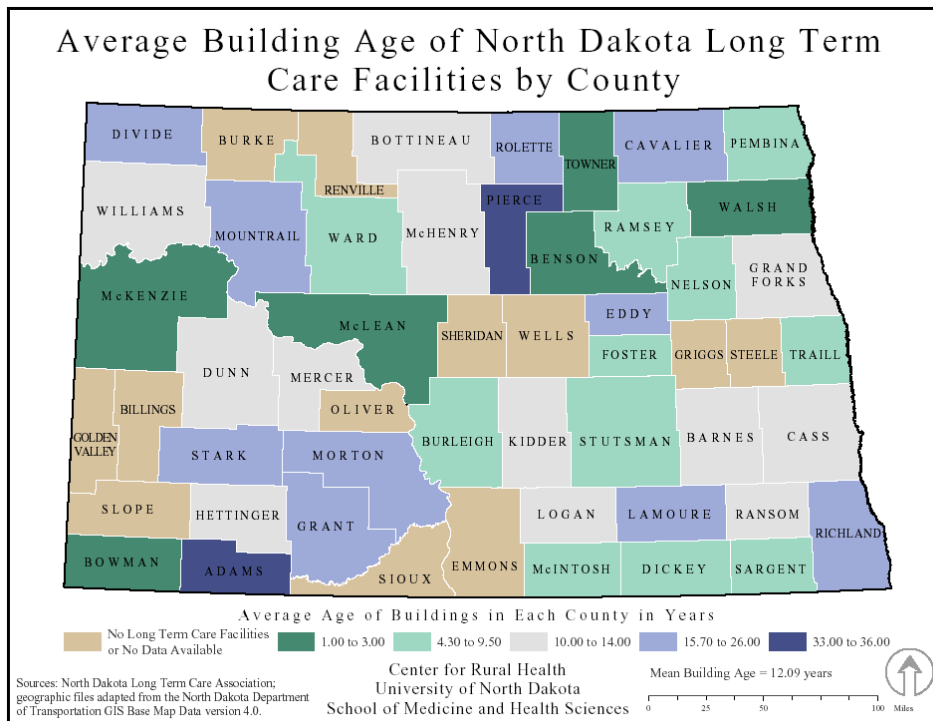
Figure 4. Average Building Age of North Dakota Long Term Care Facilities by County

12

Facility age as indicated by year of last construction, shows rural facilities were slightly older (on average) than urban facilities (rural = 11.7 yrs, urban = 9.7 yrs). The age difference was greater for assisted living, with rural facilities with assisted living averaging a facility age of 8.8 years and the urban facilities averaging 4.6 years. While one normally expects newer facilities to fill over time, this does not appear to be a factor for rural assisted living occupancy rates.

Table 9. Mean Occupancy Rate by License Types: Rural and Urban.

Type of Bed	Rural	Urban	Total
Nursing Beds	89.2	93.4	90.1
Assisted Living	79.2	95.3	87.2
Basic Care	83.3	98.7	85.4
Independent Apts.	90.5	96.7	91.6

Staff Vacancies

Vacancy rates for staff openings were calculated for the total full time equivalent (FTE) vacancy rate per 100 beds and a similar measure was developed reflecting vacancy rates for RNs, LPNs and CNAs. The overall vacancy rate was 3.37 FTE openings per 100 beds, with rural facilities posting a higher rate (3.62) than the urban facilities (2.55), suggesting greater difficulties with staffing in rural facilities. The differences varied according to the level of training and were not consistently higher for rural facilities. For example, rural places had an average opening rate for RNs of 1.01 FTE openings per 100 beds while urban facilities produced a rate of .38 FTE openings per 100 beds for RNs. This is a substantial difference. Urban facilities, on the other hand, had more openings for LPNs with .80 FTE openings per 100 beds as compared to the rural rate of .37 FTE openings. Differences in the rates for CNA vacancies were very small, suggesting that staffing issues at that level of training are similar for rural and urban facilities.

Recruitment Difficulties

Difficulties in recruitment were reportedly greater in rural facilities. The mean scores to the item asking administrators to rate their facilities difficulty in recruiting staff for direct patient care using a scale of 1 to 5 with 5 representing great difficulty produced a mean of 2.87 for urban facilities and 3.27 for rural. Analysis of the individual recruitment strategies produced no significant differences in terms of the mean ratings of effectiveness. Similarly, there were no differences of significance in the rates of use for strategies employed to recruit staff. The only significant difference observed overall among the recruitment strategies was that more urban facilities used child care services. Evidently the differences observed in rates of vacancies are not a function of recruitment effort.

Retention Difficulties

Retention difficulties were analyzed in a similar fashion to determine whether differences existed in practice and/or perceptions of effectiveness. When responding to the general question of how they rated the retention difficulties of their facilities, the rural administrators had scores that were only slightly higher than the urban administrators (2.82 vs 2.54) suggesting essentially no difference in their perceptions of retention issues. The scores are both below the middle point of 3. Rural and urban facilities were also similar with respect to the types of retention strategies utilized. Only the use of dental insurance was significantly different, with 67.9% of the rural facilities and 92.6% of the urban facilities offering this benefit.

Similarly, analytic comparison of the effectiveness scores for specific strategies yielded few differences between the rural and urban facilities. Only one strategy – flexible scheduling- produced a statistically significant difference with the urban administrators rating the

effectiveness of this practice higher than rural administrators (mean scores of 4.24 and 3.85, respectively).

Distance Learning

Access to distance learning was clearly favored by rural administrators as they were more than twice as likely to acknowledge having access to distance learning technology. Fifty-six percent of the rural administrators reported having access to such distance learning while only 25.9 per cent of the urban administrators reported such access. This statistically significant finding underscores the importance of distance learning for facilities located our rural communities.

Barriers to Recruitment

Analysis of recruitment barriers yielded several differences in perceptions among between rural and urban administrators. In table 10 there are 15 potential barriers listed. Two thirds of these yielded statistically significant differences, with rural facilities facing greater barriers in all cases. It is also of note that all of the items, whether statistically significant or not, placed urban facilities at an advantage. Problems that deal with undesirable work hours could be overcome to some extent by flexible scheduling practices, but these practices may be inhibited in institutions with small staff size. Similarly, shift work may be more essential in smaller facilities. Training requirements, especially those for RNs are seen as placing rural facilities at a disadvantage. These requirements are an issue to be considered by legislative and policy groups, as they are beyond local administrator control. Benefits were significantly different, with rural facilities experience greater barriers due to the benefit side of compensation. As was noted earlier, they were less likely to offer dental insurance. This may be symptomatic of the benefits issue. Work related stressors were also viewed as greater obstacles for rural facilities, with

psychological, physical and overwork stressors all high in rural facilities. Lastly, community

characteristics produced greater barriers for rural facilities. The size of community, opportunity

for spousal employment and geographic isolation produced significantly greater barriers for rural

communities. Not all of these barriers are within the capacities of administrators to address, yet

each represents a consideration that merits attention in efforts to create uniformity in access to

quality care.

Table 10. Rural /Urban Differences in Barriers to Recruitment

Barriers to Recruitment	Rural	Urban	Significance
Undesirable work hours	2.82	2.22	Yes
Shift Work	3.36	2.74	Yes
Training Requirements	2.56	1.85	Yes
Pay	3.42	3.04	No
Benefits	3.00	2.22	Yes
Working conditions	2.72	2.30	No
Psychological stress of LTC work	3.59	3.00	Yes
Physical demands of LTC work	3.79	3.29	Yes
Overwork as result of short staffing	3.35	2.63	Yes
Health hazards	2.14	2.00	No
Medical liability concerns	2.08	1.85	No
Size of this community	3.49	1.59	Yes
Competition for workers	3.81	3.59	No
Local employment opportunities for spouse	3.89	1.89	Yes
Geographic isolation	3.46	1.17	Yes

Type of Facility

The question of whether the type of facility affected recruitment and retention was

addressed by creating a classification of facilities in which they are either single or multiple type.

The classification contains three single purpose types and a mixed type residual category. The

single types were nursing, assisted living and basic care. No independent apartments were found

outside of those in mixed facilities. The distribution of facilities by type is in Table 11. Mixed

facilities were clearly larger in size than single purpose facilities.

16

Table 11. Facility Type, Number of Facilities and Average Size

	Number of Facilities	Average Bed Size
Nursing Home Care	48	69.4
Assisted Living	7	42.1
Basic Care	17	39.4
Mixed	39	81.3

The data analysis yielded non-significant differences between the types with respect to issues of recruitment, retention, or barriers to recruitment. However, it did produce some differences with respect to vacancy rates. Nursing care only facilities had the highest rate of vacancy overall and for each type of employee. Assisted living facilities were found to have the lowest vacancy rates.

Table 12. Staff Vacancy Rates per 100 Beds by Facility Type.

	RNs	LPNs	CNAs	Total*
Nursing Care	1.39	0.91	1.94	5.00
Assisted Living	0.00	0.00	0.59	0.60
Basic Care	0.36	0.17	0.67	1.84
Mixed	0.58	0.14	1.37	2.53

* Total includes non direct care positions.

SUMMARY AND CONCLUSIONS

This survey of long term care administrators sought to capture input from facility administrators with respect to issues of recruitment and retention for caregiving staff. The survey produced an excellent rate of response, but did not produce dramatic results. When searching for guidance regarding matters of recruitment and retention, administrators did not appear alarmed over the difficulties in either recruitment or retention and tended to rate the effectiveness of most strategies at the neutral point of a 5 point scale. Informal recruitment using word of mouth was the most common and was deemed the most effective method of recruitment.

Retention was rated as slightly less difficult that recruitment, yet the 10 of 12 the listed strategies were employed by a majority of the facilities. The average ratings of effectiveness were also higher than the ratings of effectiveness for recruitment strategies. It appears that once recruited, efforts are made to retain staff and are modestly successful. The most effective strategy appears to be flexible scheduling and this is one that does not carry additional costs.

Barriers to recruitment with relatively high ratings as barriers were job related in psychological and physical stress of the work and community based in competition for workers and local employment opportunities for spouses. While these are difficult to address, staff development activities can respond to the stressors of the work place and work place policies can mitigate some of the stress. Indeed, the threat of substantial stress may be greater than the reality. The community based barriers direct our attention to the need for economic development in rural communities to diversify employment options and create better opportunities.

Rural/urban differences do exist. Urban facilities tend to be larger and enjoy higher occupancy rates. Urban facilities are less likely to have openings for RNs and rural facilities are less likely to experience openings for LPNs. It may be that the use of LPNs has been a rural

adaptation to recruitment problems. Rates for CNA openings were quite similar for rural and urban facilities. While differences were not apparent for recruitment and retention strategies, there were apparent differences when examining barriers to recruitment. Rural administrators reported significantly higher barriers for a series of items reflecting the conditions of work, including undesirable hours, shift work, training requirements, pay, benefits, psychological stress, physical demands, and overwork. They also reported higher community barriers including small community size, isolation and few local employment opportunities for spouses. In short, the barriers appear much greater for rural facilities.

Comparisons by facility type did not produce difference with respect to the measures of effectiveness for recruitment and retention or with barriers. There was a difference for staff vacancy rates, with nursing care and mixed facilities having the highest vacancy rates for direct care providers.

Recommendations

The following recommendations are presented as possible actions that may be considered by the Legislature, Department of Human Services and/or facility administrators. They are not in any ranked order and are not exhaustive of the possibilities.

- CNA vacancies represent the largest category and special attention may be required to their wage levels, opportunities for advancement and work conditions

- Staff vacancy rates for LPNs are highest in urban facilities, while the vacancy rates for RNs are highest in rural facilities. This may suggest that an adaptation to workforce availability has been made by rural administrators where staff vacancy rates overall were higher. Programs targeting enhancing staff, especially targeting rural facilities, would seem in order. These could reflect recruitment, retention and the generation of supply.

- Accommodation of individual staff through work place modification such as flexible scheduling may assist in recruitment and retention.

- Stress management represents a need among long term care providers. Both psychological stress and physical demands of the work ranked high as barriers to recruitment. Creative stress reduction through in-service education and training may minimize stress of both varieties and improve the perception of long term care environments.

- Rural communities continue to need economic development of a more diverse variety in order to overcome an economic disadvantage in the overall opportunity structure for employment.

2001 SURVEY OF NORTH DAKOTA LONG-TERM CARE
FACILITY ADMINISTRATORS

1. Name of your LTC facility _____

2. Town name _____

3. How long have you been the Administrator of this facility? _____ years

4. When was this facility built? _____ (year)

5. If applicable, when was the last building structure renovation completed? _____ (year)

6. How many beds are licensed in each of the following categories for your facility?

   _____ Nursing Care   _____ Assisted Living   _____ Basic Care   _____ Independent Apts.

7. What is the current percent occupancy in your facility (based on staffed beds)? _____

8. Is this facility?   a public facility
                            private non-profit
                            private for-profit

9. Is this facility?   attached to a hospital
                            freestanding

10. Please list your LTC facility's current staff vacancies.

11. In general, how would you rank your facility's problems in <u>recruiting</u> staff involving direct patient care?

No Difficulty				Great Difficulty
1	2	3	4	5

12. In general, how would you rank your facility's problems in <u>retaining</u> staff involving direct patient care?

	No Difficulty				Great Difficulty
	1	2	3	4	5

13. How effective would you rate the following **recruitment** strategies in your facility (for personnel involving direct patient care)? Please indicate on a scale of 1 to 5, with 1 being not effective and 5 being very effective, the level of effectiveness you see for each. If you do not use some of the methods, please check 8.

Recruitment Strategy	Not Effective 1	2	3	4	Very Effective 5	N/A Don't Use 8
Word of mouth						
Media						
Newspaper						
Radio						
Television						
Newsletter/Journal						
Personal Letter						
Sign On Bonuses						
Relocation Assist						
Continuing Educ. Asst.						
Child Care Services						
Paid Licensure						
Other, please list:						

14. How effective would you rate the following **retention** strategies in your facility (for personnel involving direct patient care)? Please indicate on a scale of 1 to 5, with 1 being not effective and 5 being very effective, the level of effectiveness you see for each. If you do not use some of the methods, please check 8. Please add strategies not included in the space provided.

Recruitment Strategy	Not Effective 1	2	3	4	Very Effective 5	N/A, Don't Use 8
Career Ladders						
Continuing Education						
Tuition Reimbursement						
Flexible Scheduling						
Education-Based Wage Differentials						
Certification-Based Wage Differentials						
Child Care Services						
Maternity Leave						
Health Insurance						
Dental Insurance						
Retirement Plans						
Shift Rotation						
Other, please list:						

15. Do you currently have access to distance learning (e.g., computer- or Internet-based modules) programs for direct patient care staff to receive certification, re-certification or continuing education? _____ Yes _____ No

16. What programs are available?

17. How are programs delivered? (i.e., Interactive TV, Satellite, Computer, Telephone, Correspondence)

18. **In your opinion, to what extent do the following issues act as <u>barriers to recruitment</u> of local individuals into the local LTC facility (for direct patient care)?**

Issue	Not a Barrier 1	2	3	4	Major Barrier 5
Undesirable amount of work hours					
Shift work					
Training requirements					
Pay					
Benefits					
Working conditions					
Psychological stress of LTC work					
Physical demands of LTC work					
Over work as result of short staffing					
Health hazards					
Medical liability concerns					
Size of this community					
Competition for workers					
Local employment opportunities for spouses					
Geographic Isolation					
Other, please list:					

19. What, in your opinion, are the most important actions the North Dakota legislature can take to improve your capacity to provide quality long term care in the future? Please list the top two or three actions you would recommend.

Thank your for your participation!