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The need for leadership training in long-term care settings

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Abstract

Purpose – Globally, in 1980, approximately 5.8 per cent of the world population was 65 years old and older. By 2050, this number will more than triple to 16 per cent. From a leadership perspective, there is at least one challenge (among many others challenges) to consider. This paper (viewpoint) aims to provide support for the growing need for academically prepared managers.

Design/methodology/approach – This paper is a viewpoint which presents several characteristics of the long-term care (LTC) field that support the need for academically trained leaders.

Findings – LTC leaders in all countries must be sufficiently versed in numerous management areas to provide leadership when called on by those assigned to their care. Given local area variations in population needs present across all countries, it may be unwise to advocate for national, countrywide standardization of requirements. Yet, older adults accessing LTC services should expect a minimum level of knowledge from all of their providers – not just those who provide direct, hands-on care. However, similar to those who provide direct care, leaders should receive competency-based education with specific attention to effective communication skills, team-based approaches to care delivery, information technologies and population health.

Originality/value – Although much of the extant literature focuses on the delivery of care to older persons, there is a dearth of literature addressing the role of LTC leaders in light of global aging. Establishing a minimum level of academic training and increasing transparency focused on the positive experiences of elders residing in LTC facilities should help dispel the notion that placement in an LTC facility reflects filial failure.

Keywords Viewpoint, Leadership

Paper type Viewpoint

"The global boom in aging might be the most important phenomenon of our time", said Jack Rosenthal, co-founder of Age Boom Academy (Eisenberg, 2015). Changes are happening across all countries, regardless of the level of economic development. According to data from the United Nations (n.d.), globally, in 1980, approximately 5.8 per cent of the world population was 65 years old and older. By 2050, this number will more than triple to 16 per cent. The percentage of people over 80 years of age, i.e. those with the greatest need for long-term care (LTC) services, will increase from 0.8 per cent in 1980 to 4.5 per cent by 2050. Recognizing the critical nature of this global trend prompted the editors of one journal to create a section specifically devoted to country-specific perspectives on population aging (McCutcheon and Pruchno, 2011). The message of these articles and many others specific to this topic is that global aging is upon us and ignoring it is not a choice for governments or health care providers. Although much of the extant literature focuses on the delivery of care to older persons,

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there is a dearth of literature addressing the role of health-care leaders in light of this emerging trend. From a leadership perspective, there is at least one challenge (among many others challenges) to consider, specifically, the growing need for academically prepared managers.

Although it may be argued that leaders in LTC settings need the same skill sets as leaders in other health-care settings, Dana and Olson (2007), contend that the nature of LTC organizations and clients demand a unique set of skills or traits. More specifically, "[…] the high interaction of people, the regulatory-driven environment, a predominantly non-professional work force, a flat organizational structure, the frequent change in leadership positions, and a lack of understanding and sensitivity of governing authorities" require individuals who are creative, compassionate, innovative, and good communicators (p. 1). Though the extent to which these characteristics applied to a given country may vary, LTC leaders in all countries must be sufficiently versed in these areas to provide leadership when called on by those assigned to their care. Although not all of these traits may be taught in an academic setting, there should be a minimum level of academic training necessary to prepare individuals for a successful LTC career.

Academic training of LTC administrators vary by the type of facility and country. For instance, in England, there are minimum standards for those who manage organizations that deliver care to older adults (www.cqc.org.uk/; www.skillsforcare.org.uk/home.aspx). However, there is no requirement specific to training in management or leadership. In the USA, all nursing home administrators and most assisted living administrators must be licensed. In some states, a prerequisite for the licensure examination is a college degree. Yet, in other states, there are no such requirements. Thus, individuals with a high school diploma may train for these positions without academic training beyond high school. Essentially, as each state may establish its own rules for licensure, there is no requirement or standardization across states. Given state-by-state and country-by-country population needs, it may be unwise to be an advocate for national, country-specific standardization of requirements. Yet, older adults accessing LTC services should expect a minimum level of knowledge from all of their providers – not just who that provide direct, hands-on care. However, similar to those who provide direct care, leaders should receive competency-based education with specific attention to effective communication skills, team-based approaches to care delivery, information technologies and population health (World Health Organization, 2015).

Research supports the premise that LTC administrators will develop a given leadership style based on numerous factors, not the least of which may be associated with the leader's age, type of facility, staffing characteristics, etc. (Carr-Marcel, 2014; Castle *et al.*, 2009). Research further purports a positive link between leadership style and organizational performance (Carr-Marcel, 2014; Griffith *et al.*, 2013). Thus, having a clearly defined style of management can lead to important benefits to both the LTC facility and to the residents residing in those facilities. Thus, adding the component of academic training with specific focus on management or courses in leadership should aid the novice develop the competencies necessary for choosing a particular style of leadership and to understand why certain styles may be ineffective in this setting.

One of the challenges of global aging is the need for formal LTC services in light of the *myth* of families caring for their elders (Eisenberg, 2015). Given the aforementioned trends in aging coupled with the decreasing fertility rate, there often is no one available to care for an aging loved one at home. Thus, the formal system

must become a positive resource for families when a loved one requires services. Some countries are struggling with the perception (and reality) that those receiving care in LTC settings are receiving poor care and enduring a poor quality of life (Anonymous, 2013; Harrington *et al.*, 2011). Yet, there are numerous improvements occurring in all parts of the globe. For instance, Alzheimer Europe (www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons) provides information on how European countries are addressing the needs of individuals with dementia. It is clear from their report that LTC facilities in certain countries are developing innovative strategies for improving the quality of life for elders with this condition. In addition to the activities of non-governmental organizations and other relevant agencies, appropriately trained leaders should focus on greater transparency with their stakeholders and the broader community. Sharing the successes of elders living in their communities will help dispel the notion that placement reflects filial failure, and, hopefully, with time, families faced with this decision will seek out those facilities managed by these innovative and visionary leaders (Graupner, 2013).

Establishing a minimum level of academic training and increasing transparency focused on the positive experiences of elders residing in LTC facilities should then help improve our ability to provide resident-centric care. Moving away from the medical model of service delivery in LTC settings will become imperative as the number and type of elders using these services steadily increases. For all countries, a critical mass may lead to greater demands for person-centric care. Key terms such as culture change, home-like, dignity, respect, age-friendly, etc. will take on new meaning. It will no longer be sufficient to imply that elders residing in a LTC setting are respected, but stakeholders will require tangible evidence of activities aimed at creating a home-like environment and resident-centered care. Leaders in these settings may need to develop skill sets that will allow them to achieve long-term viability. The nascent stage of innovation and vision may occur during the academic training period for future LTC managers.

I will close with a quote from Dana and Olson (2007), "the best way to predict the future of long term care is to have effective leaders create it" (p. 22).

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