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Promoting Cultural Humility, Belonging, and Inclusion to Improve Well-Being among Direct Care Staff in Oregon Assisted Living, Residential Care, and Memory Care Communities, 2024

Jacklyn Kohon
Portland State University, jacklynk@pdx.edu

Dani Himes
Portland State University, dani5@pdx.edu

Laura Rodriguez
Portland State University, rodrig29@pdx.edu

Sarah Dys
Portland State University, sdys@pdx.edu

Paula Carder
OHSU-PSU School of Public Health, carderp@pdx.edu

See next page for additional authors

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Authors

Jacklyn Kohon, Dani Himes, Laura Rodriguez, Sarah Dys, Paula Carder, Diana Jacoby, and Madeline Fox

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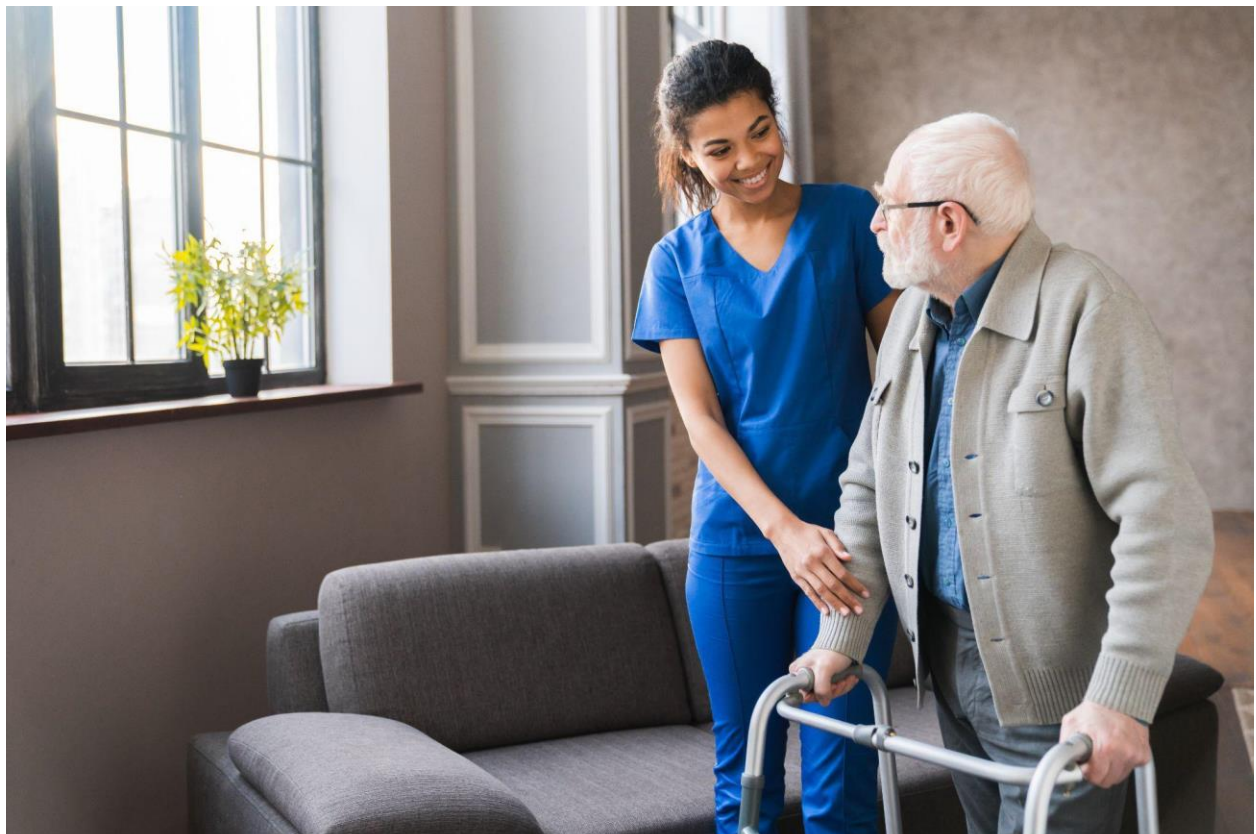

August 2024

Promoting Cultural Humility, Belonging, and Inclusion to Improve Well-Being among Direct Care Staff in Oregon Assisted Living, Residential Care, and Memory Care Communities, 2024

A study completed by the Institute on Aging at Portland State University in partnership with Oregon Department of Human Services

About the Institute on Aging at Portland State University

IOA/PSU strives to enhance understanding of aging and facilitates opportunities for elders, families, and communities to thrive.

Oregon Department of Human Services

ODHS is Oregon's principal agency for helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice, and preserve dignity, especially for those who are least able to help themselves.

IOA/PSU Study Team:

Jacklyn Kohon
Dani Himes
Madeleine Fox
Laura Rodriguez
Sarah Dys
Diana Jacoby
Paula Carder

ODHS Study Team:

Regan Sheeley
Jane-ellen Weidanz

Additional Contributors:

Community Engagement Liaison Services, LLC

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Report Summary

The voices and experiences of those working and living in assisted living, residential care, and memory care (AL/RC) settings in Oregon are highlighted in this study to understand cultural humility, belonging, inclusion, and intersectional experiences related to sustaining the workforce and promoting quality care. This qualitative study collected data through individual and focus group interviews with a total of 68 people, including 25 direct care staff, voice memos or interviews with 9 former direct care staff, interviews with 9 administrators, interviews with 7 management representatives (owner/operators, human resources specialists, directors of operations, among other titles), and interviews with 18 current residents in AL/RC settings in Oregon. See Appendix A for detailed study methods.

Key Findings

The Institute on Aging study team identified ten primary themes based on the voices of these 68 study participants. Themes summarize what we learned within and across participant types and provide an overview of study findings.

Protection from Harm

Theme #1. Care staff face discrimination, physical and verbal abuse from residents and colleagues.

Theme #2. Those who experience discrimination or not belonging were more likely to be from a minoritized group, such as identifying as persons of color, LGBTQIA2S+, or a religious minority.

Theme #3. Within and across AL/RC, there is inconsistency in the existence, awareness, and currentness of diversity, equity, inclusion, and accessibility (DEIA) policies, making implementation challenging.

Connection and Community

Theme #4. Company culture can support feelings of connection and belonging among staff members.

Theme #5. "Having each others' backs": Care staff look to peers and coworkers for support.

Theme #6. Workplaces need infrastructure that reflects language diversity of residents and care staff.

Work-Life Harmony

Theme #7. Work-life harmony is challenging to achieve when there is a staffing shortage, however it has led to innovative changes that promote greater flexibility.

Theme #8. While rewarding, providing care is demanding work that leads to injury, stress, and burnout.

Mattering at Work

Theme #9. Care staff wages do not compensate for the demands of the work and the prevalence of understaffing adds more stress for everyone, including residents.

Opportunity for Growth

Theme #10. Leadership support for ongoing, responsive training and educational opportunities are crucial for providing care workers with the necessary tools for their work and reducing turnover.

These themes are described in more detail in the following report, within the conceptual framework of the U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being. Examples and participant quotes are provided for context and to describe relevant sub-themes that were discussed by participants.

Introduction

This qualitative study builds on previous work by Portland State University's Institute on Aging (IOA/PSU) during fall 2022 that focused on direct care staff experiences in Oregon assisted living and residential care facilities (AL/RC).[1] During individual and focus group interviews, direct care workers, state policy analysts, and AL/RC administrators and executives discussed diversity and inclusion. IOA/PSU learned about the ways that AL/RC providers promote acceptance, respect, and belonging among their care staff. For example, staff talked about feeling welcome and hosting potlucks with international foods, and some providers hired interpreters to assist with training and respected holidays important to staff from diverse cultures. However, some direct care workers experience racism, sexism, and other forms of interpersonal discrimination at work, as well as structural inequities that can affect well-being, job performance, and job tenure.[2]

The direct care workforce is diverse in terms of age, race, ethnicity, national origin, gender identity and sexuality, faith, and culture.[3] PHI National, a leading research and policy firm specializing in direct care, studied Oregon's direct care workforce .[4] They reported that Oregon's residential care aides are primarily women (80 percent), 29 percent are persons of color, 14 percent are ages 55 and older, and 15 percent have emigrated to the U.S. from another country.[5] Through understanding the socio-demographic makeup of Oregon's direct care workforce, as well as the policy context, PHI recommended ways to strengthen and stabilize the direct care workforce. Relevant to the IOA/PSU study were the recommendations to engage direct care workers in developing strategies and solutions and improving direct care workforce data collection.

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[1] Carder, P., Dys, S., Schwartz, L., Jacoby, D., Kohon, J., Himes, D., Fox, M., Elliott, S., & Bouchard, L. (2023). *Direct Care Staff Experiences in Oregon Assisted Living, Residential Care and Memory Care Communities, 2022*. Portland, OR: Portland State University Institute on Aging. https://archives.pdx.edu/ds/psu/39347

[2] Travers, J. L., Teitelman, A. M., Jenkins, K. A., & Castle, N. G. (2020). Exploring social-based discrimination among nursing home certified nursing assistants. *Nursing Inquiry, 27*(1), e12315. https://doi.org/10.1111/nin.12315

[3] McCall, S., & Scales, K. (2022, February). Direct care worker disparities: Key trends and challenges. Bronx, NY: PHI. https://www.phinational.org/wp-content/uploads/2022/02/Direct-Care-Worker-Disparities-2022-PHI.pdf Accessed June 11, 2024.

[4] Scales, K. (2022, September 30). Strengthening and stabilizing the direct care workforce in Oregon [PowerPoint slides]. Oregon Department of Human Services . https://www.oregon.gov/odhs/data/apddata/apd-direct-care-workforce-presentation-2022.pdf

[5] Ruggles, Steven, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. 2022. IPUMS USA: Version 12.0. https://doi.org/10.18128/D010.V12.0; analysis by PHI (Sept. 2022).

Oregon has been actively promoting its long-term care workforce through various initiatives aimed at addressing workforce shortages and enhancing care quality. Recent efforts include training and education programs; workforce development initiatives; collaboration across healthcare, education, and community organizations; and policy advocacy. Promoting the long-term care workforce in Oregon is crucial for meeting the healthcare needs of our growing aging population, improving care quality, supporting direct care staff, and contributing to workers' economic stability.

This qualitative study aimed to highlight the voices of AL/RC direct care staff, former direct care staff, residents, administrators, and management representatives to understand how belonging and inclusion can promote well-being in these care settings. This study can inform Oregon's efforts to support the long-term care workforce and inform future quantitative data collection on AL/RC and other long-term care workers.

Study Goals

1. Understand direct care worker, AL/RC, and resident experiences with cultural humility, belonging, inclusion, and intersectionality as they relate to sustaining the workforce and promoting quality care.
2. Learn from participants about their ideas for creating more inclusive and supportive workplaces that can sustain a robust workforce and promote quality care.
3. Understand how extreme weather events may impact resident care, direct care workers' work-life balance, and AL/RC's readiness plans.

This report describes results from objectives #1 and #2. Results from objective #3 are summarized in a supplemental report, available here: www.pdx.edu/institute-on-aging/climate-change-and-older-adults-impacts-and-adaptations

Conceptual Framework

The U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being served as a guide for this study (Figure 1). This framework supports workplace well-being by prioritizing key human needs and centering worker voice and equity.[6] This framework was developed in recognition that our workplaces play a significant role in our lives. In a recent national study, 84

[6] Office of the Surgeon General. (2022). Workplace Mental Health and Well-Being. www.hhs.gov/surgeongeneral/priorities/workplace-well-being/index.html

percent of respondents reported that workplace conditions had contributed to at least one mental health challenge.[7]

Care workers, in particular, must find ways to cope with the mental and physical demands of their work. Support from organizational structures, management, and coworkers is crucial to creating positive work environments. Lack of support for mental health and well-being leads to adverse health outcomes, poor job performance, reduced organizational performance, and employee turnover.[8] In another national study, 81 percent of respondents reported that they will be seeking future workplaces that support mental health.[9]

Figure 1. Surgeon General's Framework for Workplace Mental Health and Well-Being

[7] MindSharePartners. (2023). MentalHealthatWorkReport. https://www.mindsharepartners.org/mentalhealthatworkreport-2023

[8] Czuba, K. J., Kayes, N. M., & McPherson, K. M. (2019). Support workers' experiences of work stress in long-term care settings: A qualitative study. *International Journal of Qualitative Studies on Health and Well-being, 14*(1), 1622356

[9] American Psychological Association. (2022). *Workers appreciate and seek mental health support in the workplace.* American Psychological Association. https://www.apa.org/pubs/reports/work-well-being/2022-mental-health-support

This framework describes five domains of mental health and well-being, each built on two key human needs, as well as several key components (Table 1). Underlying all of these elements is the inclusion of worker voice and promotion of equity. This framework promotes organizational practices and initiates dialogue for positive change in workplace mental health and well-being. Developing multi-faceted ways of supporting mental health and nurturing well-being among workers, particularly in mentally and physically demanding jobs, such as care work, can contribute to a robust, thriving care workforce.

Table 1. Key Components of Surgeon General's Framework for Workplace Mental Health and Well-Being

	Domains	Human Needs	Key Components
Centered on Worker Voice and Equity	Protection from Harm	Safety & Security	• Prioritize workplace physical and psychological safety • Enable adequate rest • Normalize and support mental health • Operationalize Diversity, Equity, Inclusion & Accessibility (DEIA) norms, policies, and programs
	Connection & Community	Social Support & Belonging	• Create cultures of inclusion and belonging • Cultivate trusted relationships • Foster collaboration and teamwork
	Work-Life Harmony	Autonomy & Flexibility	• Provide more autonomy over how work is done • Make schedules as flexible and predictable as possible • Increase access to paid leave • Respect boundaries between work and non-work time
	Mattering at Work	Dignity & Meaning	• Provide a living wage • Engage workers in workplace decisions • Build a culture of gratitude and recognition • Connect individual work with organizational mission
	Opportunity for Growth	Learning & Accomplishment	• Offer quality training, education, and mentoring • Foster clear, equitable pathways for career advancement • Ensure relevant, reciprocal feedback

Source: Office of the Surgeon General, 2022

Study Findings

This study included the voices of currently employed and former direct care staff, administrators, management, and residents in AL/RC settings to understand cultural humility, belonging, inclusion, and intersectional experiences related to sustaining the workforce and promoting quality care. The following describes the main themes from this research and highlights voices from participants in the context of our conceptual framework. To reflect the participants' voice, we use direct quotes from individual and focus group interview conversations that might not include proper grammar and word usage.

Protection From Harm

Theme #1: Care staff face discrimination, physical and verbal abuse from residents and colleagues.

Care staff (former and current), administrators, and management participants had varying perspectives and examples of safety and security within AL/RC communities. Direct care staff described regularly experiencing verbal and/or physical abuse, including sexually suggestive comments, discrimination based on race, ethnicity, or ability to speak English, or being hit.

> *"I don't think it gets talked about a lot. I am verbally and physically abused all the time, like, I have literally been almost strangled. I've had my hair ripped out in my head. I have been kicked, spat at. I am cussed at daily."*
> ~**Direct care worker**

One care worker described a resident who repeatedly made negative comments about another care worker who was African American. It was other direct care staff, and not management, who stepped in to talk to the resident about those comments.

> *"And eventually she [the resident] did kind of come to understand that. You know it doesn't matter what he looks like as long as he's, you know, there to help and is being kind, and she eventually learned to accept him."*

Current care workers came to expect a certain level of inappropriate or offensive comments, particularly from residents, based on what was considered acceptable in past generations.

> *"Because, you know, **a lot of stuff back then was a lot more acceptable**, actually, a lot more mainstream such as like racial comments or even just like the misogyny, you know? So, yeah. I would agree like the biggest issue when it comes to that sort of thing, would be like the men to the younger female workers. Yeah, just kind of like inappropriateness."*

Some care workers talked about the difficulties they experience when working with residents with substance use disorders and other behavioral challenges.

> *"A lot of the folks [residents] that we support, struggle with substance use disorders. And there have been times when I've been in situations with people that were in heavy substance use that were, you know, not thinking clearly."*

Although many interview participants described abuse solely from residents, several direct care workers and former direct care workers shared experiences of discrimination through cliques, bullying, and "shift wars" (between day shift, swing, and night shift). These types of experiences were indicated by former direct care workers as a reason for leaving care work.

One direct care worker spoke about verbal harassment one of their colleagues endured from colleagues and then residents until they eventually quit.

"I was working for a company called ____ and they were shut down. ***But we had a transgender male come in. And of course, we work with older people. So not only was it they were calling him names****, they were trying to get it to where he couldn't work there anymore.* ***Other employees would like, write things on his car, leave nasty notes,*** *and management wouldn't do anything about it. It started with the staff and then the residents started in on it."*

Reason for leaving direct care work: Experiences of discrimination and stereotyping

One participant noted that Hispanic workers were scheduled for more double shifts noting, *"that was our schedule just because nobody else would want to do it."*
~**Former direct care worker**

"They [U.S. born staff] would not do certain duties, they leave everything like now, to us, the foreigners."
~**Former direct care worker**

Administrators were asked about challenging or negative interactions between staff and/or residents because of differences in culture, faith, gender, race, ethnicity and other perceived differences. Administrators generally stated they do not think it is an issue. As one administrator located in a small town in the mid-Willamette Valley area explained,

> *"I really haven't run into that. I'm sorry I'm not gonna be very helpful on that, you know. In the [name of town], we are not culturally diverse out here. And we're private pay."*

Inappropriate behaviors attributed to Alzheimer's disease and related dementias may be excused.

Oregon AL/RCs serve a range of residents, from those who only need minimal assistance with activities of daily living to those with complex needs (e.g., behavioral health, dementia, HIV/AIDS). Study participants described residents living with Alzheimer's disease or other dementias who say or do inappropriate things. The common sentiment that there is generally nothing to be done about it was explained by this caregiver, "*that's because they have Alzheimer's and they don't know that what they're doing is wrong."* Some care staff compared their experiences working in AL compared to memory care-endorsed settings.

> *"Well, here in assisted living, I haven't seen anything like that. Again, **with memory care, it's a whole different animal because some of those folks are verbally and physically abusive to the staff**. I've been cornered many times with someone who has dementia, highly escalated, punching, kicking, doing all that stuff. So did I get hurt? No. Was I scared? Absolutely."*

Similarly, an administrator described how care staff have to figure out how to cope with these situations,

> *"Residents have dementia, you know, how can you really, you can't move somebody out, because **they have dementia, and they don't understand**, you know… And if we ask anybody to move out, we have to go through a pretty intense state process and move-out notice. So, I mean, it's hard because that really, **our healthcare workers have to figure out how to cope with that sort of thing.**"*

There are strategies management, administrators, and staff can employ to mitigate these behaviors while still supporting residents,

> ***"So first, we'll have the conversation with them*** **[resident]** ***and say, this is not allowed here****. If this is your behavior, you will not be able to continue living here, period, you know, we treat everyone with respect, including our staff, this is unacceptable behavior."*
>
> *"There's only so much that they can comprehend. I mean, they comprehend some of it, you think they understand, but really, they don't. So then it came to the next step. You know, **let's have a family meeting, let's talk with the family, the nurse, myself, the assistant director, how can we support this individual**, and be able to keep him here in this community."*

One administrator echoed the use of residents' families and friends to help facilitate conversations around issues, *"I think family and friend engagement with their care is probably the best way to get the message across."*

Care workers described varying levels of support and response to being harmed on the job.

Most participants shared that management supports care staff when these incidents occur. Some of the coping strategies cited include walking away, switching out caregivers, sending two caregivers to care for a difficult resident, and talking with or venting to coworkers and management to process feelings. Teamwork was described as key to addressing these challenging situations.

> *"I mean, and then those days,* ***when we don't have like the brain power to deal with a particular behavior set, our teammates are pretty good about stepping in and helping us out*** *that has, I think, more to do with the amount of energy we're investing and less to do the like, differences in the relationship between us."*

Some participants desired more support from management and administrators after a negative interaction with residents or other staff members.

> *"I just feel like* ***when I go to tell management sometimes, or complain to people about it they're just like, 'Oh, ha! Ha! Laugh it off,' and I'm like, 'No, but that was actually not cool.'*** *Like I had a resident who was complaining about the kitchen the other day, and she was like, 'Well, everyone in there are high school dropouts and Mexican so', and I don't think she knew that I was Mexican or a high school dropout myself. So I went to tell my people about it, and they're like, 'Oh, ha, ha!' And I'm like, 'Oh, no, that was like really mean, though.' So yeah, sometimes I wish I could get a little bit more support from, you know, management for sure."*

Reason for leaving direct care work: Lack of support around physical and emotional safety, even when explicit requests made

"And I would never have help unless I literally threw a fit. And I said hey, I need help. I'm a little, little person. I'm not a tall person. I'm a short person. In the end, I wasn't actually given the help. I was lifting people that were heavier than me and I kind of sprained my back three times while working there."
~**Former direct care worker**

"If I had been supported, I would have gotten more people to work with. And I would not have been feeling as exhausted as I used to. And that's a request I had made several times."
~**Former direct care worker**

Because residents are seen as clients and consumers, some staff feel as though they must brush off offensive commentary or risk "ruining their careers."

"We had rapists and then we've had murderers… I've also had men be very, like, perverted because we're females and young. So it's true it does happen, and most the time the companies don't support

you. But at the same time people need to realize it's [your] job, and if you don't, it's neglect, and you could just ruin your career overall."

Theme #2: Those who experience discrimination or not belonging were more likely to be from a minoritized group, such as identifying as persons of color, LGBTQIA2S+, or a religious minority.

One DCW spoke about being called "fat" in a derogatory way because as she states, *"You know, I'm a bigger girl so they call me fat. But I understand that like, you know, but I took that with a grain of salt."*

A resident who identifies as a Black woman felt like she stuck out because she was the only Black woman in the community.

"I feel being a woman of color, it can be a little difficult in that respect, you know because we don't have a lot of people of color who work here. In that respect, there needs to be more people of color here. I feel like more training with how to associate themselves with people of color, you know. Yeah, I love people of all different backgrounds, I love all God's people that's just how I am, I don't have an attitude with anybody but here I stick out like a sore thumb.

~Resident

DCWs who may not have experienced discrimination directly spoke about seeing or hearing their colleagues being discriminated against because of sexual orientation or gender identity.

"I haven't really experienced anything personally. But ***I know other coworkers or employees we've had residents discriminate against, you know, cause they're trans or their sexual orientation****, or even because of our younger staff, we've had residents make comments to them about that, 'they're dumb, or they need to be faster', something like that."*

When asked how management and staff support DEIA efforts, study participants commonly described the importance of cultural foods and events. Two residents said that their community did not offer cultural foods, and one explained that staff wouldn't know what kosher food was even if residents asked for it. *"No, they don't offer anything. If I asked for a kosher meal, they would look at me."* Another resident talked about their African food being too expensive, but he thinks the facility cook would prepare it for him if he provided the ingredients.

One Jewish resident spoke about the entertainment revolving around Christian holidays and that staff do not seem aware of celebrating other holidays outside of Christian ones.

"I'm Jewish, and I think there's maybe two other people that are Jewish here, but all the entertainment is on Christmas or Easter.... I have it because I had a menorah. But other than that, they don't do anything towards the religion.

> *Now, there's a lot of African American people here and I don't see them celebrating the African American holidays."*

The majority of residents we interviewed identified as White and felt supported. *"It feels like a family. Yeah, they just seem to support everybody."* One female resident stated: *"I'm White, which makes it easier for me than a lot of people. Yeah. And I'm female, which makes it harder for some people."*

Just under half (seven out of 15) residents interviewed identified as gay or bisexual. Facilities that served specific types of residents seemed to be more inclusive and have more awareness than their mainstream counterparts. As one resident put it, *"I don't have to hide my sexual orientation."*

Theme #3: Within and across AL/RC, there is inconsistency in the existence, awareness, and currentness of diversity, equity, and inclusion policies, making implementation challenging.

Administrators either said there was no formal policy or they did not know about any policies in place for when challenges or issues arise due to differences in staff and resident identities, cultures, or languages. One administrator shared that they do not know if they currently have formal policies but their community is updating policies and taking part in Oregon Care Partners' training. Several administrators reflected on the diversity of their communities and how differences are navigated, as described below.

> *"I'm the type person I don't care what color, gender, whatever stuff, do your job and do good and treat people nice. And as long as they go by the golden rule to me, is you treat everybody with respect you do unto others, you want to enjoy yourself.* ***We'll get along. It don't matter and we try to keep it really kind of warm to open wide spectrum. I don't know, I don't like categorizing. I don't think that's right****. And as far as since I've been here, we've had no issues with that whatsoever.*

> *"I think the best way to support them [staff] is to just have a loving and accepting, you know, work environment and culture.* ***I don't know if acceptance can really be found in policy and procedure. It's really the individuals.*** *We do have a diversity committee. But we try to be open about discussing the needs of our diverse staff and be open to hearing from them if there's, you know, something that's occurred that's made them uncomfortable, that sort of thing. I think there's still more that we can do. But I think the most diversity is in race, religion, definitely sexual orientation, is where I see the most diversity in our work environment as far as our employees here, socioeconomic status, for sure."*

One care worker shared uncertainty about the existence of policies and procedures but believed that a policy must be in place based on their experiences, *"I don't know for sure if there's any policies and procedures, but from just visually, I mean, seeing like the dynamics of our staff and everything, I would say that yes, absolutely."*

Several management representatives confirmed that their company has a DEIA policy and identified reasons why having these policies is important, including recognizing stereotypes.

> *"People want to be in places with people like them… that feel welcoming, that serve the food I like, that speak the language I speak. So yeah, there's probably some self-selection and some taboo around Hispanic residents moving into care facilities that aren't really designed to, they don't feel that welcoming."*
> ~**Management**

Some examples of proactive approaches for understanding and addressing DEIA include collecting demographic data of staff and providing financial assistance to promote workforce stability. As one participant explained, *"if the conversation sounds like there's these performance concerns that are being generalized to a whole group of members of a particular group… we'll push on that and say, it sounds like this. Is that really true? Does that represent everybody that works there?"* One management representative shared that their company has a DEIA policy, but added, *"I don't know how implemented it is, other than when we do training with our folks and say, you know, here's what our values are."* Another management representative explained that it can be difficult to create a culture of inclusion in AL/RC communities that were not designed to be inclusive.

Management representatives also noted that they recognize that prioritizing flexibility can, at times, be at odds with standardized policies. As one noted, *"I mean, we're trying to standardize at the same time, you want to have some flexibility."* Another management participant shared that they need to balance the needs of all residents, which can be challenging.

> *"We have to troubleshoot through that because, we have to keep not just that resident safe, but all of our residents safe. So there is a fine balance there, but we're definitely, we listen to, we take complaints very seriously."*

The person-centered care paradigm can support culturally responsive care for residents but can paradoxically enable bias and discrimination.

Person-centered care is leveraged as a way to get to know residents and provide care in a way that is culturally congruent. It can also provide a format for management to ensure that staff are trained to provide appropriate care.

“Making sure that the staff are trained on that [PCC], and that could be anything from food preferences, which is a big deal, to shower preferences, prayer preferences. And so a lot of it is just really situational and getting down to like the root of it. And making sure that it's not all cookie cutter.”

One administrator shared that resident service plans are used for accommodating residents needs that diverge from the dominant culture of the AL/RC community. One resident expressed that these types of care plans are required for each resident prior to moving in, *"**Individually based to accommodate individualism.**"*

Providing person-centered care presents challenges for management when the resident’s preferences relate to an aspect of direct care workers’ identities or backgrounds. Participants commonly shared that these types of situations are resolved on a case-by-case basis. A common example offered was when a resident prefers assistance from a DCW of a specific gender, a request that participants felt could be reasonably accommodated.

“They [men] don't want women to help them. And so we worked through being able to bring over a male care staff from a different building three times a week to help with this gentleman showering”

Several participants brought up examples of residents struggling to accept trans and non-binary direct care workers, especially if they knew them before transitioning. They shared that in these scenarios they try to support the staff person and provide resident education.

“This is such a foreign thing to them, that it was really just trying to protect that employee or address those issues as they come up, have the conversations with the residents, when they were like what's going on and explain things to them.”

Participants also shared examples of times when residents have voiced racist attitudes towards direct care workers. In these situations, they support the staff person and engage in difficult conversations with the resident about refusal of services. In some cases, they may help the resident to find a different place to live.

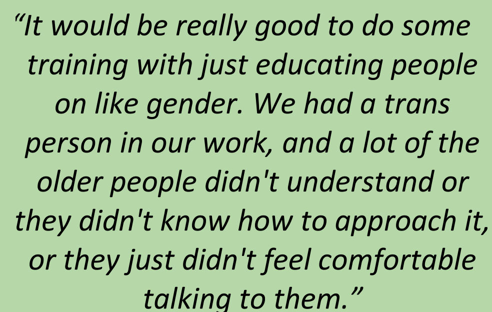
“Reality is, racism exists, right? And now, this person who maybe has some of these feelings, is having to get care from someone that they're really not that sure of, and it was hard for him [African American male caregiver].”
~**Administrator**

*“**I know there have been situations anecdotally where somebody isn't happy with an option.** And we've said, well, then you might have to look at other options of where to live. We can't*

issue an involuntary move out for that necessarily and have that get upheld, so ***we won't force them to leave… you know, we might help them find another place.****"*

Update of DEIA definitions, training materials, and employee materials are needed. Participants mentioned that DEIA trainings are outdated, should occur more than just once a year, and need to be updated to include the current demographics of care communities. For example, there is a large Filipino/Filipina staff population in one community and they need additional language support for training and working with residents. In another example, one direct care worker talked about not receiving DEIA training possibly because their community was perceived as very diverse but noted that it could be beneficial to their team.

> *"We were able to have a very diverse, like cohort of workers from all over the globe. And it was very interesting, but* ***there was times where I feel like those trainings or of like anti-discrimination and diversity trainings would have benefited*** *because I remember there were times when the Latinos would discriminate on the different cultures and how they're not as like good workers and stuff. And I would just stay back and be like, doesn't really matter where they come from. But I feel like we would have benefited from them. It just I feel like it wasn't expected from like, it wasn't given to us because we were like, already a diverse like facility."*



Another administrator talked about trainings on tolerance of gender diversity (i.e., trans, non-binary, gender non-conforming, etc).

Some administrators shared that it would be helpful to have DEIA materials in different languages with different audiences in mind, including direct care workers, residents, and resident families.

> *"It would be a few classes online about it.* ***I think it would be helpful if they made things available like the translators and things like that. And more classes that were in other languages you know, something like even a resident could watch.*** *I mean, it's all geared towards a lot of English-speaking classes or some Spanish but what about for families who, you know, speak Chinese and want to watch one of those classes or something like that. They can't do that."*

There was a suggestion that administrators have a lot of different people who they have to "please" and it would be helpful to have education, regulations, and support they can refer to when dealing with questions of diversity, equity, and inclusion.

> ***"Probably just education and scenarios of what's expected, what's regulated, so facilities know where they stand and what's required and what's expected of them.*** *Like, you get some of the kids today, you know, with 12 different hair colors, piercings and tattoos on their face. Well, our residents aren't used to that and that scares them. So how do you weigh that out? So, I think just laying out some go to's for companies to reach out if they do come across something like this so they would know what to do in that situation to maintain compliance. See, it's hard because we're trying to please everybody, you know, residents, workers, family members, doctors. There's no end and sometimes we're like, can we just take care of the people? You know,* ***you have to have stuff where you can refer to something that has to be spelled out for you.****"*

Several participants talked about the importance of updating administrative materials, such as employee handbooks, documents, and surveys, and providing them in languages that care workers and residents can understand. One management representative shared their first experience conducting open enrollment for employee benefits with a Spanish-language facilitator: *"It was the first time that some of them really understood what those benefits were, and why they should have them. And it was great."*

One administrator was unique for describing how they collaborated with their staff in developing DEIA activities, including their vision statement.

> *"**These are just needed in the workplace**. I'm trying to connect with the community… so social support and belonging. We, as the assisted living and memory care staff,* ***we created our own vision statements, and of how, what motivates us to do the work that we do. And what kind of a workplace we want to be.*** *So vision statements centered around those two kinds of concepts."*

> "*We talk about what kind of workplace we want to be. We acknowledge that… with any family of people, you're going to have conflict, acknowledge that it will occur. And so we just have to learn how to deal with it healthily... we want to be a community of people who are living life together.*"
> **~Administrator**

This administrator went on to describe other areas of the U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being, such as connection and community, work life harmony, growth, and protection from harm.

“Keeping up” with multiple types of diversity and prioritizing recognition of workplace diversity can be seen as barriers to progress.

Some direct care workers shared that while the understanding of diversity has changed in recent years, AL/RC policies and handbooks have not kept up. For example, policies recognize racial diversity but not other types of diversity that reflect their lives. Some said that managers do not recognize discrimination among/between BIPOC groups or engage in culturally specific activities because “***they don’t know how***,” and that staff are expected to keep their culture or identities to themselves. A management participant gave the example that if an LGBTQIA2S+ employee was seen by other staff and residents as “*flamboyant and crazy”* their approach would be, *“**just because you like it, don’t push your culture on us. You're welcome to it, just keep it to yourself.**”*

Comments from a few administrators underscore the importance of having DEIA policies in place that include updated knowledge, as they can protect workers from unfair differential treatment and potentially harmful language. For example, some administrators talked about preferring to hire certain ethnic groups because they are “hard workers.” One administrator shared, *"I would love to have her work because you know, just that nationality. They're hard workers."* Another administrator explained, *"we got a couple of them that are Latino, one Latino gentleman, but other than that, most of them are, some of them are in the foreign countries that are good. They're not like there's any type of barriers whatsoever.* "

Oregon’s history of being one of the least racially diverse states in the nation was reflected by some study participants. As one current direct care worker explained, *“**it's about, you know, 90% white people, too, and 90% straight. So there's not really much diversity to acknowledge for the most part.**”* Another thought that management might not be willing to pay the financial costs of supporting diversity among residents and staff.

> *“I think it will just bring, like some more cost for them, and I think they're not able to do that. So I think that's the main reason why maybe they are not so much trying to diversify or trying to employ people from different areas.”*
> **~Direct care worker**

One direct care worker thought that management was too busy focusing on other priorities, *“they're usually pretty busy. And I don't really think that's [DEIA] the first thing they're thinking about."*

Some participants would not want changes that single out one culture and said that inclusion is too subjective. One management representative indicated that everyone should be treated the same regardless of

background, *"It's just humans. It doesn't matter their culture, their family situation, or their payment situation, or anything like that."* One current direct care worker shared,

> *"**I would actually hope nothing would change.** We do well, just, you know, taking people as they are, and I feel if they tried to, you know, push one kind of, you know, culture, you know, celebrate one culture versus others. **It'll just make people feel left out, or something like that or like we should strive to be this way when we're not actually.**"*

One management representative explained the challenge of creating welcoming communities given different perspectives.

> *"**Our interest was in creating welcoming communities, both for our residents and the employees… how to operationalize that has been always the challenge**, because there's, you know, just people come at that from, from all different perspectives."*

Another management representative highlighted an important concern for residents from diverse backgrounds who might want to live in an AL/RC community,

> *"I haven't seen much diversity in our residence… Which can be a problem another way, right? Because when you want to move in somewhere, you want to see people that you're comfortable with and that you can identify with."*

Although some participants spoke about needing DEIA policies and training for LGBTQIA2S+ issues, resident behaviors and attitudes, and other concerns, many participants, across all participant groups, didn't identify it as an important priority. The reasons for this varied, such as management is busy with other priorities, the idea that we're "*we're like a family*" or "*we treat everyone the same*," being in a community that is "*all White*," or conversely being in a community where "*we're all from different backgrounds*." If participants perceived diversity in the workplace, they often felt DEIA was "achieved," whereas individuals from more homogeneous settings they often did not think it was necessary.

People generally want to create a welcoming environment for everyone, but might lack support for doing so.

> *"It's more about, you know, making people feel welcome in all the different ways that people differ. So in other ways, whether it's gender, sexual identity, class, faith, just really being mindful of getting to know people, and just having a welcoming community."*
> **~Management**

Across all participant types, individuals demonstrated a tremendous amount of care, compassion, and the desire to create a welcoming environment for all. The challenge, as some expressed,

is that people can cause harm when they are not intentional about learning, training, and educating about DEIA efforts.

Some shared the importance of a nuanced understanding of differences among staff and residents, such as different ways of communicating.

> *"**Always looking at ways to create positive opportunities for interaction that aren't necessarily about diversity. But they are about differences.** I mean, some of it has to do with how we communicate differently, and not because of our race, ethnicity, or what have you, but because of how I communicate or how I understand stuff."*

When asked about positive interactions because of differences in race, gender, and ethnicity, one administrator mentioned described staff and residents dancing together.

> *"We frequently have a lot of salsa dancing here. Which the residents absolutely adore and a lot of them will say hey, I never did that before. **But because of the difference in the culture with the staff and the residents, the staff will turn on their music and the residents will start dancing with them.**"*

Connection and Community

Theme #4: Company culture can support feelings of connection and belonging among staff members.

"We are like a family."

Many direct care workers described the feeling that their care community is like a family, such as *"we really want to be as a family accepting each other's diversity and needs."*

The notion that everyone is equal no matter their differences was shared by several other current direct care workers. *"As far as I know, we just treat everybody equal. You know, no matter age, sex, race, whatever we treat them as equals. One's not better than another."* Another explained that their diversity is a shared experience, *"we're all there we work mostly as*

"We're kind of just like a family. So I mean, we kind of, I don't think we really look at it as, like different culture… We're all mixed, and cultures and ethnicity. And so we kind of all bring it together and make it as like a family dynamic."
~Direct care worker

a team. I mean, I'm actually really happy about that. ***The way like we're just so diverse, we're all the same, you know what I mean?****"*

Direct care workers described other ways in which connection and belonging is fostered by management initiatives. One direct care worker shared some examples, such as *"random get togethers, random barbecues… they have a lot of the clients displayed in like black and white photos along the wall of all ethnicities and diversities in different situations. And I think they just pull it into this, it is what it is. So it's, I don't notice that it's anything different"*

Most of the management participants talked about their efforts to promote connection and community. One management participant spoke specifically about how language can promote belonging, sharing how some words like "family" can alienate some individuals, while others find it comforting. They described other ways to communicate the feeling of community:

> *"**We used to say, a family like atmosphere. I still kind of like to feel it that way, but not [everyone] embraces families the same. So I don't really use that term so much anymore**... But you know, we want people to feel like it's their community. It's their facility. It's their resident. And that's definitely one thing I hear from my staff all the time… a client says a certain relationship… a resident says another... I have campuses, I don't have facilities"*

Resident sense of belonging is at times connected to staff being well supported.

When there is a staff shortage or when staff are under-supported, residents feel and see it. Residents talked about having less personal interactions with staff because the staff feel rushed to get everything done. The facility feels stressful and anxious. Residents also talked about their routines getting disrupted when there are staffing changes, challenges, or shortages.

One resident said that the high stress associated with understaffing doesn't reflect the culture of their AL/RC community.

> *"**Like stress, like high stress. Yeah, high anxiety. Because they're trying to get all these things done, and there's not enough time**… And I mean, it's just a*

totally, totally different no time for chit chat. No time for laughing, no time for saying you know, how my daughter's doing. No time for talking about their pets… None of that. Yeah, it's very just business. And that is so not this place. Yeah, that's definitely not the culture. No, that's not this place. I would not like it if I had to live in a place like that."

One resident talked about repeated medication errors occurring as a "direct result" of understaffing.

"I had mistakes in my meds four times in two weeks. Now, thankfully, they weren't serious mistakes, and it didn't really matter, but they could have been. And that's a direct result of being understaffed. They're working on it. I know, it's not easy to find people right now… so we're dealing with it as best we can. Everybody's trying to be understanding and work with it. And the staff here has been very open and honest about all of that."
~Resident

Another resident shared the differences residents experience when communities use a nursing agency to fill staffing gaps.

"Recently, they've been relying on an agency nurse who has difficulty finding workers who want to work here. ***There is a large difference between agency and long-term nurses.*** *Agency nurses don't know the individual cases very well. Had to instruct agency nurses about how to do my hair. You're having to explain over and over."*

When staff have adequate support, they take their time with residents and ask about their lives, leading some residents to feel a sense of belonging. Residents appreciate when staff want to get to know them, and are not just doing a job. For example, a resident said,

"Yeah because they spend time to talk with us and interact with us… Not like you're just their paycheck you know, yeah, they actually spend quality time with us, you know… and take the time to get to know who you are and that makes you feel good. ***You know the older you get the more you feel like you're a problem, so when they come in and they're well rested and spend quality time it helps you."***

One resident discussed the issues with cross-training staff when the facility is understaffed or had staff shortages.

"This business of taking people and cross-training them to do anything and everything. And then they come to work. And okay, you're doing, you're doing

meds today. And then something happens and well, no, we need you over here on patient care. And somebody else picks up the meds and you can't do it like that."

Communicating with co-workers and managers is an important support while on the job.

Direct care workers appreciate that they can ask for and receive support from co-workers and supervisors. These individuals provide crucial support to manage the daily struggles of care work. For example, several direct care workers repeatedly shared the importance of being able to vent to co-workers when dealing with difficult resident behaviors or other stressful job situations. As one participant shared, they often seek support as a reminder that they are needed in this work.

> ***"Just go find somebody to talk to somebody you can trust and sit down and talk with them and know that you are needed.*** *You are needed.* ***This is an industry that we are needed in.*** *And so you are definitely someone with a purpose."*

Some current and former care workers shared that they felt frustrated when management did not follow through on the problems they identified. Another current DCW described the importance of open communication in fostering understanding across cultural differences.

> *"Any team that has more open communication, people that talk about it, people that can have a conversation, I really think it just helps spread understanding as long as the divisions not hostile or angry....**I think we're all pretty aware of like, we have cultural differences. And we are genuinely curious about each other's lives.**"*

Management participants talked about promoting connection between staff and management through meetings and staff recognitions such as kudos cards and awards. A common theme was for management to nurture communication and offer support. Several see this as having an open-door policy, providing a space for staff to vent and "*take a moment for yourself for some self-care."*

> *"**I understand that our home life, you know, sometimes we have to bring it to work with us**, but I have an open-door policy, and you're more than happy to leave your suitcase in my office… then you can pick it up on your way out."*

Management participants talked about challenges with rural communities being isolated even though the home office stays connected through virtual engagement. One said, *"They can definitely feel like they're on their own little islands sometimes."* One community piloted a communication app to reduce DCW isolation but found that staff did not use it.

Leadership attitudes and backgrounds influence workplace culture.

Participants from several group interviews described how leadership attitudes and backgrounds influence workplace culture. Additionally, leaders need adequate support and resources.

> *"You know, making sure that we have good support, and that we have people in each building that can really push that forward… that I have really good leaders that are instilling this and making sure that they have really good support, and that they have resources where their employees and or residents feel comfortable coming in and saying, Hey, I'm having a hard time, or I have something going on that I need to talk about"*

Management company representatives felt it was on them to ensure communities have leadership that promotes worker well-being. As one explained, "*we're trying to figure out why is this building having so much turnover? Is it culture? Is it something about the leader there who's, you know, not cutting people any slack?"*

Administrators and management often come from a direct care background themselves. One direct care worker explained how this experience, along with the diversity among management, helps care workers feel supported during difficult times.

> *"There is definitely a lot of different ethnicities within management as well, and each person that works in management, they were caregivers… like we did the same job… you know, like my, my body is hurting, or when they understand, or maybe one day, you know, something happened, and I'm emotional, and they understand, you know... It's a hard job. And it's very diverse."*

Leadership plays an important role in creating an inclusive environment and prioritizing diversity.

> *"Again, we have a wide diversity of ethnicity, gender identity, religion, religious differences here between our residents and our care team. And we just are very harmonious. But I have to say it's because of our director, she really keeps an inclusive, non-judgmental environment for everybody, including the residents, which is a very nice place to be."*
>
> **~Direct care worker**

> *"There's like a pretty strong correlation between, you know, the diversity of leadership, maybe and whether or not that's something that that the organization prioritizes. So maybe if... diversity is important to people in leadership, then they kind of make it important to spread that message throughout the company..."*

Some management representatives talked about making sure that their employees can openly communicate with them to address problems as they arise, and that this can keep leadership

accountable. Feedback comes through unstructured methods, such as an open-door policy, and structured methods like resident council meetings, committees, satisfaction surveys, and third-party engagement programs. Another management participant shared,

> *"Accountability is not so much about sort of us holding our staff accountable, but inviting them to hold us accountable by letting us know when we're missing the mark. So that's what we try to weave into the culture of how we all work with each other."*

Direct care workers feel that management could put more effort into supporting their staff by checking on their well-being more frequently, upholding the rules that have been put in place, protecting them from harm, and being in touch with what direct care workers experience on a day-to-day basis. One participant shared, *"maybe management coming out of their office once in a while to help and get to know the staff and help the staff, you know… and see what we deal with on a daily basis."* Another direct care worker stressed the importance of management follow through on conflicts between co-workers, *"Management, they need to follow through with things. If there's issues between co-workers, those need to be addressed immediately, whether then letting it drag on."*

Reason for leaving direct care work: Management at odds with personal values

"[Management] just cared more about the appearance of what the care facility looked like rather than what the care looked like for the residents."
~**Former direct care worker**

One direct care worker described leaving a company that was not properly documenting incidents that occurred. *"You know, things going undocumented. So then you leave cause you don't want to be a part of that. So I guess, just making sure that it's a good company. They follow the rules properly and have good benefits."*

Theme #5: "Having each others' backs": Care staff look to peers and coworkers for support.

Care staff share information with each other about what works in their AL/RC communities. This local understanding can complement the training sessions organized by leadership. As one participant shared, *"It's not just through management, it's through their teams, their peers… they can always reach out to somebody maybe a little more experienced."* Direct care workers often work together and form close relationships with their coworkers and compare these relationships at work to a family system. It is everyone's job to notice opportunities for quality improvement and to address issues as they occur.

> *"They have your back. They have your support. When you get to know your partners. They know when you've reached your limit, and they'll say, 'Look, I'll take over for you. Go take a break.' And that I love. Just. It's just very peaceful, very family-oriented."*

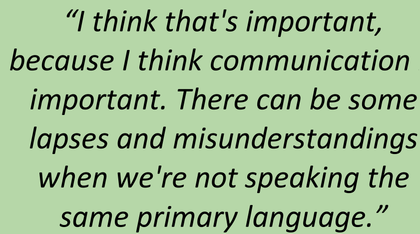
Theme #6: Workplaces need infrastructure that reflects language diversity of residents and care staff.

Language diversity includes a variety of communication topics, including language spoken and impairments that limit hearing or comprehension. Language gaps, between staff and residents, and between residents and management, indicate a need for improved support to preserve dignity and respect to all members of the care community. Many direct care staff described trying their best to communicate with residents who do not speak or understand English. Communities vary widely in their ways of responding to residents' language needs. Some care staff have developed strategies to fill gaps, such as relying on picture cards to communicate basic needs (e.g., shower, food, ADLs), while others use Google translate on phones and handheld devices. This type of communication does not account for socialization needs of the residents who might be isolated. When asked about policies for accommodations related to language for residents and staff, administrators either did not have formal policies or did not know of one.

Some management company and administrator participants felt that the industry is well prepared to support residents who speak different languages since "*a lot of what we do is not spoken… it's nonverbal. It's body language.*" They also spoke of tools to aid communication such as picture cards and translators.

> *"So I said it's no different taking care of somebody that doesn't speak English, in a sense, because we did have a lady here that did not verbalize. So we had to rule out things almost like taking care of a baby you know, you have to roll out, make sure they're warm, clean, dry, fed, stimulated, and but anyway, we had printed out cue cards and different things and plus, nowadays with all the phones and different things that can translate for you so those are things that we would use and there's different ways."*

Other management company representatives stressed that it's *"totally unfair"* to provide services to a resident you cannot communicate with and shared they would seek other linguistically appropriate settings. One participant suggested that they would refer potential residents who do not speak or understand English to adult foster homes as they are "*better at catering to a particular market.*"



Residents felt that language barriers matter more than other differences because they need to be able to regularly and effectively communicate about their needs with care staff.

Others talked about the importance of communicating in shared language for building and maintaining rapport with care staff. One resident had a hearing impairment that made it difficult to communicate with staff whose primary language is not English, *"I have to be able to understand them. And I am already hard of hearing. So sometimes the broken English comes, you know a lot of it is too difficult for me. Yeah, I hope to get a hearing aid in the near future."* All interviews were with English-speaking residents, this may differ if residents spoke languages other than English.

Management representatives shared different perspectives on care staff language and communication with residents. One explained that care staff must be able to speak enough English to communicate with residents: *"Policy, procedures, things like that are written in Spanish… but they need a certain amount of English to communicate with residents."* On the other hand, another participant explained that the company needs to change how they operate to accommodate care workers who communicate in Spanish. ***"We have all these staff that are able to communicate in Spanish, what are we going to get rid of? They do a great job with the residents, we have to change our how we do things."***

Work-Life Harmony

Theme #7: Work-life harmony is challenging to achieve when there is a staffing shortage, however it has led to innovative changes that promote greater flexibility.

Most of the management participants described work-life balance as the most difficult domain to meet. Due to the challenge of staffing shortages, current staff who have family and personal obligations might be expected to pick up extra shifts. They also spoke to the increasingly high acuity of residents and suggested a solution of bringing in not only more care staff but different types of support workers.

> *"But a lot of times we forget that they have their own little family that's waiting for them. And so really making sure that we have the right people and enough of the right people to really do the jobs."*

Many of them talked about creative and flexible ways that their company responds to staffing challenges such as a variety of new work-shift schedule options and opportunities for staff to temporarily move to different roles to prevent burnout.

"I think the staffing crisis these past couple of years has forced employers to be a lot more flexible than they were before... scheduling is one of the biggest challenges"

"If you look around at community-based care, they haven't really changed the pattern of workers in their communities to meet the needs. And that's, you know, adding the social workers and adding different key positions that are going to be crucial to taking on higher acuity."
~Management

"So in trying to create more time off, we built it into the schedule. And by doing so, got us more staff for the schedule, so that people weren't being asked to work so many extra hours"

"Sometimes they get burnt out on that, I just need a break from memory care, and they go to mental health care… we pull them into the office for a while or pull them into activities just to give them a break"

Some management participants talked about offering flexibility when personal emergencies or self-care needs arise among their staff. This included providing extended time off, allowing children to come to work with their parents, and encouraging administrators to be flexible with staff doctor's appointments or other incidental needs.

Theme #8: While rewarding, providing care is demanding work that leads to injury, stress, and burnout.

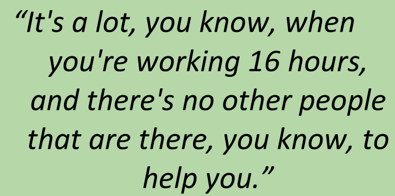
All participant types agreed that providing care requires great physical and emotional strength. One direct care worker said:

"Everyone in the caregiving job knows that it is very stressful. I mean, yeah, it demands energy. And it really makes you exhausted, especially when it comes to using, like, physical strength and all of that."

Having a passion for the work is seen as an essential characteristic of the direct care worker, but that passion can also be a factor that causes stress and burnout in a non-supportive work environment. This direct care worker describes a sense of deep frustration and disillusionment:

"The fact that you do give, you are passionate about your job. And you know… ***things are falling through the cracks, and people are suffering for it.*** *And you gotta come back tomorrow, and your residents are like, you dropped the ball, what happened? And you've spent the whole day just working your tail off."*

Direct care workers echoed the experiences shared by residents of not being able to provide high quality care when severely understaffed. Many direct care worker participants talked about working extra hours for months on end, having time and energy for nothing but work and sleep, and work interfering with quality time with their families.



This type of stress also came up in a number of former direct care worker interviews. One shared that being a new parent and working as a care worker was detrimental to their health.

> *"I was very exhausted when I was working. And it was taking a toll on my health. And at the same time, I have two little babies twins in one year, so I was not able to balance both work and looking after my babies."*

Another former direct care worker observed that they cannot be referred to as a "caregiver" because their workload does not allow them to truly "give care."

> *"And now, you notice we are not called caregivers. We are called care partners because this is not caregiving. Working at a facility is not caregiving. Caregiving, I think, is for a specific individual, you know, their care of life, not 15 - 16 people, you know, you're out of control."*

While we most commonly heard about how emotional exhaustion and injury impact direct care workers' ability to maintain work-life balance, some participants also shared how physical injuries have impacted them. One said,

> *"I've been injured, and one thing that's hard is, you know, life goes on. They don't help pay for the time off… life goes on so we have to, you know, keep working, and the injury doesn't always heal and then you just re-injure yourself."*

Suggestions from direct care workers on how to address these concerns involve concrete policy changes such as reduced work hours, confidence staff won't be called in on their days off, acknowledgement from management that the work environment leads to burnout, and set procedures for how to obtain support when experiencing burnout.

*“**They don't have something specifically for burnout. They don't even talk about it, there's no policy and procedure, no, nothing for it.** So I think that needs to be something that is talked about in these facilities is caregiver burnout. From personal experience, burnout really does affect you… **And I think it should be in black and white. What procedure to do if you get burnout? Who to call what to do? You know?**"*

"I know a lot of turnover is because of caregiver burnout. It needs to be more recognized in facilities… we need some time, like our days off, not to be called in not to, you know, we need reliable management to allow us not to get that burnout.”
~Direct care worker

Mattering at Work

Theme #9: Care staff wages do not compensate for the demands of the work and the prevalence of understaffing adds more stress for everyone, including residents.

Consistently across all participant types, respondents shared their concern that the pay for care staff is too low compared to the unique and varied demands of the work. Relatedly, understaffing contributes to many challenges that care staff, and therefore, residents, must endure. A common comment is that care staff could make higher wages working in the fast-food industry than in caregiving positions, though care for older adults in these settings requires much more physically demanding work and significant emotional investment.

Participants shared that some care staff experience houselessness with reports of care staff living in cars, housing insecurity, and trouble finding affordable housing in many communities where facilities are located. One participant from a coastal community indicated that their AL/RC has trouble recruiting care staff who cannot find affordable housing nearby. Direct care worker participants shared varied levels of satisfaction with their company’s benefits.

One former direct care worker found that the only way to make enough money to support their family was to work “*a ton of overtime.*” Participants reported that employers often provide free meals and support with accessing additional benefits to help offset low wages that care staff receive. Direct care workers and former direct care workers shared that some management companies have raised the hourly rate to attract new workers but don’t extend those same pay increases to current workers, creating pay disparities and resentment in the workplace. Participants described several difficulties involving relying on temporary staff from agencies

including lack of accountability, not understanding resident care needs, and tension stemming from being paid as much as three times more than regular staff.

Reason for leaving direct care work: Rate of pay is unsustainable for a long-term commitment to the work

"I was being paid peanuts, I can say. So it made me feel like it's not secure or not safe, because it's not being paid well…So I think that in some way, it led to me having low self-esteem at my workplace, not being motivated. And I think that all led me to quit the job."
~Former direct care worker

"Also the pay rate just isn't that high. Honestly for the type of that work. I feel like it should go a little bit higher due to getting hit, dealing with bodily fluids, dealing with, you know, basically a toddler in an adult body. But it's like 10 times worse than that, depending on how far or where their diagnosis is."

"It's been tough when staff feel like I would rather work for you, but I make $1 more an hour working at Taco Bell. So I have to work at Taco Bell."

One management company representative shared that they do not raise pay rates because of "cliff effect," meaning they cannot raise pay enough to make it worth it for their employees to lose government assistance.

*"**It's really hard for us to meet the wages that some of those staff need to get off of government assistance.** They earn more whether it's through food, their housing, their insurance. It all adds up to be more than what we can pay them hourly."*

Participants across all groups connected the low pay rate to the high rates of employee turnover in AL/RC settings across the state.

"I think paying them what they're worth. Paying a better wage or having better benefits and they're leaving our place, like crazy. Then our admin are sitting there just like, 'Oh, why are we having this mass exodus of CNAs and caregivers?' Well, this is why."
~Management

Some participants stressed the importance of tapping into the heart behind the work and the importance of placing value on care work in our society to shift the balance toward a more sustainable workforce. As one direct care worker explained, "***You know, this is work of the heart. So you have to tap into that passion. Why are we here? We're here because we feel passionate about caring for people.***"

Management company representatives had several suggestions that pertained to what ODHS could do differently to support better pay for care staff and reduce turnover. They stressed that the Medicaid reimbursement rate needs to be higher to support more diverse communities and increase worker compensation. Another recommendation is to nurture better relationships with ODHS regulators as tensions and stress around the survey process can drive away workers. They also pointed to challenges related to the acuity-based staffing tool, which can make hiring strategy more difficult.

"The Federal reimbursement, whatever the program is, it's ridiculously low. And to get good quality people that can actually live off these wages, doing the most important work that there is, that's where they need to put their money."
~Management

"Sometimes I feel like we're not on the same team with DHS... sometimes there's surveyors and policy analysts that it doesn't feel like we are on the same team. It feels like they are against us and the staff had bad experiences with that and will drive them away, for sure."

"I think direct care has to be valued in society, kind of like educators, we're just chronically underpaid and underappreciated, and the need is never going away. So until people actually prioritize paying people what their time is worth, I think that we can just expect more of this."
~Direct care worker

"You have to be creative, you know, because I am not getting rid of the staff if my acuity goes down, because you're going to lose that staff… So, but yeah, that's been a challenge and a lot of people talked about that."

Addressing compensation and cost of living

Within the management participant group, compensation came up once again as it relates to dignity and meaning. Some companies attempt to address this by completing periodic wage analyses and making adjustments. Others have policies that attach bonuses or pay increases to taking on additional roles.

“That's a big deal to us is making sure that we are providing a living wage, especially in today's economy of inflation and everything else going on.”

“So as a company really looking at how we can continue to take care of our people, and I know that's a big struggle. You know, I have a lot of people that try to work as many hours, not only to get the hours and the money, but truly, because they don't want to leave work and go home and sit in the car for the next, you know, 12 to 16 hours. And so that's a big one for us.”
~Management

Lack of affordable housing came up across several of the participant groups. One management participant shared that their company is looking into developing employee housing in some geographic areas because many of their employees are living in the cars.

Rethinking hierarchical structure of the assisted living industry.

Management participants also shared efforts to rethink the hierarchical structure of the industry. As one explained, *“I set this up like a well-oiled machine. Most employees don't talk on an equal level with management. My employees do.”* One participant described their business as a “bottom-up management company” while others strive to flatten their companies but struggle to operationalize because it’s not how the sector, or most systems, are structured. As one management representative explained, ***“I think the challenging part is still in terms of getting to the middle of it in terms of worker voice and equity. We still are an industry that's fairly hierarchical and structured.”*** Another explained how they give the power to their caregivers to make decisions about resident needs.

> *“There's the caregivers and they do all of the interaction with the tenant and their families… they have the power to do whatever is necessary to make things work. And they don't have to ask permission for hardly anything. I wouldn't make a decision without taking them into account and saying "what is your opinion on this?”*

One participant pointed to the Green House model as a *“more caregiver driven model”* that might inform more nonhierarchical ways of operating. Another participant talked about changing their approach over the years to put staff first and that leading to better resident care,

"I came from that old school model of you know, it's the customer's always right. And after a few years, I was like, I don't think that's right. I started believing that it's our staff who are needing to be put first… If we put our staff first under all circumstances, and we elevate them, and we let them know it's them that need support. They're going to feel supported, and they're going to take care of the resident, which is all we really want to happen is that rest is taken care of. But if we don't support our staff, and they feel like we're listening to the residents or families over there, well, then they feel second rate, and they're not going to care for the residents we want them cared for."

Honoring and valuing the role of care staff in AL/RC and the larger society.

"And also just creating awareness overall that direct care people just play a very vital role in this society." ~**Former direct care worker**

Management participants stressed that the skills and value that direct care workers bring need to be recognized and elevated as an important way to retain the workforce. As one explained, *"it's a role that you don't need a lot of education or experience for but really making it really elevated. It is the most important position in our company, period."* Several participants recognized that the initial months after hiring a new employee brings *"a lot of feeling stressed and overwhelmed about the job"* so it's critical that new workers are trained and supported appropriately, including honoring and valuing their role in the organization and in society. One direct care worker shared, ***"I've noticed a lot of caregivers, whenever they come in, they'll come in for a couple of weeks and they won't really want to be there anymore.***" One management participant shared the unfortunate results of a survey of new employees that underscored this need.

"Recently did a survey for employees who started working within 100 days with a question that was like "do you feel like you're making a difference" and caregivers had the largest response of "no"... and the housekeeper's behind that. That was like, Oh, my goodness, like, these are the, like, critical positions to the care that we're giving, they're the most important"

When asked about ideas for retaining staff, administrators talked about increasing pay, mandating CNAs for AL, and showing value and appreciation for caregivers in ALs.

*"**Well, I sometimes feel like especially our caregivers in this setting are kind of like the forgotten people.** People focus on hospitals are focused on the nurses focus on all this but they don't really remember the caregivers in this kind of setting. You know, it's just kind of a lot of people even memory cares of people don't want to talk about it unless there has to be there. You know, a lot of family members, a lot of community they're not educated on it. And a lot of doctors*

aren't even educated on how to take care of people with dementia. They don't even know that what we offer, I wish we could mandate that our professionals learn more about my setting…"

Opportunity for Growth

Theme #10: Leadership support for ongoing, responsive training and education opportunities are crucial for providing care workers with the necessary tools for their work and reducing turnover.

Management participants talked about ongoing and responsive training for care providers on a range of topics and in a range of modalities. Direct care workers and former direct care workers shared a need for more training and support for resident behavioral health challenges and end-of-life issues. Several management participants connected training to open communication and addressing when things come up so that managers know what care workers are struggling with or need education on. One example of a successful method of training is to have experienced direct care workers share their experiences rather than having training all come from management.

"Goes back to the training, the education, and that open communication... So I know what to do to make sure… that they feel safe and secure being there for sure… ***I feel like people don't realize that the training should never stop, and it's never going to be enough and that we need to continue training and training and training and just have that clear open communication about the good and the bad."***

"It was really important to me that they feel like what they're hearing they can relate better to. So I use my staff to do a lot of my training. I didn't initially because I didn't know which ones knew what, but once I did, I really implemented it."

Participants talked about a wide breadth of training topics outside of the technical

Reason for leaving direct care work: Need for more training and support, especially around end-of-life issues and behavioral health challenges

"I was still in high school when I first passed my first morphine and then our resident passed right after. So we definitely, there's no support. It just feels like it was your fault, even though you're following the doctor's orders."
~**Former direct care worker**

"But I feel like they also lacked in training us because it was my first time ever caregiving in a place like that, and they didn't ever train me. Oh, here's what you do for a resident who gets aggressive and pushes you around or hits you. Because we did have residents like slap us and punch us. Yeah, they chase us around. Nobody knows what to do."
~**Former direct care worker**

skills to do the job; examples included preventing burnout and mental and physical safety topics. One participant who oversees many behavioral health communities talked about training staff to maintain strong boundaries.

> *“And so that's where it comes with training staff. You know, they don't need to know how many kids you have. They don't need to know where you live in town, they don't need to know your level of education. They don't, you know, don't let them into your personal life... So we try and teach them to you know, what's okay to share and what isn't, because you don't want to just be non-responsive.”*

Several different types of participants talked about the importance of ongoing training and mentorship for new hires to prevent turnover. One management participant shared an example of how training and extra support at the beginning really made a difference in keeping a new employee and developing their confidence as a care provider.

“She didn't think she had it in her. And guess what, the individual is still here, because of the process that we took to educate her. And to work with her. She's still here. She's still working. So I think that ***a little extra attention, a little bit of extra reassurance, a little extra education.****”*

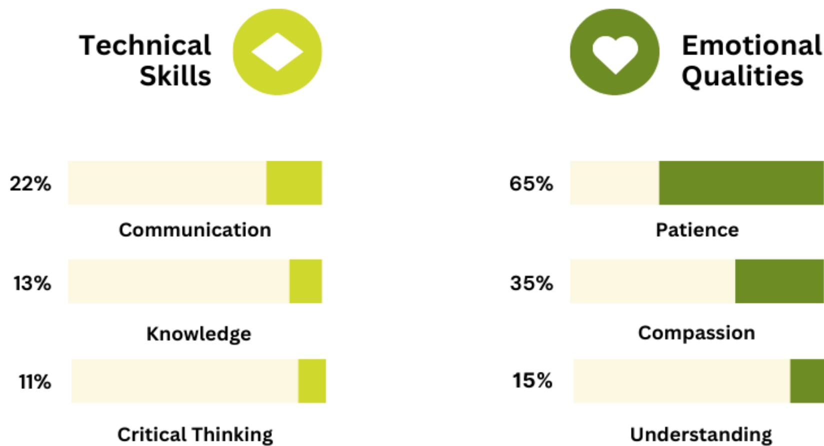
Hiring for passion, providing training and promoting from within.

Direct care workers feel it is essential to hire workers who are less motivated by monetary rewards and more so by fueling a passion they have to help others. According to direct care workers themselves, care staff should possess ideal emotional qualities, (especially patience and compassion as illustrated in the figures below) to be successful at working in AL/RC.

> *“Really think that they need to hire people or look more into people that are more big hearted in wanting to care for people, than people who are here for the paycheck, and they don't do that they just kind of start hiring people."*

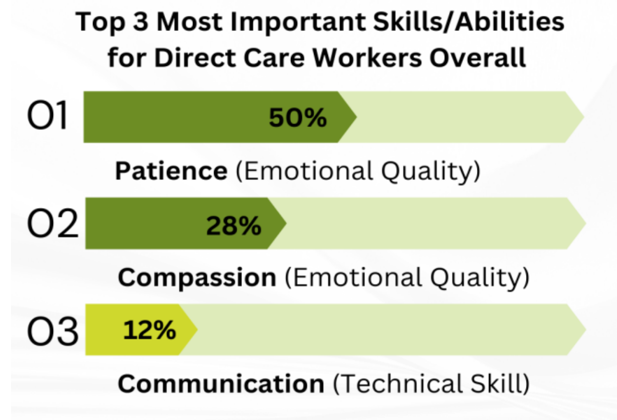
When asked "What are the three most important skills and/or abilities someone needs to do this type of work?" we received a total of 96 responses that could be organized into two main categories: technical skills and emotional qualities (see Figure 1). Technical skills, as defined here, often require the use of specific tools and technologies and can include specialized training or education. Emotional qualities, as defined here, are traits that demonstrate one’s ability to both manage their own emotions and understand the emotions of those around them. The three most common technical skills listed were communication, knowledge, and critical thinking, while the three most common emotional qualities were patience, compassion, and understanding.

Figure 1. Most Important Skills and Abilities for Direct Care Workers



The three most important skills or abilities cited overall were patience, compassion, and communication (see Figure 2).

Figure 2. Top 3 Most Important Skills and Abilities for Direct Care Workers Overall



Clearly, respondents agreed that a combination of emotional and technical skills is required for this kind of work.

> *"**We hire for attitude and train for skill.** And that means that we're working hard at figuring out who really does want a service-related industry. Who wants this to be a lifestyle type job, who really wants to feel like they're contributing. And then we make sure that they know that they do contribute. We do that and our monthly meetings are regular check-ins with them. And I think it's pretty obvious when you're taking someone and giving them a shower and brushing their hair that you make a difference in their lives."*

Management participants also talked about hiring staff for passion and attitude rather than experience helps with retention. Several participants also shared observations, or possibly stereotypes, that direct care workers from some cultures are more aligned with care work. Some suggested that immigration policy should be reformed in order to strengthen the workforce. One of the participants used discriminatory language to talk about immigration and the care workforce.

> *"It seems like non-Hispanic white caregivers... just didn't grow up in multi-generational households, there's an aversion to working with older people, they think it's maybe depressing to work with older people, and providing care to older people. And that's different in other cultures, where you've had multi-generational households, maybe."*

> *"There's been a lot of interest in changing immigration reform, how that might be helpful to addressing the workforce shortage. And it's not so much that we're just trying to find people that will work for cheap. It's more about like, compatibility, like, if you talk to people that hire people from Eastern Europe, from the Philippines, from Africa, from Hispanic, they they're just have this wonderful caregiving thing that you just don't automatically see, it doesn't come naturally to the non-Hispanic, some of the non-Hispanic white [caregivers] that we employ."*

Many participants shared anecdotes of people who had started as caregivers and worked their way up to administrators or executive directors or regional management. One management representative shared that their company had over 200 internal promotions in 2023.

> "***As business has grown, so has opportunities for staff.*** *We've grown as a company, which is great, because that allows for more growth, you know, if I need an administrator, because I built a new campus,* ***every time I build something new, lots of people get to advance because we give them the option.****"*

Some participants also talked about cross-training and lateral movement within company including moving around different facilities. One talked about these types of lateral moves in relation to worker age and physical ability: *"They start going into activities or other roles that don't require the physical exertion that caregiving does. Because they're like, I'm 55 years old, I'm 60 years old, I can't do this. But I still want to work for you."*

Internal promotions allow for a leadership pipeline that trains leadership skills that fit company culture. *"I like the opportunity for coaching, teaching and supporting them, because that's going to help them grow into an individual hopefully like me. And they're going to be able to serve the population, you know, when I'm no longer around."*

“But I think providing more education to make it more accessible… Like, that's how I got into it. And I'm still doing it. I could say I was 16 years old, and the nursing home, they paid for the training, and you took the state tests, and you passed and you had a job. And I remember not everybody made it that far. And I think that's a good way for the facility to see ahead of time who's in it for the long haul, so to speak.”
~**Direct care worker**

Several participants talked about providing tuition assistance for CNA and other programs and administrator licenses in order to be able to promote internally. As one management participant explained,

> *“So looking at opportunities for people to grow, encouraging them to pursue certification if they want to, and providing tuition assistance grants so that people can get certified as a certified nurse's aide. I think that this industry is always wanting to move people up into leadership positions, as they can, or as they want to.”*

One challenge with internal training is that there is little time for continuing education when staff are all so busy.

> *“Ideally, we know that the more we give people opportunities to grow and learn, the more they're going to want to remain part of the organization. So how well we walk that talk is another question, because we just, you know, how much time do we have to focus on everything?”*

An administrator shared an example of an ODHS-program for licensed practical nurses (LPNs) to provide staff coverage for medication administration while direct care staff attend training to become medication technicians.[10] This administrator felt that it could be replicated for their staff for diversity training purposes, also noting the challenge of training all staff when staff are required to be supporting residents at all times.

> *“And we were able to pull all of our med techs and train them for two days and not only train them like spend time together and connect and build that community and things like that.* ***To me that was a very impressive program by the state because instead of just reprimanding us for making med errors and having things go wrong in the med room, they’re actually giving us that preventative tool to set us up for success.*** *And more like that are needed. If they can send people to take over our building for a day or two, and bring our entire team in to connect and talk about diversity, and like, learn and grow together…*

[10] Oregon Department of Human Services, Aging and People with Disabilities. (2023, May 15). *Nurse Crisis Team (NCT) Staffing Support Available through July.* https://www.oregon.gov/odhs/licensing/apd/provideralerts/odhs-23-035-cbc-nurse-crisis-team-support-update.pdf Accessed June 17, 2024.

it's very, very challenging to educate and build connection and things like that when somebody always has to be on the floor.*"*

Supporting education and career goals outside of the company.

Some participants talked about growth external to the company and encouraging staff's longer-term career goals:

> *"One of the questions we ask people during their annual reviews, and other times even when we hire them is what's their career path, what's their goal? You know, for example, if somebody is hired on they say, 'Well, I want to be a nurse, then we know that we need to get them into a med passing role when they get a chance, because that elevates their education, their level of experience."*

One participant really sees their business as only a starting point: *"So that hopefully they'll leave our business and go to a better one and improve their standards... We can get them sharp enough that they can leave and go to… a couple I've got to go to the hospital and things or nursing school."*

One participant specifically talked about how the younger generation workforce doesn't stay with one company long-term as much as previous generations and are adjusting their support to fit:

> *"We understand that you might only be with us, you know, one to 3 years now versus the standard 5 to 12 but during that one to 3 years for your time, our return is to make sure that you have the best skill set that we could possibly give you to be successful in your next adventure.* ***So really looking at it differently nowadays, as this new generation is coming on board, and what's important to them is so different.***

Summary and Recommendations

This study aimed to understand direct care worker, AL/RC, and resident cultural humility, belonging, inclusion, and intersectional experiences as they relate to sustaining the workforce and promoting quality care. Second, this study aimed to learn from participants about their ideas for creating more inclusive and supportive workplaces that can sustain a robust workforce and promote quality care. Through individual interviews, focus groups, and voice memos, 68 participants shared their experiences and insights from their respective roles as direct care staff, management representatives, administrators, former direct care staff, and residents. The IOA/PSU research team identified ten primary themes across all participant types, as detailed within the context of the U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being. In addition to the key components within the framework, the recommendations detailed below emerged from the voices of participants and findings in this study.

1. **Establish comprehensive DEIA policies with clear implementation plans:**
    - Provide initial and ongoing training (e.g., culturally responsive care) for staff in all roles, in multiple modalities (e.g., in-person, self-paced, virtual).
    - Develop and communicate clear protocols for reporting, response, and consequences for incidents of discrimination, abuse, or harassment; conduct regular audits of compliance.
        - Provide supportive resources for staff who are affected by such incidents.
    - Promote and support workforce diversity through:
        - Recruitment (e.g., increased gender diversity) and retention plans (e.g., support for marginalized populations),
        - Linguistic accessibility (e.g., onboarding documents, benefits), and
        - Clear policies about spoken language expectations while at work.
    - Engage research and data collection (e.g., collect REALD/SOGI data, disaggregate incident report data, fund and/or participate in studies).

2. **Implement DEIA training programs for residents:**
    - New resident (and family) orientations that communicate community living expectations and policies and procedures related to discrimination, abuse, etc.
    - Ongoing and responsive educational materials and trainings to promote inclusivity, respect, and understanding of diverse backgrounds and identities.

3. **Invest in creating a supportive and inclusive environment:**
    - Utilize linguistic accessibility resources, such as interpreters, instead of relying on only flash cards or non-verbal communication, to preserve dignity and respect to all members of the care community.

- Support & train administrators and managers to provide inclusive leadership.
    - Consider direct care worker experience as preferred experience when hiring for administrator roles.
    - Implement robust feedback mechanisms (e.g., surveys, grievance procedures, quality improvement committees).
    - Encourage non-hierarchical and participatory management practices.
- Provide physical environments and activities that promote belonging and reflect the cultural diversity of both residents and staff.
- Address disconnection in specific scenarios, such as rural facilities and overnight shifts.
- Address burnout through proactive and responsive policies and procedures, including acknowledgement from management that work environment leads to burnout.
    - Ensure staff won't be called in on days off.
    - Provide easily accessible mental health and self-care resources.
    - Outline clear pathways for obtaining support for care staff experiencing burnout.
    - Shift work responsibilities and reduce work hours, when needed.

4. Prioritize reaching and maintaining appropriate staffing levels:

- Increase direct care worker wages and benefits (e.g., raise Medicaid reimbursement rates and require funds are allocated to worker compensation or provide tax incentives for competitive wages and benefits).
    - Ensure pay equity between existing staff, new employees and agency staff.
- Explore innovative staffing models.
    - Consistent and flexible scheduling; consider options like three 12-hour shifts, four 10-hour shifts, or reduced work hours.
    - Limit call-ins on days off, for example by hiring dedicated on-call or PRN employees.
    - Cross-train employees and consider universal employee models (not simply moving people across departments without proper training).
    - Increase the diversity of mandated positions to meet acuity (e.g., behavioral health roles).
    - Build time into the schedule for rapport building between staff and residents while care is being delivered.
- Implement worker burnout and injury prevention programs (e.g., ergonomic education, mental health and self-care resources).

- Engage in advocacy relevant to workforce (e.g., affordable housing, pathways to citizenship, childcare support, etc.).
- Provide enhanced training and support for direct care workers, especially those in their first few months of employment (e.g., peer support programs, individualized hands-on training, frequent supervisor check-ins).

5. **Improve training, education, and career pathways for current and future workforce:**
    - Enhanced training and support on specific challenging topics including end-of-life care, dementia, and behavioral health challenges such as substance use, serious mental illness.
    - Provide training in a multitude of formats including on-demand virtual, video-based, reading, self-paced, classroom, hands-on, discussion, case studies, webinar, etc.
    - Partner with educational institutions to develop new and connect workers with existing apprenticeship programs including CNA and LPN pathways.
        - Look at promoting career pathways outside of the nursing trajectory (e.g., social work, counseling, occupational therapy, speech and language pathology, etc.).
    - Offer tuition assistance, financial aid and scholarships, paid training, and raises associated with specialized certifications.
    - Explore micro-credentialing, coaching, mentoring, and leadership development opportunities.

6. **Develop a widespread awareness campaign that promotes direct care as a skilled workforce:**
    - Stress the honorable and crucial nature of the work.
    - Communicate honestly the challenges and rewards of the career.

7. **Nurture a more collaborative relationship between facilities and regulators:**
    - Create learning and capacity building opportunities instead of punitive measures.

Conclusion

This qualitative research highlights the voices of AL/RC direct care staff, former direct care staff, residents, administrators and management representatives to understand how workplace belonging and inclusion can promote well-being.

Across all participant groups, respondents shared their love for the job and their passion for caring for older adults. Among former direct care workers, feeling the joy of helping people, particularly older adults. As detailed by the participants in this study, discrimination can happen overtly and subtly. In many instances, overt discrimination can be easier to address and handle, while subtle forms of discrimination happen daily and many times are invisible or look like unspoken norms. Treating everyone the same or not having standards for communicating with residents who do not speak English are examples of subtle forms of discrimination. These can create barriers to socialization, cultural inclusion, belonging, or feeling part of the community where care staff work or residents live. Residents from different cultural backgrounds may need different things like certain foods, or may celebrate different holidays or events that are not mainstream and well-known. Diversity needs to be defined broadly starting with race, but not only by race. All cultures and communities have prejudices and preconceived notions about different cultures; therefore, everyone can use DEIA and cultural competency training to support cultural humility, belonging and inclusion in AL/RC communities.

With high turnover rates among direct care staff, one of the biggest issues that participants and policymakers alike want to understand and address is why care staff leave this crucial work of caring for our growing older adult population. Former direct care workers shared their reasons for leaving, such as low pay, understaffing, discrimination, lack of work-life balance, inadequate training, burnout and other mental health reasons involved with the work, various types of abuse from residents, injuries, and seeking career development. Some cited issues with management, such as poor communication, profit motive over resident care, tensions between care shifts, and chaotic management. Current direct care workers echoed the stresses of many of these same elements of the job.

The key components of the U.S Surgeon General's Framework on Workplace Mental Health and Well-Being and the above recommendations from study participants provide guidance for supporting the many challenges care staff experience in their difficult, yet crucial work, and for developing a robust direct care workforce in Oregon's assisted living, residential care, and memory care communities.

Appendix A. Study Methods

This qualitative study collected data using primarily focus group and individual interviews with five groups of participants, as follows.

1) **Direct care workers** (also called caregivers, resident care assistants, personal care aides, among other titles) (n=103) from 49 unique assisted living, residential care, and memory care communities across Oregon signed up to participate in a focus group interview. Of these, 24 took part in group interviews and 1 in an individual interview (originally scheduled as a focus group), for a 24 percent participation rate. We conducted 9 focus group interviews online (via Zoom) with 25 direct care staff employed in AL/RC communities, including some endorsed for memory care. Two focus groups were offered in Spanish, though only one of these groups was ultimately conducted due to participant attendance. Focus group interviews took about one hour to complete. Resident care assistants received a $50 incentive for their time and participation in the study. These staff worked in 23 unique AL/RC communities across the state of Oregon, with 10 from Portland Metro, 9 from Willamette Valley/North Coast, 5 from East of Cascades, and 1 from Southern Oregon/South coast (Table A1). See Appendix B for focus group interview questions.
2) **Former direct care workers.** We conducted 4 individual phone interviews and collected 5 voice memos for a total of 9 former resident care assistants; 3 were from Willamette Valley/North Coast, 2 were from Portland Metro, 1 was from East of Cascades, and 3 participants did not provide this information. Former resident care assistants received a $50 incentive for their time and participation in the study. Phone interviews and voice memos took between 30 minutes and one hour to complete. See Appendix C for focus group interview questions.
3) **Administrators**. We conducted 9 interviews with administrators from AL/RC communities; 8 were conducted online (via Zoom) and 1 was conducted by phone. Of the administrators interviewed, 3 were from East of Cascades, 2 were from Willamette Valley/North Coast, 2 were from Portland Metro, and 2 did not provide this information. Interviews took about one hour to complete. These administrator participants have been in the fields of healthcare or caregiving for between 9 and 30 years. All have worked their way up from entry-level positions in healthcare or caregiving positions to the administrator role. See Appendix D for focus group interview questions.
4) **Management representatives**, including owner/operators, human resources specialists, directors of operations, among other titles. We interviewed 7 management representatives online (via Zoom). Interviews took about one hour to complete. Management representatives that we interviewed came from companies that oversee

communities throughout the Pacific Northwest. See Appendix E for focus group interview questions.

5) **Residents** currently residing in assisted living, residential care, or memory care communities. Our team conducted 18 in-person interviews with residents of AL/RC communities. Participants were primarily from Portland Metro including 17 participants from Multnomah and Clackamas counties, while 1 participant was from Willamette/North Coast. Interviews took between 30 minutes and one hour to complete. Residents received a $50 cash incentive for their time and participation in the study. See Appendix F for focus group interview questions.

All participants were recruited with support from Oregon Care Partners, Oregon Health Care Association (OHCA), Livewell, Leading Age, Oregon Healthy Aging, AL/RC administrators, and senior housing professionals. All interviews were audio-recorded, transcribed, and analyzed as described in 'Thematic Analysis' below. The Portland State University Institutional Review Board reviewed and approved the study (protocol # 227818-18). To protect participants' privacy, their names and other identifying information are not included in this report.

Qualitative Data Analysis

The Study Team

This project's research team at IOA/PSU was comprised of individuals with many years of experience conducting qualitative research. In addition, Drs. Kohon and Carder have taught several research methods courses. Drs. Kohon, Carder, Dys, and Rodriguez collectively have previous experience interviewing AL/RC residents, family members, direct care staff, administrators, among others. Dani Himes, Diana Jacoby, and Madeleine Fox have previous experience supporting interviews of direct care staff and administrators. All study team members have experience with thematic qualitative analysis.

Thematic Analysis

Thematic analysis is a type of qualitative analysis in which data are synthesized and categorized into themes. These themes represent the underlying meaning and findings within the data. In this study, we used iterative thematic analysis, which consists of four main phases: 1) identifying initial perspectives and beliefs, 2) using data to build, expand, or challenge these initial perspectives, 3) listing preliminary themes, and 4) evaluating themes.[11]

[11] Morgan, D. & Nica, A. (2020). Iterative thematic inquiry: A new method for analyzing qualitative data. International Journal of Qualitative Methods, 19, 1-11. https://doi.org/10.1177/1609406920955118

In Phase 1, the research team at IOA/PSU collaborated with ODHS to discuss study goals, identify priorities, and develop interview guides based on existing perspectives, existing beliefs, previous study findings, and current socio-political context of AL/RC direct care workforce concerns in Oregon. IOA/PSU also collaborated with external colleagues actively working in AL/RC management who provided additional feedback on interview guides.

In Phase 2, scheduling and conducting individual interviews with management kicked off data collection, followed by individual interviews with administrators. Individual interviews were conducted with only one moderator. Focus group interviews were scheduled and conducted with direct care workers. Two focus group interviews were offered in Spanish while all others were moderated in English. Focus group interviews were comprised of a moderator and a notetaker and between two and five participants currently working in direct care roles in AL/RC. At the conclusion of each focus group interview, the research team would debrief and reflect on the interviews to summarize topics and categories of the discussion in a brief memo. These reflections included summaries of the interview conversation, general themes that emerged, researchers thoughts about how the focus group interview went, as well as how well the online format may have influenced participants' level of engagement in the discussion.

Former direct care workers were recruited for voice memo data collection. A voice memo is a brief audio recording completed by the participant, in which they respond to a list of questions provided following signing up for participation in the study. Anticipating that this group would be particularly challenging to recruit, we chose this method as a way to potentially simplify participation and make the process more accessible in terms of time and privacy. After not receiving many completed voice memos, we decided to offer an additional phone interview option for participants. Individual interviews were then scheduled with residents. All resident interviews were conducted in-person.

In Phase 3, transcribed interviews and memos were compiled by participant type and used to generate a preliminary list of themes. The research team used Excel and Google Sheets to organize the data for analysis with separate sheets for each of the five participant types and columns for each question and associated responses. The research team then completed multiple readings of the interview data, including reading each entire interview transcript from start to finish and then reviewing responses across interviews for each specific question for each participant type. The research team was then divided into "Theme Teams" to review responses for each participant type. Research team members were organized for these "Theme Teams" to include at least one member who had participated in data collection for that participant type and at least one member who had not participated in that part of data collection or had only minimal involvement in that segment of data collection. This organized allowed for more varied perspectives on the data, included at least one member more

immersed in the data and at least one member reviewing with fresh eyes. "Theme Teams" met to discuss responses from their designated participant type and summarized key findings and key themes into a summary memo for each participant type.

In Phase 4, the whole IOA/PSU research team then met internally over a period of one month to discuss key findings and key themes across participant groups. This process of sorting and sifting generated an initial list of themes with supporting quotations sourced from interview transcripts. These themes were then folded into the U.S. Surgeon General's Framework for Workplace Mental Health and Well-being where appropriate. The initial themes and subthemes were prepared in an interim report that was shared with ODHS for feedback. Feedback was integrated to create a final list of themes and subthemes in a final report of findings.

Demographics of study sample and participants

The following tables detail the demographics of our study sample and participants. Totals may not always add up to participant totals due to non-response to some questionnaire items.

Table A1. Demographics of Study Sample and Participants: Direct Care Workers

Characteristics	Study Sample (N=103)	Participants (N=25)
Gender		
Man	15	6
Woman	86	17
Non-Binary	2	0
Race/Ethnicity (alone or in combination)		
African American/Black	9	3
American Indian/Alaskan Native	4	0
Asian/Asian American/South Asian	3	0
Hispanic/Latinx	13	5
Native Hawaiian or Pacific Islander	2	1
Non-Hispanic	70	14
Age (years)		

Under 20	1	0
20-29	35	7
30-39	21	5
40-49	20	5
50-59	17	3
60-69	6	3
70+	2	0
Sexual Orientation		
Asexual	7	1
Bisexual	13	2
Gay	2	2
Lesbian	2	0
Pansexual	2	0
Queer	1	0
Straight	66	13
Years Working in CBC		
0-2	26	6
2-5	27	5
5-10	21	4
10+	27	6
Language (primary)		
English	96	18
English and Spanish	5	4
English and Another Language	2	2
Disability		
Yes	28	0
Works More Than One Job		

Yes	28	0
No	73	0
Region		
Southern OR/South Coast	11	1
East Of Cascades	7	5
Willamette Valley / North Coast	39	9
Portland Metro	27	10

Table A2. Demographics of Study Sample and Participants: Former Direct Care Workers

Characteristics	Study Sample (N=29)	Participants (N=9)
Gender		
Man	6	2
Woman	20	6
Non-Binary	2	0
Transgender Man	1	0
Race/Ethnicity (alone or in combination)		
African American/Black	4	2
American Indian/Alaskan Native	3	1
Asian/Asian American/South Asian	1	1
Hispanic/Latinx	5	2
Native Hawaiian or Pacific Islander	1	0
Non-Hispanic	15	1
Age (years)		
Under 20	1	1
20-29	8	1

30-39	7	3
40-49	7	1
50-59	6	2
Sexual Orientation		
Asexual	1	0
Bisexual	4	1
Gay	2	1
Lesbian	1	0
Pansexual	2	0
Queer	1	0
Straight	16	6
Years Working in CBC		
0-2	11	4
2-5	4	0
5-10	9	3
10+	5	1
Language (primary)		
English	26	4
English and Spanish	3	3
English and Another Language	1	1
Disability		
Yes	5	2
Region		
Southern OR/South Coast	8	0
East Of Cascades	3	1
Willamette Valley / North Coast	8	3

Portland Metro	8	2

Table A3. Demographics of Study Sample and Participants: Administrators

Characteristics	Study Sample (N=17)	Participants (N=9)
Gender		
Man	1	0
Woman	16	6
Race/Ethnicity (alone or in combination)		
African American/Black	1	0
American Indian/Alaskan Native	1	0
Hispanic/Latinx	1	0
Non-Hispanic	13	6
Age (years)		
20-29	2	0
30-39	1	0
40-49	5	2
50-59	6	2
60-69	2	2
Sexual Orientation		
Bisexual	1	1
Straight	10	3
Years Working in CBC		
0-2	2	1
2-5	1	0
5-10	4	1
10+	10	5
Language (primary)		
English	15	6

English and Another Language	1	1
Disability		
Yes	3	1
Region		
Southern OR/South Coast	1	2
East Of Cascades	5	3
Willamette Valley / North Coast	6	2
Portland Metro	3	2

Table A4. Demographics of Study Sample and Participants: Residents

Characteristics	Participants (N=18)
Gender	
Man	10
Woman	8
Race/Ethnicity (alone or in combination)	
African American/Black	2
American Indian/Alaskan Native	1
Non-Hispanic	15
Age (years)	
40-49	2
50-59	2
60-69	4
70-79	2
80-89	6
90+	1
Sexual Orientation	
Bisexual	1

Gay	6
Straight	8
Years living in CBC	
0-2	9
2-5	4
5-10	4
10+	1
Language (primary)	
English	18
Nanfanara	1
Disability	
Yes	17
Region	
Southern OR/South Coast	0
East Of Cascades	0
Willamette Valley / North Coast	1
Portland Metro	17

Appendix B. Direct Care Worker Focus Group Interview Questions

1. To begin, please tell me a little about yourselves and the work you do? Let's start with [FIRST NAME]
    a. How long have you worked in your current job? What shift do you usually work?
    b. How long have you done this type of work (as a resident care assistant)?

2. We all bring many parts of ourselves to our work, such as our culture, faith, and other backgrounds. In what ways does your workplace feel like an inclusive environment?
    i. Can you talk about a specific example of how your coworkers, managers, and others at work support you to be yourself?
3. We know there are many other types of diversity represented in the workforce including racial, ethnic, cultural, disability, gender, sexual orientation, age, and many others.

    a. Does your workplace have policies and procedures in place to support diversity? [Probe: Such as clearly identified goals, diversity statement, diversity team, support for cultural events, religious holidays recognized by supervisors Structural: Do they have mandatory DEIA training sessions? Talk about cultural humility? Employee handbooks and trainings in different languages?]
    b. How do the relationships formed between staff members and managers creates/supports culture of inclusion?
    [Probe: Can someone give me a specific example?]
    c. Has there been a time when staff members have felt discriminated against or treated unfairly by your employer or co-workers because of their identities?
    d. Has there been a time when you felt discriminated against or treated unfairly by your employer or co-workers?
    e. For anyone whose workplace isn't doing such a good job at recognizing the diversity of their workers, why do you think that is?
        i. What would you like to see change to better respect workers for who they are, create an inclusive workplace, to make people feel that they belong?
4. Residents also come from many different backgrounds and life experiences. [Privacy reminder, if needed]

    a. Would someone be willing to share a time when you felt discriminated against or treated unfairly by a resident or residents' family because of your skin color, gender, culture, faith, native language or accent, or something related to your identity or background?
    [Probe: or something you heard about that happened to a coworker, for example]
    [Probe: For example a resident commented on your accent or your level of education.]

b. Has anyone felt that you could not support a resident very well because of their skin color, gender, culture, faith, native language or accent, or something related to their identity or background? Can you tell us about that?
   [Probe: For example a resident asks you to pray with them and that makes you uncomfortable.]
   i. Did you take any actions to try to support them better? For example, discuss with a supervisor or coworker?
      1. If yes, what did you do? If no, why not? [Probe: How did you learn these strategies or actions? On the job, orientation training, etc.?]
c. How do person-centered care plans support residents' different cultural or religious backgrounds and other individual identities?
   i. How do these plans play into how you interact with residents?
   [Probe: Some aspects of culture that could be in care plan can include: food, language, family structure and responsibility, time orientation, decision making, personal space, communication style]

5. STAFFING Hiring and retaining staff has been a big challenge for long-term care communities. What do you think could be done to keep resident care assistants and to reduce turnover in the industry? [Probe: What could upper management do to support the workforce? What could administrators do? Anyone else?]

6. We'd like to hear your thoughts about safety and security at work.
   a. Do you feel safe from injury, illness, discrimination, bullying, microaggressions, and harassment at work?

These next questions are about your experiences with extreme weather events or climate emergencies such as heat waves, wildfires, smoke, ice storms, power outages, or flooding.

7. Have you experienced any of these things while working as a resident care assistant?
   a. How did it affect your work as a resident care assistant? [probe: difficult to pass meds, unable to get to work, increased resident illness]
   b. And personally?
      i. What barriers did you experience, if any?
         [probe: transportation, childcare, psychological or physical distress]
   c. How did management respond?
   d. Do you feel informed and prepared with the community's policies and plans for future extreme weather events or disasters if they were to occur?
   e. Any suggestions for improvement?

Just a couple of final questions to wrap things up…
8. We have heard about challenges that many of you experience in your work, such as (…examples from what has been shared) as well as some ways of improving the job of resident care assistants. Is there anything that we should have asked or talked about today that didn't come up?

[If needed:] What are some of the most important reasons why you do this type of work?

Appendix C. Former Direct Care Worker Interview Questions

1. To begin, please tell me a little bit about yourself and the work you do?
    a. How long did you work in long-term care settings such as assisted living and residential care facilities?
    b. What brought you into that field?
    c. What did you enjoy most about the work?
    d. What did you enjoy the least about working as a resident care assistant?
2. Why did you quit working as a direct care professional?
    a. When did you leave the profession?
    b. What are some of the challenges you faced in your work as a direct care worker?
    c. What were some positive experiences?
    d. What do you think the general public does not understand about the work you did as a direct care worker?
    e. Is there anything that could change about the way that assisted living/residential care facilities are run that would bring you back to doing this kind of work?
    f. What industry did you go to after leaving long-term care?
    g. There are staffing shortages in long-term care; what do you think ODHS could do to promote and support a more robust direct care workforce?
3. People who work in care settings are racially, ethnically and culturally diverse. There are many other types of diversity to consider too, including disability, gender, education level, economic status, family status, sexual orientation, faith, native language, age, and many others.
    a. What are some ways that assisted living or residential care facilities support belonging and inclusion of workers with diverse identities and backgrounds?
    b. What about the place where you worked made you feel (or not feel) safe, supported, and secure?
4. Residents also come from many different backgrounds and life experiences.
    a. Has there been a time when you felt treated unfairly by a resident or residents' family because of something related to your identity, background, or life experiences? Can you tell us about that?
        i. If you haven't experienced this, have you seen or heard of a co-worker being treated unfairly?
    b. Have you ever had a difficult time supporting a resident because of something related to their identity, background, or life experiences? Can you tell us about that?
        i. If you haven't experienced this, have you seen or heard of a co-worker treating a resident unfairly?
    c. In either example, did you take any actions? For example, discuss with a supervisor or coworker? What did you do? What did they do?
5. Part of this study is about trying to understand why direct care workers are leaving these jobs and leaving the work of caring for older adults in assisted living and

residential care settings. What do you think are some of the reasons why people leave this type of direct care work?

6. We have heard about challenges that you have experienced in your work as well as some ways of improving the job of resident care assistant. Is there anything that we should have asked or talked about today that didn't come up?

    a. [If needed:] What are some of the most important reasons why you were involved in this type of work?

Appendix D. Administrator Interview Questions

1. To begin, please tell me a little bit about yourself and the work you do?
    a. How long have you worked here (in this assisted living/residential care community)?
    b. Have you worked in other communities or had other jobs in long-term care or aging services?
        i. If you started out as a resident care assistant or similar role, what was your path to administrator?
    c. If you've worked in other communities, why did you leave?

2. Residents and care staff come from many different racial, ethnic, and cultural backgrounds and identities. There are many other types of diversity represented in the workforce too, including disability, gender, socioeconomic status, sexual orientation, and age.

    a. Can you tell me about the ways [name of community] supports resident and staff backgrounds, identities, and cultures? [probe: training, policies, clearly identified goals, cultural events, diversity team, etc.]

    [Probe: other identities? Familial responsibilities? Specific aspects of culture including food, education, time orientation, decision making, personal space, communication…]

3. Giving or receiving care to or from people from other backgrounds or identities can present some challenges. Can you tell me about a time there was a challenging or negative interaction between a care provider and a resident due to a difference in background, culture, faith, native language or accent, or for any other reason? [Probe: How was this interaction resolved? Ongoing?]
    a. How about a positive interaction?
    b. Do you have policies in place for when these issues arise? How do you communicate these policies to residents and staff?

4. Do you have policies in place for accommodations related to language (for residents and staff)? What do you see as your responsibility when it comes to meeting language needs? Would you recommend a different setting when you can't meet a resident's communication needs?
    [Probe: other similar scenarios related to cultural or religious diet, etc.?]

5. Now, I'd like to look at this visual together of the US Surgeon General's Framework for Workplace Mental Health & Well-being [link].

    Considering this framework, what are some examples of how your community supports diversity, equity, and inclusion? How do you support direct care workers and residents in each of these domains? [You can discuss them one-by-one or altogether, whichever works best for you.]

    [Probe: Centering worker voice and equity in the following areas:

-Protection from harm (safety and security)
-Connection and community (social support and belonging)
-Work-life harmony (autonomy and flexibility)
-Mattering at work (dignity and meaning)
-Opportunity for growth (learning and accomplishment)

   a. Can you provide examples of when efforts to support have gone well? Or when they've failed?

6. Think about what it's like to live and work in this community - things like visitor policies, pet policies, food options, events, rules, and schedules. How do you seek input and feedback from residents and staff about these things?

7. Do you have any suggestions for ways that state policymakers can address diversity, equity, and inclusion challenges in assisted living, residential care, and memory care?

8. Staffing has been a big challenge for long-term care communities. What do you think could be done to retain a strong direct care workforce and to reduce turnover in the industry? [Probe: What could upper management do to support the workforce? What could other administrators do? What could ODHS do? Anyone else?]

9. This question is about your experience with extreme weather events or other climate related emergencies such as heat waves, wildfires, smoke, ice storms, power outages, or flooding. Did you experience any of these things while working as the administrator at this community? What impacts did it have on you / your long-term care community? [probe: transportation; childcare; psychological or physical distress]
   a. How did you respond?
   b. How have you / are you preparing for future extreme weather events? Including, how are you communicating with and preparing residents and direct care staff?
   c. Does your facility have a backup generator?
   d. Suggestions for your community? For ODHS to support long-term care communities in these situations?

10. You've talked about some of the experiences you've had while working as an administrator in this community. Is there anything that we should have asked or talked about today that didn't come up?

Appendix E. Management Interview Questions

1. To begin, please tell me a little bit about yourself and the work you do?
    a. How long have you worked at this management company?
    b. Have you had other roles in long-term care or aging services?
    c. What brought you to this type of work?

2. Residents and care staff come from many different racial, ethnic, and cultural backgrounds and identities. There are many other types of diversity represented in the workforce too, including disability, gender, education, socioeconomic status, family status, sexual orientation, and age.

    a. Can you tell me about the ways [name of company] supports resident and staff backgrounds, identities, and cultures? [probe: training, policies, clearly identified goals, cultural events, diversity team, etc.]

    b. Does [name of company] have a policy, value statement, or framework related to diversity and inclusion? (if yes) Can you tell me what it is? (or send it to me via email)

    [Probe: other identities? Familial responsibilities? Specific aspects of culture including food, education, time orientation, decision making, personal space, communication…]

3. Giving or receiving care to or from people from other backgrounds or identities can present some challenges. How do you support administrators in addressing challenging or negative interaction between care providers and residents due to a difference in backgrounds, cultures, or identities?
    a. How does your company promote positive interactions in light of these differences?
    b. Do you have policies in place for when these issues arise? How do you communicate these policies to residents and staff?

4. Do you have policies in place for accommodations related to language (for residents and staff)? What do you see as your responsibility when it comes to meeting language needs? Would you recommend a different setting when you can't meet a resident's communication needs? [Probe: other similar scenarios related to cultural or religious diet, etc.?]

5. Now, I'd like to look at this visual together of the US Surgeon General's Framework for Workplace Mental Health & Well-being [link] & PDF Link.

Considering this framework, do you have specific requirements or tools for your communities to support diversity, equity, and inclusion? How do you promote the support of direct care workers and residents in each of these domains? [You can discuss them one-by-one or altogether, whichever works best for you.]

[Probe: Centering worker voice and equity in the following areas:
-Protection from harm (safety and security)
-Connection and community (social support and belonging)
-Work-life harmony (autonomy and flexibility)
-Mattering at work (dignity and meaning)
-Opportunity for growth (learning and accomplishment)

   a. Can you provide examples of when efforts to support have gone well? Or when they've failed?

6. Think about what it's like to live and work in the community - things like visitor policies, pet policies, food options, events, rules, and schedules. Does your company have a policy for seeking input and feedback from residents and staff about these things? Can you tell me about that? Does each community approach this differently?

7. Do you have any suggestions for ways that state policymakers can address diversity, equity, and inclusion challenges in assisted living, residential care, and memory care?

8. Staffing has been a big challenge for long-term care communities. What do you think could be done to retain a strong direct care workforce and to reduce turnover in the industry? [Probe: What can you / operations directors / CEOs do to support the workforce? What could administrators do? What could ODHS do? Anyone else?]

9. This question is about your experience with extreme weather events or other climate related emergencies such as heat waves, wildfires, smoke, ice storms, power outages, or flooding. Did you experience any of these things while working as you've worked for this company?
   a. How did you respond in order to support the affected communities?
   b. How have you / are you preparing for future extreme weather events? Including, how are you communicating with and preparing administrators?
   c. Do all of your communities have backup generators?
   d. Suggestions for improving disaster preparedness within/across your communities? Suggestions for ODHS to support long-term care communities in these situations?

10. You've talked about some of the experiences you've had while working in this industry. Is there anything that we should have asked or talked about today that didn't come up?

Appendix F. Resident Interview Questions

1. To begin, please tell me a little bit about yourself.
    a. How long have you been living here (in this AL/RC community)?
    b. Have you lived in any other communities like this before?
2. Residents come from many different racial, ethnic, and cultural backgrounds and have different beliefs.There are many other types of diversity too, including disability, gender, sexual orientation, and age.
    a. Can you tell me about the ways you feel that your background, identities, and culture are supported at [name of community]? [Probe: other identities? professional or personal roles you've held?]
    b. Are there ways in which your background, identities, and culture are NOT supported? [Can you tell me about some examples of times when you didn't feel supported because of your background, identities, and culture]?
    c. What are some examples of how management and care staff support diversity, equity, and inclusion at [name of community]? [Probe: Do they have mandatory DEIA training sessions? Policies, clearly identified goals, diversity statement, diversity team, cultural events, etc.]
        i. Do you have suggestions for ways that management, care staff, and state policymakers can address challenges?
3. Care staff are quite racially, ethnically, and culturally diverse nationally as well as in Oregon. How important is it for your care providers to:
    a. Speak your native or primary language?
    b. Belong to the same racial or ethnic group?
    c. Be of the same gender as you?
    d. Be open to different treatments, such as acupuncture, massage, spiritualism, nutritional supplements, and so forth?
    e. Understand your culture?
        i. Specific aspects of culture including food, education, time orientation, family relationships, decision making, personal space, communication…

    [Probe: can you tell me more about why that's important to you?]
4. Living with and receiving care from people from other backgrounds or identities can present some challenges. Can you tell me about a time when you had a challenging or negative interaction with a care provider because of a difference in backgrounds or identities? [Probe: this could be a misunderstanding, care delivered in a way that felt uncomfortable, etc.]
    a. How did care staff and management get involved?
        i. [Probe: was the situation resolved? Ongoing?]
    b. How about a positive interaction?

c. What about a negative or positive interaction between neighbors? This could involve you or other residents (please don't share their names). How did care staff and management get involved? [Probe: was the situation resolved? Ongoing?
d. Have you seen or heard about challenging or negative interactions that happened to others in your community at [name of community] that occurred because of a difference in backgrounds or identities? Or for other reasons?

5. Did you feel a sense of belonging when you moved in? Why or why not?
    a. If yes, what did care staff and management do to help you to feel a sense of belonging?
    b. If no, what could care staff and management have done to help you to feel a sense of belonging?
6. What does your community feel like when/if you perceive that care staff are well supported? [examples, such as fully staffed, not overworked, adequately compensated, etc.]

    a. What about when you perceive there to be a shortage of care staff and/or they don't seem supported?

7. Think about what it's like to live in this community - things like visitor policies, pet policies, food options, events, rules, and schedules. How do management and care staff seek input and feedback from residents about these things? [Probe: resident meetings, surveys, comment box, face-to-face, etc.]

8. This question is about your experience with extreme weather events or other climate related emergencies such as heat waves, wildfires, smoke, ice storms, power outages, or flooding. Did you experience any of these things while living in this community?

    a. How were you affected? How did the community's management and staff respond?

    b. Do you know the community's policies and plans for future extreme weather events or disasters if they were to occur?

        i. Do you feel confident in your community's ability to maintain care should these events occur in the future?

    c. Are there any suggestions you have for improving preparedness or response at your community?

9. You've talked about some of the experiences you've had while living in this community. Is there anything that we should have asked or talked about today that didn't come up?