THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

REPORT by KATE BARNETT  - 2014 CHURCHILL FELLOW

THE TEACHING NURSING HOME MODEL AND ITS PLACE IN THE AGED CARE SYSTEM IN THE USA AND CANADA

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Signed: Kate Barnett

Dated: July 20th 2015
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INTRODUCTION: WHY WE NEED TEACHING NURSING HOMES

As advanced Western societies see increasing numbers of people living to much older ages than ever before, the need has increased for aged care services to be informed by purpose-designed research evidence, to be supported by workforces whose skills keep pace with changing demand and system reform, and to attract future workforces by providing effective student clinical education. Health workforces need to be educated to support an ageing population and are unlikely to develop the capacity to manage complex and chronic conditions associated with ageing if their only training is in acute care settings which require a different skill set. Aged care organisations have the knowledge base required to care for older people but usually lack the resources and expertise to be teachers as well as service providers.

The ‘Teaching Nursing Home’ model addresses these challenges, but it is a selective model. Just as all hospitals are not, and do not need to be, teaching hospitals, so too do only some aged care services need to also be providers of high quality education and research. Those that do, provide leadership for the rest of the sector and are recognised as innovators in their field.

In Australia, the Teaching Nursing Home model received a significant boost when the Commonwealth Government provided three year funding for the TRACS Program (Teaching Research Aged Care Services). TRACS took its inspiration from the inventors of the model who were based in the United States.

This Churchill Fellowship involved visiting leaders with highly regarded applications of the model in the USA and in Canada where the Ontario government recently funded three – known as Centres for Learning Research and Innovation. It enabled me to make a comparative analysis of the place of this model in the broader aged care system, to better understand its potential strengths and how to maximise these, and to link Australian leaders of the model with their overseas counterparts.

The Dorothea Sanders and Irene Lee Churchill Fellowship has provided me with a once in a lifetime opportunity to obtain an in-depth knowledge of a model about which I am passionate because of its ability to lift the profile of the aged care sector and its leading providers, and ultimately to improve the quality of aged care, and I thank the Winston Churchill Memorial Trust for this wonderful experience.

I am also indebted to the Australian Workplace Innovation and Social Research Centre (WISeR) at The University of Adelaide for providing me with the time to undertake the Fellowship, and to the 61 individuals listed in the Program for their time, insight and warm hospitality.
2 EXECUTIVE SUMMARY

2.1 FELLOWSHIP DETAILS

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2.2 PROJECT DESCRIPTION

A study of the Teaching Nursing Home model in North America designed to increase understanding of the model and its relevance for Australia, and to share insights and lessons learned with those applying the model in Australia. The Project involved in-depth interviews with experts in the field as well as site visits to aged care services pursuing innovation and best practice based on the model. These interviews, and the four public presentations about the model in Australia, supported knowledge exchange and the building of linkages between leaders in the field in the USA, Canada and Australia.

2.3 HIGHLIGHTS

The knowledge gained from this Fellowship has reinforced for me the importance of the Teaching Nurse Home/TRACS model in lifting best practice in aged care, in providing leadership for the sector in educating current and future workforces, and in leading research that improves the quality of older people’s lives. Key highlights were:

- Simulation Labs – Portland and Conestoga College, Kitchener – because of the value they add to student learning and readiness for work.
- The Living Classroom model, Conestoga College and Schlegel Villages, and the Dedicated Education Unit, Portland – again because of their capacity to enhance graduates’ work readiness.
- The extensive use of videoconferencing – both to enhance access for workforce and student education, and also because of its capacity to support interprofessional education.
- The 3 CLRIs (Centres for Learning Research and Innovation) in Ontario and their aged care research, student and workforce education, and aged care innovations.
- The power of philanthropy and aged care benefactors in enabling leading aged care providers to showcase what they are capable of with the appropriate support.
The PACE program in the USA and the ‘service bundling’ models I saw in Canada – because of the potential relevance for Australia as we grapple with providing holistic services that not only provide care for an older person, but more broadly, enable them to live their lives as well as possible.

Seeing the common lessons across the US, Canada and Australia in applying the TNH/TRACS model and the basis this has provided for linking those involved in an international ‘Community of Practice’.

### 2.4 Major Lessons Learned

1) **The Teaching Nursing Home/TRACS model requires dedicated funding to make an impact** (although funding alone will not bring success as the other critical success factors are strong and effective partnerships involving leaders in the aged care and education sectors who are committed to the model). Funding enables those involved to focus on the work associated with the model and provides the infrastructure needed to support learning and capacity building.

   Resourcing, whether by private benefactors or by governments, enables partners to showcase what is possible. It can be compared to provide university scholarships for talented students without the financial means to otherwise engage in higher education. This is particularly important for the aged care sector in lifting its profile and providing leadership in enhancing the quality of care.

   It takes time for the TNH/TRACS model to make an impact and to collect longitudinal data to measure its impact on workforce capacity building and therefore on improved aged care outcomes. Therefore, funding needs to be long term, preferably ongoing (as occurs in Norway).

   Nevertheless, even shorter term funding has a positive impact. It enables aged care organisations to pilot innovation and then obtain the support of their Boards or of funders to implement change. For those visited in the USA, the Robert Woods Johnson Foundation TNH Program’s five year funding had the effect of increasing participants’ competitive ability in attracting subsequent TNH-related funding, lifting their profile and demonstrating the value of ongoing partnerships between aged care and education.

2) **The Canadian part of my Fellowship showcased what is possible when leading aged care organisations are resourced to be drivers of research designed to change older people’s lives for the better.** Each of the CLRI aged care partners housed a major research institute, supported in the main by private benefactors. While research involved partnerships with universities, this was led by the aged care partner when usually the reverse is the case.

3) **Interprofessional Education or Interprofessional Learning is a central feature of both student clinical education and workforce education, and supports the challenge of better meeting the complex care needs of older people.** This trend is also apparent in Australia.
4) As in Australia, there is a growing recognition of the need to address the gap between student education and their capacity to practice in the aged care work setting. The Dedicated Education Unit program in Portland (which originated at the Flinders University of South Australia) and the Schlegel-Conestoga College Living Classroom initiatives both involve immersion of students in the aged care work site and are successful in ensuring that graduates are work-ready. The superior learning achieved in both programs has relevance for Australia, and synergy with similarly innovative programs operating here.

5) The important role of technology in enhancing student and workforce education was evident, particularly in the use of videoconferencing and of simulated learning through purpose-designed Simulation Laboratories that included hi tech Mannikins.

6) The partnerships which are the essence of the TNH/TRACS model face similar challenges as they do in Australia but are also highly valued as they are here in enabling innovation, creative resource sharing and leveraging, and ongoing learning. But the partners need themselves to be ‘learning organisations’ and their partnership needs to be built on trust and mutual respect, in order to provide the foundation that is so critical to the model’s effectiveness.

2.5 INFORMATION DISSEMINATION STRATEGY

This Fellowship has multiple information dissemination strategies, beyond this Report.

Prior to leaving for my visit I contacted all TRACS projects to identify specific issues in which they were interested to see if I could bring back information for them from the US and Canada.

I will be sharing my findings through a combination of individual interviews, seminars with TRACS aged care staff, and presentations to State and national conferences.

I am also linking individuals from particular TRACS projects to individuals at different sites visited in the US and Canada with shared interests. This begins to link people in an international ‘Community of Practice’ but I am also seeking to develop an International Conference for people involved in a TNH or TRACS initiative that would be hosted by Australia in the first instance, but then rotated across the other nations pursuing the model – Canada, the USA and Scandinavia. The business model for this makes sense as conference participation would cover organisational and operational costs. There was strong interest in such a Conference ever where I visited.

In addition, I have approached the convenors of the 2017 IAGG Conference in San Francisco to organise a dedicated teaching nursing home symposium involving the people I visited, those in Australia and Scandinavia and others pursuing the model. The conference organisers have agreed to a submission being made and those I visited are interested in being part of this.

Finally, I will be organising joint publications where appropriate with the people visited for my Fellowship.
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<tr>
<th>PERSON INTERVIEWED</th>
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<tr>
<td><strong>LOCATION: SAN FRANCISCO</strong></td>
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<tr>
<td>Prof Meg Wallhagen</td>
<td>School of Nursing, University of California San Francisco and Director, UCSF Hartford Center of Geriatric Nursing Excellence</td>
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<td>Dr Susan Chapman</td>
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<td><strong>LOCATION: PORTLAND, OREGON</strong></td>
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<tr>
<td>Dr Juliana Cartwright</td>
<td>Assoc Professor, School of Nursing, Oregon Health &amp; Sciences University (OHSU), Director ECLEPS program</td>
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<tr>
<td>Dr Joanne Radner</td>
<td>Former Nurse Practitioner at Benedictine Nursing Center that was part of the Robert Woods Johnson Foundation funded Teaching Nursing Home Program (1985-1990) in partnership with OHSU School of Nursing</td>
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<tr>
<td>Dr Jane Hagan</td>
<td>Clinical Asst Professor of Nursing, and Liaison with Mary’s Woods long term care, School of Nursing, Oregon Health &amp; Science University (OHSU)</td>
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<tr>
<td>Dr Pat Berry</td>
<td>Professor and Director, Hartford Center of Gerontological Nursing Excellence, OHSU</td>
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<td>Belinda Brookes</td>
<td>Clinical Placement Team Leader, Baccalaureate Completion Program for RNs, School of Nursing, OHSU</td>
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<td>Dr Mary Cato</td>
<td>Asst Professor, Simulation Specialist, School of Nursing, Oregon Health &amp; Sciences University</td>
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<tr>
<td>Ruth Tadesse</td>
<td>Asst Professor, Undergraduate Program, School of Nursing, Oregon Health &amp; Sciences University</td>
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<td>Jesika Gavilanes</td>
<td>Director of Operations, Simulation Center, School of Nursing, Oregon Health &amp; Sciences University</td>
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<td>Nancy Koerner</td>
<td>Director of Nursing, Mary’s Wood Continuing Care Retirement Community, Portland</td>
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<td>Kira Karinen</td>
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<tr>
<td>Dr Donna Fick</td>
<td>Distinguished Professor of Nursing, Co-Director, Hartford Center for Geriatric Nursing Excellence</td>
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<tr>
<td>Dr Ann Kolanowski</td>
<td>Elouise Ross Eberly Professor of Nursing and Director, Hartford Center for Geriatric Nursing Excellence</td>
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<tr>
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<td>Dean and Professor, College of Nursing, The Pennsylvania State University</td>
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<td>Jane McDowell</td>
<td>Project Director, Clinical Registered Nurse Practitioner Program, College of Nursing, The Pennsylvania State University</td>
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**LOCATION: THE ABRAMSON CENTER FOR JEWISH LIFE, PHILADELPHIA**

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<tr>
<td>Carol Irvine</td>
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</tr>
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<td>Val Palmieri</td>
<td>Chief Operating Officer, Madlyn and Leonard Abramson Center for Jewish Life, Philadelphia</td>
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<td>Karen Eshragi</td>
<td>Quality Improvement Coordinator, Abramson Center</td>
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<td>Dr Kimberly Sue Van Haitsma</td>
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**LOCATION: UNIVERSITY OF WISCONSIN AND CAPITOL LAKES HEALTH CENTER TEACHING NURSING HOME, MADISON, WISCONSIN**

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<td>Dr Lynn Phelps</td>
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<td>Sally Davis</td>
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<td>June Blanchard</td>
<td>Resident of Capitol Lakes Health Center</td>
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**LOCATION: CASE WESTERN UNIVERSITY, CLEVELAND, OHIO**

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<tr>
<td>Dr Elizabeth Madigan</td>
<td>Independent Foundation of Nursing Professor, Frances Payne Bolton School of Nursing</td>
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**LOCATION: BRUYÈRE CENTRE FOR LEARNING, RESEARCH AND INNOVATION IN LONG TERM CARE, OTTAWA, ONTARIO**

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<th>Name</th>
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<tr>
<td>Dr Melissa Donskov</td>
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<td>Dr Tracy Luciani</td>
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<td>Simon Akinsuli</td>
<td>Executive Director for Long Term Care, Bruyère Continuing Care</td>
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<td>Josie d'Avernas</td>
<td>Vice President, Schlegel Research Institute for Aging</td>
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<td>Dr Mike Sharratt</td>
<td>President, Schlegel Research Institute for Aging</td>
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<tr>
<td>Susan Brown</td>
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<tr>
<td>Dr Veronique Boscart</td>
<td>Schlegel Industrial Research Chair for Colleges in Seniors Care and Professor at Conestoga College Institute of Technology and Advanced Learning</td>
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<tr>
<td>Dr Heather Keller</td>
<td>Schlegel Research Chair in Nutrition and Aging and Professor at the University of Waterloo</td>
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In addition to this program of interviews and site visits to leading aged care services, I also provided 4 presentations on the Teaching Nursing Home model in Australia – the TRACS Program. These presentations overviewed all 16 funded partnerships while identifying challenges faced and lessons learned.

1. Presentation to the Polisher Research Institute and Abramson Center for Jewish Life, Philadelphia, June 11th 2015 – The TRACS Footprint: Developing Capacity through Australian Teaching Research Aged Care Services.

2. Presentation to the Bruyère Centre for Learning Research and Innovation in Long-Term Care, Ottawa and via webinar to Bruyère health and aged care services and the other CLRIs, June 23rd 2015 – Designing Optimal Student Clinical Placements and Continuing Education for Staff in Long-Term Care.


4. Presentation to the Schlegel Centre for Learning Research and Innovation, Kitchener, Ontario, June 29th 2015 – Lessons learned from the Australian Teaching Research Aged Care Services (TRACS) Program.

4 FINDINGS AND LESSONS LEARNED

The Fellowship was structured to identify lessons in relation to all three features of the Teaching Nursing Home model – research designed to improve the quality of aged care, workforce education to support innovation and best practice in aged care, and student clinical education that prepares the future health and aged care workforces to meet the needs of an ageing population. Because the model is centred on partnerships – between aged care, education and research providers – lessons were also sought about creating and sustaining effective partnerships. More broadly, the Fellowship was designed to
ascertain the impact of the Teaching Nursing Home model on the wider aged care system and to compare its application between Australia, Canada and the United States.

4.1 Aged Care Trends

Although my Fellowship was not focused on the aged care system itself, there were a number of observations that were apparent and which provide context for the teaching nursing home models which I visited.

Aged care systems in Australia, Canada and the USA are clearly grappling with similar challenges in being able to respond to a growing ageing population while managing two competing tensions – operating effectively in an environment of limited resources while pursuing ongoing reform.

As reform in the Australian aged care system sees the adoption of consumer-directed care (CDC), and the challenges that brings – particularly in preparing the aged care workforce – in both the US and Canada a similar need to prepare the workforce for person centred care (PCC) was evident. All three countries recognise the need not only for specific skills but for a ‘mindset’ that supports the shifting of service locus to the person rather than the provider.

Noting the importance of having workforce members who can model the new behaviours required in a PCC model, teaching nursing home partners Penn State University and the Abramson Center have implemented a research project that involves rethinking for the resident, family, enrolled nurse, RN, and Social Worker – training all of them to develop a Person Centred Care ‘mindset’. It will also identify and develop Unit Champions. The Program for Person-Centered Living Systems of Care Project is occurring within Penn State University’s Hartford Center for Geriatric Nursing Excellence (see below) and the Project Manager is the former Director of the Polisher Research Institute which is part of the Abramson Center for Jewish Life in Philadelphia. The Institute is co-funding her salary for this project. More information about the Program can be found at www.nursing.psu.edu/hartford/ppclsc

There was significant attention being paid to the personal care workforce, which like Australia, represents the majority of the direct care workforce in aged care. This included innovative research by the Bruyère Centre for Learning Research and Innovation (CLRI) in Ottawa with two innovative research programs offering potentially valuable information for Australian aged care providers and policy makers. The Long Term Care Health Human Resources Forecasting Model is being undertaken in partnership with the University of Toronto, University of Ottawa and Algonquin College and is designed to identify current and projected use of personal support workers in the long term aged care sector – more details are at http://clri-ltc.ca/files/2015/05/HHR-panel-presentation_vs.pdf. The Case Costing in Long term Care project is being led by the CLRI and involves developing a framework and tool kit for case costing methodology (a feature of acute but not aged care systems) in long term care at Bruyère Continuing Care. This will provide a model which can be applied in Ontario and is expected to bring a range of resourcing and financial decision
making benefits arising from the greater accuracy possible in measuring resource utilization.

I also saw a number of innovative student and workforce education programs designed to build a workforce that meets the needs of the aged care sector and these are discussed in Section 4.6 below.

All of the aged care facilities I visited, like their Australian counterparts, were focused on designing and continuously improving the long term care environment and making it less like an institution and more like a normal community. Several fostered intergenerational programs, including locating child care centres on site, both for the positive interactions between young children and older people, and for the practical purpose of providing accessible childcare for a workforce made up largely of parents.

I was particularly inspired by the ‘Yes’ campaign at Mary’s Wood in Portland where staff had achieved a logistical success in arranging a whole of staff and residents pool party, which had been an outstanding success for everyone. Because this had been considered ‘undo-able’ managers and staff developed a series of reminders of what they could achieve with the right level of commitment, and had badges (worn by most) and posters made with the word ‘Yes’ to provide an ongoing reminder.

The Schlegel Villages in Kitchener, Ontario are a family of 15 ‘continuum of care’ campuses across southwestern Ontario that are owned and managed by the Schlegel family – see http://schlegelvillages.com/. (The continuum of care model was evident in both the US and Canada and involves providing a range of aged care services, typically ‘assisted living’ and ‘long term care’ as well as retirement living. These were usually known as Continuing Care Retirement Communities.) Each Schlegel complex is designed and constructed to resemble a village, with a Main Street (a glass roofed internal corridor made to look like a street) that provides a ‘spine’ linking all buildings and a Town Square that usually joins the long term care facility to the Retirement Home. Schlegel seeks strong integration with the local community by choice of location (on a public transport line, on residential land rather than outer industrial land) and an open door to the community to be involved in Schlegel Village programs and to use their services. The new Centre of Excellence for Innovation in Ageing which I visited includes a general medical practice and services which are open to the local community.

Taking the model further, Schlegel Villages use the Neighbourhood concept to provide and manage care. The model promotes resident-centred care by moving more control and decision making to a ‘neighbourhood level’ (30-32 residents) which is smaller than the total organisation that usually involves between 100-200 residents. The Neighbourhood
Development Team is a flat decision making structure that develops work teams in the residential facility—Personal Support Workers, Registered and Enrolled Nurses, Occupational Therapists, Dieticians and other key workforce members including domestic staff and janitors. Each neighbourhood team is a work group who are self-directed and make decisions about budgeting, staffing and so on. Each has a Coordinator who can be anyone from the team and a Supervisor leads the overall team. The teams are supported with Interprofessional training provided for half a day every quarter and involving the whole unit who are backfilled during this time. National funding has been received to evaluate the program and this is linked to clinical outcomes. An early outcome identified by Schlegel staff is that absenteeism has been reduced.

There is one noticeable difference in relation to aged care resourcing compared with Australia—the significant injection that is received from organised philanthropy in both the US and Canada. In the leading aged care providers I visited, this had made the difference in being able to conduct best practice research to inform better quality care and to provide leading edge workforce education that is enhanced by technology, for example, videoconferencing and simulated learning laboratories. The next section discusses how private benefactors have shaped best practice.

4.2 THE ROLE OF PHILANTHROPIC ORGANISATIONS IN APPLYING THE MODEL

The Robert Woods Johnson Foundation philanthropic organisation funded the 1985-1990 Teaching Nursing Home Program that established the US as a leader in the Teaching Nursing Home model, and inspired the adoption of the model in Scandinavia and Australia. Its impact has been far reaching and other workforce capacity development programs that continue to fund teaching nursing home programs are also supported by philanthropic groups. The centres that I visited in the US which had originally received funding from this Program continued to pursue the model all these years later, building on its foundation and seeking new funding from other sources, including the Hartford Foundation.

4.2.1 THE HARTFORD FOUNDATION

Established in 1929 with funds from the bequests of its founders, the brothers John and George Hartford, its overall goal is to improve the health of older adults by creating a more skilled workforce and a better designed health system. Today it is considered to be the USA’s leading philanthropy with a dedicated focus on health and ageing. The Foundation’s Guiding Philosophy reflects its approach—

**It is necessary to carve from the whole vast spectrum of human needs one small band that the heart and mind together tell you is the area in which you can make your best contribution.**

For a long time the Foundation had supported medically focused research but was persuaded by Matty Mezey (from the Robert Woods Johnson Foundation TNHP) to address the limited ability of nursing schools to adequately prepare geriatric nurses due to the small number of nursing faculty with this expertise. This led to the establishment in
2000 of **BAGNC (Building Academic Geriatric Nursing Capacity)**. In its first 10 years, BAGNC alumni taught 20,000+ undergraduates and 3,500+ graduate and doctoral students and had 2 main components:

- Establishing **Centers of Geriatric Nursing Excellence (CGNE)** at schools of nursing to advance geriatric nursing research, education, and practice. Initially 5 were funded and a further 4 in 2007.
- Developing academic leaders through a Scholar and Fellow awards program.

The **Hartford Centers of Geriatric Nursing Excellence (CGNE)** were located at these universities (those in bold were visited as part of my Fellowship tour):

- Arizona State University
- Oregon Health and Sciences University
- Pennsylvania State University
- University of Arkansas for Medical Sciences
- **The University of California, San Francisco**
- The University of Iowa
- The University of Pennsylvania.
- University of Minnesota
- University of Utah.

The program is finishing in 2015 and its impact has been significant. The Directors I interviewed from the 3 Hartford CGNEs visited identify these outcomes (most of which will be relevant to the potential impact of TRACS, albeit with only 3 years’ funding compared to 15 years). The program ....

- Enabled a focused and improved geriatric nursing program.
- Expanded this program significantly.
- Upskilled university nursing faculty to deliver the program.
- Significantly lifted the profile of Nursing in the sponsoring university.
- Created a cohort of graduates whose influence is expected to be significant.

Gerontology is now seen as important across the disciplines of sponsoring universities. It has attracted students and a key drawcard for them is the networking that comes with participation in Hartford funded programs.

In Australia the focus on geriatric education in university health schools varies widely, ranging from non-existent to specialist attention as seen in schools associated with the Hartford program. In the face of an ageing population and the need to educate future health professionals, there is scope for a similar program here that would not be confined to nursing, but would extend to other health related disciplines.

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**4.2.2 CANADA: THE ROLE OF BENEFACtors IN THE CENTSRES FOR LEARNING RESEARCH AND INNOVATION**

The three **Centres for Learning Research and Innovation** (CLRI) were funded for 5 years by the Ontario Government but each has leveraged substantially from the strong foundation of partnerships that pre-existed funding. This was also the case with the TRACS Program in Australia.
For the CLRIs, those partnerships were each led by a leading aged care provider in turn supported by generous benefactors.

At the Baycrest CLRI, which is housed in a major health and aged care complex targeting Jewish people, the effect of donor contributions is apparent, with state of the art infrastructure and a diverse range of programs.

The photo on the right shows the imposing foyer of Baycrest’s Apotex Jewish Home for the Aged building which houses long term care residents.

The photo below reinforces the extent of benefactor input.

Similarly the Schlegel CLRI in Kitchener (about an hour out of Toronto) is based on a partnership between several local universities and the Schlegel family’s long term care and retirement ‘villages’. The Schlegels are generous benefactors (see Section 4.5.2 below) and their new Centre of Excellence for Innovation in Ageing in Kitchener is a three phase development that includes a major research institute – the Research Institute on Aging,
simulation laboratories and other technology driven education facilities, and long term aged care as well as retirement living. The Schlegel family's vision has always been to create an organisational structure that facilitates practice-relevant research, and research informed practice, as well as curriculum development to guide continuous improvement in the continuum of aged care services.

The Research Institute on Aging is located along the ‘spine’ that links all buildings. Its ground floor includes an education space involving classroom facilities, Simulation Labs and computer space (as well as the CLRI). There is an Ideas Café to connect different stakeholders, and the latest communication technologies feature, including videoconferencing. There is also a Primary Health Care (GP) Practice on site. The second level of the building houses the Research Chairs and their labs. See http://www.the-ria.ca/

The photo below shows the planned final product, the first stage of which (the long term care and research and education facilities) was being completed at the time of my visit.

4.3 Impact of the 1985-1990 Robert Woods Johnson Foundation TNH Program

Within the USA, my Fellowship sites included original recipients of the Robert Woods Johnson Foundation Teaching Nursing Home Program funding. These were Schools of Nursing in Portland, Oregon (the Oregon Health and Sciences University), the University of Wisconsin-Madison, and Case Western University in Cleveland, Ohio.

Case Western University’s Frances Payne Bolton School of Nursing is one of the top ranked schools in the USA and houses one of only 10 Pan American Health Organization/World Health Organization Collaborating Centers in the country. The School
of Nursing's current program has evolved over time from the original TNHP in the 1980s and while the partnership no longer exists (the aged care provider, Benjamin Rose was sold to another group and lack of TNH Program funding inhibited ongoing development) it has provided the foundation for the work they do today.

The School now collaborates with a small number of aged care providers all of whom are regarded as providing high quality care. They are Judson (one of the first continuing care providers) - [http://www.judsonsmartliving.org/](http://www.judsonsmartliving.org/); McGregor Home - [http://mcgregoramasa.org/about-mcgregor](http://mcgregoramasa.org/about-mcgregor) and Eliza Bryant Village - [http://www.elizabryant.org/](http://www.elizabryant.org/). The partnerships are based on research, student education and workforce development.

While the focus has been on Nursing, the School has always worked with Medicine, Dentistry and Social Work and at the time of interview was seeking to formalise an Interprofessional Education (IPE) program that will include a number of disciplines, and be based in multiple sectors – aged care, primary care as well as acute care. The four Schools are all moving into a purpose built building designed to support IPE and it will include new Simulation Labs (see Section 4.6.1 for discussion about Sim Labs).

Ongoing application of the Teaching Nursing Home model is supported through alternative resourcing, including the PACE program – with Case Western University having the only PACE program in Ohio (see below – Section 4.4). The Professor of Nursing observed that the reputation of the Robert Woods Johnson Foundation Teaching Nursing Home Program raised the profile of those involved and even today good providers want buy-in to the current application of the TNH model.

A similar impact was evident at the Oregon Health and Sciences University (OHSU)’s School of Nursing where original funding from the Robert Woods Johnson Foundation TNH Program had lifted the School’s profile and demonstrated the value of ongoing partnerships with the aged care sector. The Program was described as having made ‘a profound impact’.

The original partnership with the Benedictine elder care organisation continued for 4-5 years after funding ceased, driven by the success of the partnership and the outputs and outcomes it produced, particularly in research-based changes to care. There were two key people, one based at the Benedictine Nursing Home in Mt St Angel, a rural town outside of Portland (Joanne Radner, whom I was able to interview) and the Chair of her School at OHSU. These two worked harmoniously and each was a champion in their work environment. There were other active Champions associated with the Program in particular, Carol Lindemann from OHSU.

Regarding the commitment to the THNP post-funding, Joanne commented:

> We couldn’t let it go … it was such a powerful tool … it generated research that changed practice not only in Benedictine but was shared across the wider long term care sector.

The partners were keen to sustain their TNHP work and developed a Succession Plan to support this goal and keep the benefits generated. This included OHSU being able to provide high quality clinical education focused on the care of older people, Benedictine staff and clients enjoying the students’ visits and work with them, and the opportunity to
undertake clinically powerful research. They established the Benedictine Institute as the vehicle to continue the work.

However, Benedictine Nursing Home (which had a recognised tradition of high quality care and an embedded learning culture) was having financial and administrative problems and they were taken over by a large health provider called Providence. OHSU was unwilling to continue with them as their partner. This, combined with the withdrawal of TNHP funding, saw the end of the partnership.

Despite this turn of events, longer term the TNHP left a foundation for future partnering with similar goals. Like the Frances Payne Bolton School of Nursing, the OHSU School is a partner in Oregon’s only PACE program and has received critical funding from the ECLEPS program and the Hartford Center of Geriatric Nursing Excellence program. They also received funding to be 1 of 5 Demonstration Projects in Oregon from the Better Jobs Better Care workforce development initiative which supported the direct care workforce and included partnerships as a feature.

New partnerships have continued the TNH model and I visited two of these:

- **Mary’s Woods Continuing Care Retirement Community** - a non-profit established by the Sisters of the Holy Names of Jesus and Mary (Holy Name Sisters) to provide a continuum of housing, health and educational services for both Sisters and the local community. [www.maryswoods.com](http://www.maryswoods.com)

- **Providence ElderPlace** which provides the PACE program (see below Section 4.4.2) [http://oregon.providence.org/our-services/p/providence-elderplace/](http://oregon.providence.org/our-services/p/providence-elderplace/)

For both the OHSU and Case Western University Schools of Nursing, being a Robert Woods Johnson Foundation TNHP recipient had given competitive edge in applying for other funding that supports clinical education in health and aged care services. It is likely that Australia's TRACS Projects will face a similarly positive outcome when they seek funding to continue their application of the TNH model.

The **University of Wisconsin at Madison** was also an original TNHP participant and the lingering impact of their role as a teaching nursing home partner is likely (but I was unable to substantiate this) to have played a role in the more recent partnership which I was able to visit. This involves a partnership between the University’s School of Family Medicine and the Capitol Lakes Health Center in downtown Madison – see [http://www.retirement.org/madison/](http://www.retirement.org/madison/). At present the partnership involves only medicine but the plan is to increase this to involve other disciplines.

Initiated by one of the School’s physicians and the leader of the TNH, it sees Capitol Lakes supporting 20% of her salary in return for which she provides physician services to Capitol Lakes long term care residents. Capitol Lakes provides a range of community, residential (LTC and Assisted Living) and retirement living, rehabilitation, short stay services.

It was very clear from my visit that the residents and staff value Dr Hamrick’s work highly. She has a program of seminars designed to increase consumer health literacy and self-management and a viable clinical education program for 3rd year and on medical students. Some do mandatory education and for others it is an elective. Currently rotations are for 6 weeks, involving 3 x 0.5 days a week.
Dr Hamrick also provides physician services and student clinical education at 4 other local aged care services - Four Winds (Verona), Ingleside (Mt Horeb), Karmenta (Madison) and Belmont (Madison). This part of the TNH Program takes students rotating as an elective, so there are smaller numbers involved than in the Capitol Lakes partnership.

4.4 **THE ROLE OF GOVERNMENT PROGRAMS IN SUPPORTING THE MODEL**

In the USA two government funded programs stood out for their impact in progressing the TNH model and for their potential application in Australia – ECLEPS and PACE.

4.4.1 **ECLEPS – ENRICHED CLINICAL LEARNING ENVIRONMENTS THROUGH PARTNERSHIPS IN LONG TERM CARE**

This was a program that began in the US in 2006 and involved partnerships between academics, care providers, regulators and professional organisations. Funding supported training and the development of resources to develop long term aged care facilities as clinical sites of excellence where nursing students could learn best practice in the care of older people. The Program was designed to improve practice in skilled nursing in residential aged care, provide clinical experience focused on older people for nursing students, and improve residential aged care work environments to encourage recruitment and retention of the aged care workforce.

This program has been valuable in continuing the work of the Oregon Health Sciences University’s School of Nursing which I visited in Portland and which, as discussed, had been a Robert Woods Johnson Foundation program recipient. It leveraged from its Hartford Center of Geriatric Nursing Excellence program, and a focus has been on person-centred care. They continue to use the partnership model providing training to direct care workers and others to support person centred care.

4.4.2 **PACE® (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY)**

PACE began in San Francisco’s Chinatown and brought a wide range of services to a single venue as part of a Federal Demonstration Project. It was highly successful and achieved some 25% savings for Medicaid, an outcome which saw it replicated nationally. Designed to keep older adults as healthy as possible and living in the community for as long as possible, it is widely viewed as a program that enhances the quality of life for seniors.

PACE supports people who are 55 or older, assessed as needing residential aged care, and able to live safely in the community. It bundles services across a range of programs including day care, nursing, physical, occupational and recreational therapies, meals, social work, personal care, medical care provided by a PACE physician familiar with the history needs and preferences of each participant, home health care and personal care, medication and medical speciality services (such as audiology, dentistry, optometry, podiatry and speech therapy), respite care and hospital and nursing home care when necessary. Further information can be found at http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_Is_PACE?

Providence ElderPlace in Portland Oregon is an ECLEPS partner with the Oregon Health Sciences University and hosts a PACE program which I visited. Its comprehensive care model offers an alternative to long term residential aged care) by bringing together a
group of PACE services in a holistic and user-friendly way. Providence ElderPlace coordinates all of the care services that older people need to remain as active and independent as possible and is the only PACE program in Oregon.

As discussed earlier, the Frances Payne Bolton School of Nursing at Case Western University in Cleveland Ohio (another of my interview sites) has the only PACE program in Ohio.

PACE is a model that has potential relevance for Australia as we grapple with providing holistic services that not only provide care for an older person, but more broadly, enable them to live their lives as well as possible. In Canada, there were a number of pilots in evidence that involve ‘bundling’ services from different sectors, not only aged care, to provide a more seamless set of supports to older people.

4.4.3 THE CENTRES FOR LEARNING RESEARCH AND INNOVATION (CLRI), ONTARIO

Funded for five years by the Ontario Government, the three CLRIs were developed to enhance quality of care in the long term care sector through education, research, innovation, evidence based service design and delivery and knowledge transfer. The program began through unsolicited proposals by Schlegel Villages in September 2010 and Promoting Partnerships (Bruyère and their academic partners) in March 2011. The Ministry of Health and Long Term Care then called for proposals through an open tender process in May 2011 and received 22 applications. The 3 successful proposals came from:

- Schlegel-University of Waterloo Research Institute for Aging and Schlegel Villages Inc
- Baycrest Centre for Geriatric Care in partnership with the Jewish Home for the Aged (Apotex)
- Bruyère Research Institute in partnership with its long term care facility, Residence Saint-Louis.

Each has received $625,000 annually (significantly more than was offered to TRACS Projects and for a longer period of time) and Schlegel also received funding for 192 long term care places in their new Centre of Excellence at Kitchener. Bruyère also received funding for renovations to provide educational infrastructure. There are 4 components to the overall CLRI Program – all could easily be used to describe the TRACS Program:

1. Education – innovative, interdisciplinary through team based and blended learning models – virtual or face to face. This includes contributing to evidence informed curriculum development that enhances the ability of graduates to improve older people’s quality of life.

2. Research – conducted in partnership within practical settings to develop evidence based practices and pilot innovative models with the goal of creating innovative care solutions that can be transferred to the wider sector.
3. Partnerships – to improve integration of aged care across the continuum of care, and to better understand the business of ageing and leverage innovation from private businesses.

4. Knowledge Transfer – promote continuous knowledge exchange among researchers, faculty, policy makers, government and care providers regarding the lessons learned.

### 4.5 THE RESEARCH ROLE OF THE TEACHING NURSING HOME

The Canadian part of my Fellowship showcased what is possible when leading aged care organisations are resourced to be drivers of research designed to change older people’s lives for the better. Each of the CLRI aged care partners housed a major research institute, supported in the main by private benefactors.

For most Australian aged care providers, the absence of philanthropic contributions means that research is usually undertaken in partnership with universities rather than in their own right (other than for small scale organisation-specific studies), and often without playing a leadership role. There are some exceptions of course, notably IRT’s Research Foundation in Wollongong, New South Wales. A handful of aged care providers, including TRACS services, fund ageing-related Chairs with University partners – examples include HammondCare NSW, RSL Life Care in NSW, and ACH Group in SA. But without private donors, none would have the capacity of the Schlegel group who fund 6 Research Chairs at partner universities with a further 9 planned over the next few years.

### 4.5.1 THE RESEARCH INSTITUTES ASSOCIATED WITH THE CLRIS IN ONTARIO

**Schlegel CLRI**

Revenue generated after costs by Schlegel Villages is returned to fund the Research Institute on Aging and associated Research Chairs. The Institute is based on a series of partnerships with universities, with primary partners being the University of Waterloo and Conestoga College. The Schlegel family have donated substantial sums of money to support the Research Institute on Aging (RIA) beginning with $6 million in 2005, and increasing to a commitment of over $45 million to support infrastructure costs and at least 15 Schlegel Chairs by the time of completion of Stage 3 of the Centre for Excellence. At the time of my visit 6 of these Chairs were in operation.

**Baycrest CLRI**

The Baycrest CLRI benefits from the research foundation of Baycrest’s Rotman Research Institute which is considered to be one of the top five brain institutes internationally and within the Institute, the Kunin-Lunenfeld Applied and Evaluative Research Unit conducts research in collaboration with clinicians to apply findings to client care. Further information is at [http://www.baycrest.org/research/rotman-research-institute/](http://www.baycrest.org/research/rotman-research-institute/)

**Bruyère CLRI**

The Bruyère CLRI is housed in the Bruyère Research Institute and this CLRI has the strongest research focus of the three. The Bruyère Research Institute undertakes research on cognition and mobility, equity, health system and services, primary and community
care and promising practices. It is also one of 11 national data collection sites for the Canadian Longitudinal Study on Aging (CLSA) - http://www.bruyere.org/en/bruyere-research-institute.

4.5.2 THE POLISHER RESEARCH INSTITUTE, ABRAMSON CENTER FOR JEWISH LIFE, PHILADELPHIA

The Robert Woods Johnson Foundation TNH Program has left a legacy that is visible in embedded research institutes like the Polisher Research Institute at the Abramson Center for Jewish Life. For many years these embedded research institutes were free standing, however, increasingly in recent years they have started forming official relationships with universities. The Institutes are expensive and resource intensive and benefit from sharing costs with the universities.

This was the case for the Polisher Institute which for about 50 years was free standing and wholly supported by the Abramson Center. Its partnership with Penn State University means costs and resources are now shared. The Abramson Center serves as a ‘living laboratory’ for research on new interventions and their development, quality improvement efforts and clinical education. Examples of the applied work being undertaken can be found at www.polisherresearchinstitute.org and in Section 4.1 of this report.

4.6 THE WORKFORCE AND STUDENT EDUCATION ROLE OF THE TEACHING NURSING HOME

The approaches to student and workforce education that I observed were similar to those being pursued by TRACS partnerships in Australia, and the challenges faced, and lessons learned, were almost identical. The major difference lies in the larger scale use of learning infrastructure, particularly videoconferencing and simulation laboratories. When used appropriately, these enhance learning and make it more accessible. I visited Sim Labs (Simulation Laboratories) in Portland, Oregon and at Conestoga College in Kitchener, Ontario.

4.6.1 SIM LAB – PORTLAND, OREGON

The Collaborative Life Sciences Building on Portland’s South Waterfront brings together Oregon Health and Sciences University (OHSU), Oregon State University and Portland State University in one location – see www.ohsu.edu/simulation.

The vision for this remarkable facility is that students from different health care professions work in shared spaces, learn alongside each other, and work collaboratively through a variety of inter-professional education courses. Every aspect of the building’s design encourages collaboration and reflects a new approach to health and aged care education. In 2015, the building was named one of the winners of the American Institute of Architects COTE Top Ten Awards program. Each day approximately 3,000 medicine, nursing, dentistry, pharmacy, chemistry and biology students use the Collaborative Life Sciences Building.
I was given a tour of the building by faculty from OHSU for whom the Sim Lab builds on some 10 years of work in simulation education by their School of Nursing. They have 200 cases on their data base that are designed to meet learning objectives and simulation is both lab based with hi-tech mannikins and interpersonal involving actors working through scenarios with students (the latter playing a key role in simulating interactions with older people in their homes).
In all of the Sim Labs I visited high tech Mannikins were pivotal to learning. These are realistic life size computerised mannequins that serve as simulated patients. They can breathe, blink (as I discovered when one blinked at me!), speak, and have pulses. Students can practice a range of bedside and emergency procedures such as assessment, physical examination, patient monitoring, defibrillation, intubation, nasogastric tube insertion, urinary catheter insertion, and taking blood. I noticed across Sim Labs that staff had named their Mannikins, highlighting their personalisation. Feedback from teachers indicated that students regard the learning experience as 'real' and can be highly distressed when they 'harm' their 'patient'. Hence, the learning process requires careful preparation of students and management of learning outcomes.

Although there are infant Mannikins there were none that I saw, or that the people working with them were aware of, that are specifically designed to simulate working with older people. Given the very different nature of an older body, coupled with our ageing population, this is a major gap. When I asked how teachers address this gap, one observed wryly that they 'put a grey wig on the mannikin's head'!

The photos below illustrate some of the Mannikins seen.

Baycrest’s Centre for Education and Knowledge in Aging plays a critical role in the Baycrest CLRI, which like the Schlegel CLRI, has a strong focus on education. In partnership with the Michener Institute it has developed a curriculum to educate health students about the care of older people. A unique part of their education involves wearing a suit that simulates frail old age. This weighs the person down, impairs both their vision and hearing and significantly hampers their mobility. A relatively short period in the suit provides students with insights into the daily challenges faced by a frail older person. The potential for this in the education of health and aged care students is enormous. This is a link to a video showing a student working with the simulation suit - [http://www.baycrest.org/AnnualReport/20142015/partners-in-education/](http://www.baycrest.org/AnnualReport/20142015/partners-in-education/)

4.6.2 Video conferencing

In the sites I visited in the USA and Canada, videoconferencing was used extensively. This was particularly evident at the 3 CLRIs in Canada and at Penn State University due to the
need to link 5 campuses spread across a largely rural geographical area, and to link
different professional groups within an Interprofessional Education model.
Videoconferencing plays a valuable role in making student and workforce education
accessible and affordable for participants and was considered to be a standard (rather
than a special) feature of education offered at all of the sites I visited.

Two lessons identified were the need to have a technician available (also a finding of the
two TRACS programs at Hammondcare and RSL Life Care in New South Wales) and when
introducing a video-conferenced program to a new site, to have a trial before
implementation. Penn State University personnel highly recommend the use of Zoom
technology because it is not high tech, is free and works well for education sessions. Zoom
is a cloud based meeting platform, that is high quality but user-friendly – see
https://zoom.us/about

Videoconferencing supports one of the Penn State University College of Nursing’s most
successful capacity building programs - the Journal Club – which provides 3 per semester
for up to 40 practising nurses. Participants select a paper and discuss it with faculty, in the
process enhancing collaboration, and speakers are brought in for the session which is
delivered by videoconferencing over the lunch period. Participants receive points that
count towards the renewal of their nursing certificates, which (as was the case with TRACS
projects) has been found to provide an important incentive for participation. This model
has also been used successfully by some TRACS Projects (for example, The University of
Adelaide and Resthaven Inc G-TRAC partnership and that of the RSL Life Care NSW and
Australian Catholic University).

4.6.3 UNIVERSITY OF PORTLAND, DEDICATED EDUCATION UNIT

I was particularly impressed by the Dedicated Education Unit (DEU) model of health care
education which is operated by the School of Nursing at the University of Portland. This is
a strategy that deserves wider application in Australia, although interestingly, it originated
in South Australia at the Flinders University School of Nursing.

The DEU is a clinical setting (aged care or health care) that is developed into an optimal
teaching and learning environment through the close collaboration of nurses, health care
team members, faculty and management. It is designed to provide students with a
positive clinical learning experience by integrating them into the workforce under close
support and supervision of clinical nurses who have been trained to educate and support
students.

Interestingly, the DEU began without a specific funding program, and is now cost-neutral
(making it attractive for replication). The model has been so successful that it is reported
to be effortless to get aged care providers and university Faculty to contribute the human
resources needed to make it function. It is regarded as a win win for all – students get
superior education and are more confident and better prepared than the norm, the
university gets a better cadre of students graduating (better prepared, progress at faster
rate) and therefore a better profile, while the aged care provider sees the benefit of
training the staff as educators and how its lifts its workforce profile and capability. Staff
take great pride in what they do and are inspired to further their education.
Partnerships are a cornerstone of this model and the University and Providence care services built on a long standing relationship that began 80 years ago. The partnership is supported by a defined communication process and structures. It takes time, but not a lot of time, to demonstrate the benefits. For the university it took less than 1 year, for the aged care providers it took between 1 and 2 years. Evaluation of the DEU at Portland has been very positive, finding that:

- Nurses and faculty members improve their practice, learn professional skills and enjoy their teaching.
- Students receive individualised teaching, mentoring and a realistic perspective of nursing as they learn alongside their appointed nurse educator.
- The University has doubled the number of students supervised by each clinical faculty member and increased the number of clinical placements while consistently exceeding national licensing exam scores.

This initiative, and the Living Classroom (described below in Section 4.6.5) both highlight a trend that is also evident in Australia – namely, a recognition that health and aged care education requires greater location of students working on site with staff in order to be work-ready when they graduate. Australian aged care providers have been expressing significant dissatisfaction with the low levels of job readiness of particularly certificate level graduates and are seeking different models of student education. This is interesting when we consider the debates that took place in Australia in the 1970s when nursing education was moved from hospital based to university based learning. Perhaps we are needing to revisit that debate in redesigning student education to reduce the gap between classroom learning and practice.

4.6.4 INTERPROFESSIONAL EDUCATION

Interprofessional education (IPE) was central to both student and workforce education in all of the places I visited. IPE involves two or more health care professions learning simultaneously and interactively and is increasingly relevant as our population ages and complex care becomes more of a feature. IPE promotes respect and appreciation of differing roles and differing approaches to clinical or social problems. IPE students learn to draw knowledge from different disciplines and synthesise the evidence, tailoring care to meet the needs of individuals in the process. IPE promotes the increase of students’ and graduates’ communication skills, knowledge, attitudes and understanding of roles of different members of an interprofessional healthcare team.

As with Australia’s TRACS Program, IPE (or Interprofessional Learning – IPL) was a consistent feature of the student and workforce education programs I saw in the US and Canada. As with Australia, IPE did not always include the non-university trained workforce, but as some of our TRACS projects found, when it was applied across the workforce, it brought more positive outcomes for those involved. I saw this in evidence at Baycrest CLRI where workforce education brings both university and college trained staff together and ‘shifts staff dynamics’ away from segregation and towards integration. But this was the exception rather than the norm, as is the case in Australia.
4.6.5 The Living Classroom

A key issue for aged care providers in Australia, the US and Canada, is the uneven quality of graduates from the college or vocational education and training system where personal care workers and enrolled nurses are trained. In all three countries these constitute the overwhelming majority of the workforce and it is critical that they are work-ready.

The Schlegel Villages-Conestoga College partnership has developed a model of student learning that involves full integration of theoretical and clinical learning with students learning on site and not at Conestega College, and being immersed in the aged care setting. Schlegel Village staff participate in classes and residents and families are also involved. Students also work as volunteers. The program has required:

- a different orientation for students;
- different mentorship; and
- the development of specific training in areas like end of life, leadership, team development and data collection as students are much more advanced than under the normal model of teaching.
- There have been new policies and practices developed eg the role of the student as learner, or volunteer, or visitor and how staff respond to students being there 24/7 for 30 weeks.

The program is highly valued – all students get jobs on completion and have a core knowledge that is described as lacking in most new graduates. Program leaders note that it requires trust and time to get to this stage and requires careful management in the early stages of implementation. Strategies include:

- Selection of the students – not all will want to learn off campus and those who participate must do so willingly.
- Orientation is undertaken as a team by both faculty and Schlegel staff.
- Faculty must be on site at all times.
- Regular meetings between teams and faculty are essential for fine tuning and communication.
- Student graduation is celebrated and occurs in the aged care facility.
- Creative modification of infrastructure is needed.

This model has significant relevance for application in Australia.

4.7 Partnership Findings and Lessons

The greatest contrast observed was that in the US the partnerships I visited were clearly led by the universities, while the three CLRIs in Canada were led by aged care organisations. In Australia, TRACS projects were sometimes led by universities and sometimes by aged care providers. However, the US sites were selected for their original involvement in the Robert Woods Johnson Foundation TNH Program and/or their involvement in similar TNH initiatives and these have been centred on Schools of Nursing in universities making the sample biased in this sense.

The importance of partnership as the central feature of the model was apparent regardless of its leadership.
For all of those interviewed, there was strong agreement that teaching nursing home partnerships...

- must involve a win-win for both or all partners, and be seen to do so by both,
- must be dynamic with each partner bringing a contribution for which they are valued,
- require carefully thought out decision making and communication processes,
- demand commitment to the partnership because of the investment of time involved,
- require Leadership and Champions at multiple levels in each organisation, and
- take time to build trust and mutual understanding in order to develop to a state of strength, and then to sustain.

Challenges were shared across the three countries, mainly involving changes in leadership and turnover of key stakeholders, difficulties associated with clear and consistent communication, and the interference of extraneous influences that limit the time a partner can invest (temporarily or longer term) – a key example being audits and restructures arising from a review process.

It was also clear that when funding from a major program was withdrawn this left a significant and negative impact, and when this coincided with the loss of a champion or changes at organisational level in one partner, the partnership was unlikely to continue regardless of what it had achieved. (This has also been apparent in Australia with some Projects when TRACS funding ceased.) Partnerships were usually able to continue in the short term, but without alternative sources of funding being found, foundered. The TNH model requires specific resourcing, it cannot be expected to operate as part of ‘normal’ resourcing but it is considered in Australia and by those I visited, as an investment rather than a cost because of the returns it brings. It is also seen as a resource-effective model because its partnerships enable a leveraging of other resources that is not usually possible.

This resourcing needs to occur over a considerable period of time – about 10 years seemed to be appropriate, with the Norwegian model of ongoing funding seen as ideal, because of the time taken to make a discernible impact and to collect longitudinal data to measure impact.

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS AND RECOMMENDATIONS

Given the limited period of funding provided for the TRACS program in Australia, I was interested to see if short term as opposed to ongoing funding would have an impact on the viability of the teaching nursing home model. My conclusion is that with a ‘perfect storm’ of factors it is possible and those critical ingredients are:

- The partnership involved has a prior strong foundation and is a dynamic one, where both partners see a win-win and are invested in continuing to work together in applying the model.
Both partners are recognised leaders in their respective sectors, known to provide high quality aged care or education, and to be innovative in their fields.

Another funding source is found to support the work involved in applying the model. Having received funding from a recognised and respected program, partners have a competitive edge in applying for future funding – it is akin to a powerful work experience on a person’s resume.

It was evident that cessation of funding from a major program jeopardised the medium to long term future of a TNH partnership, and when this intersected with the loss of a TNH Champion or changes at organisational level in one partner, the impact was usually fatal.

It needs to be recognised that the TNH model requires dedicated resourcing, but that this involves an investment rather than a cost because of the returns it brings. Furthermore, its partnerships enable a leveraging of other resources that multiply the effect of that investment.

Resourcing cannot be for a short period and needs to occur over a considerable period of time, for example, 10 years but preferably ongoing, because of the time taken to make an impact on workforce capacity, and to develop a research evidence base (and therefore, improve quality of care).

It is recommended that the Australian Government consider funding an ongoing TRACS Program, either by quarantining existing aged care workforce funding, or by dedicating a separate funding stream.

In Australia the focus on geriatric education in university health schools varies widely, ranging from non-existent to specialist attention as seen in schools associated with the Hartford program of geriatric nursing excellence. In the face of an ageing population and the need to educate future health professionals, there is scope for a similar program here that would not be confined to nursing, but would extend to other health related disciplines.

It is recommended that the Australian Government consider funding a program designed to build the capacity of health professions to work effectively with an ageing population, using the Hartford CGNE program as a reference point.

The approaches to student and workforce education that I observed were similar to those being pursued by TRACS partnerships in Australia, and the challenges faced, and lessons learned, were almost identical. The major difference lies in the larger scale use of technology driven learning infrastructure, particularly videoconferencing and simulation laboratories. When used appropriately, these enhance learning and make it more accessible, and it is important that the both the health and aged care sectors in Australia have greater access to these resources, and that they collaborate to share them as happens with the Sim Labs overseas.

It is recommended that the Australian Government consider developing a fund that would support health and aged care providers’ access to new technology based learning resources, in particular, videoconferencing and Simulation Laboratories that include Hi Tech Mannikins.
The Canadian part of my Fellowship showcased what is possible when leading aged care organisations are resourced to be drivers of research designed to change older people’s lives for the better. Each of the CLRI aged care partners housed a major research institute, supported in the main by private benefactors. For most Australian aged care providers, the absence of philanthropic contributions means that research is usually undertaken without playing a leadership role. There are some exceptions of course. If Australia establishes a network of TRACS centres should there be a specific research fund, involving partnerships with university researchers but led by aged care providers, with funded support to build the capacity of those providers to undertake research and apply research evidence in the aged care setting? This is a question that only leaders in the sector can answer, but if we are serious about enabling better quality of care through growing the research evidence base, surely this should be led by the aged care sector?

The Dedicated Education Unit initiative, and the Living Classroom both highlight the recognition that health and aged care education does not always guarantee work-ready graduates. We need to revisit the role played by health and aged care sites in student education, and again the TNH/TRACS model provides an ideal mechanism to develop best practice.

The PACE program and the ‘service bundling’ models in Canada have potential relevance for Australia as we face the challenge of providing different services to meet the care and lifestyle needs of older people as ‘seamlessly’ as possible. The application of the consumer directed care (CDC) model only intensifies the demand to do this better, and to make it easier for people to navigate complex service systems, and multiple service systems. It would be interesting to pilot Australian-adapted versions of these models within the CDC context.

5.2 SHARING THE FELLOWSHIP FINDINGS

This Fellowship has multiple information dissemination strategies, beyond this Report.

Prior to leaving for my visit I contacted all TRACS projects to identify specific issues in which they were interested and designed my interviews accordingly. I will be sharing my findings through a combination of individual interviews, seminars with TRACS aged care staff, and presentations to State and national conferences. I will also be organising joint publications where appropriate with the people visited for my Fellowship.

I am also linking individuals from particular TRACS projects to individuals at different sites visited in the US and Canada with shared interests. This begins to link people in an international ‘Community of Practice’ but I am also seeking to develop an International Conference for people involved in a TNH or TRACS initiative that would be hosted by Australia in the first instance, but then rotated across the other nations pursuing the model – Canada, the USA and Scandinavia. The business model for this makes sense as conference participation would cover organisational and operational costs. There was strong interest in such a Conference ever where I visited.

In addition, I have approached the convenors of the 2017 IAGG Conference in San Francisco to organise a dedicated teaching nursing home symposium involving the people I visited, those in Australia and Scandinavia and others pursuing the model. The conference organisers have agreed to a submission being made and those I visited are interested in being part of this.