

BACKGROUND MATERIALS

Nursing Aides, Home Health Aides, and Related Health Care Occupations -- National and Local Workforce Shortages and Associated Data Needs

Executive Summary¹

National Center for Health Workforce Analyses, Bureau of Health Professions, Health Resources and Services Administration

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PREFACE

Nursing aides and home health aides are two of the major occupations responsible for providing patient care of a paraprofessional nature to chronically ill, disabled, and elderly persons in nursing homes and other institutional or community-based settings as well as at home. The challenges faced by long-term care facilities in recruiting and retaining these workers have been increasing in recent years, resulting in reduced services for many Americans.

Recognizing the importance of this segment of the health workforce in meeting the care needs of an increasing percentage of the population, the National Center for Health Workforce Analysis (NCHWA) in the Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHPr) has commissioned and directed this study. The study concludes that informed workforce planning is needed to document the extent of existing shortages in these occupations and thereby assist states and institutions in addressing them, as well as to assess the impact of present and future initiatives to balance supply and demand.

The comprehensive assessment presented in this report was based on a review of eight key Federal datasets, certified nursing aide registries in 45 states, and fieldwork in four states (California, Illinois, New York, and Wyoming). The fieldwork included interviews and focus groups with long-term care providers and State officials to assess both their current data collection activities and the data needed for future program and policy development. The project was guided by an expert advisory panel and interviews with leaders in the long-term care field. These efforts, along with a review of the literature, resulted in (a) confirmation that there exists a widespread shortage of long-term care paraprofessionals and (b) affirmation that the shortage is likely to be far more severe in the future. The report concludes with a series of suggested strategies for improving data collection relating to these occupations, building on existing datasets and data collection activities.

EXECUTIVE SUMMARY

Introduction

This report focuses on nursing aides and home health aides, two of the major occupations responsible for providing patient care of a paraprofessional nature to chronically ill, disabled, and elderly persons in nursing homes and other institutional or community-based settings as well as at home. Faced with an aging population and a material shift of patient care to non-hospital venues, the Nation is experiencing an unprecedented demand for individuals with the training and experience needed to provide such care.

¹ The full paper is available online at <http://bhpr.hrsa.gov/healthworkforce/reports/nursinghomeaid/nursinghome.htm>.

There is a high turnover rate associated with these occupations, the result of a variety of factors relating to job satisfaction, such as low pay, lack of a career ladder, and occasional less than ideal treatment by supervisors. As a consequence, the supply of these individuals, while continuing to grow, has been slipping relative to demand, a situation likely to continue well into the future.

Because of the importance of this segment of the health workforce in meeting the care needs of an increasing percentage of the population, the National Center for Health Workforce Analysis (NCHWA) in the Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHP) has commissioned and directed this study. The study concludes that informed workforce planning is needed to document the extent of existing shortages in these occupations and thereby assist states and institutions in addressing them, as well as to assess the impact of present and future initiatives to balance supply and demand. Current data systems were found to be limited in their ability to assist in such planning efforts. They do not, for the most part, accurately estimate the supply of individuals working in these occupations, including their numbers, locations, characteristics, and qualifications.

The comprehensive assessment presented in this report was based on a review of eight key Federal datasets, certified nursing aide registries in 45 states, and fieldwork in four states (California, Illinois, New York, and Wyoming). The fieldwork included interviews and focus groups with long-term care providers and State officials to assess both their current data collection activities and the data needed for future program and policy development. The project was guided by an expert advisory panel and interviews with leaders in the long-term care field. These efforts, along with a review of the literature, resulted in (a) confirmation that there exists a widespread shortage of long-term care paraprofessionals and (b) affirmation that the shortage is likely to be far more severe in the future. The report concludes with a series of suggested strategies for improving data collection relating to these occupations, building on existing datasets and data collection activities.

Nature of the Problem

Across the United States, there is growing concern about current and projected shortages of frontline, direct care workers who provide care and services to the elderly, chronically ill, and disabled. National studies cite annual turnover rates in nursing homes ranging from 45 to 105 percent (Stone, 2001). In 1999, Ohio's nursing assistant turnover rate ranged from 88 to 137 percent while in Florida, only 53 percent of the state's certified nursing aides (CNAs) were working in a health-related field one year after certification. Long-term care provider organizations have either reduced services due to shortages of permanent staff or, alternatively, hired temporary replacement staff at significantly higher hourly rates (Forschner et al., 2001). In areas where levels of service have been reduced, elderly or chronically ill persons deprived of access to care must either remain in more restrictive, more costly environments (notwithstanding the Supreme Court Olmstead decision affirming the right of nursing-home-eligible people to live in the "least restrictive" setting) or seek care from family or friends. Both quality of care and quality of life suffer as people are denied services, or services are provided by persons less qualified or experienced.

Over the next several decades, as population aging and advances in medicine increase the number of persons living with chronic medical conditions, the need for long-term care workers will continue to grow. The Bureau of Labor Statistics (BLS) projects that between 2000 and 2010, an additional 1.2 million nursing aides, home health aides, and persons in similar occupations will be needed to (a) cover the projected growth in long-term care positions and (b) replace departing workers. This rapid increase in demand--over half the year 2000 supply--can be expected, for similar reasons, to continue well beyond 2010. The pool, however, from which such workers have traditionally been drawn--largely women between 25 and 50 without post-secondary education--continues to shrink. It is questionable, therefore, whether the Nation will have an adequate supply of workers in these occupations to meet the expected increase in demand.

Nursing aides and home health aides provide much of the care in long-term care settings, both in nursing homes and in the community. Policymakers and the health care community have sought to understand the problems in maintaining an adequate supply of such healthcare workers. While some studies have led to an improved understanding of these occupations and the causes of the shortages, they have tended to rely on case studies, focus groups, and data that are incomplete. The lack of system-wide data has weakened efforts to understand the scope of the problem and to develop programs and policies that could address it.

Characteristics of Long-Term Care in the United States

Recipients. Long-term care recipients in the United States numbered about 12.1 million in 1995 (Kaiser Commission on Medicaid and the Uninsured, 1999). A diverse population with a wide age range and variety of service needs, the common element linking these individuals is their need for assistance with activities of daily living (ADL). Most received services at home or in community-based settings such as adult day care facilities, although about 12 percent (1.5 million) were cared for in nursing homes or other institutional residential facilities (ibid.).

As shown in Table ES-1, persons 65 or older constituted slightly over half (6.4 million) of the estimated 12.1 million long-term care recipients in 1995. Within that group, 1.3 million (20 percent) received care in nursing homes; the rest were cared for at home or in community settings. Of those receiving care at home or in the community, about two-thirds relied exclusively on unpaid caregivers, i.e., family and friends (Stone, 2001).

TABLE ES-1. Recipients of Long-Term Care in the U.S., 1995			
Age Group	Setting in Which Care Was Received		All Settings Combined
	Nursing Home	Home or Community	
65 or Older	1.3 million	5.1 million	6.4 million
Under 65	0.2 million	5.5 million	5.7 million
All Ages	1.5 million	10.6 million	12.1 million
SOURCE: Kaiser Commission on Medicaid and the Uninsured, 1999			

The dichotomy between nursing home and community-based care is even more pronounced for persons under 65. Of the nation's long-term care recipients below the age of 65, well over 95 percent--all but about 0.2 million--received care at home or in community settings. Of these, roughly three-fourths relied exclusively on family and friends for care. Long-term care recipients below the age of 65 include persons with mental retardation and serious mental illness, as well as adults living with AIDS or other chronic disorders and children with developmental disabilities.

Providers. The three major categories in the latest (1998) Standard Occupational Classification (SOC) system whose members provide long-term care of a paraprofessional nature are as follows:

Nursing aides, orderlies, and attendants (SOC 31-1012)

Provide basic patient care under the direction of nursing staff. Perform attendants duties such as feeding, bathing, dressing, grooming, moving patients or changing linens.

Home health aides
(SOC 31-1011)

Provide routine personal health care such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons at patient's home or residential care facilities.

Personal and home care aides
(SOC 39-9021)

Assist elderly or disabled adults with daily living activities at person's home or daytime non-residential facilities. Duties may include keeping house and preparing meals. May also provide meals and perform supervised activities at non-residential care facilities.

The number of individuals employed in these categories, based on year 2000 BLS data, are as follows:

Nursing aides, orderlies, and attendants	1,262,000
Home health aides	577,700
Personal and home care aides	366,600
Total	2,206,300

Table ES-2 shows their percentage distribution by industry group in which employed.

TABLE ES-2. Paraprofessional Workers by Industry Group: 2000					
Occupational Category	Industry Group				
	Home Health Care	Nursing and Personal Care	Residential Care	Other	Total
Home Health Aides	32.9%	5.4%	22.3%	39.4%	100%
Nursing Aides, Orderlies, and Attendants	2.7%	51.9%	4.5%	40.9%	100%
Personal and Home Care Aides	30.8%	3.5%	24.1%	41.6%	100%
SOURCE: BLS Occupational Employment Survey					

Approximately 60 percent of the workers in each occupational category are seen to be employed in the three industry groups most clearly associated with the delivery of long-term care (home health care, nursing and personal care, residential care). In addition, a significant portion of those in industries classified as "Other" may also be assumed to have been engaged in the delivery of long-term care. For example:

- A substantial percentage of nursing aides, orderlies, and attendants in industries classified as "Other" work in specialty hospitals that provide long-term care for the chronically ill or rehabilitation/restorative/adjustive services to physically challenged or disabled persons.

- One of every five home health aides in industry groups classified as "Other", as well as one of every ten nursing aides, orderlies, and attendants in that category, work for Personnel Supply Services, i.e., temporary agencies. When employed in that capacity, they too may provide long-term direct care.

There also exists a substantial "gray market" of individuals hired directly by individuals and families, who do not show up as employed in either BLS or other government data systems. One national study found that 29 percent of workers providing assistance to the Medicare population in the home were self-employed (Leon and Franco, 1998a).

Workers in the described occupational categories earn relatively meager wages. In 2000, the median wage for each of these categories was less than \$9 an hour, an annualized salary of less than \$19,000 for a full work-year of 2,080 hours (BLS, National Occupational and Wage Estimates for 2000). Many of these individuals work only part-time. Long-term care paraprofessionals are reported to work only about 30 hours a week on average, reducing their annualized earnings to well below \$15,000. A high percentage (28 percent) live in poverty, and are more likely than other workers to rely on public benefits to supplement their wages (Himmelstein et al., 1996). Among single-parent nursing home and home health aides, 30 to 35 percent receive food stamps (General Accounting Office, 2001). Many also rely on publicly funded health care.

Data from the BLS Current Population Survey (CPS) March Supplement indicate that over 90 percent of the two specific occupations "nursing home aide" and "home care aide" are female, with the vast majority falling between the ages of 25 and 54. A significant percentage of these individuals (12 to 23 percent) are foreign-born, of whom only about a third are naturalized. Contrary perhaps to public perception, a substantial proportion (28 to 35 percent) reported at least some college education.

Provider Organizations. Organizations that draw upon long-term care paraprofessionals to provide needed services include:

- Nursing facilities
- Intermediate care facilities for the mentally retarded
- Residential facilities for adults or aged
- Residential facilities for non-aged
- Adult day care centers
- Home health agencies (certified or licensed)
- Hospice organizations (certified or licensed)

There were approximately 120,000 such organizations in the United States in 1998 (Harrington et al., 1999), of which roughly 43 percent (51,200) were residential facilities for adults or the aged and another 20 percent (23,300) were home health care agencies. Nursing facilities accounted for 15 percent (17,500) and residential facilities for the non-aged for 11 percent (13,300).

In addition to these types of organizations, there are a growing number of alternative organizational and service configurations as consumers and providers seek to expand the options for both health services and housing arrangements for the elderly and chronically ill. Many states have developed Home and Community Based Services (HCBS) options, with a sharp increase in assisted living arrangements and options. In addition, many states are promoting approaches to giving individuals more control over the selection of caregivers under programs generally referred to as "consumer-directed care".

Shortage Issues

Factors affecting supply. The high turnover and vacancy rates associated with these occupations are consistently found to be the result of job dissatisfaction stemming from the following:

- Jobs are physically and emotionally demanding. Many nursing home injuries consist of back problems resulting from lifting or transferring residents, a high rate of injury corroborated by data from the BLS Survey of Occupational Injuries and Illnesses (BLS, 1999). Patient load in many nursing homes is excessive; the consequent pressure to "speed up" results in increased job stress (Wilner, 1994; Foner, 1994; Diamond, 1992).
- Wages and benefits are generally not competitive with other available jobs (Case et al., 2002; Himmelstein et al., 1996).
- Jobs are often not well designed or supervised (Kopiec, 2000), with few or no opportunities for advancement. Workers perceive a general lack of respect from management.

Factors affecting demand. Factors responsible for the increased demand for long-term care include:

- Aging of the population as baby boomers advance to the ranks of the elderly.
- Technological advances that extend the lives of those with chronic ailments.
- The greater availability of services in less restrictive, less costly community settings.

Population aging, in and of itself, might present less of a problem if the supply of care providers were growing at approximately the same rate. Unfortunately, it is not. It is growing at a significantly lower rate-- not only are providers leaving the field for reasons of job dissatisfaction but the pool from which such providers have typically been drawn in the past has been dwindling compared to the growth in demand due to aging. In 2000, there were 1.74 females between the ages of 25 and 54 for every person 65 and older; by 2030, that ratio is projected to drop to 0.92 (calculations based on Census Bureau National Population Projections). Since women provide the majority of both paid and family-provided long-term care, this "care gap" will increase. Families unable to care for their loved ones by themselves will find, when they turn to the formal system for assistance, relatively fewer paid staff available.

Data Issues

Need for Data. Data that are clear, comprehensive, current, and correct are needed in the case of long-term care paraprofessionals, as they are for any other health occupation. Such data are a valuable tool for meeting the following purposes:

- Workforce planning. Providing planners and managers at all levels, especially State and local, with accurate, timely data to help them plan and effectively manage health care delivery.
- Policy formulation. Informing the process by which public policies and programs that could influence workforce supply and demand are generated, e.g., setting reimbursement policies and rates for Medicare and Medicaid, establishing licensure and regulation policies as well as policies involving employee benefits, upward mobility, etc.
- Patient safety. Promoting patient safety by ensuring that individual workers are properly trained and have no record of inappropriate activities.
- Quality improvement. Monitoring the performance of facilities and provider organizations for dissemination to patients and their families.
- Program evaluation. Monitoring and assessing program performance over time and identifying best practices.

- Informing the marketplace. Supplying education and training organizations, health providers, and the public with useful information to serve their individual needs.

Relevant Data Sources. As noted earlier, the data systems reviewed in this study, although helpful in many respects, were limited in their ability to present an accurate and timely picture of nursing aides, home health care aides, and related occupations in the United States. The datasets reviewed included six maintained by the Bureau of Labor Statistics, one on nursing homes maintained by the DHHS Centers for Medicare and Medicaid Services (CMS), one maintained by the Bureau of the Census, and 45 certified nursing aide (CNA) registries maintained at the State level. A brief summary of these datasets follows:

Bureau of Labor Statistics. The six BLS datasets cover six separate aspects of the Bureau's data collection activities:

- Occupational Employment Statistics (OES). A mail survey of 400,000 establishments per year, resulting in a total sample of 1.2 million establishments over three years.
- Current Population Survey (CPS). A monthly survey of 50 to 60 thousand households, conducted on behalf of BLS by the Bureau of the Census (personal and/or telephone interview).
- CPS March Supplement. A somewhat more detailed version of the CPS, conducted once a year on a slightly larger sample.
- National Compensation Survey (NCS). An annual compilation of data on earnings, benefits, and work hours, based on visits to some 36,000 establishments.
- Employment Projections. Projected labor force trends based on analysis of OES and CPS survey results.
- Survey of Occupational Injuries and Illnesses. An annual survey of 250,000 private sector organizations with at least eleven employees to obtain data relevant to occupational safety.

Centers for Medicare and Medicaid Services. The CMS dataset, labeled Online Survey Certification and Registration or OSCAR, consists of staffing data and associated facility characteristics for approximately 17,000 CMS-certified nursing homes. The data are self-reported and updated once a year as part of the CMS annual recertification process.

Bureau of the Census. The decennial Census collects limited data on the occupation of residents of the United States. These data, updated every 10 years, provide estimates of the numbers of persons employed in different occupations by Census tract. The data are tabulated by place of residence rather than employment.

State CNA Registries. Registries of this nature, mandated by the Omnibus Budget Reconciliation Act of 1987, are maintained by every State and the District of Columbia. Used for background checks and other relevant purposes, they contain information on certified, licensed, or registered nursing aides working in skilled nursing facilities (SNFs), although some states have gone beyond the legislative mandate to include other direct care paraprofessionals. Of the 45 State registries reviewed, nine include home health aides as well.

Data Limitations. The limitations presented by these data sources, in terms of meeting the purposes of this study, fall into three categories: data exclusions, inconsistency of definitions, and categorizations that are in some cases excessively broad.

Data exclusions. Important data exclusions are as follows:

- State CNA registries. As noted above, State CNA registries are required by legislation to cover nursing aides only; only a small percentage--less than a fourth--include health aides or other occupational categories as well. Moreover, these systems were designed--and in most cases are being used--to track eligibility (completion of mandatory training) rather than employment. While most State registries include some information of a demographic nature, about a fourth do not. Since most registries do not track the actual employment of eligible CNAs, they do not generally provide information on work setting or location.
- Online Survey Certification and Registration (OSCAR). OSCAR covers staff in nursing homes only. Nursing aides, LPNs, and RNs are the only professions/occupations for which separate tabulations are available.
- BLS Occupational Employment Statistics (OES). OES data, while disaggregated to the State and metropolitan area level as well as to industry group, provide no detail on demographic characteristics, work conditions, or setting in which services are delivered. Also, the numbers do not include self-employed or unpaid family providers of care.
- BLS Current Population Survey (CPS) March Supplement. Since the CPS March Supplement contains no State variable, the employment numbers cannot be disaggregated to the State level.

Inconsistency of definitions. Occupational and industry classifications used have differed by dataset and varied over time. However, as announced in the Federal Register Notice of September 30, 1999, all Federal agencies that collect occupational data are now required to use the 1998 Standard Occupational Classification, the largest revision to the SOC in two decades. In addition, all State and local government agencies, as well as private sector organizations, that gather occupational data are strongly encouraged to use the 1998 SOC. In the words of the announcement, "This national system ... provides a common language for categorizing occupations in the field of work."

While the Federal government has attempted to standardize classifications through the SOC, inconsistencies among state-reported data remain; this includes differing definitions of workers and different methods used to quantify the number of workers.

Excessively broad categorizations. The occupational category "nursing aides, orderlies, and attendants", retained in the 1998 SOC, includes three separate occupations, each with its own set of demographic characteristics, work settings, and job responsibilities. Similar problems exist with respect to the classification of industries: some industry codes contain work settings irrelevant to the provision of direct care, e.g., medical laboratories, youth services, crisis centers, food banks, etc.

Making Workforce Data More Useful

The limitations noted above apply not only to the present study but also to future attempts to achieve a comprehensive assessment of the long-term care paraprofessional workforce at national, state, and local levels. To assure the accurate, comprehensive, timely data needed to support workforce planning in this area and offset possible future shortages, the following options are identified:

Upgrade and augment existing CNA registries. Possible options in this area include:

- Expanding the occupational categories included in the registries beyond nursing aides to include home health aides and personal care aides, with agreed-upon definitions.
- Expanding the recorded data elements to include demographic characteristics, educational background, and current job status, among others.

- Maintaining data timeliness and accuracy by requesting employers to submit annual lists of individuals currently employed, including hours worked and other non-sensitive information.

Adopt and implement state-level workforce data collection systems for nursing aides, home health aides, and related health care occupations. Such systems, using standard definitions and terminology, would permit useful totals and subtotals to be collected from facilities and agencies, to be shared and compared across states. A proposed data collection instrument of this form is shown in Appendix B of this report.

Involve long-term care provider organizations and professional associations in data collection efforts. Such groups would be a valuable source of information. Organizations that collect and maintain informative workforce data report fewer recruitment and retention problems than their relatively data less counterparts.

The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress Executive Summary²

Department of Health and Human Services and Department of Labor
May 14, 2003

PREFACE

In the FY 2002 Senate Appropriations Subcommittee for Labor-HHS Education and the Conference Committee Report for the FY 2002 Labor-HHS Appropriation, Congress requested that the Secretaries of Health and Human Services and Labor identify the causes of the “shortage” of frontline workers (registered and licensed practical nurses, certified nurse aides and other direct care workers) in long-term care settings such as nursing homes, assisted living and home health care. The Subcommittee and Committee requested that the Department of Labor (DOL) and Department of Health and Human Services (HHS) make comprehensive recommendations to the respective Committees to address the increasing demand of an aging baby boomer generation.

This report is a product of collaboration between HHS and DOL in response to the requests from the U.S. Congress. Staff at these Departments worked collaboratively to share information and data pertaining to direct care workers in long-term care settings and to develop a joint set of recommendations for the future. The results of those efforts are presented in this unified Report to Congress. In addition, HHS and DOL included information from the following activities:

- HHS’s recent meetings with state and local policy makers, long-term care providers, direct care workers, researchers, and labor economists on recruitment and retention of direct care workers in long-term care. Topics included: (1) extrinsic rewards and incentives (such as wage and fringe benefits), (2) workplace culture (organizational structures, social factors, physical settings, environmental modifications and technology), and (3) expanding labor pools of direct care workers.
- Survey data from both Departments on the supply of and demand for direct care workers in long-term care settings, including DOL’s industry and occupational employment data from its Occupational Outlook Program and HHS data on the direct care workforce from the National Nursing Survey and the National Home and Hospice Care Study. New projections were developed for some occupational groups.
- Research and practice literature related to the shortage of long-term care workers, including information from surveys of direct care workers, and a review of state-sponsored efforts and provider surveys.

EXECUTIVE SUMMARY

One of the challenges facing the U.S. in the 21st Century will be to ensure that individuals throughout their life will have the supports they need and will be treated with dignity. For the growing population of the elderly and people with disabilities, ensuring the adequacy and availability of direct care workers is key to meeting this ideal. As this report shows, the aging “baby boomer generation” will be the most significant

² The full paper is available online at <http://aspe.hhs.gov/daltcp/reports/ltcwork.htm>.

factor increasing the demand for long-term care services over the next half century. The number of individuals using either nursing facilities, alternative residential care, or home care services is expected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be driven by the growth in the number of elderly in need of such care, which is expected to double from approximately 8 million in 2000 to 19 million in 2050.³

In 2000, approximately 1.9 million direct care workers (defined in this report as including registered nurses (RNs), licensed practical and vocational nurses, nurse aides (NAs), home health and personal care workers) provided care to 15 million Americans in long-term care settings (defined in this report as including nursing and personal care facilities, residential care facilities, and home health care services).⁴ The Bureau of Labor Statistics (BLS) estimates that by 2010, direct care worker jobs in long-term care settings should grow by about 800,000 jobs, or roughly 45 percent.⁵ Paraprofessional long-term care employment will account for 8 percent of the estimated increase in the nation's jobs for workers in occupations generally requiring only short-term on-the-job training.

According to estimates developed by HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), after 2010, the demand for direct care workers in long-term care settings becomes even greater as the baby boomers reach age 85, beginning in 2030. ASPE estimates project the demand for direct care workers to grow to approximately 5.7-6.6 million workers⁶ in 2050, an increase in the current demand for workers of between 3.8 million and 4.6 million (200 percent and 242 percent respectively). This increase in demand will be occurring at a time when the supply of workers who have traditionally filled these jobs is expected to increase only slightly.

These projections indicate that it is critical to retain existing long-term care workers and attract new ones. Since many industries will be competing for the supply of workers, pay and working conditions will play a key role in attracting new workers and consequently influencing the supply of long-term care services. Providing adequate levels of high quality, compassionate care will require sustained effort by many actors. While the Federal Government has an important role to play, much of what needs to be done will require action on the part of current and new employers who will expand and alter the market itself and shape new solutions. Other solutions will inevitably be crafted by state and local governments, health care providers and industry associations, education and training institutions, workforce investment systems, faith-based organizations, and workers themselves.

Recommendations

HHS and DOL identified a comprehensive set of recommendations to address potential imbalances between the future demand for and supply of direct care workers in long-term care settings. The recommendations are geared to address key issues relating to:

- Finding new sources of workers;
- The initial and continuing education of workers;
- Compensation, benefits, and career advancement; and
- Working conditions and job satisfaction.

³ Elderly Long-Term Care Projections, prepared by the Lewin Group for ASPE, draft July 15, 2002.

⁴ Estimates developed by the ASPE Office of Disability, Aging and Long-Term Care Policy, using data from the 1994 National Health Interview Survey, and 2001 Census population projection. For the institutionalized population: 1998 Residential Information Systems Project, 1996 Medical Expenditure Panel Survey.

⁵ Bureau of Labor Statistics, National Employment Matrix, 2000-2010.

⁶ This estimate varies due to different assumptions of the growth rate of home health care. See discussion associated with Table 7 for a more in depth explanation.

The recommendations include:

National Dialogue With Employers: Engage employers and employees as well as medical professionals and state and local government, in a dialogue on issues relating to improved pay, benefits, career ladders, and working conditions in long-term care.

Outreach to Faith and Community-Based Organizations: Explore with faith and community-based organizations their potential roles in addressing shortages in labor imbalances through strengthening relationships with the workforce investment system, and in recruiting volunteers for respite care for family members, “back-up” services, and home-based support.

Enhanced Use of Technology: Explore use of new technology in recruitment, education and training, recordkeeping and patient care. Expand and work with industry to market CareCareers.net.

State and Local Initiatives: Encourage and support state and local efforts, involving both the private and public sectors to explore use of business partnerships with individual employers or consortiums of employers, training providers and public agencies.

Enhanced Training and Education: Support multiple initiatives including implementation of the newly passed Nurse Reinvestment Act, expanding efforts to leverage private sector funds similar to DOL’s Partnerships for Jobs, encouraging states to expand training slots for nurses and paraprofessionals, promoting registered apprenticeship training programs to paraprofessional occupations, and others.

New Sources for Workers: Seek ways to broaden the supply of frontline long-term care workers by reaching out to older workers, former Temporary Assistance for Needy Families (TANF) recipients, military personnel transitioning to civilian life, individuals with recent experience providing care to family members, dislocated workers from other industries and young people.

Support for Informal Caregivers: Continue efforts to support informal caregivers, such as through tax incentives and grants to state and local organizations (e.g., the Administration on Aging’s (AoA) National Family Caregiver Support Program), provide information and referral resources, and explore the effectiveness of respite care demonstrations.

Regulatory Changes: Explore areas for potential federal and state regulatory changes, which could include enhanced information sharing and policy coordination among states, and possible federal requirements on patient recordkeeping.

Worker Safety: Continue to support worker safety education and outreach to employers, such as through DOL’s National Emphasis Program, and through enhanced safety training within schools of nursing and within the paraprofessional training curriculum.

Research Efforts: Continue to support research and evaluation activities on such subjects as wages, benefits, worker characteristics, and workplace cultures.

Results of the 2003 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce⁷

Paraprofessional Healthcare Institute and North Carolina Department of Health and Human Services

March 2004

BACKGROUND INFORMATION

The Paraprofessional Healthcare Institute (PHI) and the North Carolina Department of Health and Human Services (NCDHHS) have once again collaborated to survey states about direct-care workforce issues. The 2003 survey updates and expands upon information collected from states in prior surveys to examine public policy actions taken by states to strengthen the direct-care workforce. Specifically, the purpose of this survey was to:

- Obtain an updated assessment from states as to whether directcare worker vacancies are currently a serious workforce issue;
- Determine whether state budget constraints during 2003 had any effect on planned or existing direct-care worker initiatives, and/or whether the direct-care workforce was affected by Medicaid program changes;
- Identify new direct-care workforce public policy actions taken by states since the June 2002 survey;
- Determine the degree to which states are, or are considering, tying reimbursement to outcomes associated with direct-care workforce and/or quality of care initiatives;
- Compile additional information from states that use a uniform methodology to track turnover rates of direct-care workers in one or more long-term care settings regarding data tracking methods used, data trends, etc.; and
- Update individual state charts of known public policy actions taken since the first survey conducted in 1999.

METHODOLOGY

This is the fourth national survey on the direct-care workforce developed by PHI and NCDHHS. Surveys were sent to all state Medicaid agencies and state Units on Aging in September 2003; some surveys were redirected to a more appropriate state entity for completion. Completed surveys were received between October and December 2003; clarification was sought as needed. Responses were received from 44 states, representing an 88% response rate.

A summary of results from the 2003 survey is available in **Table 1** and detailed comments are described in **Table 2**. A snapshot of each state's existing or enacted direct-care worker initiatives is presented in individual charts in **Appendix A**, reflecting information collected from this and prior national surveys conducted by PHI and NCDHHS. New information provided from the 2003 survey is reflected in bold type.

Data Caveat: All analyses and percentages reported are based on the 44 states responding to this survey.

⁷ The full paper is available online at http://www.directcareclearinghouse.org/download/2003_Nat_Survey_State_Initiatives.pdf.

NATIONAL STATISTICS ON THE DIRECT-CARE WORKFORCE

Employment Growth:

Many states continued to indicate that high rates of vacancies exist among direct-care workers occupations. This is not surprising given the growth in demand nationally for direct-care workers as projected by the US Bureau of Labor. Between 2002 and 2012, the Bureau of Labor projects employment growth of direct-care workers to more than double (33.8%) the projected growth in overall employment nationally (14.8%).

Wage Rates:

The national average of median hourly wages for the three major categories of direct-care workers (nurse aides, orderlies, and attendants; home health aides; and personal and home care aides) has increased from \$7.97 in 1999 to \$8.70 in 2002. This represents a 9.15% increase over the four-year period for an average annual increase of 2.28%. Wage rates for direct-care workers in 2002 are presented below:

National Wage Data for Direct-Care Workers, 2002	
	Median Hourly Wage
Nurse Aides, Orderlies, and Attendants	\$9.59
Home Health Aides	\$8.70
Personal and Home Care Aides	\$7.81
Average median wage across 3 categories	\$8.70
See Table 3 for state unemployment data from 2001 to 2003. Also included in Table 3 are average median hourly wages, by state, across direct-care worker categories from 1999 to 2002.	

NATIONAL ECONOMIC OUTLOOK

During calendar year 2003 the national unemployment rate peaked at 6.3% in June and dropped to 5.7% by December. When examining individual state unemployment rates, however, twelve states had unemployment rates at, or in excess of, 6.0% in November 2003. Of these, three states (**Alaska**, **Michigan**, and **Oregon**) had unemployment rates of 7.0% or higher.

Information collected during the 2003 survey continued to show that, generally, vacancies of direct-care workers continued to be a serious workforce issue for most states. This trend has continued since the first survey conducted in 1999 and in subsequent surveys conducted during both strong and declining economic periods. It is worth noting that the severity of direct-care worker vacancy rates did diminish for some states: in 2003, 79% of the 44 states responding to the survey indicated that high vacancy rates continue, compared to 88% of states in 1999 and 86% of states in 2002. Thus, the recent high unemployment rates may have contributed to improved vacancy rates in some states. It will be interesting to observe whether those workers who were attracted to enter (or re-enter) direct care during the recession because of limited job opportunities, remain in the field once the overall job market significantly improves.

However, responses received from states re-affirm that the economy is not the primary factor impacting serious vacancies of direct-care workers. Repeating trends found in previous surveys, both the state with the highest unemployment rate as of November 2003 (**Alaska** at 7.5%) and the state with the lowest unemployment rate (**North Dakota** at 3.2%) reported serious direct-care workforce vacancies.

In spite of the unemployment rate and continued slow job growth during 2003, there were clear signs an economic recovery was underway. Indications that state economies were improving were welcome news for states, which have struggled to balance their budgets over the past several years. A November 12, 2003 article in USA Today reported that state and local spending increases were annualized at 1% for the two consecutive quarters ending September 2003.⁸ This growth rate represented the smallest growth spending during back-to-back quarters reported since 1952. In contrast, the good news for states during this same period was that revenue collection was picking up, increasing to a 9.2% annualized rate during these same two quarters. However, much of these increases was reportedly due to increased federal payments to states, a significant portion of which was one-time money to offset Medicaid costs, and increased tax collections.

The December 2003 Fiscal Survey of States published by the National Governors Association and the National Association of State Budget Officers confirmed that while the economy was improving, states continued to have difficulty balancing their budgets during State Fiscal Year 2003.⁹ Medicaid is a major expense for states, and the report indicates that every state has taken at least one step to control Medicaid costs during State Fiscal Years 2002-2004. The report listed the following key actions:

- All 50 states either reduced or froze payments to provider organizations;
- All 50 states took steps to control prescription drug costs;
- 35 states reduced benefits;
- 34 states took steps resulting in reduced or restricted eligibility for services; and
- 32 states increased co-payments required by consumers.

Some of these actions have had a direct impact on direct-care workforce issues. Detailed Medicaid policy actions taken by states during the 2003 fiscal year are described in *Section D* below.

⁸ Cauchon, D. "States Getting Budgets Under Control." USA Today. November 12, 2003.

⁹ National Governors Association and the National Association of State Budget Officers. *Fiscal Survey of States*. Washington, DC. December 2003.

Federal Workforce Development Programs: A New Opportunity for Recruiting and Retaining Direct Care Workers in the Long-Term Care Field¹⁰

Charissa R. Raynor

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INTRODUCTION AND PURPOSE

Across the country, long-term care providers are facing a shortage of qualified and committed direct care workers--those certified nursing assistants (CNAs), home health aides and personal care workers who provide hands-on care to millions of older adults and individuals with physical disabilities. Vacancy rates in excess of 10 percent and turnover rates in excess of 100 percent are not unusual.¹¹

Over the next 10 years, the country will need an estimated 874,000 additional direct care workers to meet growing demand.¹² At the same time, the supply of workers traditionally relied upon to fill these positions - middle-age women -- will fall by about half by 2030.¹³ To address this emerging "care gap," providers, policy-makers and consumers are likely to consider a broad range of strategies: improving wages and benefits of direct care workers, tapping new worker pools, strengthening the skills that new workers bring at job entry and providing more relevant and useful continuing education and training. A key strategy in this mix will be a focus on workforce development -- providing workers with the knowledge and skills they need to perform their jobs.

The purpose of this report is to describe five federal workforce development programs and how some long-term care agencies and service providers use them to improve the recruitment and retention of direct care workers. The five programs are:

- The Workforce Investment Act;
- The Perkins Act;
- Temporary Assistance for Needy Families;
- Job Corps; and
- National Registered Apprenticeships.

¹⁰ The full paper is available online at <http://aspe.hhs.gov/daltcp/reports/fedwfdp.htm>.

¹¹ Stone, R.I. and Wiener, J.M. (2001). *Who will care for us? Addressing the long-term care workforce crisis*. Washington, DC: The Urban Institute and the American Association of Homes and Services for the Aging. [Can be accessed at <http://aspe.hhs.gov/daltcp/reports/lcwf.htm>.]

¹² Hecker, D.E. (2001). Employment outlook: 2000-2010. Occupational employment projections to 2010. *Monthly Labor Review*, 57-84.

¹³ Scanlon, W.J. (2001, May 17). *Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern*. Testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate (GAO-01-750T). U.S. General Accounting Office. Retrieved July 1, 2002 from <http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IpAddress=162.140.64.21&filename=d01750t.pdf@director=/diskb/wais/data/gpo>. In 2000, there were 16.1 traditional caregivers per person aged 85 and older. By 2030 it is estimated that there will only be 8.5 traditional caregivers per person aged 85 and older. Traditional caregivers are women between 25 and 54 years of age.

FEDERAL WORKFORCE DEVELOPMENT PROGRAMS

Workforce Investment Act (WIA)¹⁴

Purpose	To design, with states and local communities, a revitalized workforce investment system that provides workers with the information, advice, job search assistance and training they need to get and keep good jobs and to provide employers with skilled workers. ¹⁵
Administration	U.S. Department of Labor
2002 Budget	Adult and Dislocated Worker formula funds: \$2,189,200,000 ¹⁶ Youth formula funds: \$1,127,965,000 ¹⁷
Reauthorization	2003
Long-Term Care Uses	Job preparation, job awareness, supportive services, training

The Workforce Investment Act (WIA) integrates employment, adult education and vocational services into a federal workforce development system for adults, dislocated workers and youth. Under WIA, three key funding streams are authorized -- adult, dislocated worker and youth funds.¹⁸ These funds are allocated by formula to states that reserve 15 percent and pass the remaining 85 percent on to the local level.

Workforce investment boards (WIBs)¹⁹ oversee WIA service delivery and decide how funds will be used. Each state has a single statewide WIB and multiple local WIBs. This decentralized structure enables WIBs to respond to variation in local workforce needs. The community's highest-ranking official appoints WIB members at the local level and the governor appoints those at the state level. Business leaders, representing industries with employment opportunities, make up the majority of WIB members at both levels.

One-stop centers are the hub of WIA service access and delivery, providing job seekers with access to WIA services, as well as other program services including some services under the Perkins Act.²⁰ One-stop center locations conform to local labor markets.

¹⁴ *Statewide and local workforce investment systems. U.S. Code, Title 29, Chapter 30, Subchapter 2.* Cornell Law School, Legal Information Institute. Retrieved August 1, 2002 from <http://www4.law.cornell.edu/uscode/29/ch30schII.html>. Unless otherwise noted, technical information referenced in this section was directly sourced from U.S. Code.

¹⁵ U.S. General Accounting Office. (2000). *Multiple employment and training programs: Overlapping programs indicate need for closer examination of structure.* Report to the Chairman, Committee on the Budget, House of Representatives (GAO-01-71). Retrieved July 1, 2002 from <http://frwebgate.access.gop.gov/cgi-bin/useftp.cgi?Iaddress=162.140.64.21&filename=d0171.pdf&directory=/diskb/wais/data/gao>.

¹⁶ Employment and Training Administration. (n.d.). *Summary of Budget Authority, Fiscal Years 2002-2003.* Retrieved May 31, 2002 from [http://www.doleta.gov/budget/03req\\$.txt](http://www.doleta.gov/budget/03req$.txt).

¹⁷ Ibid.

¹⁸ Adult, dislocated worker and youth funding streams are authorized under Title I of the Workforce Investment Act.

¹⁹ More information on WIBs, including contact information for state and local WIBs, can be found at the National Association of Workforce Boards, <http://www.nawb.org/asp/wibdir.asp>.

²⁰ The Workforce Investment Act mandates specific federal programs as one-stop partners. One-stop partners make their services accessible at one-stop centers and have membership on state and local WIBs. This is an effort to coordinate program delivery. Notably, Temporary Assistance for Needy Families was not mandated as a one-stop partner, although there are provisions within the statute to allow this program to be a one-stop partner.

How Can Local WIA Adult and Dislocated Worker Funds Be Used?

One-stop centers and approved training providers deliver adult and dislocated worker services in a three-tier system -- core, intensive and training services. The services begin with the least resource intensive type and move upward. Supportive services such as transportation and childcare can be made available at any time.

Core services. Core services, available to any adult or dislocated worker, include:

- Information on how to access supportive services such as childcare and transportation.
- Job search, placement assistance and career counseling.
- Labor market information (including earnings, job demand and skills required to obtain those jobs).
- Training provider information.
- Assistance in accessing financial aid for training and education.

Intensive services. Intensive services are available to an adult or dislocated worker who is (a) unemployed, unable to obtain employment through core services, and who has been determined by the one-stop center to need more intensive services to obtain employment; or (b) employed but is determined by the one-stop center to need intensive services to obtain or retain employment that allows for self-sufficiency. Intensive services include:

- Employment plan development, counseling and case management.
- Prevocational services such as learning skills, communication skills, interviewing skills, punctuality, personal maintenance skills and professional conduct.

Training services. Training services are available to an individual who (a) is eligible for intensive services but unable to obtain or retain employment through these services; (b) is assessed by the one-stop center to need training services and to have the skills and qualifications to successfully participate in the selected training program; and (c) selects a training program that is directly linked to employment opportunities in the local area, or outside the local area if the individual is willing to relocate.²¹ **Training services include:**

- Occupational skills training, such as training for CNAs.
- On-the-job training and workplace training with related instruction.
- Skill upgrading and retraining.
- Job readiness training.
- Adult education and literacy activities.

Some observers believe that WIA discourages training in favor of moving unemployed people directly into the labor force. However, "federal regulations reflect an intention to provide broad discretion to local WIBs to develop detailed policies to determine who is eligible for intensive training services."²²

²¹ It is important to note that in the event that adult funds are limited, priority must be given to recipients of public assistance and other low-income individuals for intensive and training services. The local board, in consultation with the governor, makes this determination.

²² Savner, S. (1999). Kellogg Devolution Initiative paper: Key implementation decisions affecting low-income adults under the Workforce Investment Act. Center for Law and Social Policy.

How Can Local WIA Youth Funds Be Used?

Youth services are available to low-income youth, ages 14-21, who face barriers²³ to successful employment or completing their education. Services are based on participants' individual needs. Community organizations and training providers deliver youth services through competitive grants awarded by WIBs. Youth services include:

- Preparation for postsecondary education.
- Development of strong linkages between academic and occupational learning.
- Occupational skill training, such as CNA training.
- Summer employment opportunities directly linked to academic and occupational learning.
- Paid and unpaid work experiences.
- Supportive services (including transportation and childcare).
- Mentoring, follow-up services and counseling.

How Can State 15 Percent Reserve Funds Be Used?

Although state reserve funds are derived from three different funding streams -- adult, dislocated worker and youth -- they can be used together or separately to target any one of these groups, regardless of the original funding stream. State reserve funds can be used to:

- Provide incentive grants, such as awards to local areas for exemplary performance.
- Develop and implement projects for incumbent workers, such as an employer loan program to assist in skills upgrading.
- Demonstration and research activity.

How Are WIA Programs Designed?

State and local WIBs must develop five-year plans outlining how funds should be used. WIBs at both the state and local levels consider various factors when deciding how to use funds, including:

- Employment opportunities for entry level workers.
- Industry's workforce needs as identified through a workforce analysis and/or communication with industry representatives. (Industry representatives may participate as elected members of the WIB or request meetings with the WIB to present needs and ways in which these needs could be addressed by the WIB.)
- Potential of state and local WIBs to meet performance goals, including earning levels and retention rates. Failing to meet performance goals may result in financial penalties and/or having WIB membership restructured.

Special Issues for Long-Term Care Providers

WIB Membership. WIA requires that the majority of any WIB's members consist of business leaders representing industries with employment opportunities. This suggests that long-term care providers should be represented on state and local WIBs. Such representation may help leverage WIA funds and services for direct care workforce development in long-term care. There is no national source of data to identify members on these boards.

²³ Barriers include: deficient in basic literacy skills; a school dropout; homeless, a runaway, or a foster child; pregnant or a parent; an offender; or an individual who requires additional assistance to complete an educational program or to secure or hold employment. At a minimum, 30 percent of youth funds must be used to provide services to out-of school youth.

Clarifying the “Self-Sufficiency Standard Rule.” Under WIA, self-sufficiency is a “wage-level threshold below which employed workers become eligible for intensive and training services.”²⁴ In other words, employed individuals who are interested in direct care worker training (or any other type of training) could receive services as long as their current wages do not exceed the local self-sufficiency standard.

Carl D. Perkins Vocational and Technical Education Act²⁵

Purpose	To develop more fully the academic vocational and technical skills of secondary and postsecondary students who elect to enroll in vocational and technical programs. ²⁶
Administration	U.S. Department of Education
2002 Budget	State basic grants: \$1,180,000,000 ²⁷ Tech-prep grants: \$108,000,000 ²⁸
Reauthorization	2004
Long-Term Care Uses	Job preparation, job awareness

The Carl D. Perkins Vocational and Technical Education Act (Perkins Act) provides funding for vocational and technical education services to youth and adults. Vocational and technical education refers to a sequenced course of study to prepare individuals for further education and careers in current or emerging employment sectors.

The Perkins Act authorizes two key funding streams: state basic grants and tech-prep grants.²⁹

- **State basic grants** are awarded to states by a formula that reserves 15 percent of the funds and passes the remaining 85 percent to secondary and postsecondary schools at the local level.
- **Tech-prep grants** are awarded to states by formulas that pass 100 percent of the funds down to local consortia, including secondary and postsecondary schools, as well as employers. Local allocation can be made by formula or competitive grant award.

How Can Local Level State Basic Grant Funds Be Used?

State basic grant funds are awarded to secondary and postsecondary schools to develop vocational and technical education programs and provide services, including:

²⁴ AFL-CIO Working for America Institute. (n.d.). *Self-sufficiency and good jobs: Setting standards for wages and eligibility for services under the Workforce Investment Act*. Action brief. Retrieved June 25, 2002 from <http://documents.workingforamerica.org/PDF/SelfSufficiency.pdf>.

²⁵ Vocational and Technical Education. U.S. Code, Title 20, Chapter 44, Cornell Law School, Legal Information Institute.

²⁶ U.S. Department of Education. (n.d.). *Guide to Education*. (CFDA #84.048A). Retrieved July 1, 2002 from <http://web99.ed.gov/GTEP/Program2.nsf>.

²⁷ U.S. Department of Education, Office of Vocational and Adult Education. (2002). *FY 2002 Vocational and Technical Education Allocations*. Retrieved July 1, 2002 from <http://www.ed.gov/offices/OVAE/CTE/2002allot.html>.

²⁸ Ibid.

²⁹ State basic grants are authorized under Title I of the Perkins Act. Tech Prep Grants are authorized under Title II of the Perkins Act.

- Helping students gain experience in and understanding of all aspects of an industry.
- Extending professional development opportunities to teachers, including internships with industries.
- Involving business and/or labor organizations in the development of vocational and technical education programs.
- Offering career guidance.
- Making work-related experiences available, such as internships, cooperative education and job shadowing.
- Forming local education and business partnerships.
- Assisting students with job placement.

How Can State 15 Percent Reserve Funds Be Used?

State reserve funds can be used for statewide activities, including:

- Professional development for teachers and other personnel.
- Supporting partnerships with educational institutions and employers, among others.
- Cooperative education (through an agreement between schools and employers, students receive instruction by alternating study in school with a job in any occupational field).
- Supporting education and business partnerships.
- Assisting students in finding appropriate jobs.

How Can Tech-Prep Grant Funds Be Used?

Tech-prep grants are awarded to secondary and postsecondary schools, as well as employers, to provide a sequenced course of study in a specified area, such as health occupations. Study programs are designed as either 2+2 programs (two years of high school plus two years of postsecondary education) or 4+2 programs (four years of high school plus two years of postsecondary education). Programs culminate in an associate degree or certificate and ultimately in job placement or further education.

How Are Perkins Programs Designed?

States and local organizations develop five-year plans outlining how they intend to use funds. They consider these factors when deciding how to use funds:

- The potential of the state and local organizations to meet performance goals, including school completion rates, employment placement and retention rates. Failing to meet performance levels could result in funds being withheld.
- How vocational and technical education will relate to state and regional occupational opportunities.

Special Issues for Long-Term Care Providers

The Perkins Act explicitly encourages partnerships between educators and employers, thereby presenting opportunities to long-term care providers who want to improve direct care workforce recruitment and retention through education, training and awareness activities. Employers can become involved at multiple points. For example:

- ***State five-year plan:*** Development must include representatives of business and industry and must provide public hearings to allow employers, among others, an opportunity to present their views and make recommendations.
- ***State 15 percent funds from state basic grants:*** May be used to support cooperative education and education and business partnerships.
- ***Local state basic grant funds:*** May be used to provide work-related experience (such as internships, cooperative education and job shadowing) and provide local education and business partnerships.

- **Tech-prep funds:** Special consideration in awarding tech-prep grants goes to programs that provide education and training in areas or skills that are experiencing a significant workforce shortage, programs that are developed in consultation with business and industry and programs that include employers.

Temporary Assistance for Needy Families (TANF)³⁰

Purpose	To provide assistance to needy families with children so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. ³¹
Administration	U.S. Department of Health and Human Services
2002 Budget	State block grants: \$16,488,667,000 ³² State maintenance-of-effort funds: \$11,106,907,662 ³³
Reauthorization	2002 pending
Long-Term Care Uses	Job preparation, job awareness, supportive services, training

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the Temporary Assistance for Needy Families (TANF) block grant program, replacing Aid to Families with Dependent Children (AFDC), the country's basic cash assistance program, and related programs. TANF espouses a "work first" philosophy, emphasizing work and responsibility over dependence on government benefits -- the hallmark of welfare reform.

TANF is a federal/state program funded through federal block grants made to states and state generated maintenance-of-effort funds.

How Can TANF Funds Be Used?

In addition to meeting overall programmatic purposes, three guidelines frame how TANF funds can be used:

- Funds must be used to serve families with children.

³⁰ U.S. Department of Health and Human Services, Administration for Children, and Families, Temporary Assistance for Needy Families Program; Final Rule. Federal Register, 64(69):17719-17931.

³¹ U.S. General Accounting Office. (2000). *Multiple employment and training programs: Overlapping programs indicate need for closer examination of structure. Report to the Chairman, Committee on the Budget, House of Representatives* (GAO-01-71). Retrieved July 1, 2002 from <http://www.gao.gov/new.items/d0171.pdf>.

³² U.S. Department of Health and Human Services, Office of Legislative Affairs and Budget. (n.d.). *All purpose table: Fiscal years 2001-2003*. Retrieved August 8, 2002 from <http://www.acf.dhhs.gov/programs/olab/budget/apt03.htm>.

³³ U.S. Department of Health and Human Services, Office of Financial Services. (n.d.). *Table E: Analysis of state maintenance of effort spending levels in FY 2000 through the 4th quarter*. Retrieved June 25, 2002 from <http://www.acf.hhs.gov/programs/ofs/data/q400/TableE.htm>. Note that the figure cited is from FY 2000. This is the most recent figure that the Federal Government has posted.

- Cash assistance and other “benefits directed at basic needs”³⁴ have a five-year time limit. This rule does not apply to some benefits such as employer subsidies to cover the cost of wages, benefits, training, or supervision and supportive services.³⁵
- Families must meet income thresholds set by the state. Thresholds vary widely from state to state.³⁶ States may choose to have different income thresholds for different TANF-funded programs. For example, a state could make cash assistance available only to very poor families and make transportation assistance available to working families making higher incomes.³⁷

TANF funds can be used to provide the following:

- Cash benefits.
- Supportive services, such as transportation and childcare.
- Employment counseling and job placement.
- Employability training.
- Postsecondary education³⁸ and occupational training.

How Are TANF Programs Designed?

In general, state welfare agencies, in conjunction with the governor and state legislature, determine how programs are designed. However, the U.S. Department of Health and Human Services encourages states to “develop collaborative relationships with businesses, local agencies and community organizations in developing strategies and delivering services.”³⁹ **States consider various factors when designing TANF programs, including:**

- How they will meet work participation goals. Work participation refers to subsidized and unsubsidized employment, on-the-job training, and education directly related to employment for recipients without a

³⁴ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. (n.d.). *Helping families achieve self-sufficiency: A guide on funding services for children and families through the TANF program*. Retrieved on June 26, 2002 from <http://www.acf.dhhs.gov/progrms/ofa/funds2.htm>.

³⁵ Schott, L., Lazere, E., Goldberg, H., & Sweeney, E. (1999, April 29). *Highlights of the final TANF regulations*. Center on Budget and Policy Priorities. Retrieved on July 17, 2002 from <http://www.cbpp.org/4-29-99wcl.htm>. Basic assistance cannot be provided to a family with an adult head-of-household who has received such assistance for five years cumulatively over that individual’s lifetime. Because these guidelines do not apply to state matching funds, some states separate their matching funds from their block grant to support more flexible program options. For example, states that do this can extend services beyond the five year time limit.

³⁶ The Urban Institute. (2002). *Fast facts on welfare policy: Initial TANF income eligibility thresholds*. Retrieved July 16, 2002 from <http://www.urban.org/UploadedPDF/900529.PDF>. In 2000, a family of three would qualify for cash assistance in Alabama if their earned income was \$205 a month, whereas in Hawaii a family of three would qualify if their earned income was \$1,641 a month.

³⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. (n.d.). *Helping families achieve self-sufficiency: A guide on funding services for children and families through the TANF program*. Retrieved June 26, 2002 from <http://www.acf.dhhs.gov/progrms/ofa/funds2.htm>.

³⁸ Greenberg, M., Strawn, J., & Plimpton, L. (Revised February, 2000). *State opportunities to provide access to postsecondary education under TANF*. Center for Law and Social Policy. Retrieved June 17, 2002 from <http://www.clasp.org/DMS/Documents/997204029.279/state%20opportunities%20to%20provide%20access.pdf>.

³⁹ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. (n.d.). *Helping families achieve self-sufficiency: A guide on funding services for children and families through the TANF program*. Retrieved June 26, 2002 from <http://www.acf.dhhs.gov/progrms/ofa/funds2.htm>.

high school diploma or equivalent. States failing to meet participation goals are subject to financial penalties.⁴⁰

- Labor market employment opportunities for entry-level workers.

Special Issues for Long-Term Care Providers

Some have suggested welfare-to-work recipients as a new pool from which the long-term care industry could recruit direct care workers. However, anecdotal evidence suggests that long-term care providers' experiences with hiring these workers have been mixed. Understanding variation in the TANF population may provide some explanation.

Roughly half of the TANF population is long-term welfare recipients, with the remainder being short-term and return welfare recipients. Long-term welfare recipients face multiple barriers to successful employment.⁴¹ Data show that this group is more likely to be in poor physical or mental health, have not worked for three years or more, and have less than a high school education.⁴² These barriers highlight the need for additional services, such as employability skills and ongoing childcare, to support successful employment. By contrast, short-term and return welfare recipients face fewer barriers and seem to transition more easily from welfare to work.⁴³

Despite these barriers, many employers have had success with hiring welfare recipients. A 2001 survey showed that retention rates for welfare recipients are comparable to employees hired through "standard channels."⁴⁴ And at least one study suggests that retention rates for former welfare recipients are higher than retention rates of other entry-level workers.⁴⁵ Primary predictors of job retention for welfare recipients include "starting off in higher-paying jobs; working steadily, initially; finding jobs with benefits; and working in certain occupations, including health care."⁴⁶

⁴⁰ Ibid.

⁴¹ Weil, A. (2002). *Ten things everyone should know about welfare reform*. The Urban Institute, New Federalism: Issues and options for states (Series A, No. A-52). Retrieved June 4, 2002 from <http://www.urban.org/Template.cfm?NavMenuID=24&Template=/TaggedContent/ViewByPubID.cfm&PubID=310484>. Figures cited are from 1999.

⁴² The Urban Institute. (n.d.) *Fast facts on welfare policy, long-term welfare recipients are more likely to face barriers to work than other welfare recipients*. Retrieved July 23, 2002 from <http://www.urban.org/UploadedPDF/900527.PDF>.

⁴³ Weil, A. (2002).

⁴⁴ Wirthlin Worldwide. (2001). Business makes the case for continued efforts to hire off welfare. *The Wirthlin Report*, 11(4). Retrieved July 8, 2002 from http://www.wirthlin.com/extra1/publicns/report/TWR0_501.pdf.

⁴⁵ Lippman, H. (2000, March). Off welfare and off to work. *Business & Health*: 23-29.

⁴⁶ W.K. Kellogg Foundation. (n.d.). *Devolution initiative. Workforce development: Employment retention and advancement under TANF*. Retrieved June 16, 2002 from <http://www.clasp.org/DMS/Documents/1011214527.14/workforce%20development%20employment%20retention.pdf>.

National Registered Apprenticeship

Purpose	To provide highly skilled workers -- through employer-based training -- to employers who are experiencing worker shortages.
Administration	U.S. Department of Labor
Long-Term Care Uses	Recruitment, training, job preparation

The National Registered Apprenticeship program⁴⁷ provides a framework for employers who are experiencing skilled worker shortages to improve recruitment, retention and the quality of their workforce through on-the-job training and classroom instruction. Apprentices “earn as they learn” and upon graduation receive a nationally recognized certificate of completion from the U.S. Department of Labor. While the program does not provide grants or funding to employers, it does provide a nationally recognized framework for training that may attract previously untapped worker pools such as high school students. The program may also improve the quality of training, which may lead to increased retention.

Since its inception in 1977, the program has primarily focused on construction and manufacturing industries. However in the past two years, this focus has expanded to include apprenticeships in health care, including long-term care. Today, more than a quarter million employers offer registered apprenticeships, representing approximately 440,000 apprentices.

Employers and Apprenticeship

While the program is administered nationally by the U.S. Department of Labor, individual apprenticeship programs are employer-based. That means employers recruit apprentices, develop on-the-job training and classroom instruction standards, and are otherwise responsible for the administration and oversight of their program. In addition to decreased vacancies, benefits of having an apprenticeship program include:

- **Reduced recruitment costs.** Established relationships with a Job Corps center may provide a significant source of recruitment, which would offset the cost for additional recruitment activities.
- **Reduced training costs.** Customized training from the beginning eliminates the need to “retrain” workers.
- **Reduced turnover costs.** These skilled workers tend to stay employed longer than their counterparts do because they are expertly prepared to meet work expectations and have developed a good working relationship with the employer.
- **Reduced worker’s compensation.** Training standards include safe workplace practices and responsibilities.

Employers from across the spectrum of long-term care -- nursing homes, assisted living facilities, home care agencies and adult day care centers -- are eligible to develop an apprenticeship program.

Certified Nursing Assistant (CNA) Apprenticeship in Long-Term Care

CNA is one example of apprenticeship in long-term care.⁴⁸ This apprenticeship can be used to train experienced CNAs, newly hired CNAs and individuals who are pursuing certification as nursing assistants. The CNA apprenticeship offers 2,000 hours of on-the-job training and 144 hours of classroom instruction, usually simultaneously, which can be completed over one year full-time or one and a half years part-time.⁴⁹

⁴⁷ More information on this program can be found at <http://www.doleta.gov/atels-bat/reg-apprentice.asp>.

⁴⁸ Licensed practical nurse is also a federally registered apprenticeship.

⁴⁹ These standards compare to the 75 hours federally mandated and up to 175 hours mandated by some states for CNA training.

Federal and state-approved CNA training leading to a certification is generally completed early on in the apprenticeship, either by the long-term care provider, if approved to do so, or by a local training program. Becoming certified as a nursing assistant early on allows apprentices to fully maximize on-the-job training. Here is an example of on-the-job training and classroom instruction standards for the CNA apprenticeship:⁵⁰

On-the-Job Training
Orientation and safety
Maintenance of good patient environment
Vital signs
Patient care: <ul style="list-style-type: none"> • Pass trays, assist in transferring, and assist with Sitz baths. • Assist with ambulation, ice bags and throat collars. • Stool and urine specimens, feeding, record intake and output. • Specific housekeeping duties assist in skin treatment. • Activities of daily living (ADL) care: assist with turning, repositioning, dressing, and bathing.
Classroom Instruction
<ul style="list-style-type: none"> • Applied math, applied communications, employability. • General administrative duties, computer literacy. • First aid and medical emergencies, psychology of human relations. • Infection control and risk management, medical law and ethics, nutrition. • Patient education, basic pharmacology, professionalism, teamwork. • Medical terminology, vital signs, lab test and diagnostic procedure. • Clinical chemistry, bacteriology, urinalysis, hematology, phlebotomy. • Documentation, human anatomy and physiology.

The employer develops standards for on-the-job training and classroom instruction, based on the Registered Apprenticeship program’s national standards for the CNA apprenticeship.⁵¹ Although national standards for other direct care workers have yet to be developed, the CNA apprenticeship standards can be modified to meet the needs of home care, assisted living, adult day care and other home and community-based employers. Program officials provide significant technical assistance to help employers develop standards that meet their unique workforce needs.

Implementing Apprenticeship

Community colleges, independent vocational education programs and, in some cases, employers themselves provide classroom instruction. In addition, many high schools offer students the opportunity to earn credits for completing an apprenticeship through their “school-to-work” program. In these cases, the high school or affiliate vocational education program provides the classroom instruction.

Once hired, apprentices are matched with a mentor who provides on-the-job training. Mentors may be registered nurses, licensed practical nurses or experienced CNAs who are employed by that provider organization. While there are no minimum program requirements, employers who are selecting mentors can consider a person’s experience in adult education and interest in apprenticing a new worker.

⁵⁰ Standards listed are from Englewood Manor, Englewood, Ohio CNA registered apprenticeship program.

⁵¹ Standards of Apprenticeship for the Apprenticible Occupations: Nurse Assistant Licensed Practical Nurse. U.S. Department of Labor. February 1, 2001. These standards are not long-term care specific but were designed to meet the general needs of health care employers who employ CNAs.

Recruiting Apprentices

Employers select apprentices based on the employers' workforce needs and criteria. At a minimum, apprentices must be at least 17 years old and have a high school diploma or equivalent (or complete one of these within a year of beginning the apprenticeship).

Apprentices are often recruited from high schools, vocational education programs, community-based organizations and welfare-to-work agencies. Successful recruitment depends on the relationships that employers build with these organizations to promote apprenticeship as a vehicle for beginning a career in long-term care. Program officials can help employers identify and establish relationships with organizations that may be a source of apprentices.

Cost of Apprenticeship to Employers

Upfront costs may include:

- Lower productivity as the apprentice develops skills and knowledge.
- Cost of classroom instruction if not supported by other resources.

In addition, employers are required to provide progressively higher wages to apprentices as they demonstrate new competencies and skills. For CNA apprenticeships, the apprentice may be hired at the local starting wage for CNAs and then receive a 50 cent per hour increase upon completion of the apprenticeship.

For high school apprentices, the public school system provides classroom instruction. For others, this cost can be defrayed through federal, state and local scholarship programs; local workforce development training programs; and existing scholarship programs that providers offer. Program officials can assist providers in identifying these resources.

Technical Assistance

Registered Apprenticeship program officials are available in each state to provide technical assistance to employers, including registering as an apprenticeship site, developing standards for on-the-job training and classroom instruction, establishing relationships with organizations that may be sources of apprentices and implementing the apprenticeship program.

Because training is tailored to each employer's specific workforce needs, apprentices are highly skilled and knowledgeable about their work. Program officials conduct confidential annual audits to provide feedback to employers on how they could improve on-the-job training and classroom instruction standards, enhance on-the-job training and improve apprentice recruitment even more.

Job Corps

<i>Purpose</i>	To provide at-risk youth with the education, training and supportive services they need to develop employment related skills and obtain a decent job.
<i>Administration</i>	U.S. Department of Labor
<i>Long-Term Care Uses</i>	Recruitment, training, job preparation

Job Corps⁵² is the nation's largest residential training and education program for at-risk youth. Through Job Corps, students earn their general education diploma (GED), learn a vocational trade and develop employment related skills. They also receive a host of supportive services, including on-site housing, transportation, meals, clothes and a stipend. The typical Job Corps student is an at-risk youth, 18-24 years old, who is economically disadvantaged and a high school dropout. On average, students are enrolled in Job Corps more than seven months, although they may stay for up to three years to seek advanced training. For employers seeking to improve recruitment of direct care workers, Job Corps provides a pool of future workers that can be trained to meet workforce needs. Nationwide, there are 119 Job Corps centers serving almost 70,000 participants annually.

Employers and Job Corps

Long-term care providers can use Job Corps to improve recruitment and retention, primarily by hiring students for permanent and temporary positions. In addition, employers can offer their local Job Corps guidance on improving training programs to better meet the needs of long-term care providers. That advice, in turn, may reduce turnover rates among graduates once employed.

Benefits of partnering with Job Corps include:

- ***Decreased vacancy rates.*** Job Corps is a source of trained, competent and motivated long-term care workers.
- ***Reduced recruitment costs.*** By establishing a relationship with Job Corps, employers may be able to reduce costly advertising and other recruitment activities.
- ***Decreased training costs.*** Customized training from the beginning eliminates the need to “retrain” workers.

Long-Term Care Training through Job Corps

An estimated 80 percent of Job Corps centers offer CNA/home health aide training and 5 percent offer licensed practical nursing training. Training curricula vary by Job Corps center because they are developed with input from local long-term care providers. This ensures that graduates are equipped to meet the unique needs of these employers. All training programs meet federal and state training requirements.

Each Job Corps center has an Industry Council, made up of local employers, that helps identify which vocational training programs should be offered based on local workforce needs. The council also advises Job Corps on how training curricula can be improved to better meet employer needs. Generally, any interested employer is eligible to participate on a council. There is no national source of data to assess the extent to which long-term care providers participate on these councils.

Partnering with a Local Job Corps Center

Any long-term provider, including nursing homes, assisted living facilities and home care agencies, can partner with their local Job Corps to improve recruitment and retention. Strategies include:

- ***Hire Job Corps graduates.*** Job Corps centers offer placement services to match graduates to employers' hiring needs. Job Corps graduates are placed in employment providing at least \$8.50 an hour.
- ***Hire Job Corps interns.*** This offers temporary placement from three weeks to six months, giving the employer a chance to assess potential for permanent employment, assist in student training and fill temporary staffing needs.

⁵² More information on this program can be found at <http://www.doleta.gov>.

- **Build a relationship with Job Corps students.** Serve as a guest instructor, participate in job fairs and open houses, allow students to tour your organization and host a student to shadow staff at your organization.
- **Serve as a member of a Job Corps Industry Council.** Industry Council members are local employers who provide the center with input on how to improve the quality, appropriateness and usefulness of training. Council members ensure that curricula reflect both current technology and industry standards to meet employer needs. Industry Councils also assist centers in assessing labor market information to make decisions about what types of vocational training to offer.
- **Take advantage of customized training.** Work with Job Corps staff to update their training curricula, serve as a clinical training site and provide industry-specific equipment for students to train with.

PARTNERSHIPS BETWEEN LONG-TERM CARE AGENCIES/PROVIDERS AND FEDERAL WORKFORCE DEVELOPMENT PROGRAMS

The following vignettes show how state agencies and long-term care providers have creatively employed the federal workforce development programs highlighted in this report to address critical shortages of direct care workers in the long-term care field.

Getting the Message Out: Media Campaigns

What	Health Care Worker Media Campaign
Where	Lancaster County, Pennsylvania
Who	Lancaster County Workforce Investment Board, Berks County Workforce Investment Board, South Central Workforce Investment Board
Partners	Providers and local television outlet
Funding	Workforce Investment Act, health and long-term care providers
Vision	Increase the supply of workers through an intensive and long-term television campaign to encourage people who are already working to consider health care careers.

The Lancaster County WIB convened stakeholders throughout the area, including long-term care providers, to form the Lancaster County Working Group on Health Care Employment and Training. The Working Group is a permanent infrastructure for employer input to the WIB, drawing on a 10-county area in south central Pennsylvania. Partnering with WGAL-TV, the Working Group launched a television media campaign to increase the supply of workers in health care, including long-term care. The project targets existing health care workers who want to advance their careers and workers in other industries who are looking for a career change.

The media campaign averages 30 messages weekly during high profile time slots. Each message concludes with a toll-free number for more information, which directly connects the caller to his or her local one-stop center. The staff answers questions and invites callers to information sessions. The Health Care Careers Briefing orients participants to various careers, including long-term care, and assists participants in job placement. The Health Care Careers Orientation provides career information, placement testing, site visits and individual consultation with training providers.

Preliminary evidence suggests the program is successful. The region's nursing schools have waiting lists and allied health training programs are approaching capacity.

A \$100,000 grant from the Pennsylvania WIB provided seed money for production of the messages. Thirty-four providers, including 15 long-term care providers, have contributed \$560,000 to buy airtime for the project by purchasing "employer recognition tags" for each televised message. Tags provide employers an opportunity to advertise themselves to potential employees as an employer of choice.

Onward and Upward: Building Skills with Supports to Succeed

<i>What</i>	CNA Training Pilot Project
<i>Where</i>	Delaware County, Pennsylvania
<i>Who</i>	Delaware County Workforce Investment Board
<i>Partners</i>	Women's Association for Women's Alternatives, Delaware County Community College, Fair Acres Geriatric Center
<i>Funding</i>	Workforce Investment Act
<i>Vision</i>	Reduce the turnover rate of entry-level employees by providing them with the skills and supportive services that will enable them to succeed on the job and prepare them to move up the career ladder.

The CNA Training Pilot Project is a partnership between the Delaware County WIB, the Women's Association for Women's Alternatives, the Delaware County Community College and Fair Acres Geriatric Center. The goal is to improve vacancy and turnover rates among direct care workers through a comprehensive training and preparation program. The program targets low-income youth, 18-21 years old, who face at least one employment barrier such as school dropout. Long-term care is seen as a good match for this target group because it offers easy entry into a high growth industry with self-sufficient wages and career advancement opportunities. Policy-makers will use findings from the pilot to decide how WIA funds can best be used to train CNAs.

The program is organized into four components:

- Employability skills training (employer expectations, cultural diversity, communication) provided by Delaware County Community College.
- Literacy/documentation skills development also provided by Delaware County Community College.
- Career coaching and case management services provided by the Women's Association for Women's Alternatives.
- A 90-hour CNA training curriculum provided by Delaware County Community College and Fair Acres Geriatric Center.

Up to 40 participants will be recruited from local high schools and community service programs. Fair Acres Geriatric Center, along with other providers, has committed to hiring graduates of the training program. Students will be placed in full-time employment immediately after completing the classroom and clinical training.

The CNA Training Pilot Project is funded by the Delaware County WIB through a grant awarded to the Women's Association for Women's Alternatives, partnering with the Delaware County Community College and Fair Acres Geriatric Center.

Sectoral Response: Making Informed Decisions about Needs

What	Delaware County Sector Employment Intervention Project
Where	Delaware County, Pennsylvania
Who	Women's Association for Women's Alternatives
Partners	Delaware County Office of Employment and Training, Delaware County Commerce Center, National Economic Development and Law Center, Delaware County Legal Assistance Association, Wider Opportunities for Women
Funding	Workforce Investment Act, Delaware County Office of Employment and Training, Pennsylvania Department of Community and Economic Development
Vision	Help health care employers recruit, hire, train, retrain and provide upward mobility to low-income Delaware County residents.

The Delaware County Sector Employment Intervention Project is an initiative of the Delaware County Sector Project Collaborative, a partnership among key community stakeholders including educators, employers and workforce development agencies.

In phase one of this three-phase project, a labor market study was conducted to understand workforce supply and demand, including:

- Assessment of industry and occupational information, demographic information, self-sufficiency data and employment and training resources.
- Focus groups with employers, residents and employment and training service providers.

Study findings identified health care (including long-term care) as one of two target industries on which WIB initiatives should focus. Health care was identified as a high-growth industry that provides easy entry and upward career mobility.⁵³

Phase two of this project involved the creation of an ad hoc consortium of health care and long-term care providers, training providers and government agencies. This group met quarterly to explore, define and promote systematic responses to the problems facing the health care sector in Delaware County. This phase supported the development of:

- **Directory of Healthcare Training Providers**, a publication for job seekers, guidance counselors, employment training programs, TANF- and WIB-funded programs, schools, social service agencies, faith-based organizations, the community college and other educational institutions.
- **Day Care/Transportation/Healthcare Employer Map** so job seekers can find daycare and transportation available near health care employers.
- **Delaware County WIB's Strategic Plan** for meeting local health care workforce needs.

Phase three of this project involves implementing a CNA Training Program, also discussed in this report (see "CNA Training Pilot"). This project was funded through local WIA funds.

⁵³ Lavelle, M. & Wong, S. (2001) *Delaware County sector employment intervention project: Technical report*. Swarthmore, PA: Women's Association for Women's Alternatives, The Pennsylvania Family Economic Self-Sufficiency Project. A copy of this report is available by contacting Women's Association for Women's Alternatives.

Tapping New Worker Pools: Migrant Farm Workers

What	Migrant Farm Worker and Limited English Proficiency Training Program
Where	Riverside and San Bernardino Counties, California
Who	Riverside County Workforce Development Board and Economic Development Agency
Partners	California Workforce Investment Board, California Employment Development Department, California Monitor Advocates Office, California Workforce Association, College of the Desert, Campfire Boys and Girls Club, California Nurses Educational Institute, Coachella Valley Housing Coalition, United Farm Workers of America
Funding	Workforce Investment Act, Welfare-to-Work
Vision	Develop partnerships to further long-term care training, train non-traditional populations for the long-term care field, and develop non-traditional methods of training with a long-term care industry.

Through a local workforce analysis, the Riverside County WIB identified high demand for direct care workers in long-term care. In response, the WIB convened long-term care providers, training providers and local businesses to strategize about how to address this need. The Migrant Farm Workers and Limited English Proficiency program is an outgrowth of these meetings.

This initiative matches employers' need for direct care workers with migrant farm workers' need to increase and stabilize their income. The skills developed through this program are intended to promote stabilized, higher incomes for this population while addressing the critical shortage of direct care workers in long-term care.

The initiative is organized into three components:

- Comfort of Home Caregiver Training is a 40-hour course developed by the College of the Desert to train students to provide basic care. It is offered in English, Spanish and English as a Second Language.
- Vocational English as a Second Language for CNA Training teaches medical terminology in English. The course is offered by the Campfire Boys and Girls Club.
- CNA Training curriculum is a 160-hour course provided by the California Nurses Educational Institute. Class schedules are flexible to accommodate students' needs.

Three partners provide intensive outreach within migrant farm worker communities: the California Employment Development Department, which has a migrant and seasonal farm worker program in the Coachella Valley; Coachella Valley Housing Coalition, which has more than 2,500 units of affordable housing; and the United Farm Workers, which saw value in participating because it offered members the opportunity to diversify their income while providing a mobile skill.

The program offers two transportation options for students, meeting substantial need in this rural area. Ready Rides, created through the local public transportation system, provides door-to-door service for students going to and from classes. Share a Ride reimburses individuals who carpool to classes.

This project was funded through the California Training Initiative using WIA and Welfare-to-Work funds.

Building the Future: Students as Workers

<i>What</i>	Health Occupations Program
<i>Where</i>	Charlotte, North Carolina
<i>Who</i>	West Mecklenburg County High School
<i>Partners</i>	Health and long-term care providers
<i>Funding</i>	Perkins Act, state general revenues
<i>Vision</i>	Prepare high school students for employment and/or continued education by providing them an opportunity to master a specific skill set; expand the number of qualified health care workers, including long-term care workers.

The Health Occupations Program at West Mecklenburg High School provides students a sequenced course of study in health occupations. This program is one of 15 in Charlotte-Mecklenburg County and is an example of such programs throughout the country. West Mecklenburg is classified as a “high risk” school, meaning that students face barriers to completing school and then, after graduation, to securing employment. The health occupations program addresses these barriers by framing high school study as meaningful. It links study to jobs. As one respondent stated, “The Health Occupations Program gives kids a skill to prepare them for self-sufficiency beyond high school.”

The program incorporates academic and hands-on clinical learning including shadowing and internship experiences in long-term care settings. Students have an opportunity to complete a CNA training course that includes a 40-hour experiential component in long-term care.

West Mecklenburg’s program has more than 250 students enrolled from 9th-12th grade. Some students work part-time as CNAs while finishing their high school degree and graduates often work full-time as CNAs.

Long-term care providers have been actively involved, offering program guidance, providing clinical opportunities for students, recruiting graduates and serving as guest speakers to help students explore long-term care as a career path. Currently, 11 long-term care providers participate as clinical sites for the CNA training component.

Strategic Workforce Development: Beginning in Kindergarten

<i>What</i>	Pitt County Health Careers Development Program
<i>Where</i>	Pitt County, North Carolina
<i>Who</i>	Pitt County Memorial Hospital, University Health Systems of Eastern North Carolina, Pitt County Schools, Pitt Community College, Eastern Carolina University, Brody School of Medicine, Greenville-Pitt County Chamber of Commerce, Eastern AHEC
<i>Funding</i>	Perkins Act, private funding
<i>Vision</i>	Contribute to meeting the health care career needs of the community by preparing students for future health care careers.

The Pitt County Health Careers Development Program addresses the health care workforce shortage, including long-term care, in Pitt County. Educators, health care employers (including long-term care) and the greater business community have come together to develop and support the program, all seeing it as a win-win opportunity.

This comprehensive program begins in kindergarten and culminates in high school with the Health Sciences Academy. The program consists of three levels: kindergarten through 5th grade, 6th-8th grade and 9th-12th grade.

Each level promotes awareness of careers in health and long-term care through:

- Career fairs.
- Health professional speaking engagements.
- Career development portfolio construction.
- Instruction and mentoring by health professionals in math and science.
- Kid's Healthy Careers College, a summer camp.
- Mentoring with health care professionals.
- Participation in various summer academies.
- Health careers presentations.
- Nursing careers recruitment program.

Beginning in 9th grade, participants enter the Health Sciences Academy. They take courses based on one of four pathways: therapeutic (which includes nursing), diagnostic, information services and environmental services. Activities include CNA training, internships and job shadowing, tours of health care facilities and scholarship program. Program staff characterizes the Health Careers Development Program as a strategic and long-term solution -- not a quick fix. Program sustainability capitalizes on the idea that building a competent and committed health care workforce is in the interest of educators and employers, as well as the community at large.

Sectoral Workforce Development: Statewide Action

<i>What</i>	California Training Initiative
<i>Where</i>	California
<i>Who</i>	California Employment Development Department
<i>Partners</i>	University of California at Los Angeles, University of California at San Francisco, long-term care providers, labor organizations, education and training providers
<i>Funding</i>	Workforce Investment Act, Welfare-to-Work
<i>Vision</i>	Ensure that California's communities have well-trained caregivers necessary for all levels of care for the elderly population; communities have caregivers necessary for continuity of long-term care; caregivers have opportunities for entry-level employment and for career advancement.

As part of the Governor's Aging with Dignity Initiative, the Caregiver Training Initiative (CTI) awarded \$25 million in grants to assist in developing qualified caregivers to meet the growing needs of California's aging and disabled populations. The program will test various recruitment, retention and training methods within the long-term care workforce. Twelve grants were awarded to the state's nine regions. Grantees are regional partnerships comprised of multiple counties, community colleges, investment zones, area training collaborations, and the long-term care industry and welfare programs. A state advisory council -- comprised of providers, educators, businesses, labor organizations and state agencies -- provides program guidance and oversight.

Grantee activities vary depending upon regional variation in long-term care workforce needs, but often include career ladder opportunities for CNAs interested in becoming LPNs, RNs and nurse practitioners. Programs target both current and new workers, including welfare recipients, low-income individuals, dislocated homemakers, migrant workers and "aged out" foster youth. Grant programs will be carried out over 18 months and are expected to train 5,000 workers. The regional partnerships that are formed through the grant program are expected to support program sustainability after the grant ends.

The program has commissioned two studies:

- The California Employment Development Department studied how labor supply and demand principles affect direct care worker shortages in long-term care. The report found that compared to other occupations, caregiver occupations may be viewed as less desirable due to lower wages, fewer benefits, higher risk for injury/illness, certification requirements and less opportunity for advancement. The study suggests ways in which providers can position themselves to successfully recruit and retain caregivers in this market, such as job redesign, positive marketing campaigns and career path development.⁵⁴
- The University of California at Los Angeles and the University of California at San Francisco analyzed wages, benefits and job stability for caregivers. The report found a significant wage spread across employers for entry-level caregivers, although on average it is \$7.00 an hour. Examination of benefits showed that most full-time caregivers have benefits, but part-time caregivers do not. The majority of caregivers are part-time. Analysis of job stability found high levels of turnover, with lower wage caregivers experiencing the highest level of job instability.⁵⁵

Flexible Solutions: Enabling Providers to Support Workers

What	TANF Health Worker Training Initiative
Where	New York
Who	New York Department of Health, New York State Department of Labor, Office of Temporary and Disability Assistance, Office of Children and Family Services
Partners	Nursing homes, home care agencies, hospitals, related not-for-profit association
Funding	TANF
Vision	Support the recruitment, training and retention of individuals eligible for TANF for jobs in the health care sector, including hospitals, nursing homes and home care service sectors.

The TANF Health Care Worker Training Initiative is a \$100 million program to implement interventions at the provider level that will improve the recruitment, training and retention of entry-level health care workers, including those in long-term care. The initiative awards grants on a competitive basis to hospitals, nursing homes and home health agencies, as well as related non-profit associations. In the first round of grants, nearly 80 percent of funds awarded to nursing homes and home agencies. The initiative targets both new and existing workers eligible to receive TANF benefits.

Funds can be used to:

- Conduct needs assessments to determine appropriate training needs.
- Provide training including remediation.
- Do basic skill development and educational enhancement.
- Provide retention programs, such as career ladder and subsidies.
- Supply supportive services, such as childcare or transportation subsidies.

The funds cannot supplant existing funds used for services such as childcare, transportation and CNA training when the participant is eligible to benefit from these programs. Preference is given to grant applicants whose project design includes training for long-range employment potential or recruitment into

⁵⁴ Rickles, J and Ong P.M. (2001) California Caregivers: Preliminary Labor Market Analysis, California Employment Department.

⁵⁵ State of California Employment Development Department, Labor Market Information Division. (2000). *The Quest for caregivers: Helping seniors age with dignity.*

high demand health care jobs; have labor union concurrence where appropriate; and develop linkages with social service agencies, Workforce Investment Act Agencies and other community resources.

Rural Strategies: Training Welfare Recipients for Work

What River Bend Health Care Provider Training
Where Vermont
Who River Bend Career and Technical Center
Partners Vermont Department of Prevention, Assistance, Transition and Health Access (PATH), nursing homes, hospitals
Funding Partially through TANF
Vision To address the shortage of health care workers in the region and prepare welfare recipients for self-sufficiency.

The River Bend Health Care Provider Training program offers CNA training opportunities to welfare recipients. The program is a partnership between the River Bend Career and Technical Center, local health and long-term care providers and the Department of Prevention, Assistance Transition and Health Access (PATH), which administers the TANF program for Vermont. The partnership is an outgrowth of PATH's interest in offering more training opportunities for welfare recipients and the community's need for more CNAs. PATH views CNA training as a way for welfare recipients to gain self-sufficiency by developing a skill set that is in high demand. in an industry that offers relatively high wages and good health benefits.

Referrals to the program are screened to identify individuals who would benefit from literacy skill development and/or employability training. These services are provided before and during the program to improve participants' chances for success.

The program provides both classroom and clinical training. Provider partners, including nursing homes, serve as sites for clinical training. The eight-week program is scheduled so that TANF work activity rules are met. Although adult classes are traditionally during the evening, this program makes a point to schedule classes and clinical time during the day because childcare is generally easier to obtain then.

Immediately after graduating from the program, students are placed in employment available through providers who have committed to hiring graduates from this program. As graduates become employed and increase their earned income cash benefits end, however supportive services continue for up to 12 months through PATH's JobKeeper program. This program provides assistance with transportation, childcare and other needed supports to help employees succeed on the job as they transition out of welfare. To date, the program has graduated its first class of CNAs and generated many more interested participants.

HCR Manor Care Partnership with Job Corps

What HCR Manor Care
Where Pennsylvania and Cleveland
Partners HCR Manor Care facilities, Pennsylvania Keystone Job Corps centers, Cleveland Job Corps centers
Funding Job Corps

HCR Manor Care, one of the largest long-term care providers in the country, has been using Job Corps to improve recruitment and retention over the past four years. Perhaps the best-known long-term care

provider-Job Corps partnership, HCR Manor Care began by establishing a relationship with the Keystone Job Corps Center in Pennsylvania. Since that time, the provider network has established relationships with more than 25 Job Corps centers.

HCR Manor Care facilities partner with their local Job Corps centers by serving as clinical training sites, offering shadowing and internship opportunities, and hiring program graduates. HCR Manor Care has helped several Job Corps campuses update their CNA training program to better meet their workforce needs and improve Job Corps students' success once on the job. Most recently, the provider network has partnered with the Pennsylvania Keystone Job Corps and Cleveland Job Corps centers to establish on-campus LPN programs.

Although HCR Manor Care's experience has been positive, it cautions that Job Corps participants require extended orientation and ongoing support to be successful. Support may include everything from assistance with transportation or childcare to help with managing personal responsibilities such as balancing a checkbook.

HCR Manor Care recruits an estimated 400 Job Corps students each year. While the provider network does not analyze retention and performance rates for Job Corps employees specifically, it says that "facilities derive immediate value from their involvement with Job Corps" and consider the partnership a success. The partnership is valuable to Job Corps, because HCR Manor Care "offers students decent health insurance benefits, competitive wages and the opportunity to advance through career ladders."

Cascades Job Corps Center

<i>What</i>	Cascades Job Corps Center Training for CNAs
<i>Where</i>	Washington State
<i>Partners</i>	Cascades Job Corps Center, Mira Vista long-term care facility
<i>Funding</i>	Job Corps

Cascades Job Corps Center, a 327-student campus in Washington State, prepares students for successful work lives while providing employers with workers who have the skills needed in today's work force. Cascades offer training in 11 vocations, including CNA, which they have provided for 15 years. On average, 100 students complete CNA training every year at Cascades and many go on to complete advanced training as an LPN or RN through Cascade's Advanced Training program at Skagit Valley College.

Mira Vista, a 94-bed skilled nursing facility, is a long-term care provider who has partnered with Cascades to address a workforce shortage. Mira Vista states that its experience with Cascade's students has been "very positive," helping them to address both temporary and continuous workforce shortage needs. Mira Vista staff says Job Corps students are "diverse, motivated and excited to apply their classroom knowledge on the job." Mira Vista views itself as a starting point for students, many of whom continue to work at Mira Vista part-time while studying to become nurses and physicians.

While Mira Vista has not found it necessary to make special accommodations for students, it does offer "student-friendly" schedules for Job Corps students -- just as for all of their employees -- to support their continued education and training. Mira Vista believes that it "has become a more diverse and stronger organization because of affiliation with the Cascades Job Corps Center."

In addition to Mira Vista, Cascades has partnered with ten other local long-term care providers including nursing homes and assisted living facilities. Providers generally offer employment both before and after employees obtain their nurse aide certification, shadowing days where students learn about the rewards of

working in long-term care, clinical training as part of their CNA training program, and volunteer opportunities.

School-to-Work Apprenticeship in Ohio

What CNA Apprentice Program
Where Ohio
Partners Englewood Manor Nursing Home, Miami Valley Technology Center, Department of Labor National Registered Apprentice Program

Englewood Manor Nursing Home in Ohio has operated an active CNA apprenticeship program for two years. Many of Englewood's apprentices have been recruited from the Miami Valley Technology Center, a vocational education school. The center offers high school juniors and seniors a program of applied academics and hands-on experience in more than 50 high tech careers. Students have an opportunity to earn high school credit while completing a "school-to-work" CNA apprenticeship in long-term care.

As in most school-to-work programs, Englewood's apprentices complete all of their classroom instruction at the center. In addition to providing classroom instruction, the center provides substantial technical assistance to Englewood, including registering Englewood as an apprenticeship site, recruiting apprentices, developing on-the-job training standards and monitoring apprentices' progression through weekly progress reports.

Englewood's success relies on the relationship that it has with the center and its students. Long-term care providers serve as guest lecturers, participate in job fairs and sit on the school-to-work program advisory committee, where they provide input on program development. Englewood states that its CNA apprentices are "trained as you would like them to work" and that "students are more motivated to learn and do a good job because they have the added goal of completing their apprenticeship." Students see the apprenticeship program as a first step toward a career in long-term care and a way to make money while earning high school credit. While the program does not guarantee retention for more than one year, some apprentices remain full-time employees. Others continue part-time employment while continuing their education to become nurses and other long-term care professionals.

Englewood uses its apprenticeship program as one tool in a multi-faceted approach to improve recruitment and retention of quality direct care workers. The apprenticeship program offers them an opportunity to leverage an untapped source of workers -- high school students -- who are prepared to meet their specific workforce needs.

Combining Apprenticeship and Distance Learning in Rural Areas

What Comprehensive Model for Long-Term Care Apprenticeship
Where South Dakota
Partners South Dakota State Office on Apprenticeship and Training, local universities, long-term care providers

Like other rural states, South Dakota is experiencing a migration of direct care workers from small rural communities to metropolitan areas. These workers move to metropolitan areas to pursue training in long-term care that their own communities do not have the capacity to provide. Without instructors and training programs in long-term care, these students leave their communities and often do not return. Because most of South Dakota is rural, this migration contributes to critical and widespread direct care workforce shortages in long-term care throughout much of the state.

In response, the South Dakota State Office on Apprenticeship and Training is developing a comprehensive model for long-term care apprenticeship, using distance learning technologies to build training capacity in rural communities. The model will use local long-term care providers for on-the-job training and university professors for classroom instruction via distance learning technologies. CNAs, LPNs and potentially RNs will be prepared to work in long-term care.

While the model is only in the early planning stages, South Dakota apprenticeship officials are optimistic that it will improve training opportunities in rural communities, thereby helping to address the direct care workforce shortage in long-term care. Because the model is by nature decentralized -- provider-based on-the-job training and classroom instruction through distance learning technologies -- program officials believe that eventually it could be adopted throughout the country.

CONCLUSION

Options for addressing workforce shortages in long-term care often require job preparation, training resources and job supports those long-term care agencies and providers are not able to assemble independently. This report has identified five federal programs -- the Workforce Investment Act, the Perkins Act, Temporary Assistance for Needy Families, National Registered Apprenticeship and Job Corps -- that are being used by state agencies, academic institutions and long-term care providers to recruit and train direct care workers for the long term-care field. These programs offer flexible opportunities to address the direct care workforce shortage, including short-term solutions -- such as CNA training, childcare and transportation -- and long-term solutions such as familiarizing youth with careers in long-term care. By partnering with these programs, long-term care providers and policy-makers can build upon their mutual interest in moving job seekers into successful employment in long-term care.

Health Care Industry: Identifying and Addressing Workforce Challenges

Executive Summary⁵⁶

Alexander, Wegner, & Associates
February 2004

PREFACE

The following is a report prepared by Alexander, Wegner, & Associates for the U.S. Department of Labor, Employment and Training Administration's Business Relations Group. This report details what the U.S. Department of Labor, Employment and Training Administration (DOL ETA) has learned from employers, employees, educators, workforce professionals, and researchers about health care workforce challenges and solutions. It provides the basis for developing strategic partnerships that include industry, education, and the public workforce system.

At the federal level alone the public workforce system invests over \$15 billion each year providing employment and training services to people who need them. ETA is always looking for more effective and efficient ways to use these resources. The Initiative, of which this report is a part, is directed toward forging these partnerships and making these improvements.

To address workforce needs in health care and other industries, ETA created the Business Relations Group. Recognizing that workforce development is part of economic development, the Business Relations Group's focus is on the *education*, *employment*, and *economic development* partnerships that are needed to fuel our nation's economy. ETA's goal is to prepare the workforce system to better serve the needs of business, and to connect businesses with the workforce system through targeted initiatives.

Based on ETA's review of major areas of job growth, the health care industry was selected as one of 12 industries for the High Growth Job Training Initiative.

The reality of the situation allows employers the opportunity to reach out and offer jobs in health care that are enticing to potential job seekers. Health care occupations are attractive because they are located across the nation, provide a professional work environment, and are portable. The health care industry needs greater diversity among its workforce, and therefore may be attractive to new labor pools. There is an increased building of career ladders and lattices that are available to workers so they can shape their careers.

Meeting the short-term needs and the projections for the coming decade is only part of the challenge. The long-term care sector alone will see an increase of 5.7 to 6.6 million direct-care workers by the year 2050.⁵⁷ Even the most optimistic hopes for increased technological solutions or improvements in the health of Americans will not prevent this increased need for direct care workers.

ETA heard from employers, and others associated with health care, of some of their actions to identify challenges and implement effective workforce strategies. ETA heard of the pressures they experience to

⁵⁶ The full paper is available online at <http://www.doleta.gov/BRG/pdf/pdf3.pdf>.

⁵⁷ U.S. Department of Labor. Bureau of Labor Statistics. July 2002. *Projected Growth Rates by Industry (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation)*.

do much more, to do it quickly, and to do it in a way that is sustainable over a long period of time. Health care leaders are committed to dealing with major workforce issues. However, the challenges they face are far too complex for any one institution or sector to solve alone. It has never been more important for ETA to build partnerships between employers, employees, educators, workforce professionals and government.

The Employment and Training Administration and the public workforce system will now move to partner with industry and education institutions to act on solutions from this report that highlight innovative ways that the workforce system can be a catalyst for meeting the health care industry's workforce needs.

To those who gave generously of their time, effort and other resources for this initial work -- thank you for your thoughtful contributions. To those reading about this initiative for the first time -- ETA looks forward to your contributions to building a responsive and sustainable health care workforce system throughout the country.

As ETA heard from different industries, it found several workforce challenges that are common throughout different sectors. ETA will look to partner to address these workforce problems across industries. Solutions will be categorized under the following categories: pipeline, competency models, post-secondary and alternative training, new labor pools, retention, transitioning/declining industries, and small businesses.

EXECUTIVE SUMMARY

A top priority for the Department of Labor's (DOL) Employment and Training Administration (ETA) is serving America's workers through effectively meeting the workforce needs of business. The High Growth Job Training Initiative of ETA and its Business Relations Group recognizes that workforce development is not separate from economic development but an integral part of it.

The health care industry was selected as one focus within the High Growth Job Training Initiative. Health Services comprised 5.8 percent (\$589.9 billion) of Gross Domestic Product in 2001.⁵⁸ In 2002, the total employment in health services was 11,529,000.⁵⁹ The Labor Department's Bureau of Labor Statistics projects that the industry will add 3.5 million new jobs, or 16 percent of all wage and salary employment, between 2002 and 2012. Nine out of the twenty fastest growing occupations will be in health care.⁶⁰

Significant workforce supply and demand gaps currently exist across the U.S. that affect acute care, long-term care and primary care health care provider sectors. These gaps are even more significant across all three sectors in rural America.

This report provides the results of *information gathering* from key health care informants regarding workforce issues as reported by the 'demand' side of the workforce. The provider or owner/operator associations employing the greatest numbers of health care workers are the primary employer informants. Parallel to meetings and interviews with employers, relevant workforce reports and information were sought from the DOL Bureau of Labor Statistics, the Department of Health and Human Services Health Resources and Services Administration, health care workforce researchers, reports of provider associations, educators, public and private workforce professionals -- including Workforce Investment Boards, and the contacts suggested in interviews with members of these sources.

⁵⁸ U.S. Department of Commerce. Bureau of Economic Analysis. November 2002. *Gross Domestic Product by Industry for 2001*.

⁵⁹ U.S. Department of Labor. Bureau of Labor Statistics. February 2004. *Monthly Labor Review*.

⁶⁰ Ibid.

The initial *analysis* of the information generated concluded with a clustering of the workforce issues or challenges by topic and by sector within the health care industry:

- Pipeline Challenges/Issues: Recruitment and Retention
 - Increasing available labor pool
 - Increasing diversity and seeking workers from non-traditional labor pools
 - Reducing turnover
- Skill Development Challenge/Issues
 - Entry-level worker preparation
 - Incumbent worker training
 - Need for targeted and specialized areas of skills
- Capacity of Education and Training Providers Challenges/Issues
 - Lack of academic and clinical instructors
 - Lack of facilities and resources
 - Lack of alignment between employer requirements and curricula, and specialized skills areas
- Sustainable Workforce: Leadership, Policy, and Infrastructure Challenges/Issues
 - Need for sustainable and adaptive workforce partnerships at national, state and local levels
 - Opportunities to leverage funding and other resources
 - Planning tools (data, projections, and information systems that are useful in projections of demand at the single facility and local levels)
 - Policy issues including those of regulation

The majority of the workforce issues reported are the same or similar across primary, long-term care and acute care sectors. For example, all types of provider groups report that the current number one problem in occupational vacancies is for registered nurses. There are, however, some identifiable differences among the provider sectors. For example, long-term care providers identify a serious concern regarding the current and projected supply/demand gap of senior managers, while neither acute nor primary care providers share the same degree of concern. The acute care providers' vacancies include a significant number of direct care workers, medical diagnostic and treatment technologists and support workers. The rural health vacancies across a wide spectrum of occupations are of continuing concern and made more problematic with the current vacancy rates nationally.

A second step in *information gathering and analysis* was performed prior to and during the course of three Workforce Development Industry Forums held in October 2003. The 126 forum participants were selected from a pool developed through nominations from owner/operator associations, the National Association of State Workforce Agencies, the National Association of Workforce Boards, the American Association of Community Colleges, and other workforce leaders from whom project staff had previously sought information. Some of the participants represented health care workforce projects currently funded by the Employment and Training Administration. Participants were asked to complete a validation tool containing challenges gathered in Phase I and invited to suggest additional issues. In addition, at the forums they were presented with an overview of the challenges and issues and asked for additional input. No changes in the challenges were made.

Participants in the forums were assigned to one of four groups. They clarified challenges or issues, generated 1001 solutions, and ranked the solutions by a voting procedure. For the 83 highest-ranked solutions, small teams worked to develop a matrix that includes the challenge, the solution, critical attributes for a successful solution, key stakeholders, resources required, policy barriers at the local, state and national or federal level, and any other needed clarifications.

The highest-ranked solutions include recommendations in the following areas:

- Issue: Pipeline: Recruitment and Retention
 - Solution: Creating and expanding youth-focused programs to better inform young people about health care careers and encourage them to consider health care occupations.
- Issue: Pipeline: Recruitment and Retention
 - Solution: Ensuring that public workforce programs provide adequate preparation of entry-level workers in the basic knowledge required to enter many health care occupations, adequate social and financial supports during the training period, opportunities for work placement, and support during the transition to the workplace so these workers can succeed and be retained in the health care industry.
- Issue: Pipeline: Recruitment and Retention
 - Solution: Marketing health care career opportunities to youth, potential worker pools that do not traditionally enter the health care industry, dislocated workers, immigrant communities, older workers, and traditional worker pools.
- Issues: Pipeline: Recruitment and Retention and Skill Development
 - Solution 1: Attracting and retaining workers through significant improvement of the “culture” of the health care workplace by implementing shared governance, incumbent worker training, career ladders, access to education and training opportunities, and other attributes identified by employees, researchers, and from exemplary continuous improvement programs.
 - Solution 2: Providing management training and credentialing in long-term care, consistent with this type of workplace improvement.
- Issue: Skill Development
 - Solution: Designing health care occupation curricula that provide the basic knowledge and skills needed for effective entry to practice in the high-growth areas of employment in primary care, long-term care and acute care sectors. Develop curricula so that there is a fit between programs for advancing the careers of health care workers (often provided through the workplace) and the requirements of the educational institutions.
- Issue: Skill Development
 - Solution: Examining the state credentialing requirements with the goal of expanding less traditional paths to meeting occupational requirements, such as career ladders, apprenticeships and other workforce development strategies. Creating “cross walks” from practice to educational programs and credentialing requirements based on nationally developed measurement of worker skills.
- Issue: Capacity of Education and Training Providers
 - Solution: Addressing the capacity problems (i.e., lack of faculty, resources, etc.) in many community colleges and other post-secondary education and training organizations where barriers to applicants exist and where there are inadequate numbers of qualified applicants for actual or projected demand for some health service occupations. Capacity is affected by lack of faculty and other resources.
- Issue: Sustainability: Leadership, Policy, and Infrastructure
 - Solution: Partnering among a wide range of stakeholders in the health care workforce in order to project changes in workforce demand at the local/regional, state and national levels and to generate long term, efficient, and sustainable approaches to those changes.

- Issue: Sustainability: Leadership, Policy, and Infrastructure
 - Solution: Developing methods for projection of medium-term occupational needs that can be used by a health care entity, such as a hospital or home care agency, as a basis for internal planning and for planning with partners in education, workforce development and other health care workforce stakeholders.

The Department of Labor Employment and Training Administration's Business Relations Group reviewed the solutions generated during the Workforce Development Industry Forums. The purpose of the review was to:

- Identify for referral those solutions that are both the responsibility of other entities and not in the domain of the Department of Labor;
- Identify solutions that are jointly in the domain of the Department of Labor and another federal department;
- Identify solutions where the Department of Labor or the public workforce system already have program commitments; and,
- Identify solutions within the Department of Labor's domain that if implemented effectively and widely will have a significant impact on managing the present and future workforce challenges of the health care industry. The latter group of solutions was examined by asking the question: "How can the Employment and Training Administration best use its resources and influence to have a positive impact on the challenges identified by the health care industry?" The solutions selected for initial action are ones that can be adapted to many settings, that are built on partnerships among stakeholders, that provide other opportunities to leverage resources (including funding), and that are relevant to the basic problem of adapting the workforce to changing industry needs.

The solutions anticipated to have the clearest impact include the following program areas:

- Youth-related programs developed and implemented by partnerships that include schools, health care employers, post-secondary programs for health occupations, and public workforce system entities.
- Programs focused on non-traditional and traditional pools for health care entry-level workers that both broaden approaches to preparation programs and enhance career mobility in health care and related industries. Competency models for these programs should be developed through a partnership of educators, employers, and workforce professionals.
- Initiatives that meet the needs for academic and clinical faculty in high-demand health care education programs and that are designed to adapt to changing levels of workforce demand.
- Programs that deal with the community college and other educational organizations' insufficient capacity through innovative partnerships and other approaches. These capacity issues include the need for appropriate clinical practice opportunities, funding for students, diagnostic and treatment equipment, and laboratory support.
- Improvement of health care workplaces by interventions such as management training, incumbent worker training, career mobility programs, accessible education and training opportunities, and reducing staff fluctuations through workforce projections.
- Effective initiatives to build a sustainable national infrastructure with local, state, and national elements tasked with continuous balancing of workforce demand and supply within the health care industry.

The majority of the solutions identified by forum participants are not sector specific. However, many solutions can be adapted to the particular needs of a sector or a community.

National, State and Local Partnerships for Implementing Workforce Solutions

Dealing with workforce challenges in the health care industry requires collaboration at the national, state and local levels, and between these levels. Executive and Workforce Development Industry Forum participants recommend a national, systemic approach that aligns the workforce resources available with the challenges facing the health care industry today and well into the future. This direction is consistent with the thinking behind the High Growth Job Training Initiative.

A central role of the Employment and Training Administration is that of identifying and communicating effective workforce solutions that can be replicated to respond to national challenges such as management training or youth-related recruitment programs. A second aspect of that role is the funding of pilot programs, by ETA alone or in partnerships, that are most effective in dealing with some aspect of workforce challenges, and that are replicable by other entities. At the national level, providers and others also identify the need for a national warehouse of sound and effective workforce interventions with a search engine that makes it possible for a local Workforce Investment Board, a human resources manager, or others to identify solutions that have worked elsewhere.

The actions of state governments and state-level entities are pivotal to any national workforce effort. State government decisions direct how some federal funding is used to support some workforce programs. For example, the Workforce Investment Act provides funding to states, and through the states to local Workforce Investment Boards and workforce-related programs. These funds and others, such as Temporary Assistance to Needy Families and Medicaid, are used to provide training, support, and placement for many occupations including those in health care. It is at the state level that policy and funding decisions are made about higher education, licensing and regulation. Medicaid programs that directly affect employment conditions and delivery of care, worker training, collection of information for programs and policy development, and other initiatives that directly influence the implementation, are among many of the solutions recommended in the Executive Forums and Workforce Development Industry Forums. A sustainable, adaptive and effective workforce strategy in health care requires strong public and private partnerships in every state. Without these partnerships ETA cannot respond adequately to current problems or prevent future ones.

Local partnerships, including Workforce Investment Boards, employers, employees, educators and other community members, are needed to implement workforce solutions closest to health care delivery sites, and to potential labor pools. Through such partnerships, both the workforce demand and supply sides can identify the needs in their own communities. Partners can use their state and national networks to find solutions to better manage their particular challenges.

President's High Growth Job Training Initiative: Health Care Industry⁶¹

Employment and Training Administration, U.S. Department of Labor

The New Americans in Nursing Program, a \$1.4 million grant to Florida International University's School of Nursing, retrains unemployed or underemployed foreign-educated physicians to become registered nurses. (\$60,150 in leveraged funds)

Efficacy of Tutoring to Reduce Health Care Occupation Bottleneck, a \$224,088 grant to Capital IDEA, Austin, Texas, fills the health care pipeline by offering tutoring to students who fail a key course required for graduation in a nursing or allied health occupation. (over \$700,000 in leveraged funds)

Oregon Governor's Healthcare Workforce Initiative is a \$300,000 grant to the State of Oregon to enhance the capacity of educational institutions to provide health care clinical requirements by funding seven Sim Man® real-time interactive human patient simulators. This technology will be used by faculty and over the state's broadband Internet network. (\$450,000 in leveraged funds)

Grow Our Own, a \$4 million grant to the Rio Grande Valley Health Training Alliance for the region surrounding McCallum, Texas, will enroll students in Post-Licensure Specialty Training, create a Skills Workforce Academy, and develop a comprehensive Faculty Sharing Program. (\$4.5 million in leveraged funds)

Specialty Nurse Training is a \$4 million grant to a partnership between the Hospital Corporation of America (HCA) and Broward Community College in Ft. Lauderdale, Fla., and Austin Community College in Austin Tex. To address the nursing shortage, the Florida program will create a distance learning model; the Texas fellowship program will create an intensive, hands-on, accelerated learning setting similar to a medical residency program. Both programs provide approaches that produce quicker results than traditional on-the-job training. (over \$6 million in leveraged funds)

The Hospice and Palliative Care Certificate Program, a \$516,154 grant to Excelsior College, Albany, N.Y., will develop curriculum and deliver an online hospice and palliative care certificate program that can be accessed from any location.

Johns Hopkins Health System's Incumbent Worker Career Acceleration Program, a \$3 million grant to the Johns Hopkins Health System, Baltimore, Maryland, provides a continuum of solutions for incumbent workers to move up the health career ladder starting at entry-level. (\$3.9 million in leveraged funds)

Healthcare Career Lattice: A Model for Enhanced Learning, a nearly \$1.9 million grant to Evangelical Lutheran Good Samaritan Society (ELGSS), addresses the need to attract more youth and other alternative labor pools into health care occupations, including non-nursing occupations. The project, which will operate in North Dakota, South Dakota and Minnesota, will also build the capacity of education providers. (\$1,204,000 in leveraged funds)

The Maryland Healthcare Workforce Initiative is a \$1.5 million grant to the State of Maryland and the Governor's Workforce Investment Board. The grant provides strategies, including scholarships, to

⁶¹ This information is available online at <http://www.doleta.gov>.

enhance the skill levels of nurses along the career ladder and to back fill the gaps left by nurses transitioning into teaching. (\$700,000 in leveraged funds)

Developing Partnerships and Initiatives to Resolve Long-Term Care Workforce Challenges, a \$113,296 grant to the American Health Care Association Foundation, will provide a practical “How To” or “Cookbook” for nursing home managers and administrators combating the nursing shortage in long-term care. The information can be used to spearhead the formation of partnerships across the country.

Recruitment and Retention of Direct-Care Workers, a nearly \$1 million grant to the Paraprofessional Healthcare Institute, will focus on multiple workforce challenges related to recruitment and retention of direct care workers in the long-term care industry. The project, operating in New York, North Carolina and Pennsylvania, will demonstrate problem-solving training curriculum and publish a series of guidebooks and teaching manuals in both English and Spanish on effective paraprofessional workforce development practices. (\$999,902 in leveraged funds)

Three-Year, Hospital-Based Degree Nursing At a Rural Community Hospital is a \$200,000 grant to the Berger Health System in Circleville, Ohio. To increase the number of trained nurses, Berger Health System will provide instructors, space for training, and clinical experiences; Ohio University will supply curriculum and faculty for a three-year, university-based Associate Degree nursing program. (\$405,939 in leveraged funds)

Pueblo Project HEALTH, a \$715,402 grant to Pueblo Community College, Colorado, will assist counties designated as Health Professional Shortage Areas and Medically Underserved Areas. The program delivers training to rural areas through traditional classroom instruction, distance learning, and mobile clinical experiences.

The Contextualized Literacy Pre-LPN Program is a \$192,500 grant to 1199 SEIU League Grant Corporation, New York. The grant will help entry-level health care workers, out of school for a long period of time, to enter LPN training by providing literacy and pre-LPN classes. (\$100,000 in leveraged funds)

Rural Health Care Job Training Pilot Economic Recovery Demonstration Project is a \$1.2 million grant to Columbia Gorge Community College, Oregon. The grant will implement a health care career ladder program with multiple entry points to enable individuals, at any place in their career, to enter or move ahead in the health care field. (\$870,982 in leveraged funds)

Healthcare Services Business Connection is a \$762,659 grant to the Tacoma-Pierce County Workforce Development Council in the State of Washington. Ten regional health care organizations are partnering with the public workforce system to develop of Western Washington Invasive Cardiovascular Technologist Program, a Healthcare Educator Network, and strategies to reach out to minority populations and youth. (\$751,000 in leveraged funds)

Project H.E.A.L.T.H., a \$1.5 million grant to the North Carolina Department of Commerce, is designed to help transition North Carolina workers in declining industries into health care jobs experiencing shortages. (\$170,504 in leveraged funds)

Meeting America’s Healthcare Employment Needs: The Job Corps/Community College Solution is a \$1.5 million grant to Management and Training Corporation. The grant will link Job Corps health care training with advanced training in community colleges leading to certification for health care occupations. It also provides easy access for Hispanic youth to take advantage of English courses and become part of a high-demand bilingual workforce.

President's High Growth Job Training Initiative: Health Care Industry Demonstration Grants⁶²

Employment and Training Administration, U.S. Department of Labor

LOCAL SOLUTIONS WITH NATIONAL APPLICATIONS TO ADDRESS HEALTH CARE INDUSTRY LABOR SHORTAGES

U.S. Secretary of Labor Elaine L. Chao is pleased to announce a series of investments totaling more than \$24 million to counter health care labor shortages. For the past nine months, the U.S. Department of Labor has taken part in forums with health care industry leaders, educators, and the public workforce system.

DOL has sought to understand and implement industry-identified strategies to confront critical workforce shortages. It has listened at sessions conducted by associations representing thousands of health care institutions, and considered viewpoints expressed in-person by over 300 health care leaders. Solutions that have been adopted as a result of eight forums will act as national models through the President's High Growth Job Training Initiative.

This set of solutions cuts across the national labor needs of the health care industry in acute care, long term care, allied health care professions, as well as the unique challenges facing rural areas. It focuses on specific as well as the broader range of challenges in the health care arena, including:

- expanding the pipeline of youth entering the health care profession;
- identifying alternative labor pools such as immigrants, veterans, and older workers that can be tapped and trained;
- developing alternative training strategies for educating and training health care professionals, such as apprenticeship, distance learning, and accelerated training;
- developing tools and curriculum for enhancing the skills of health care professionals for nationwide distribution;
- enhancing the capacity of educational institutions through increased numbers of qualified faculty and new models for clinical training;
- developing strategies to retain and help current health care workers move into higher level positions in shortage areas;
- helping workers in declining industries build on existing skills and train for health care professions.

Overall, grants totaling more than \$24 million are being funded across the nation. They are intended to provide genuine solutions, leadership, and models for partnerships that can be replicated in different parts of the country. The U.S. Department of Labor anticipates offering additional grants in a competitive process later this year.

⁶² This information is available online at <http://www.doleta.gov/BRG/IndProf/HCEIA.cfm>.

SPECIALTY NURSE TRAINING

Grant amount: \$4,000,000 Total (*Florida:* \$2,000,000; *Texas:* \$2,000,000)

Leveraged amount: \$6,076,930
Florida: \$4,303,350 in cash from HCA
149,580 in-kind from Broward Community College
Texas: \$1,624,000 in-kind from St. David's HealthCare Partnership

Grantee: Hospital Corporation of American (HCA)

Key partners: Broward County Community College, Ft. Lauderdale, FL; Austin County Community College, Austin, TX; St David's HealthCare Partnership, Austin, TX

Grant activities will take place in South Florida and Austin, Texas

Challenge

A shortage of critical care nurses threatens the nation's health care system. In addition, without sufficient patient contact, inexperienced graduate nurses cannot fill openings in critical care areas quickly enough. Unless innovative solutions are developed, this lack of experienced nurses will continue to adversely affect health care services in the U. S.

Addressing the Challenge

With its \$4,000,000 grant from ETA, this Specialty Nurse Training pilot program will implement two approaches to address the lack of experienced nurses and set standards that can be replicated across the country. The Florida program will create a distance learning model, and the Texas fellowship program will create an intensive, hands-on, accelerated learning setting similar to a medical residency. Both programs furnish the specialized training nurses need to perform at higher levels more quickly than traditional approaches.

Projected Outcomes

Florida: At least 100 students will enter the critical care core program during the grant's first year. In their second year, these students will specialize in either critical care or the emergency department. Meanwhile, another 100 students will enroll in the critical care core program. When their clinical rotations end, students will be able to provide care on their own. *Texas:* Eighty candidates will complete a year in the Nursing Apprenticeship/Fellowship program, qualifying them to work in specialty areas such as intensive care units, emergency departments, and surgical services.

Sustainable Impact

This grant's partners are committed to these activities beyond the grant period. A new, self-supporting Specialty Training Institute that will offer courses and technical expertise nationally will assure the sustainability of the program. Grant funds will offset start-up costs associated with curriculum development for both programs.

GROW OUR OWN

Grant amount: \$4,000,000

Leveraged amount: \$1,620,000 cash and \$2,837,200 in-kind from participating hospitals.

Grantee: Rio Grande Valley Allied Health Training Alliance -- Weslaco, Texas

Key partners: 10 hospitals, five educational institutions, four counties, two workforce development boards, and one faith-based community organization.

Grant activities will take place in Cameron, Hidalgo, Starr, and Willacy Counties, Texas.

Challenge

Multiple barriers contribute to the severe nursing and allied health professionals shortages occurring in rural border communities. If these barriers are not addressed, the skills shortage will worsen, jeopardizing health care services in these communities.

Addressing the Challenge

With its \$4,000,000 grant, the Rio Grande Valley Allied Health Training Alliance will assist area businesses and community leaders to develop, attract, and retain homegrown talent. Key objectives include enrolling students in Post-Licensure Specialty Training, creating a Skills Workforce Academy for Nursing and Allied Health candidates, retaining them through tuition assistance, and developing a High School Concurrent Enrollment Program and comprehensive Faculty Sharing Program while drawing from Alliance hospitals' supply of Masters of Science in Nursing.

Projected Outcomes

Grow Our Own will: a) Enroll 135 participants in Post Licensure Specialties with a completion rate of 95 percent; b) Prepare 70 students annually in academies; c) Write curricula and learning objectives so that 90 high school juniors and seniors have the annual opportunity to take college classes d) Expand comprehensive case management services to 360 participants with retention rates for all students reaching 90 percent; e) Utilize online coursework by Fall 2005 as part of the Faculty Sharing Program for one allied health specialty; and f) Develop an online, regional scheduling system in 2004 for coordinating 400 students' clinical rotations in Fall 2005.

Sustainable Impact

The members that comprise the Alliance are well positioned to ensure the sustainability of this project beyond the cessation of federal funds.

A SYSTEM FOR UPGRADING INCUMBENT HEALTH CARE WORKERS INTO HIGH-SKILL JOBS

Grant amount: \$3,000,000

Leveraged amount: \$3,900,000 in-kind from Johns Hopkins Health System

Grantee: Johns Hopkins Health System

Key partners: Baltimore City Community College; Community College of Baltimore County

Grant activities will take place in Baltimore, Maryland

Challenge

There is an immediate, severe shortage of skilled health care workers, and a wide range of evidence exists that the demand for these workers will increase while the number of individuals enrolled in accredited programs to receive training for the most critical skills is decreasing. If unaddressed, this problem will continue to threaten the availability and quality of health care in the United States.

Addressing the Challenge

Under its \$3,000,000 grant from ETA, Johns Hopkins Health System will develop and execute an Incumbent Worker Career Acceleration Program, which will be comprised of five components: (1) An

initiative for addressing retention and growth of at-risk workers; (2) A GED and diploma preparation program; (3) An initiative for retraining of employees in declining jobs for emerging jobs; (4) A high-potential worker assessment and skills training program; and (5) An initiative to upgrade training of incumbent workers into critical skills shortage positions.

Projected Outcomes

Johns Hopkins projects an 80% success rate in employment retention for 100-150 employees participating in the Retention and Growth of At-Risk Workers initiative. It also expects to achieve a 70% retention rate among 50 incumbent workers receiving a GED or diploma through this initiative. In addition, of those 70% at least 50% are expected to go on to further skills training and higher-skilled positions. 75 of Johns Hopkins' workers will be assessed, counseled, and provided skills-based training for emerging new jobs. High-Potential Worker Assessment will result in an estimated 200- plus workers entering either remedial education or various skills-based training programs leading to the staffing of more critical skilled positions.

Sustainable Impact

Johns Hopkins is strongly committed to share all initiatives of its Incumbent Worker Career Acceleration Program with the health care industry and the public workforce system.

A MODEL FOR ENHANCED LEARNING

Grant amount: \$1,877,517

Leveraged amount: \$910,000 in cash and \$294,000 in-kind from Evangelical Lutheran Good Samaritan Society (ELGSS)

Grantee: The Evangelical Lutheran Good Samaritan Society, Sioux Falls, South Dakota

Key partners: *In South Dakota:* Lake Area Technical Institute, Watertown; South Dakota State University, Brookings; University of South Dakota, Vermillion; Sioux Valley Hospitals and Health System, Sioux Falls; pullUin software/South Dakota Health Technology Innovations Inc., Vermillion. *In Nebraska:* Bellevue University, Bellevue.

Grant activities will unfold through the use of distance learning technology. Mentoring will be delivered at 25 sites mostly in Minnesota, North Dakota, and South Dakota.

Challenge

Recruitment and retention of health care professionals is especially challenging in rural communities where educational opportunities are limited. Without more access to education, the health care industry's labor pool will keep shrinking.

Addressing the Challenge

With its \$1,877,517 grant, ELGSS will recruit from high schools and non-traditional labor pools such as displaced workers, and collaborate with Sioux Valley Hospitals and Health System to raise public awareness of health care career opportunities. To increase retention, ELGSS will start a Mentor project for entry-level workers and develop Management Certificate training. To build the capacity of education and training providers, ELGSS will deliver online nursing programs up through the Master's degree level. Training will be offered in employees' own ELGSS long-term care facilities -- 50% of which are located in Minnesota, South Dakota, North Dakota, Iowa, and Nebraska -- through an innovative blend of distance learning, mentoring, and clinical experience in health care sites near the employees' homes.

Projected Outcomes

ELGSS will implement an apprenticeship model program for Management Certificate Training with DOL and Bellevue University. ELGSS also will partner with Lake Area Technical Institute to develop and deliver an online LPN program, as well as with South Dakota State University to deliver online BSN and MSN programs, with an emphasis on geriatrics. Each part of the overall project is replicable for use throughout the nation's health care industry.

Sustainable Impact

ELGSS has made a strong commitment sustain this project. Tuition and fees generated by education providers involved in this initiative will sustain their established history of producing qualified nurses.

MARYLAND HEALTHCARE WORKFORCE INITIATIVE

Grant amount: \$1,500,000

Leveraged amount: \$700,000 from State of Maryland Employer Matching Fund

Grantee: State of Maryland

Key partners: To be determined during grant activities

Grant locations: Statewide

Challenge

There are two major challenges facing the health care industry: (1) lack of nurses and allied health professionals; and (2) lack of qualified academic and clinical health care faculty. The lack of faculty is preventing the admission of applicants into nursing and allied health programs which ultimately affects the number of qualified nurses and allied health professionals available for employment. If these two challenges are unaddressed, this worker shortage will have severe and damaging impacts upon the availability and quality of health care services in the United States.

Addressing the Challenge

Under its \$1,500,000 grant from ETA, the Maryland Governor's Workforce Investment Board (GWIB) will address the faculty capacity problem by implementing a scholarship program for nurses who pursue credentials to teach nursing and allied healthcare professions. The GWIB will also implement a scholarship program for Licensed Practical Nurses (LPNs) and other incumbent workers that are seeking their Registered Nurse (RN) credentials to backfill the RNs that pursue their Master's Degree. Additionally, an Incumbent Worker Training strategy will be implemented to assist health care employers to upgrade the skills of existing workers.

Projected Outcomes

The "Teaching for the Health of It" scholarship program will provide 40 one-time only scholarships in the amount of \$10,000 each for nurses pursuing teaching credentials. The other scholarship program will provide 40 one-time only scholarships in the amount of \$10,000 for LPNs and other incumbent workers who are seeking their RN credentials. Partnerships between employers and the community college system will be created to provide allied health care training for incumbent workers.

Sustainable Impact

The GWIB has established a Governor's Healthcare Workforce Steering Committee that consists of members from industry, economic development, employment services, and education to develop and implement collaborative solutions. Currently the health care industry in Maryland spends over \$11,140,000 to educate, attract, and retain health care workers because of the faculty shortfall. The GWIBs and the

Maryland Healthcare Workforce Steering Committee are committed partners for continuing and sharing the model throughout the nation.

PROJECT H.E.A.L.T.H.

Grant amount: \$1,500,000

Leveraged amount: \$170,504 in-kind contributions from most key partners listed below

Grantee: North Carolina Department of Commerce, Commission on Workforce Development -- Raleigh

Key partners: NC Hospital Association, NC Community College System, University of North Carolina System, NC Department of Health and Human Services, NC Area Health Education Centers, JobLink Career Center system, and local Workforce Development Boards

Grant activities will take place in the western, eastern, and piedmont regions.

Challenge

Since the mid-90's, North Carolina's health care industry has experienced severe shortages of registered nurses and direct care workers due to the aging of nurses and nursing educators. Meanwhile, the state has been devastated by worker dislocation.

Addressing the Challenge

With its \$1,500,000 grant, Project H.E.A.L.T.H.: Helping Employers and Labor Transition to Health Care will address North Carolina's critical nursing and direct care worker shortages. It targets the state's large and diverse labor pool of dislocated workers, and will test and expand innovative approaches to worker education, training, and employment in the nursing and direct care workforce sectors. In this model, H.E.A.L.T.H. will work to enhance health career development and employability of dislocated workers and provide the needed support for an education and training institution for nursing.

Projected Outcomes

Up to 450 displaced workers are projected to enroll in Human Resource Development Plus pilot sites that support other initiatives addressing direct care shortages. Additional outcomes include 300 workers expected to enroll in further training, 200 placed in jobs -- of which 120 will be direct care workers. Thirty-three individuals will be placed in degree programs to increase the availability of instructors and applicants for health care programs.

Sustainable Impact

An advisory team drawn from hospitals, the long-term care industry, and key Project H.E.A.L.T.H. partners will build the foundation for sustainability. Project H.E.A.L.T.H. will provide innovative models that can be replicated throughout North Carolina and the nation.

MEETING AMERICA'S HEALTH CARE EMPLOYMENT NEEDS: THE JOB CORPS/COMMUNITY COLLEGE SOLUTION

Grant amount: \$1,500,000

Grantee: Management & Training Corporation, Centerville, Utah

Key partners: *In Illinois:* City Colleges of Chicago and the Metropolitan Chicago Healthcare Council; *In Ohio:* Cincinnati State Technical and Community College and Sinclair Community College; *In Pennsylvania:* Luzerne County Community College and Lehigh/Carbon County Community College

Grant activities will take place at the Paul Simon Chicago Job Corps Center, the Cincinnati Job Corps Center, the Dayton Job Corps Center, and the Keystone Job Corps Center in Drums, Pa.

Challenge

The health care industry faces three key problems: a shortage of qualified health care employees, a lack of bilingual employees, and available, yet untrained out-of-school youth.

Addressing the Challenge

Management & Training Corporation will unite the efforts of Job Corps Centers with community colleges to address the health care workforce challenges in Illinois, Ohio, and Pennsylvania. Job Corps students finished with their vocational training in basic health will be recruited to pursue advanced training and certification at the community college. Additionally, this project provides instruction, assessment, career development, academic training, and support services. It also provides easy access for Hispanic youth to take advantage of English courses, and become part of a high-demand bilingual workforce.

Projected Outcomes

Management & Training Corporation's projects will affect four Job Corps Centers and 125 students, who will ultimately be employed in health care.

Sustainable Impact

Management & Training Corporation, Job Corps Centers, and participating community colleges will provide a firm foundation for sustainability once federal funding has been expended. The model will be documented so that it can be replicated in Job Corps Centers across the nation.

NEW AMERICANS IN NURSING PROGRAM

Grant amount: \$1,421,639

Leveraged amount: \$500,000 in cash from the Hospital Corporation of America (HCA)
60,150 in-kind from Florida International University (FIU)

Grantee: Florida International University School of Nursing

Key partners: Hospital Corporation of America, Nashville, TN

Grant activities will take place in Miami-Dade County and Tallahassee, Florida

Challenge

Nurse shortages left unaddressed will have severe and damaging impacts upon the availability and quality of health care services in the United States.

Addressing the Challenge

With its \$1,421,639 grant, the New Americans in Nursing Program will address the challenges by retraining unemployed or underemployed foreign-educated physicians to become registered nurses.

Projected Outcomes

One hundred nursing students with prior clinical knowledge and experience will graduate during the grant period. Under this grant, FIU also will test distance education through the use of interactive television, with

70 students in Miami and 30 in Tallahassee. The grantee will also share data on the program's effectiveness as a retraining model for other areas of the country.

Sustainable Impact

FIU's School of Nursing, through its strong track record of attracting financial support, will ensure the sustainability of this project. FIU will evaluate this program's impact and effectiveness for foreign physician students and the overall nursing workforce. Because of the large applicant pool of foreign-educated physicians and the worsening nursing shortage, there will be lasting interest from various hospital and corporate entities to support the continuation of this program.

RURAL HEALTHCARE JOB TRAINING AND ECONOMIC RECOVERY PROGRAM IN THE COLUMBIA RIVER GORGE

Grant amount: \$1,250,000

Leveraged amount: \$542,501 from four local hospitals, four long-term care facilities, foundations, and Columbia Gorge Community College; \$328,481 in-kind from health care businesses and Columbia Gorge Community College

Grantee: Columbia Gorge Community College, The Dalles, Oregon

Key partners: Eight area hospitals and health care providers, Region 9 Workforce Investment Board and its One-Stop Career Centers, K-12 school districts, Oregon Health and Science University, and city and county governments

Grant activities will take place in Gilliam, Hood River, Sherman, Wasco, and Wheeler Counties in Oregon; Klickitat and Skamania Counties in Washington.

Challenge

Economic downturns have left high numbers of displaced workers requiring education and retraining to transition into health care positions. Without programs, the health care industry will not be able to draw from this non-traditional labor pool to fill vacancies.

Addressing the Challenge

With its \$1,250,000 grant, Columbia Gorge Community College and its partners will create a Health Occupations Career Ladder Nursing Program to train 200 new workers. CGCC will expand its offerings and opportunities for an Associate Degree in Nursing and a distance learning option for a Bachelor Degree of Nursing Program.

Projected Outcomes

Trainees will emerge from the Health Occupations Program with the skills, licenses, and experience needed for health care employment. Of the 200 trainees who enter the Career Ladder, 85 percent will pass licensing exams, and 85 percent will achieve employment at their target career level within the grant period. Further, 90 percent of incumbent workers will receive pay raises as a result of their additional credentials. Forty nurses of 200 total trainees will have the opportunity to earn a BSN through Columbia Gorge's dual admission agreement with Oregon Health and Science University.

Sustainable Impact

Besides the matching funds already supplied, regional businesses have committed financial support to the program for at least one year after the grant. Also, the Healthcare Demonstration Project grant will be replaced with Oregon State Reimbursement Funds at the end of the grant period.

RECRUITMENT AND RETENTION OF DIRECT-CARE WORKERS

Grant amount: \$999,902

Leveraged amount: \$999,902 cash from the Charles Stewart Mott Foundation and The Atlantic Philanthropies

Grantee: Paraprofessional Healthcare Institute, Bronx, New York

Key partners: Lehman College of New York; North Carolina Foundation for Advanced Health Programs; Workforce Investment Board of Lancaster County, Pennsylvania; local community colleges and workforce investment boards

Grant activities will take place in New York City, in and around Lancaster County, Pennsylvania, and at sites to be determined in North Carolina.

Challenge

The long-term care industry's shortage of direct-care workers is particularly acute in home-based care. Long-term care providers realize that they must transform standard practices regarding recruitment, training, supervision, and support in order to effectively attract and retain new workers as paraprofessionals.

Addressing the Challenge

With its \$999,902 grant, the Paraprofessional Healthcare Institute will provide a range of technical assistance, training initiatives, and materials for the long-term care workforce. Emphasis will be placed on Hispanic caregivers and supporting the nation's Workforce Investment Boards and community colleges in recruiting and training.

Projected Outcomes

The Paraprofessional Healthcare Institute will: (1) develop a recruitment and apprenticeship career-lattice model; (2) create a coaching approach for front-line supervisors, with a curriculum designed for employer-based community colleges; (3) demonstrate a problem solving training curriculum, in partnership with Lancaster's Workforce Investment Board; (4) publish a series of guidebooks, curricula, and teaching manuals -- written in English and Spanish -- on effective paraprofessional workforce development practices; (5) create strategic relations with faith-based health systems capable of bringing about nationwide change.

Sustainable Impact

Well-established partnerships of The Paraprofessional Health Institute, The Charles Stewart Mott Foundation, and The Atlantic Philanthropies along with local community colleges and Workforce Investment Boards will provide a firm foundation for replicating the model throughout the nation after the federal funds have been expended.

HEALTHCARE SERVICES BUSINESS CONNECTION

Grant amount: \$762,659

Leveraged amount: \$200,000 in cash and \$500,000 in-kind contributions from multiple partners

Grantee: Tacoma-Pierce County Workforce Development Council

Key partners: More than 20 organizations ranging from health providers to universities, community colleges, and workforce boards

Grant activities will take place in Pierce County, Washington.

Challenge

Serious health care workforce shortages exist throughout the United States. Without a multi-pronged, regional approach, gaps in the health care workforce will not be filled.

Addressing the Challenge

With its \$762,659 grant, the Tacoma/Pierce County Workforce Development Council will implement four distinct projects to improve and expand the pool of qualified professionals in high-demand health care jobs. The first project confronts a clear need to train invasive cardiovascular technologists; the second targets current health care workers through a Comprehensive Career Coaching Program; the third seeks to establish connections through a Healthcare Educator Network; and the fourth project incorporates multiple strategies to reach out to minorities and youth.

Projected Outcomes

Tacoma/Pierce County Workforce Development Council will (a) admit 15 students to the Invasive Cardiovascular Technologist Program; (b) develop and launch the Healthcare Educator Network website; (c) translate Healthcare Occupations Workshop materials into Spanish, Korean, and Russian; (d) increase the Medical Rotation Program participants by eight; (e) start a Health Summer Camp for youth; (f) increase minority youth participation in job shadow and volunteer programs by 10 percent.

Sustainable Impact

At least 10 regional health care organizations will commit to ongoing funding of the Invasive Cardiovascular Technologist Program. At least 10 organizations, including regional colleges, universities, and the Washington State Nursing Association, will be approached for resources for the Healthcare Educator Network beyond the grant period. The partners involved in the Targeted Populations Outreach Program -- community colleges, the local workforce system, and health care providers -- already have a strong history of collaboration and will continue to work together after the grant ends.

PUEBLO PROJECT HEALTH

Grant amount: \$715,402

Leveraged amount: \$595,062 from grantee and state and local governments

Grantee: Pueblo Community College, Pueblo, Colorado

Key partners: Pueblo Work Link (One-Stop Career Center), Trinidad State Junior College, Parkview Episcopal Medical Center

Grant activities will take place in Colorado's Pueblo, Costilla, Conejos, and Alamosa Counties.

Challenge

A shortage of medical personnel in rural Colorado, communities is compounded by two key challenges. First, many rural communities have Emergency Medical Services comprised of volunteer personnel, who often leave to pursue paid employment elsewhere. In addition, there are no training programs in rural Colorado to prepare health care practitioners.

Addressing the Challenge

With its \$715,402 grant, Pueblo Project HEALTH addresses this shortage by bringing training opportunities to outlying areas, and helps volunteer medical personnel secure paid employment. Pueblo Project HEALTH combines the Emergency Medical and Respiratory Care positions into one hybrid curriculum, and administers their training through traditional classroom instruction, distance learning technology, and mobile clinical experiences. Graduates will be able to secure employment in Respiratory Care and serve as volunteer Emergency Medical Technicians. This project will assist counties that have been designated as Health Professional Shortage Areas and Medically Underserved Areas, and will target minority/disadvantaged individuals.

Projected Outcomes

The hybrid curriculum will prepare individuals for both the Intermediate Emergency Medical Technician and the Respiratory Care Practitioner positions. The number of minority/disadvantaged individuals enrolled in the program will increase significantly during the second and third years of the project.

Sustainable Impact

Pueblo Project HEALTH will result in an innovative curriculum that can be used by community colleges throughout the state. Further, local WIA funds can continue to be a source of funding after ETA demonstration funds expire. Third, Pueblo Project HEALTH is committed to expanding the program throughout the state using the community college system.

HOSPICE AND PALLIATIVE CARE CERTIFICATE

Grant amount: \$516,154

Leveraged amount: \$80,556 in-kind from Excelsior College

Grantee: Excelsior College, Albany, New York

Key partners: Fourteen hospices in New York state, along with one each in Montana, North Carolina, Rhode Island, South Carolina, and Texas

Grant activities will take place at locations determined immediately following implementation. Local hospices will be identified in Montana, New York, North Carolina, Rhode Island, South Carolina, and Texas.

Challenge

Many hospices and their associations have reported that the shortage of nurses is having a significant impact on access to hospice services, and that hospices have had to deny services to eligible patients because they do not have adequate staff to provide nursing care. Without immediate solutions to the hospice nurse shortage, dying patients and their families will increasingly face abandonment by the health care delivery system.

Addressing the Challenge

With its \$516,154 grant, Excelsior College will develop a Hospice and Palliative Care Online Certificate Program (HPCC) that includes a period of practical experience and training supervised by an expert or specialist. In doing so, HPCC will directly address two major national health care workforce needs: (1) expanding the number of registered nurses (RNs) working in the health care field; and (2) creating a stable, highly skilled RN workforce for hospices throughout the nation.

Projected Outcomes

Excelsior College will operate HPCC for 16 months as a pilot program in Montana, New York State, North Carolina, Rhode Island, South Carolina and Texas. The program will serve 60 interns and approximately 30 preceptor supervisors affecting the quality of care of over 15,000 patients from 19 hospice partners.

Sustainable Impact

Excelsior College has over 30 years of experience in developing educational programs for working adults. While other organizations have educational materials for hospice and palliative care, none are online and easily accessible. By the 17th month, the HPCC program will be offered nationally and will be self-sufficient.

OREGON GOVERNOR'S HEALTHCARE WORKFORCE INITIATIVE

Grant amount: \$300,000

Leveraged amount: \$200,000 in cash and \$250,000 in-kind from the State's Employer Workforce Training Fund

Grantee: Governor's Healthcare Workforce Initiative, Salem, Oregon

Key partners: *In Portland:* Oregon Consortium for Nursing Education (OCNE); Oregon Center for Nursing; Northwest Health Foundation. *In Tualatin:* Oregon Health Career Center; Community College Healthcare Action Plan.

Grant activities will take place statewide.

Challenge

Overcoming nursing shortages requires that the education system devise ways to supply clinical facilities and faculty. Otherwise, the education system will be unable to fill the pipeline with qualified nurses.

Addressing the Challenge

With its \$300,000 grant, the Oregon Governor's Healthcare Workforce Initiative will purchase seven SimMan,® real-time interactive human patient simulators made by Laerdal Medical Corporation. The simulation technology will be integrated into health care curricula for use by well-prepared and networked faculty, available over the state's broadband Internet network, and affordable for all education and service groups in the state.

Projected Outcomes

The Governor's Healthcare Workforce Initiative will report on the use of simulators to ensure that they: (a) Increase the capacity of educational programs; (b) Increase access to simulation-based education; (c) Increase simulation technology expertise statewide; and (d) Prove satisfactory as a quality educational tool.

Sustainable Impact

Firm commitments from community colleges, universities, high schools and health care organizations will help to ensure this project's long-term sustainability. This project's major stake-holding partners have each demonstrated their continuing efforts to meet the demand for a qualified health care workforce.

EFFICACY OF TUTORING TO REDUCE HEALTH CARE OCCUPATION BOTTLENECK

Grant amount: \$224,088

Leveraged amount: \$456,091 in cash contributions from public and private sources.

Grantee: Capital IDEA, Austin, Texas

Key partners: *In Austin:* Austin Community College; Seaton Healthcare Network; St. David's Healthcare Partnership; Austin Heart; Worksource-Greater Austin Area Workforce Development Board; *In San Marcos:* Central Texas Medical Center.

Grant activities will take place in Central Texas.

Challenge

A Department of Labor-funded research project in Central Texas found that candidates for health care occupations had a very high failure rate in a key prerequisite course, Anatomy and Physiology I (A&P I). About one-third of students interested in health care careers were eliminated by A&P I. Taking A&P I multiple times delays admission for approximately one-quarter of the students.

Addressing the Challenge

With its \$224,088 grant, Capital IDEA will test a strategy that starts tutoring the first week of classes in order to: (a) Increase the success rate of students, thereby reducing the extra expense of tuition, counseling, child care, and time associated with students repeating the course; (b) Accelerate graduations; and (c) Increase the success rate of disadvantaged students. Rather than take remedial action after students fall behind, the tutoring will raise their chances of enrolling in a nursing or allied health occupation.

Projected Outcomes

The Capital IDEA project will increase the percentage of students achieving a C or better in A&P I from 50 percent to at least 70 percent. Students achieving a B or better will rise from a baseline of 25 percent to at least 45 percent. Removing this bottleneck will then enable students and lower-skill hospital employees to advance to the career training courses much more quickly, thus addressing recruitment and retention issues of health care employees.

Sustainable Impact

Capital IDEA is a joint effort of Austin Interfaith and leaders in the business community, including the area's two largest hospital systems. Along with Austin Community College and local Workforce Investment Boards, a firm foundation for continuing the model will be in place after federal funds have been expended.

TELELINK CONSORTIUM NETWORK

Grant amount: \$215,600

Leveraged amount: \$196,000 in cash and in-kind contributions from key partners listed below.

Grantee: Telelink Consortium Network, Ashland, Wisconsin

Key partners: Burnett Medical Center, Grantsburg; Flambeau Hospital, Park Falls; Memorial Health Center, Medford; Memorial Medical Center, Ashland; Northwest Wisconsin Workforce Investment Board, Ashland

Grant activities will take place in Northwest Wisconsin.

Challenge

Small, rural health care providers often do not have the resources to implement the continuous training and skills-upgrading programs necessary to keep employees.

Addressing the Challenge

With its \$215,600 grant, the Telelink Consortium Network (TLC) will establish ongoing, collaborative relationships among rural health care providers in Northwest Wisconsin and the One-Stop Career Center system. TLC will pool financial, material, and human resources of small, remote hospitals and clinics for the purposes of increasing the supply and retention of health care professionals.

Projected Outcomes

TLC's efforts will concentrate on delivering higher skills training using appropriate, cost effective, web-based means. Training topics will include continuing professional development, managerial subjects, and skills upgrading in such areas as sonograms, Xrays, CAT scans, and MRIs -- all of which have a significant impact on worker retention. Under the project, 300 incumbent workers will complete at least one professional development/skills upgrading module, and a 15 percent larger pool of candidates interested in training for higher skilled health care occupations will be created.

Sustainable Impact

Four of the region's largest hospitals form the core of the TLC Network, and have agreed to take responsibility for the sustainability of this project. A combination of TLC Network membership fees and access fees will be the specific method for achieving self-sustainability.

THREE-YEAR, HOSPITAL-BASED NURSING DEGREE AT A RURAL COMMUNITY HOSPITAL

Grant amount: \$200,000

Leveraged amount: \$405,939 cash and in-kind contributions from Berger Health System

Grantee: Berger Health System, Circleville, Ohio

Key partners: Ohio University

Grant activities will take place in Pickaway County and adjacent counties and small cities in Ohio.

Challenge

The acute care sector in rural areas experiences nursing shortages due to up-front costs for education and books, lack of role models, and a lack of knowledge of career opportunities. Hence, rural citizens often do not take advantage of the opportunity to attain the professional goal of becoming a registered nurse. There is also a lack of capacity at the local university to educate all qualified nursing school applicants.

Addressing the Challenge

With its \$200,000 grant, the Berger Health System and Ohio University will meet the needs of the rural community hospital by holding all classes and clinical rotations at the Berger Hospital facilities for the three-year, university-based Associate Degree nursing program. Berger Health System agreed to sponsor one instructor, provide space, and accept students into clinical rotations. Ohio University agreed to supply the curriculum, faculty, and degrees.

Projected Outcomes

The Berger Health System and Ohio University will educate 30 incumbent employees and non-traditional students to become registered nurses in a community hospital versus a university setting. They also will document their progress and results so that the program can serve as a framework for other rural communities and hospitals.

Sustainable Impact

The project provides new and innovative ways to meet educational and workforce needs in rural regions. Due to the strong partnerships of the Berger Health System, Ohio University, and the local community, the project will serve as a model and be able to be repeated throughout the nation.

THE CONTEXTUALIZED LITERACY PRE-LPN PROGRAM

Grant amount: \$192,500

Leveraged amount: At least \$100,000 in matching funds from Service Employees International Union's Training and Upgrading Fund (TUF)

Grantee: 1199 SEIU League Grant Corporation -- New York City

Key partners: NYC Department of Education; the Consortium for Worker Education

Grant activities will take place in New York City, Nassau, and Westchester Counties.

Challenge

Shortages of nursing and affiliated health care workers will have severe impacts upon the availability and quality of services if they are not addressed. One strategy for addressing the need for Licensed Practical Nurses (LPNs) calls for low-level health care workers to complete LPN training programs and secure employment. However, the challenge of the work-family balance, as well as other issues, make it difficult for workers who are new to academic environments to perform well on training programs' entrance exams.

Addressing the Challenge

SEIU's TUF will expand its Contextualized Literacy Pre-LPN Program, which combines literacy and job training in preparation for LPN programs. This pre-LPN program has been designed for low-level health-care workers who have been out of school for a long period of time and have had difficulty passing entrance exams. TUF will provide 10 classes and train instructors, enabling New York City area health care workers to enter LPN programs and find employment.

Projected Outcomes

Pre-LPN classes will prepare 250 students to pass entrance exams and enroll in LPN programs. 90 percent of the 250 participants will complete the pre-LPN program and advance to LPN programs within six months. The number of students in pre-LPN classes that successfully complete the LPN program will increase by 80 percent over last year.

Sustainable Impact

The Contextualized Literacy Pre-LPN Program will have a sustained impact on the LPN shortage because additional instructors will increase the TUF's training capacity. In addition, the pre-LPN program will have a sustained impact because the TUF has demonstrated its commitment to the program, providing at least \$100,000 in matching funds to expand the program. Finally, the program will serve as a replicable model for other entities, with recommendations and best practices disseminated through papers and conferences.

DEVELOPING PARTNERSHIPS AND INITIATIVES TO RESOLVE LONG-TERM CARE WORKFORCE CHALLENGES

Grant amount: \$113,296

Leveraged amount: \$7,615 from the American Health Care Association

Grantee: National Foundation for the Advancement of Elder and Disabled Care in America (part of the American Health Care Association) -- Washington, D.C.

Key partners: George Washington University's Center for Health Services Research and Policy and Wertlieb Educational Institute for Long Term Care Management.

Grant activities will take place at locations determined through research proposed as part of this grant.

Challenge

Adequate staffing of facilities is essential for providing quality nursing home care. Without an infrastructure for this high-growth sector, nursing homes are challenged in building their workforce.

Addressing the Challenge

With its \$113,296 grant, the American Health Care Association will develop an infrastructure of "Best Practice" models that can be expanded, evaluated, replicated, and transported to other areas of the country.

A major objective of this effort includes the development of a practical "How To" or "Cookbook" to build partnerships for combating the nursing shortage in long-term care. Another major objective calls on long-term care providers to develop ways to effectively team up with the public workforce system and take actions that will make the profession an attractive employer.

Projected Outcomes

The American Health Care Association will develop the infrastructure of "Best Practice" models for long-term care facilities along with a "How To" book of best practices, and partner with the public workforce system to make the long-term care sector an attractive employment option.

Sustainable Impact

The American Health Care Association (AHCA) and the National Commission on the Nursing Workforce for Long-Term Care have the foundation to communicate and implement the "Best Practice" models identified by the project.

Keeping America in Business: Advancing Workers, Businesses, and Economic Growth⁶³

102nd American Assembly, Columbia University
February 2003

PREFACE

On February 6, 2003, seventy-five men and women representing business, labor, academia, government, workforce intermediaries, academia, nonprofit organizations and the media gathered at Arden House in Harriman, New York, for the 102nd American Assembly entitled "Achieving Worker Success and Business Prosperity: The New Role for Workforce Intermediaries." For three days, participants examined policies, approaches and actions that need to be taken to assure that workers have access to economic opportunity and to assure that employers have access to the skilled workforce required for them to be globally competitive.

This project was directed by Robert Giloth, director, The Annie E. Casey Foundation; John Colborn, deputy director, Economic Development Unit, The Ford Foundation; and Betsy Biemann, associate director, Working Communities, The Rockefeller Foundation. The project was also ably assisted by a steering committee of distinguished leaders from around the country, whose names and affiliations are listed in the appendix to this report.

Background papers were prepared for participants under the editorial supervision of Robert Giloth and will appear as chapters in a book tentatively entitled *Workforce Intermediaries for the 21st Century*, to be published by Temple University Press in fall 2003. The chapters are listed on the inside back cover.

During the Assembly, participants heard formal addresses by David Ellwood, Lucius N. Littauer Professor of Political Science, John F. Kennedy School of Government, Harvard University; and Jeremy Nowak, president/CEO, The Reinvestment Fund. Richard M. McGahey, managing vice president, Abt Associates, Inc., moderated a panel of Timothy M. Barnicle, co-director, Workforce Development Program, National Center on Education and the Economy; Steve Crawford, director, Employment and Social Services Policy Studies, National Governors Association; and Jackie Edens, Commissioner, Mayor's Office of Workforce Development, Chicago. Mr. Giloth also moderated an introductory panel that included Cynthia E. Marano, director, National Network of Sector Partners, National Economic Development and Law Center; Marlene Seltzer, president, Jobs for the Future; and Julie Strawn, senior policy analyst, Center for Law and Social Policy.

Following their discussions, participants issued this report on February 9, 2003. It contains both their findings and recommendations.

The text of this report is available on both The American Assembly's website (<http://www.americanassembly.com>) and the project's webpage (<http://www.opportunitiesatwork.org>), which also contains links to many of the organizations involved in this project.

We gratefully acknowledge the support of The Annie E. Casey Foundation, The Ford Foundation, The Rockefeller Foundation, The John D. and Catherine T. MacArthur Foundation, and the Open Society Institute, Baltimore.

⁶³ The full paper is available online at <http://www.americanassembly.org/wfi/KeepingAmericaInBusiness.pdf>.

The American Assembly takes no positions on any subjects presented here for public discussion. In addition, it should be noted that participants took part in this meeting as individuals and spoke for themselves rather than for their affiliated organizations and institutions.

We would like to express special appreciation for the fine work of the discussion leaders, rapporteurs and advisors in helping to prepare the final draft of this report: Daniel Berry, Paul Brophy, Terri Feeley, Lisa Kaplan Gordon, Ed Hatcher, Cynthia Marano, Richard McGahey, Julie Strawn, and Orson Watson.

David H. Mortimer
The American Assembly

FOREWORD

Over the past decade, a set of workforce development policies and strategies has emerged to meet the needs of both businesses and low-wage, low skilled workers. In some cases, the results have been nothing less than remarkable: employers are finding a well-trained competitive workforce while at the same time workers are being placed in jobs that can sustain their families.

The opportunity exists to spread this workforce intermediary approach, as this Assembly has named it, to a wider array of existing institutions in order to achieve greater impact. Achieving this impact will not be easy. Employers and job training providers simply adopting “promising workforce practices” won’t get the job done.

The challenge ahead is about transforming workforce development practices in a variety of institutional settings, such as community colleges, workforce boards, labor unions, employer associations, and community organizations. It is about creating and sustaining entrepreneurial organizations that have the commitment and capacity for innovation and to build partnerships, learn, change directions, and relentlessly pursue results.

Transforming workforce development practices, however, will only occur if there is top-level leadership committed to this agenda. Public and private workforce development resources must lay the groundwork to support the pursuit and achievement of substantial results.

The report of this American Assembly provides hope and, most importantly, direction for a broad spectrum of workforce practitioners, business organizations, and advocates who are ready to take on this challenge. Given the current and impending workforce crises that threaten the future of America’s families and businesses, the time is right.

We are proud to have supported and participated in this important civic dialogue. But this is just the beginning. We look forward to working in collaboration with our workforce development colleagues to advance this critical agenda in the months and years to come.

Betsy Biemann
John Colborn
Robert Giloth
Co-directors
The 102nd American Assembly

At the close of their discussions, the participants in the 102nd American Assembly on “Achieving Worker Success and Business Prosperity: The New Role for Workforce Intermediaries,” at Arden House, Harriman, New York, February 6-9, 2003 reviewed as a group the following statement. The statement

represents general agreement; however, no one was asked to sign it. Furthermore, it should be understood that not everyone agreed with all of it.

Introduction

As the 21st century begins, the prosperity of the United States depends increasingly on the strength of its workforce. The world is becoming one economy, and nations that fully utilize their workers are more likely to thrive than those that do not.

There is a crisis emerging in America: workforce. The future worker shortage in the United States, the lack of worker skills, the increasing wage gaps, the disjointed public programs, and the absence of business participation all contribute to the crisis. But most importantly, it is the failure of our nation to recognize and respond to these challenges that presents the greatest risk.

Over the past twenty years, a dramatic increase in the size and skill of America's labor force has driven its economic growth. Baby boomers were in their prime employment years, and large numbers of women entered the labor force. New workers emerged far more educated than those they replaced. The number of college-educated workers more than doubled.

These trends have ended. More than one third of the nation's current workforce lack the basic skills needed to succeed in today's labor market. During the next twenty years, the American workforce is expected to grow by only half of its earlier pace: there will be no growth of native-born workers in their prime working years; the percentage of the labor force composed of four-year college graduates is predicted to stagnate over the next two decades; the number of workers with two-year degrees and skill certificates will fall far short of the economy's needs.

These labor force trends are exacerbated by globalizing competition and accelerating technological requirements in both domestic and export sectors. Taken together, these trends will lead to severe consequences for the vibrancy of the American economy and businesses. Problems on the horizon include:

- Unfilled jobs and productivity;
- Skill shortages;
- A decrease in regional economic competitiveness for some of the nation's cities and rural communities;
- A loss of jobs to overseas workers.

However, these problems can create opportunities to better involve overlooked labor market pools in the United States.

A strong economy depends on labor force growth and increased productivity. But if the nation's labor force does not grow, then we must find ways to increase the productivity of *all* American workers to meet the demands of future jobs.

Today, U.S. tax dollars support workforce development through a fragmented and under-funded patchwork system. In many communities, employers indicate that the workforce development system does not meet their needs and their engagement in workforce development programs has been superficial; publicly funded workforce programs have been constrained by funding that follows individual personal eligibility and political boundaries rather than regional economies; and systems improvements have proved elusive. As a result, employers still struggle to find workers who can help their businesses succeed, and workers still struggle to find and keep jobs that can sustain their families.

A new strategy -- what this Assembly calls a "workforce intermediary" strategy -- seeks to help workers advance, help businesses fill critical job shortages, and, ultimately, change systems to bolster regional

and national economic development. This approach does not require creating a new category of organization or overhauling public systems but it does require the transformation of existing policies and programs so that they are more adaptable to the local labor markets. It challenges existing organizations and systems to redefine whom they serve and how they do business through the forging of new partnerships and building the capacity to do so.

Workforce intermediary approaches are practiced by a variety of organizations -- including community colleges, federally mandated Workforce Investment Boards (WIBs), state and local government agencies, unions, employer organizations, community development corporations, community development financial institutions, faith-based organizations, and community-based organizations. Groups using workforce intermediary approaches have these goals:

1. **To bring workers into the American mainstream.** Success for these organizations means that workers are employed in jobs that offer the promise of financial stability.
2. **To increase business efficiency and productivity.** They are equally concerned with serving employers' needs and helping businesses become increasingly productive. They realize that business and worker success are interdependent.
3. **To enhance regional competitiveness.** These groups understand that the health of regional economies affects the ability to advance workers and strengthen business.

This intermediary approach is results-driven, entrepreneurial and flexible, trusted by employers and workers, and collaborative.

A Promising Start

More and more organizations in places as diverse as Wiscasset, Maine and San Francisco are showing encouraging results by using workforce intermediary approaches to help workers and business. But what exactly are these practices?

This approach arose in response to some of the limitations of the present workforce system. The current system is characterized by single customer focus on job applicants; a lack of knowledge of employers and their needs; a focus on limited employability training and initial placement and little post-placement retention and advancement services; and the fragmentation of the workforce community and its funding streams.

The "workforce intermediary" approach has several common characteristics. At their core, workforce intermediaries:

- Pursue a "dual customer approach" by serving businesses looking for qualified workers, and by serving job-seekers and workers looking to advance their careers;
- Organize multiple partners and funding streams around common goals, bringing together businesses, labor unions, educational institutions, social service agencies, and other providers to design and implement programs and policies to improve labor market outcomes;
- Provide or broker labor market services that go beyond recruitment and referral by understanding the special needs -- and gaining the trust -- of firms and industries;
- Reduce turnover and increase economic mobility for workers by assuring continued support and opportunities to upgrade skills;
- Achieve results with innovative approaches and solutions to workforce problems;
- Improve outcomes for firms and their workers by catalyzing improvements in public systems and business employment practices.

Business organizations, labor supported programs, nonprofit community organizations, the public workforce investment system, and community colleges all can pursue workforce intermediary strategies. The number of such efforts has risen from a handful in the early 1990s to several hundred today.

Although they approach their tasks in different ways, successful intermediary organizations bring together key partners and functions to advance careers for all workers -- recognizing the special needs of low-skilled, low-wage workers -- increase business productivity, and improve regional competitiveness. (For descriptions of groups that perform workforce intermediary functions, go to <http://www.opportunitiesatwork.org>.)

Results

“There aren’t too many programs for people like me who have worked all their lives and never had a chance to move up... You need training in this world to survive and stride forward, and this program gives people that chance. I see a career path that’s open to many new things” -- Worker

“We have found that partnerships allow us to save money on a cost-per-hire basis. Our partners are actually pre-screening candidates for us and pre-training them.” -- Employer

The workforce intermediary approach promises to improve the economic well being of job seekers, workers, and their families. Outcomes, where they have been measured, are positive especially when compared to the impacts of other more traditional workforce development activities.

Early research indicates that businesses reap economic benefits from partnering with workforce intermediary organizations. These benefits include:

- Access to new sources of job applicants;
- Reduced recruitment costs;
- Higher retention rates compared to traditional hires;
- Increased productivity;
- Tax credit savings;
- An enhanced reputation within the community;

By attending to business concerns and increasing productivity, workforce intermediary organizations also bolster regional competitiveness. For example, in New York City, the Garment Industry Development Corporation introduced production changes that enabled area firms to increase profits while maintaining decent wages and benefit packages.

What Types of Organizations Use Intermediary Approaches?

More than 200 organizations in thirty-nine states responded to a recent survey that described their use of workforce intermediary approaches. Most organizations participating in the survey are just a few years old, but two-thirds of them each serve more than 500 job seekers and workers annually.

While workforce intermediary organizations take many forms, not every education, training, or economic development entity plays this role. Efforts that are single-purpose in character -- attend to one particular activity or attend to the needs of a single employer -- do not meet the workforce intermediary definition. The power of the workforce intermediary approach is its multifaceted nature, and its potential impact goes beyond the sum of its component parts.

Indeed, many public workforce development agencies -- including local Workforce Investment Boards (WIBs), economic development agencies and community colleges--act as workforce intermediaries. More often, however, workforce intermediary efforts work to complement these public systems by expanding their reach through new partnerships and adding depth in industry sectors.

Consistent with the mission of the public workforce development systems, workforce intermediary efforts seek to:

- Expand economic opportunity for workers and job-seekers and enhance the competitiveness of firms and regions by identifying the needs of a variety of stakeholders;
- Invite firms, civic institutions and leaders to address these needs;
- Integrate services and funding streams in ways that enhance effectiveness;
- Leverage new resources;
- Engage in systematic and rigorous assessment of outcomes.

A Call To Action

A workforce intermediary strategy seeks to help workers advance, businesses fill critical job shortages, and ultimately boost regional and national economic growth and productivity. Such ambitious goals require a “high impact” strategy, one that results in quality services to a greater share of workers and employers and meaningful changes to local and regional labor markets. The challenge is to get beyond what one Assembly participant called “pockets of unreplicable greatness” to a wider scale.

This strategy is an important response to the larger workforce crisis confronting this nation.

The severity of the impending workforce crisis requires nothing less than a major transformation in how the workforce system and workforce organizations go about their business. This change will require that intermediary functions and practices should be widely adopted by thousands of existing organizations -- Workforce Investment Boards, community colleges, employer associations, labor programs, community development venture capital funds and community-based organizations. New partnerships between these groups can increase effectiveness in serving employers.

To accomplish this transformation, the system will require:

- An understanding that workforce development is as much an economic policy as a social policy;
- New policies that increase the accountability and impact of programs;
- Decisions by funders to create incentives for the use of dual-customer approaches;
- A venture capital orientation on the part of funders, rewarding adaptive capacity and good results over sustained periods;
- Increasing research that demonstrates what works;
- Timely data on local labor markets for mapping labor supply and demand and career opportunities, and identifying job training opportunities and gaps and evaluating the effectiveness of workforce policies and investments;
- Leadership across employer associations, labor groups, community organizations, and community colleges with entrepreneurial vision and the skills to manage these “double bottom line” endeavors, and
- Cross-sector sharing of information and most effective practices that advance workers in the American mainstream, increase business productivity, and enhance regional competitiveness.

Implementing the workforce intermediary approach is itself a challenge. For example, finding common ground between business and worker/jobseeker interests is a challenge. At times, these two perspectives have been assumed to be in opposition. However, finding the intersection between these two is essential in order to ensure business productivity, worker advancement, and regional competitiveness in the new skills economy. In addition, intermediary organizations operate in a fragmented policy and institutional environment and must often negotiate new roles and relationships while sidestepping destructive turf battles. This requires trust, credibility, and influence -- as well as careful diplomacy.

Further, the intermediary approach often faces all the challenges of an emerging business venture. Financial instability, limited resources, strained leadership, and the risks of taking success to scale must be successfully managed.

Many organizations have struggled with the constantly changing landscape of public workforce funding. Public funds have been cut and strict eligibility requirements, short-term timelines, and disparate performance measures have negatively affected outcomes. In general, some level of funding has been available for recruiting and training, but limited funding has been available to help businesses retain new workers and to help workers advance to higher quality jobs. In addition, there is no dedicated public funding for research and planning efforts that bring together stakeholders within specific industries to implement long-term strategies that address changing skill standards and related business needs. More and smarter funding is needed.

Workforce intermediary organizations and employer partners need flexible capital to create innovations in the public or private sector. Several states have created bond financing tools and investment tax strategies to support efforts of intermediary organizations to meet skill shortage demands and wage advancement goals. Other intermediary organizations have created blended financing strategies that include public funding and revenue-generating businesses. Based on the experience of these intermediary organizations, flexible financing options are needed to expand the impact of these strategies as well as support their efforts to increase capacity.

In addition to financial challenges, a variety of environmental forces constrain the emerging workforce intermediary efforts. A sometimes rigid policy environment and long-standing practices limit the acceptance of this new approach. Furthermore, slow decision making, inappropriate outcome measures, and cumbersome rules impede the attainment of positive outcomes for workers, firms, and regions.

RECOMMENDATIONS

The crisis facing America's labor market is not widely recognized. This American Assembly recommends the following:

Raise the Nation's Awareness

Faced with the immediate threats-of international tensions and economic recession-it is easy for the nation to overlook future workforce conditions that threaten the health of our economy. This American Assembly calls on America's civic, education, labor, and business leaders to understand and address this looming crisis, which threatens the nation's prosperity and democratic future.

This Assembly thinks it is especially important for private business to play a leading role in this effort. For more than thirty years, a variety of efforts have attempted to increase support for traditional workforce development activities. Those efforts have experienced, at best, mixed success, in part because the business sector did not perceive that the system met its needs for trained and productive workers and small and medium-sized firms were not organized and supported to participate effectively in the system. If there is one lesson that successful workforce intermediary efforts have taught us, it is that business sector involvement is critical to success. This has been demonstrated by Project QUEST in San Antonio and elsewhere, and will prove true for any national effort to address these issues.

Business leaders, who create jobs, must be actively and immediately approached, invited and tasked to become key actors in local, state, and national consciousness-raising efforts. This effort could take the form of a national commission, a business-led summit, a major public awareness and media campaign, or any and all of these. This Assembly thinks these issues should be immediately debated and made part of the public policy agenda.

At the same time, given the realities of competing pressures that make it hard for this issue to be heard, this Assembly also recommends the following steps.

Develop an Effective Workforce Intermediary Policy for Business, Workers, and Regions

The current disjointed policy environment creates a multi-faceted problem, including funding streams that are not aligned, and have difficulty achieving meaningful results. Concerns have been expressed from many fronts, including businesses, community-based organizations, educational institutions, unions, and government agencies.

Addressing this workforce development problem will require:

- *Broadening the focus of public workforce development to provide both job applicants and incumbent workers with the skills training needed for competitiveness and career advancement in a technologically driven, globalizing economy.* This requires flexibility, meaningful incentives and resources for companies, industries, labor, and business organizations to foster and engage in training, growth, and productivity.
- *Incentives aimed at encouraging business investment to hiring, training, and advancing low-wage workers need to be simple to receive, administer, and address the needs of employers and workers.* For example, in Maryland, the state legislature appropriated \$2 million for worker advancement training at a coalition of hospitals and other employers, leading to significant wage increases and promotions. In Philadelphia, Pennsylvania, contributions from sixty-one employers, belonging to a Taft-Hartley labor management trust fund under the leadership of the District 1199C Training and Upgrading Fund, matched \$3 million in federal funds to prepare 1,500 incumbent, dislocated, and new workers for careers in high-skilled nursing and allied health.
- *Supporting industry-specific workforce development strategies, which engage the self-interest of key stakeholders within a particular industry that help to organize a complex web of public and private resources into effective workforce development programs.*
- *Creating strategic economic development initiatives in states, regions, and localities that fully integrate workforce and economic development.* Several states have led the way by developing such plans and integrating funding streams to support them.
- *Redesigning educational financing and regulations to support workforce development.* Much of the available student aid and state support for post-secondary education does not address the demands of both workers and firms. Because community colleges and other post-secondary education institutions are critical parts of the workforce development system, this needs to change. Policy makers should consider the promising results from Individual Development Accounts and the Lifelong Learning Account demonstration, and important proposals to expand Pell grant eligibility, adult education supports, and other student aid programs, especially for less than half-time students. Community colleges and other post-secondary institutions are critical parts of solving this problem because of the pending need for technical skills, certificates, and portable credentials.
- *Maintaining and enhancing adequate work supports that enable workers to succeed and business to increase retention.* Child care, transportation, health care, the Earned Income Tax Credit, and food stamps are essential to ensuring that no one who works should be in poverty and that workers can succeed and progress on the job. These supports should also be accessible and available for time spent in training.
- *Aligning the performance measures required by diverse funding streams to get real accountability while supporting career advancement goals.* Although a great deal of work must be done to get the measures right, this Assembly commends current efforts to establish consistent outcome measures

for diverse federal programs. Congress and the Administration should continue with this effort, making sure that their work reflects the real needs of business and workers. For example, many intermediaries, businesses, state and local officials, and others report ongoing difficulties and confusion around conflicting standards among the Workforce Investment Act (WIA), and other publicly funded workforce development programs (e.g. TANF, Perkins). These should be remedied in upcoming reauthorizations. Outcome measures in Temporary Assistance for Needy Families (TANF) must be revised to reward employment and advancement outcomes rather than just caseload reduction.

- *Developing new ways to capture the effects of workforce interventions on businesses, workers, and labor markets.* While the current workforce system stresses the importance of actual customer focus, current measures do not adequately capture the benefits that accrue to employers by participating in this system. Several new efforts are under way by the Aspen Institute, National Governors Association, and others to develop and test new demand-side measures that begin to address this problem.

Promoting Smarter Financing

Although coordinating existing public and private funding will help make progress towards growing the workforce intermediary approach, coordination alone is not enough. There is a need for more resources to help intermediary organizations meet the pressing demands of businesses, especially small businesses and workers. Even the most exemplary organizations, which juggle multiple funding streams and provide high performing services to businesses and workers, face a daily struggle to finance their work. Because of limited resources, public agencies also face impossible choices between supporting required core activities, and intermediary approaches like strategic planning and employer engagement that would strengthen their work and the critical need for training.

Federal, state, business, and philanthropic dollars all need to be expanded, and new types of financing mechanisms should be developed. Specifically, this Assembly recommends the following financing improvements:

- *Expand and target federal, state, business, and philanthropic resources for necessary intermediary functions, such as labor market information, research and development, convening of stakeholders, and business services.* New resources should be identified to support investments in intermediary functions -- including business services -- that will lead to better outcomes in the broad range of existing workforce funding streams. This includes ensuring that the WIA and TANF are flexible funding streams that allow local actors to design programs that meet local needs. Policy makers should support a proposal to provide new resources for Business Linkage Grants and other employer services in TANF.
- *Develop ways to create long-term capital flows by leveraging relevant employer investments, such as contributions to Taft-Hartley funds and/or tuition reimbursement; existing tax credits; social venture funds and other financial innovations.* The relevance and applicability for workforce development of a tax credit strategy, such as the Low Income Housing Tax Credit model, should be studied. Financing is an important topic for foundations, and their support of Living Cities, formerly National Community Development, is a model that could be adapted.
- *Connect permanent sources of public financing, such as infrastructure spending, to workforce development.* For example, in several communities, port authorities provide stable investment in workforce development and career advancement tied to their infrastructure spending. Likewise, bond financing for the Pennsylvania Convention Center in Philadelphia has generated a resource that supported training in the hospitality industry.

- *Implement major comprehensive federal, state, and private sector demonstrations of the workforce intermediaries approach.* This Assembly endorses recent efforts by the Department of Labor to create Regional Skills Alliances, help workforce boards and other workforce intermediaries begin industry-specific workforce development projects, assist health care employers address worker shortages, and expand the role of employer associations in providing intermediary services through the Workforce Innovation Networks (WINs) project. These types of demonstrations should be continued and expanded, and include partners from the philanthropic community, as WINs has since its inception.

Build Capacity

Organizations that successfully carry out these strategies conduct a dizzying range of activities to achieve their mission. They coordinate or provide training, work closely with employers, study their local and sectoral economies and labor markets, and link workers with support services like childcare. They do this in an environment where they must constantly seek funds from a variety of sources, each of which has its own demands for accountability and reporting. These demands would challenge the most sophisticated organization. Achieving higher impact, both for the specific organizations and for the system as a whole, will require investments in capacity building, like the following:

- *Invest in the adaptive capacity of organizations to learn, function, and innovate, developing the ability to effectively serve both workers and businesses.* The Annie E. Casey Foundation's Jobs Initiative and the Aspen Institute's Sectoral Employment Development Learning Project (SEDLP) are good examples of building the long-term capacity of workforce organizations to use outcome data to shape their work.
- *Develop technical assistance capacity to help organizations in fostering intermediary functions.* Public/Private Ventures' Working Ventures program, a training series for workforce development professionals, has shown both the value of and the unmet demand for this type of service.
- *Help develop the entrepreneurial skills and competencies of workforce development professionals, not only in meeting the needs of their customers, but also in running their organizations.* National centers in higher education, vocational education, and community development have contributed to the professionalization of those fields, and a similar effort is needed in workforce development.
- *Build the field by linking leading intermediaries into regional and national networks to foster innovation, provide peer learning, and develop a clearinghouse for innovative practice.* Good examples include such efforts as the National Network of Sector Partners, which has created learning forums and a peer technical assistance fund for sector programs around the country, and the AFL-CIO's Working for America Institute, which has successfully stimulated new labor/management partnerships and expanded existing partnerships to serve the interests of low-wage workers and businesses. These networks should distill and disseminate the lessons learned from decades of the nation's investment in the military addressing training and career advancement needs of highly diverse populations.
- *Build marketing and communications capacity of the organizations.* Leaders and staff need to learn to speak the language of business and frame organization-appropriate messages that counter negative employer perceptions and therefore stimulate interest in partnerships.

Build a Constituency for Action

Although it is critical for the nation's future economic success, workforce development has not been a national priority. In part, this is because of competition for public funds and attention, but also because of a perception of poor training results and little understanding or knowledge of the emerging successes. Paradoxically, the broad tasks of advancing workers, increasing business productivity, and enhancing regional competitiveness span so many institutions and stakeholders that they inhibit the necessary

attention and public support. As the nation strives to build a more effective workforce development system, the workforce intermediary strategy can serve as an effective way to simplify the system for both business and workers, and foster their long-term advancement. Part of the strategy for achieving this success is building a broad constituency for action. Building that constituency requires:

- *Engaging business as a driving force in support of this effort;*
- *Building new coalitions and alliances across traditional dividing lines, especially in states and regions.* In Massachusetts, the Direct Care Worker Initiative, led by the Paraprofessional Healthcare Institute, brought together employers, business, consumers, unions, and the workforce training community to advocate for enhanced wages and upgraded training for health care workers. These types of alliances will need to be expanded to have the high impact that is necessary;
- *Engaging political leadership at all levels.* The issues raised in this report merit attention from such organizations as the National Governors' Association, the U.S. Conference of Mayors, the National Association of Counties, and others to inform political leaders at all levels about what workforce intermediaries can do;
- *Expanding the voice of the workforce development community.* At the local, state, and national levels, the Workforce Alliance is providing valuable leadership in increasing the presence of the workforce development community in policy and legislative discussions;
- *Emphasizing workforce development as an essential element of economic policy at the federal, state, and local government levels.* This includes forging new alliances that integrate workforce development goals with those of economic development organizations, including the Council on Competitiveness, the Economic Development Administration, the International Economic Development Council, and the National Congress on Community and Economic Development, and the Community Development Venture Capital Alliance.
- *Expanding relationships with higher education organizations to create support for these workforce development initiatives.* It is critical that groups such as the American Association for Community Colleges and other members of the American Council on Education, as well as the League for Innovation, engage their members in activities that transform post-secondary education in support of the nation's workforce system.
- *Mobilizing a broader spectrum of foundations.* Regional, local, and national foundations that have invested in workforce development should continue their leadership and seek to engage other funders in support of this agenda. One promising start is an emerging group of sixty local and national foundations with an interest in workforce development that have come together under the auspices of the Neighborhood Funders Group. Another is the local funding collaboratives emerging in Baltimore, New York City, and Boston.
- *Strengthening local constituencies.* In the Southwest, community organizations affiliated with the Industrial Areas Foundation not only pioneered one of the early pilots, but then built six more workforce intermediaries in multiple states. These and similar efforts should be supported.
- *Researching and documenting the nature and extent of current investments as well as the return on those investments to employers, workers, and the community.* Expanded support for rigorous research that links outcomes with intermediary practices and documents the return on investment to employers, workers, and the community is needed. This research is essential for addressing misperceptions for documenting cases and context in which training works, and for justifying further public and private investment in these strategies.

CONCLUSION

This report builds upon twenty years of innovation, practice, and research in workforce development. It calls America to action and challenges the nation to use the workforce intermediary approach as a strategy to solve the nation's workforce crisis. There is a great deal at stake. Without aggressive action to expand the labor force in ways that increase productivity for employers, the nation's long-term economic health will be challenged. Workforce intermediary approaches can make a major contribution to meeting this national need.

Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999-2003⁶⁴

Lauren Harris-Kojetin, Debra Lipson, Jean Fielding, Kristen Kiefer and Robyn I. Stone
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INTRODUCTION

The purpose of the synthesis paper is to review, summarize, and discuss the significance of available research findings on the frontline long-term care (LTC) workforce since 1999, in both home and community-based and nursing home settings. This paper builds on the review article by Stone (2001) that reviewed the seminal practice and policy research related to recruitment and retention of frontline workers in LTC. Writing in 2001, Stone noted the lack of empirical research and, in particular, of evaluations to determine the effectiveness of programs and policies intended to recruit and retain LTC direct care workers.

This paper provides an updated review of the status of empirical findings, focusing on what has been learned between 1999 and 2003. The primary goal is to learn what initiatives have worked to reduce LTC direct care workforce recruitment and retention problems. A secondary goal is to provide empirically-based insights on the factors that contribute to recruitment and retention problems. This paper is intended to help policymakers, providers, worker and consumer groups, and researchers create a framework for future evidence-based policy, practice, and applied research initiatives to address LTC direct care workforce shortages.

BACKGROUND

The paraprofessional LTC workforce -- over 2.4 million nursing aides, orderlies, and attendants, home health aides, and personal and home care aides (USBLS, 2004a) -- forms the core of the formal LTC system.⁶⁵ Direct care workers serve as the eyes and ears of the formal LTC system and provide most of the care in this system. Even with relatively high unemployment rates, LTC providers and state agencies responsible for LTC services are reporting unprecedented vacancies and turnover rates among direct care workers, ranging from 45 percent to over 100 percent annually for nursing homes. Most states consider direct care worker recruitment and retention major issues (NCDFS, 1999; PHI and NCDHHS, 2004).

Significant societal factors are converging that will likely result in a 21st Century LTC direct care workforce crisis, or "care gap," in the US. These dynamics include an unprecedented increase in the elderly population and those with chronic medical conditions, a decrease in the traditional pool of women available to provide formal care, fewer adult children available to provide care, and a potential increase in the need for paid care for elderly parents of dual-income and single-parent households. Policymakers and providers need to know what workforce initiatives have been shown to work to address the direct care workforce shortage.

⁶⁴ The full paper is available online at <http://aspe.hhs.gov/daltcp/reports/insight.htm>.

⁶⁵ In this report we use the terms paraprofessional workers, direct care workers, and frontline workers interchangeably to refer to nurse aides or assistants, personal care aides or assistants, home health aides, home care aides and others who provide paid hands-on assistance with bathing, eating, dressing and other activities of daily living for persons with disabilities.

Previously reported research (discussed in Stone, 2001 and Stone and Wiener, 2001) highlights a variety of factors associated with LTC direct care workforce recruitment and retention problems. These factors include but are not limited to: inadequate training; poor public image of the LTC direct care workforce; low pay; insufficient benefits; inadequate job orientation and lack of mentoring; little or no opportunities for continuing education and development within the position; poor supervision; emotionally and physically hard work; workplace stress and burnout; personal life stressors, such as problems with housing, child care, and transportation; lack of respect from residents' families; and, short staffing. In the past several years, states, providers, and worker groups have developed, implemented and, in some cases, evaluated a variety of initiatives to address these challenges. This paper gives an overview of the most recent evidence base on both problems and possible solutions, to inform future investment choices and initiatives.

METHODOLOGY

We review both published reports and articles, unpublished conference presentations and working papers reporting results of research and evaluations on recruiting, retaining, and sustaining a quality frontline workforce in nursing homes, home care, and assisted living facilities. The review updates research findings reported in a seminal piece by Stone (2001) to better understand the problems facing the frontline LTC workforce and to identify effective solutions to chronic shortages, high turnover, and training needs. Studies on the relationship between LTC staffing levels and quality of care were not included, as they are beyond the scope of this paper; however, studies that examine links between staffing levels and worker satisfaction or turnover rates are included in this review.

Research and evaluation reports and articles completed or initiated between 1999 and 2003 were identified using Internet searches, personal communication with researchers, and database searches (e.g., PubMed). Search terms used when conducting web site and database searches included: LTC workforce, recruiting, labor force, nurse aides, job tenure, employment practices, work environment, aging services personnel, paraprofessional personnel, and intervention strategies. While published articles in peer-reviewed journals generally were preferred, unpublished reports and interim progress reports were included if based on sound research methods. We include studies that use qualitative and/or quantitative methods. Initiatives that were at an early stage of development in the Stone (2001) article were investigated to determine if the research or evaluation was now complete. We also obtained relevant working papers and presentations at professional conferences (e.g., American Society on Aging, Gerontological Society of America) and made personal communications.

The studies abstracted and analyzed for this report fall into two main categories: (1) empirical research (i.e., results of surveys and qualitative studies) on direct care workers that describe their working conditions or further elucidate the causes of turnover; and (2) evaluations of the implementation and impact of public and private initiatives designed to improve the recruitment and retention of direct care workers (e.g., wage and/or benefit enhancements, new training programs, and revised certification requirements).

Section IV reviews studies on characteristics of direct care workers and the wages and health insurance benefits available. Section V synthesizes research on factors contributing to high turnover and chronic shortages. Section VI summarizes findings from evaluations of interventions designed to improve recruitment and retention of direct care workers. Section VII discusses the implications of these recent findings for public policies and provider practices that seek to expand and stabilize the labor pool of direct care workers, and for future research intended to support these initiatives.

TRENDS IN CHARACTERISTICS OF DIRECT CARE WORKERS AND THE WAGES AND HEALTH INSURANCE BENEFITS OF THEIR JOBS

Eighty to 90 percent of direct care workers are women. About half of direct care workers are non-white, compared to one-quarter of all workers. The typical direct care worker is a single mother aged 25-54. Compared to the general workforce, direct care workers are more likely to be non-white, unmarried, and with children at home (GAO, 2001). Crown, Ahlburg and MacAdam (1995) conducted a comprehensive profile of nurse aides and home care workers based on nationally representative samples using data from the Current Population Survey (CPS) March supplements of the late 1980s. The profile compared demographic characteristics and work conditions for three types of aides: hospital aides, nursing home aides and home care aides. A new study by Yamada (2002) updated the data examined by Crown and colleagues, using the same data sources and methodology, in order to assess trends in the direct care workforce over the past 10 years from the late 1980s to the late 1990s.

Characteristics of Direct Care Workers

The study by Yamada found a number of important changes over this period. Compared to the late 1980s, home care aides in the late 1990s were younger, more educated and more likely to have children. While home care aides tended to be older than nursing home aides and hospital aides in both the 1980s and the 1990s, the mean age of home care aides declined in the 10-year period. While no data were available on citizenship in the late 1980s, home care aides were significantly less likely to be native-born US citizens than were nursing home and hospital aides in the late 1990s. Educational levels among aides have increased over the past 10 years; home care aides still have less education than other aides, but almost 30 percent of nursing home aides and home care aides have at least some college education.

With regard to working conditions, home care aides were more likely to work full-time and full year in the 1990s (46 percent) than in the late 1980s (29 percent), but still less likely to work full-time and full-year than nursing home aides (55 percent) and hospital aides (63 percent). Forty-two percent of part-time home care aides reported a preference for part-time work. However, 18 percent of part-time home care aides said they preferred a full-time job but could only find part-time jobs. Home care workers are somewhat more likely to have earnings from other work (23 percent) than are nursing home aides (20 percent).

Wages

Even with modest improvements in the working conditions for some groups of direct care workers over the last decade, these jobs continue to be characterized by low wages and limited benefits. According to Yamada's study of CPS data, median wages of home care aides increased slightly in the past 10 years (adjusted to 1998 dollars based on Consumer Price Index), from \$5.81 to \$6.00 hour, while both mean and median family income increased as well. However, median wages of nursing home aides and hospital aides declined, from \$7.29 to \$7.00 and \$9.81 to \$7.99, respectively. Family income for these two groups also declined over the 10-year period.⁶⁶ Hospital aides still have the highest wages of the three groups. In the late 1990s, nursing home aides and home care aides were more likely to be in poverty (16 percent and 22 percent, respectively) than the average population (12-13 percent).

⁶⁶ As these are national averages, wages vary by state. For example, in California, wages in the late 1990s for nursing aides, orderlies and attendants were higher than the national averages: \$8.40 median hourly wage, \$8.78 mean hourly wage, and \$18,260 mean annual wage, assuming year-round, full-time hours. California home health aides have much higher wages than the national averages; in 1999, the median hourly wage for these workers was \$8.54, mean hourly wage \$9.73, and mean annual wage \$20,230 (Franks et al., 2002, based on data from the California Employment Development Department).

Based on data from the Bureau of Labor Statistics' (BLS) National Occupational Employment and Wage Estimates (2002), the median hourly wage for direct care workers ranged from \$7.81 to \$9.59 in 2002. This represents a median annual wage of \$16,250 to \$19,960, if the worker is employed full-time year-round. However, as noted earlier, many direct care workers work less than 40 hours per week or do not work the full year. Direct care workers work about 30 hours per week on average. Further, the wage figure does not take into account the wages of independent home care workers, who are not employed by any agency.

Konrad (2003) found that nursing aides who had left the health field were better off financially than those who remained in the field. The study compared North Carolina workers trained as nursing aides who remained certified to work as nursing aides in a health care facility with those who did not remain certified. Among those who lost certification to work as a nursing assistant since 1990 (called "inactive registrants"), the median 1998 wage was \$14,425 compared to \$11,358 for active registrants. The median wage for inactive registrants rose to \$17,359 in 2001 compared to \$12,877 for active registrants. So, while wages increased slightly over the last few years for certified nurse assistants (CNAs) in North Carolina, median wages remained lower for active registrants than inactive registrants.

Health Insurance Coverage

Two different analyses of the health insurance status of aides over the 10-year period (late 1980s to late 1990s) show somewhat different results. Yamada found little change over the 10-year period in employer-provided health insurance coverage rates for nursing home aides and hospital aides (about 42 percent and 62 percent, respectively). However, an increasing proportion of home care aides received employer-provided health coverage -- 14 percent in late 1980s versus 26 percent in the late 1990s. Yamada also found a substantial increase in the percentage of aides with Medicaid coverage, nearly tripling in all three groups of aides -- to 11 percent of nursing home aides, 16 percent of home care aides, and 5 percent of hospital aides. While this suggests that the overall rate of insurance coverage increased, another study of CPS data found that among all three groups of aides, the proportion of those without any health insurance coverage grew from 18.6 percent in 1988 to 23.8 percent in 1998 (Case et al., 2002). Workers in the private sector accounted for all of the growth in the number of uninsured over that period. The divergence in findings by the two studies is not clear, but may be due to differences in the types of workers examined.⁶⁷

Significant increases in the amount employees contribute to health insurance premiums in all sizes and types of work establishments in the past several years could have contributed to reduced rates of employer-provided coverage among the low-wage workforce. Between 1996 and 1999, the average annual dollar amount paid by employees for health insurance coverage rose from \$342 to \$420 (Branscome and Crimmel, 2002). As a percentage of the total premium, the increase was less than one percentage point (from 17.2 percent to 18.1 percent). Nevertheless, co-insurance premiums for LTC employees can be as much as 50 percent of the total premium (Michigan Assisted Living Association, 2001). For low-wage workers, this makes health coverage unaffordable. For example, a survey of nearly 200 direct care workers in Massachusetts found that one in four were uninsured in 2002, with uninsured workers reporting average income a third less than those who were insured (Hams et al., 2002). With even larger increases in the co-insurance rates charged to employees in the past few years, employer-provided insurance coverage may show further deterioration among low-wage workers (Robinson, 2002).⁶⁸

⁶⁷ Case and colleagues used Census Bureau Occupational Classification codes 445, 446 and 447 for aides, while Yamada used 446 and 447 only.

⁶⁸ According to a survey by Watson Wyatt & Company for the Washington Business Group on Health, released in March 2003, about 80 percent of employers plan to increase employee co-pays and/or premium contributions in 2003 in response to double digit growth in employee health care costs.

FACTORS INFLUENCING THE SUPPLY AND TURNOVER OF DIRECT CARE WORKERS

Direct care worker occupations are predicted to be among the top fastest growing occupations, and those with the largest growth, among health occupations between 2002 and 2012 (Hecker, 2004; USBLS, 2004b). Estimates indicate that there will be 888,000 *additional* direct care worker jobs, an increase of about 34 percent (Hecker, 2004; USBLS, 2004b). Including both these new jobs and replacement jobs for retiring workers and those who leave the occupation, BLS projects that over 1.2 million new direct care workers will be needed over the first decade of the 21st century (Hecker, 2004; USBLS, 2004b). The demand for direct care workers in home- and community-based settings is projected to grow even higher than for institutionalized settings. Including job openings due to growth and net replacements, BLS projects a 56 percent increase in demand for home care and personal care aides and a 61 percent increase in demand for home health aides between 2002 and 2012 (Hecker, 2004; USBLS, 2004b).

According to a report by the Center for Health Workforce Studies (2002), precise numbers of workers are elusive for a variety of reasons. Many direct care worker jobs have few or no educational or training requirements, face inconsistent licensing laws from state to state, and lack clearly defined tasks, which makes it hard to track those who move in and out of these jobs. There are also independent home care workers hired directly by care recipients; they are not recorded as employed as direct care workers in government data systems (CHWS, 2002). One national study estimates that 29 percent of the direct care workers providing assistance to Medicare beneficiaries in the home are self-employed (Leon and Franco, 1998). Some data on direct care workers are available at the national level from the BLS and Centers for Medicare and Medicaid Services's (CMS) Online Survey Certification and Reporting system (OSCAR), but each has limitations that hamper its utility (CHWS, 2002).

Surveys and registries maintained at the state level yield some information and insights about trends in the supply of direct care workers over the past few years. For example, in California, the pool of active CNAs has declined by 15 percent from 120,000 in 1998 to 101,000 in 2000. The number of newly CNAs (25,388) did not keep pace with the number of CNAs who did not renew their certification (39,178) during this time period (Franks, et. al, 2002). In North Carolina, by contrast, between July 2000 to June 2002, the number of newly certified nursing assistants outpaced the number of CNAs becoming inactive; new CNAs grew from 85,148 in 2000 to 95,092 in 2002 (Konrad, 2003).

Factors Associated with Turnover

Recent studies on the turnover problem among direct care workers are providing some new insights. While most studies have gathered data directly from interviews with employees and employers, a recent study looked at the issue from a broader perspective. Brannon and colleagues (2002) examined factors that help to distinguish nursing facilities with very high and very low nursing assistant turnover rates from a middle referent group, exploring the possibility that high and low turnover are discrete phenomena with different precursors. With the exception of registered nurse turnover rate, low turnover and high turnover were not associated with the same factors. These findings suggest that future studies of facility turnover should avoid modeling turnover as a linear function of a single set of predictors. However, since there is no consensus on what constitutes optimal turnover rates, care must be taken in setting a low turnover rate cutoff based solely on statistical patterns (Swan, 2002).

Brannon examined turnover from secondary data. More common in the literature are studies based on interviews with CNAs or home health aides. Such studies are better able to explore the real-life experiences of direct care workers. However, such studies are more likely to encounter problems maintaining sufficient sample size throughout the study period. That was the case in a series of studies by Noelker and Ejaz (2001), who studied newly trained nursing assistants about to be employed for the first time in a nursing facility. Most of the recruited students were lost in follow-up interviews; some never pursued nursing home employment and many did not intend to work as a nursing assistant when they

took the training. Some claimed they entered training solely to meet requirements of the changing welfare system, while others did not keep scheduled appointments.

Despite these problems, Noelker and Ejaz were able to compare interview data from 1999-2000 with earlier studies conducted in the 1991-1993 and 1993-1994 period. They found that newly trained nursing assistants in the most recent period were more likely to be younger, unmarried, and minorities than those in the early 1990s. The group of nursing assistants in the late 1990s also expressed more worries about finances and family while at work. There were also noticeable increases in the proportion of nursing assistants reporting that they received inadequate initial training and that their supervisors did not acknowledge the importance of their observations about residents. Fewer reported a desire to continue working as a nursing assistant three years from the time of their interview. About one-third of nursing assistants in all three samples scored as being clinically depressed. Low pay ranked as the top source of job dissatisfaction in all three sample groups.

The relationship between supervisory staff and CNAs is an important contributor to worker satisfaction and turnover. Jervis (2002) explored direct care worker-supervisory relationships within the context of a "chain of command," based on ethnographic research. Findings confirmed the hierarchical organizational structure as nursing supervisors often used language such as, "delegate down" and "down at the unit level" in their conversations. Supervisory staff frequently attributed the cause of recruitment and retention problems to nursing assistants' personal problems, dysfunctional family structure, being irresponsible and lack of respect for the job. Rarely did supervisory staff mention organizational structure, or mistreatment or poor management by top-level staff, as a reason for turnover. Both the top- and mid-level staff complained about the amount of their time spent on paperwork, which causes them to be less connected to residents and direct care workers. Conversely, nursing assistants perceive their own work to be hard physical labor compared with their superiors, contributing to tension between nursing assistants and nurses.

A study by the California Association of Homes and Services for the Aging (CAHSA) and the Institute for the Future of Aging Services (IFAS) also finds this gap in perception between workers and supervisors. The team used surveys and focus groups with direct care workers and administrators, respectively, in California LTC facilities (Harahan et al., 2003). The study team found consistent complaints from direct care staff that they feel they are not valued or respected by their supervisors, coupled with the perception of charge nurses that they are not managers and have no need for management skills.

Bowers et al. (2003) conducted a study to determine why certified nursing assistants leave, using "grounded dimensional analysis" or in-depth interviews rather than structured interviews or survey instruments. This method allows nursing assistants to express their opinions on why they leave their job and how different factors influence their decision. This study confirmed many of the reasons previously shown as reasons for turnover, such as dissatisfaction with staffing and absenteeism policies, training and orientation practices, and low compensation. However, Bowers' analysis revealed that it was the perception that these policies and practices made CNAs feel unappreciated and undervalued, which in turn led to their departure from the job.

A multivariate analysis of data from a 1996 survey of nursing assistants employed in Louisiana nursing homes confirmed that professional growth, involvement in work-related decisions, supervision, and communication between management and employees were significantly related to both turnover and overall job satisfaction (Parsons et al., 2003). Previous research with direct care workers as well as qualitative interviews with and observation of direct care workers in nursing home settings (Pennington and Magilvy, 2003) reflect these same findings.

Job Characteristics and Factors Associated with Job Retention

Hunter (2000) explored factors related to defining what determined a "good job" from the perspective of nursing assistants in nursing homes. Based on survey data from 152 facilities in Massachusetts, the

study showed that aides' job preference was associated with facilities that had more private pay residents, skilled care, and religious or ethnic affiliation of the facility. These facilities tended to offer such benefits as employer-subsidized tuition, employer contributions to a deferred compensation plan, and higher wages and opportunities for wage growth. They also tended to have administrators with specialty training, while unions had a positive and significant effect on job quality, when niche markets were controlled. The study, however, did not look at the relationship between "good job" traits and retention.

On the home health side, Luz (2001) analyzed qualitative data gathered from interviews with independently employed home care workers who work without the oversight of an agency. Luz examined what led the workers to take, keep, and leave a job. Her findings suggest that these workers choose the profession as a vocation, choose clients with whom their relationships make a difference, like the ability to choose full-time or part-time work, and prefer independent work environments. Other issues that factor into independent workers' decision whether or not to take a job are family obligations, wages, whether other income and health insurance are already provided for them, entrepreneurial aspirations, personal health, and personal standards for good care services. A qualitative study of direct care workers in New Hampshire that included home health aides corroborates the perceived importance of work schedule flexibility, as well as having more time to spend on each client compared to working in a nursing home setting (Kopiec, 2000)

Based on ethnographic research involving 159 interviews and more than 100 hours of direct observation, Eaton (2001) concludes that five key managerial practices characterize environments with lower turnover and better retention of nursing staff. These practices are: (1) high quality leadership and management; (2) a practice of valuing and respecting nursing staff, especially direct caregivers; (3) positive human resource practices, both economic and non-economic; (4) a set of work organization and care practices that help to retain staff and build relationships; and (5) a sufficient staffing ratio to allow for the provision of high quality care. Eaton concludes that, "even in a complex system, one person could make a vast difference -- particularly in a key leadership role in the facility, but also as charge nurse on a unit, or an HR or staff development person, as long as the individual had direct contact with the care giving decisions and staff members." While Eaton cautions that these practices need further large-scale randomized evaluation, she notes that they can be attained by most managers, or at least those who have discipline and compassion, are open to learning and innovation, willing to delegate responsibility and to hold managers and staff accountable, and spend significant time on the floor or unit.

Based on case studies conducted as part of the CAHSA and IFAS study of California LTC facilities mentioned earlier (Harahan et al., 2003), the attributes of a successful workplace environment appear to include: (1) clearly articulated expectations from management that direct care workers, ancillary staff and nurse supervisors are to be decision-makers and problem-solvers; (2) a timely feedback system as issues and problems are identified; (3) open door management policies that are based on trust, are without repercussions, and which include follow-up that addresses issues that have been raised; (4) blurred lines between CNAs and nurses, two-way accountability, and mutual respect and acknowledgement; (5) management styles which rely on mentoring and role modeling to transfer needed skills; (6) career advancement opportunities and the facility's support to pursue them; and, (7) a Director of Nursing with strong leadership skills who is visible, accessible and intimately involved with resident care. While the pay-off of such strategies with respect to reducing staff vacancies and turnover and improving quality has not been systematically evaluated, the sites that employed these strategies, reported fewer problems with either recruitment or retention compared to the majority of respondents.

Victoria Parker and colleagues at Boston University School of Public Health are currently conducting a study that includes examining what job characteristics influence job satisfaction among certified nursing assistants in nursing facilities. Preliminary results, based on employees surveyed in 20 nursing homes in eastern Massachusetts, suggest that task identity, autonomy, and feedback from the job itself well predict job satisfaction for these workers (personal communication).

EVALUATIONS OF INITIATIVES TO ADDRESS THE DIRECT CARE WORKER CRISIS

In the past several years, providers and states have implemented a variety of initiatives to improve recruitment and retention of the direct care workforce. In addition, a number of initiatives are currently being implemented that have an evaluation component such as the Better Jobs Better Care state demonstrations and the CMS Direct Service Worker state demonstrations. This section briefly describes LTC direct care workforce programs that have been evaluated in the past few years, emphasizing their effects, if any, on direct care worker turnover and/or retention.⁶⁹ Several of these programs focus on one type of activity, such as peer mentoring, staff-family communication, career advancement, alternative management approaches, and wage enhancements for CNAs. Other programs are multi-faceted initiatives or aim to achieve broader organizational culture change. Finally, we look at the workforce component of a home- and community-based consumer-directed initiative, Cash and Counseling, as a mechanism for providing an additional labor pool of direct care workers.

Peer Mentoring

Hegeman and colleagues (2003, 2004) at the Foundation for Long Term Care conducted a CNA retention intervention and evaluation project entitled “Growing Strong Roots.” The “Growing Strong Roots” peer mentoring program uses experienced CNAs to acquaint new CNAs with the customs, resources, and care values of the nursing home. The program is intended to supplement, not replace, the usual training of new CNAs.

The program includes four key components: (1) a six-hour orientation to the program for project coordinators, including a comprehensive manual on how to operate the program and evaluate it and newsletters for mentors that reinforce key concepts; (2) a six-hour training and manual for mentors to help them develop and/or enhance the leadership, communication, mentoring, and conflict resolution skills to be successful mentors; (3) a guide to orienting mentors’ supervisors to the program, to gain facility support for the program; and (4) booster training sessions and manuals for mentors to reinforce the program. Trained mentors are matched with new CNAs. The mentoring relationship is usually active for eight weeks (more if needed), and mentors attend one or more booster sessions during this time and receive the newsletters. Each facility provides mentors a salary increase or other tangible benefits for the extra work involved.

Using a pre-post comparison group design with six nursing homes in New York state, the evaluation found a statistically significant 18-point increase in average retention rate among those who were mentored while no significant difference was found among the comparison group. Data analysis has been limited by poor facility support in obtaining pre- and post-test data.

Enhanced Staff-Family Communication

“Partners in Caregiving” is an intervention designed to increase cooperation and effective communication between family members and nursing home staff. Cornell researchers developed and evaluated the program, which includes two parallel six-hour workshops, one for nursing staff and the other for family members (Pillemer et al., 2003). Trainings focus on communication and conflict resolution skills. Participants in the randomized, controlled study included 932 relatives and 655 staff members from 20 nursing homes. Positive outcomes were found for both family and staff in the treatment group. In addition to improved attitudes toward each other, families of residents with dementia reported less conflict with staff and staff reported a lower likelihood of quitting. The control group, on the other hand, showed an increase in likelihood to quit over the same two-month period. Job burnout remained stable among the

⁶⁹ Not all studies measured both retention and turnover. As a result, we use the term “retention and/or turnover.” For each study we reviewed, we report on results for whichever of these two outcomes the study measured.

treatment group staff but increased in the control group over the study period. Though the focus of the intervention is not on direct care workforce retention, the findings seem promising for both improving worker-family relations and possibly for enhancing workers' job commitment. Examining the effect of this intervention on turnover data, rather than just workers' perceived intent to quit, would be a valuable addition to the evaluation of this program.

Career Ladders

Based on the desire of some CNAs for upward mobility within their chosen field, career ladders have been promoted by some states and providers. Career ladders are intended to reward those who stay longer with more training opportunities and increased wages or other incentives. The Extended Care Career Ladders Initiative (ECCLI) was introduced in the fall of 2000 in Massachusetts as part of a broader Nursing Home Quality Initiative. It provided funds for several consortia of workforce training partners and LTC organizations to develop opportunities for direct care workers to increase their skills in order to reduce high turnover rates and vacancies among LTC paraprofessionals and improve the quality of care provided to consumers.

An evaluation of the implementation of ECCLI projects (Wilson et al., 2002) found preliminary evidence to suggest these activities had an impact. Through a case study approach, this evaluation documents activity and effects in six facilities that were selected to reflect a range of strategies, conditions, and partnership arrangements. Investigators interviewed frontline workers, supervisors, workforce partnership organizations, project coordinators, and other staff at participating nursing homes and home health agencies. They also observed project coordination meetings and technical assistance sessions and examined spreadsheet data from facilities on consortium activities, trends in each workplace, and recruitment costs. Their preliminary findings indicate some important implementation lessons for statewide workforce improvement initiatives:

- Training, wage increases, and establishing career ladders are the most frequently used interventions among consortia members.
- Multi-year, multi-faceted initiatives are essential in organizational change initiatives.
- Working with a workforce "network" rather than just individual providers is more effective.
- Organizing and sustaining culture change and training programs require serious investment at the facility level.
- Wage increases need to be of a meaningful size to workers (commensurate with their sense of their increase in skills and/or responsibilities) to have a positive effect.
- The support of nurse supervisors is critical to the success of ECCLI initiatives.
- Working relationships developed through the implementation phase have improved through increased teamwork and communication and the relationships that have formed between departments, as well as between aides and their supervisors.

Another study on the effects of a career ladder program, by Remsburg and colleagues (2001), examined a program involving a three-step career ladder in which nursing responsibilities are delegated to unlicensed nursing assistants. As in most states, where regulations restrict the nursing tasks that can be delegated to nursing assistants, this program required a waiver. The pre-post study design examined changes in nursing assistant retention rates, the time available to licensed nurses to perform higher-level clinical tasks, and clinical outcomes, such as wound infection rates. The incidence of adverse outcomes decreased or remained at zero for eight of nine clinical functions/skills after program implementation. No significant changes in retention rates for the career ladder staff occurred over the one-year period of the study. These results, however, reflect only one year of program implementation; this time period may not have been long enough to produce changes in retention, given the focus on initial implementation issues during the first year.

Alternative Management Practice

Building on studies that find dissatisfaction with the management practices typically used in nursing homes, an approach known as “self-managed work teams” (SMWTs) has been promoted as a way to give employees a greater say in how their work is organized (Yeatts and Seward, 2000). A pilot test of SMWTs was designed to empower CNAs, improve their job satisfaction, and improve resident care. The teams consist of CNAs who work together daily to serve the same group of residents, identify clinical (e.g., skin care, weight loss) or work (e.g., absenteeism, tardiness) areas needing improvement and share decision making about how to accomplish their work. The structure includes a rotating team coordinator, 30-minute weekly meetings, support from facility leadership, and periodic meetings between team representatives and facility leadership.

In their two-month implementation pilot at two nursing facilities, Yeatts et al. (2004) found that the teams improved: (1) interpersonal relations (e.g., discussion, understanding, apologizing, praising) among the CNAs, (2) communication between CNAs and nursing home leadership (e.g., better explanation to CNAs of reasons for certain practices), and (3) understanding of nursing home policies among CNAs. Lessons learned for successful implementation include surveying management to be sure they want nurse teams, nursing staff buy-in and support, orienting and training the managers, nurses, and nurse aides, and facilitating the teams through weekly meetings between team representatives and nursing facility leadership, leadership support for the teams, and keeping charge nurses informed of team developments. The research team is now conducting an impact evaluation with five experimental nursing homes in the Dallas-Fort Worth metropolitan area and five comparison nursing homes. The evaluation will examine whether SMWTs result in reduced turnover and absenteeism and improved performance among CNAs. Results will be available in 2005, after follow-up survey data are collected 12 months after team implementation.

Wage Enhancements

To stem the tide of nursing assistants and other frontline workers leaving the LTC sector, surveys conducted by Cushman and colleagues (2001) suggest that more competitive wages are needed. Just over half the states (26) funded a wage or benefit pass-through or other increase to benefit direct-care workers between 2000 and 2003 (PHI and NCDHHS, 2004). But how much of an increase is needed? Some studies suggest that relatively modest increases in compensation should help to draw low-wage workers from other sectors. Holzer (2001), for example, cites estimates indicating that an increase in average wages paid to LTC workers of up to \$8 to \$9 per hour would make these jobs competitive for between six and 19 million low-wage workers. However, this is based on modeling projections and may not hold true in practice, or the results may differ depending on local labor market conditions.

Some recent empirical studies are beginning to shed light on this question. An analysis by Howes (2002) concluded that a near doubling in wages (not adjusted for inflation) for home care workers in San Francisco County over a 52-month period from November 1997 to February 2002, led to a 54 percent increase in the number of In Home Supportive Services (IHSS) workers, and a 17 percent drop in the proportion of the workforce in the job for less than one year. The wage increases followed passage of a Living Wage Ordinance at the county level and the establishment of a Public Authority to serve as employer of record for IHSS workers, which permitted union bargaining for higher wages. These results should be interpreted with caution as other external factors could have contributed to these workforce outcomes. For example, at the time of the first significant wage increase over the 52-month period, the CalWorks program was implemented; this required adults receiving welfare (TANF) benefits to enroll in welfare-to-work programs. Additionally, during this time, an innovative low-cost health plan called Healthy Workers was offered to any caregiver who worked a minimum number of hours and had been in the home care workforce for a specified time.

Some research with CNAs suggests that wage increases may need to be targeted, i.e. to those who stay longer or as rewards for providing good care (Bowers, 2003). In Wyoming, a mandated wage increase for

certain types of direct care workers required differential minimum wages for new staff and those with 12 months of experience. A study of the impact of increasing direct care workers' wages on turnover was conducted by the Wyoming Department of Health (2002) for the Joint Appropriations Committee. About \$22 million were allocated by the legislature in 2002 specifically to improve the salaries and benefits of non-professional direct care personnel in adult developmental disabilities community-based programs, and minimum wages for new and longer-term workers were specified. As a result, total compensation (wages and benefits) for these full-time direct care staff increased from an average \$9.08 per hour to \$13.74 per hour, 51 percent over the first three months of implementation. According to the study, turnover dropped by nearly one-third in the three month period, from 52 percent to 37 percent. However, this may be too short a time period to judge whether such an effect was due to the wage increases or to other factors, and the study did not compare the results to any control group. A Kansas study found that one year after implementation of a wage pass-through program, annualized turnover rates for all positions (not just direct care workers) decreased only slightly from 111 percent to 101 percent, probably due to less-than-adequate funds to support the projected wage increases -- only \$4.3 million were allocated for all positions.⁷⁰

Data on the impact of wage pass-through programs on direct care worker recruitment and retention are limited and inconsistent. Findings across the few evaluations completed to date -- and the lack of an appropriate comparison group in these studies -- do not support the efficacy of wage pass-through programs or of a particular type of wage pass-through approach (PHI, 2003).

Multi-faceted Initiatives

The initiatives below include some combination of education in clinical and/or interpersonal communication skills, supervisory training, support groups, mentoring, and monetary incentives for direct care workers. Among these four interventions, WIN A STEP UP seems most promising because of its clear positive effect on reducing direct care worker turnover using a string evaluation design. However, results from the other program evaluations do provide valuable lessons that can be used to inform the development, implementation, and evaluation of future workforce initiatives. Results from the Iowa Caregivers Association program show a positive effect on retention, but it is unclear whether all treatment facilities received the same set of interventions in the same way. The Kansas Long-Term Care Workforce Project study shows some positive results as well as highlights the challenges of implementing any workforce initiative when short staffing is common on a unit. The WETA program evaluation appears to reduce turnover; however, the much higher starting turnover rate among the comparison facilities compared to the treatment facilities may be confounding the intervention effects.

WIN A STEP UP. The acronym WIN A STEP UP stands for Workforce Improvement for Nursing Assistants: Supporting, Training, Education, and Payment for Upgrading Performance. This continuing education and payment incentive workforce improvement program is designed to reduce turnover of nursing assistants. WIN A STEP UP is a partnership between the North Carolina Department of Health and Human Services and the Institute on Aging of the University of North Carolina at Chapel Hill. The program operates solely in nursing homes. It is funded through civil monetary penalty (CMP) fines collected from nursing homes.

The WIN A STEP UP program includes 10 modules and accompanying detailed participant and instructor manuals that focus on clinical skills (e.g., pressure ulcers, infection control) and interpersonal skills and communication (e.g., working in a team, empathetic skills). Participating facilities must agree to commit staff time to implement the program and give either a retention bonus (\$75) or a wage increase (of at least 25 cents per hour) to participating nursing assistants starting three months after they complete the modules. In addition, the WIN A STEP UP program gives \$70 to nursing assistants for each module

⁷⁰ The Kansas data were reported in, "State Wage Pass-Through Legislation: An Analysis", *Workforce Strategies*, No. 1, by Paraprofessional Healthcare Institute, April 2003. The source of the data is unclear.

session they attend and \$75 to nursing assistants who complete seven or more of the modules and stay at the facility for at least three months after completing the modules. Annual turnover rates were significantly lower (15 percent) for nursing assistants in the program compared to those in the matched comparison groups (32 percent) (Konrad and Morgan, 2003). The program was active in 37 North Carolina nursing homes as of April 2004, with plans to involve 55 nursing homes (and 25 comparison homes) by July 2005.

Iowa Caregivers Association CNA Recruitment and Retention Project. In the belief that reducing shortages and turnover rates among direct care workers requires many changes in the way workers are treated and care is organized, some programs are intentionally taking a broader approach to the problem. For example, the Iowa Caregivers Association (ICA) managed the two-year CNA Recruitment and Retention Project. The project's goal was to reduce CNA turnover by assessing the needs of direct care workers in nursing facilities and providing programs and services responsive to their needs. Interventions implemented in facilities included: (1) CNA training in work skills (e.g. conflict resolution, team/building/communication) and clinical skills (e.g., communicating with dying residents, caring for Alzheimer's patients); (2) a CNA mentoring program, and (3) CNA support group activities. Community-based interventions included a public awareness campaign, CNA recognition programs, and CNA support groups facilitated by local community colleges.

The nursing facilities receiving interventions experienced significantly longer retention than those facilities which did not receive the interventions (18.96 months compared to 10.01 months). Two of the three treatment facilities showed progressively lower turnover during the course of the intervention period, while the third had increased turnover in the same period. Turnover data were not available for the comparison facilities (Findley and Richardson, 2000).

Kansas Long-Term Care Workforce Project. The Long-Term Care Workforce Project examined the impact of a three-part intervention -- interpersonal skills and empathy training, biweekly support groups and online supervisory training -- on frontline nursing home employees' interpersonal relationships and their supervisors' capabilities. The project was conducted through a collaboration with IFAS, Kansas Association of Homes and Services for the Aging (KAHSA), and Wichita State University. The evaluation used a comparison group design (randomized at the work group level within homes) among seven mid-sized facilities of around 100 beds each, about evenly distributed between rural and urban locations. The nursing homes in the study were among the better nursing homes in the state, relative to quality of care records and reputation (KAHSA and IFAS, 2003).

As a result of the training, nurse supervisors felt more confident about their ability to communicate with, encourage, and effectively mentor members of their work team. However, the aides failed to detect any change in their own behavior or in their supervisor's behavior, beyond providing more feedback on their progress at work. This inconsistency may be because supervisors held fast to a belief that all work group members should be treated exactly the same, even after intervention training advocated taking into account each individual's uniqueness. As a positive outcome, work group members reported better interpersonal relationships with their residents after the training. Workplace stress ranked constantly high by aides and supervisors both before and after the intervention. The stress associated with chronic short staffing played a major role in the inability of the participants to apply and internalize the lessons learned from the professional trainer. Overall, the intervention caused some changes in attitudes and behavior among frontline and supervisory staff consistent with its teachings. The intervention also demonstrated an ongoing willingness to try to continue to implement behavior change, even in a difficult short-staffed work environment. However, the lack of a stronger response to the intervention is primarily attributable to the stress and tension associated with under-staffing (KAHSA and IFAS, 2003).

Worker Education, Training, and Assistance (WETA) Program. WETA was a three-year demonstration project conducted by Sager and colleagues (2003) in Wisconsin designed to improve job satisfaction and worker retention in participating assisted living facilities. The program was designed to provide education and training, financial benefits, access to emergency assistance with child care, recognition, and advancement opportunities. A pre-post comparison group design found no significant

treatment effects for the intervention on employee satisfaction. In fact, employees in both treatment and comparison facilities showed decreased job satisfaction over the one-year data collection period. However, treatment facilities showed a marginally significant trend toward greater decline in turnover compared to comparison facilities. Comparison facilities' average turnover rate changed from 135 percent at baseline to 126 percent one year post-WETA, while treatment facilities' average turnover changed from 84 percent at baseline to 60 percent one year post-WETA (Sager et al., 2003). Because of the significant baseline differences between the treatment and comparison group facilities, interpretation of these results is difficult.

The WETA program team draws the cautious yet optimistic conclusion, however, that these differential changes provide some evidence that WETA may have influenced turnover rates among employees in treatment facilities. The withdrawal of 42 facilities from the demonstration because of financial difficulties resulted in the evaluation having only one year of results rather than two. The State of Wisconsin is presently developing a demonstration program as a result of the lessons learned from WETA.

Culture Change

Another type of multi-faceted intervention falls under the rubric of "culture change" which involves several mutually reinforcing initiatives, such as training in both clinical and "soft" (i.e. communication, problem-solving) skills; changes in management practices; and career ladders. Four culture change initiatives -- the Eden Alternative, LEAP, the Lyngblomsten House demonstration, and Wellspring -- have been evaluated in the past few years, with the LEAP and Wellspring practices showing promising evidence of positive effects on direct care workforce retention.

LEAP. Project LEAP, which stands for Learn, Empower, Achieve, and Produce, is a workforce development program that aims to educate, empower, and retain nursing managers and staff in nursing homes. Its goal is to develop high quality, dedicated LTC leaders and staff that will result in better resident quality of life and well-being. Mather Lifeways and the Mather Institute on Aging, in association with Life Services Network (the Illinois affiliate of the American Association of Homes and Services for the Aging), developed and started the LEAP program in 1999. LEAP includes training for nurses and for CNAs. A six-week 18-hour workshop series for nurse managers and charge nurses addresses nurses' four key roles (leader, team builder, care role model, and gerontological clinical expert). A seven-week 17.5-hour workshop series for CNAs focuses on career development (e.g., training on person-centered care, communication skills, cultural sensitivity, building care teams, mentoring new CNAs, and working with families). LEAP also includes a two-level CNA career ladder that allows CNAs to advance within the CNA role and gain greater responsibility, mentoring, and small pay raises. LEAP aims to encourage a sense of pride among gerontological nurses and build a bridge between nurses and CNAs (Hollinger-Smith et al., 2002; Hollinger-Smith et al., 2003).

Program developers, Ortigara and Hollinger-Smith, believe that the success of LEAP is contingent on the commitment of top management to promote LEAP and sustain the program throughout the facility. For that reason, the first step in the LEAP process is an assessment of the organization and its management to determine its management style, readiness for learning, and capacity to implement and sustain LEAP.

Two LEAP test facilities experienced a significant reduction in nurse and CNA turnover rates after the program began. One facility went from a nurse turnover rate of 36 percent and a CNA turnover rate of 43 percent before LEAP to turnover rates of 16 percent and 4 percent, respectively, one year after implementation. The other facility went from a 75 percent nurse staff turnover rate and a 113 percent CNA turnover rate to 34 percent and 44 percent turnover, respectively, over one year after implementation. CNAs in the LEAP test facilities show statistically significant improvements in work empowerment, job satisfaction, and sense of organizational climate (Hollinger-Smith et al., 2003; Hollinger-Smith and Ortigara, 2004).

As of March 2004, 15 organizations in 14 states were signed up to complete the train-the-trainer workshops and implement LEAP. LEAP organizers are exploring ways to expand the CNA career ladder to a third level, in which a CNA-Level three would become a facility-wide resource on issues such as skin care or dementia care.

Wellspring. A team of researchers from the IFAS, the University of Wisconsin-Madison, and Texas A&M University evaluated the Wellspring culture change program, which represents a model for nursing home quality improvement and a process for organizational change (Stone et al., 2002). Wellspring started as an Alliance of 11 facilities in Wisconsin that developed a mutual strategy to improve clinical outcomes, conduct staff training and empower staff. The core elements of the Wellspring model include: top management commitment to the quality improvement approach; a shared program of staff training, clinical consultation, and education from a geriatric nurse practitioner; sharing of comparative data on resident outcomes; and, use of multidisciplinary care resource teams empowered to develop and implement interventions to improve quality of care for residents.

The evaluation team used a multi-faceted methodology including site visits, interviews and focus groups with residents, families and staff, participant observation, and analyses of secondary data from diverse sources using a comparison group evaluation design. Rates of nursing staff turnover, including direct care workers, were lower or increased more slowly in Wellspring nursing homes compared to control facilities in Wisconsin. Wellspring facilities also showed improved performance on the federal nursing home survey. No additional increases in net resources were required and Wellspring facilities had lower costs than the comparison group. Staff members were more vigilant in assessing problems and took a more proactive approach to resident care, although clear evidence of improvement in clinical outcomes using MDS quality indicators could not be documented. Observational evidence and interview results indicated a better quality of life for residents and an improved quality of interaction between residents and staff.

The evaluation produced several key lessons for the successful implementation and sustainability of the Wellspring model and similar culture change initiatives:

- The philosophy of the culture change initiative must be aligned with the administrative, operational, and management structures.
- Staff nurses must be committed to work with and mentor nursing assistants.
- Having an organizing superstructure such as the Alliance helps facilities stay the course and is a key mechanism for improving quality within and across facilities.
- The full commitment of top administrative staff is required -- use of training modules alone is not sufficient to change a nursing home's culture.

The Eden Alternative. Proponents of the Eden Alternative are committed to creating better social and physical environments for nursing home residents. The Eden Alternative is an approach to creating an elder-centered community where life revolves around close and continuing contact with plants, animals and children. A one-year comparison group study implemented in two nursing homes run by the same organization found no beneficial effects for residents in terms of cognition, functional status, survival, infection rate, or cost of care (Coleman et al., 2002). Further, the Eden site had more staff terminations and new hires than did the control site during the study period.

Lyngblomsten Service House. A fourth culture change initiative replicates a Swedish model of supportive living for nursing home residents, to bridge the gap between a medical model of skilled nursing facility and a social model of assisted living (Grant, 2002). Based in Minnesota, Lyngblomsten Service House residents live in a less institutional, more "home-like" setting than residents in a typical skilled nursing facility. They live in private studio apartments with full baths, kitchenettes, and a call system wired to pagers carried by "care assistants." Care assistants are universal workers, who carry out nursing, housekeeping, food service, and other activities. Care assistants work in self-directed teams. Residents are able to decide the timing of day-to-day activities (e.g., when to awaken and when and what to eat).

The two-year randomized (resident and family caregiver, but not staff) control group evaluation found positive impacts on quality of life among service house residents and family caregivers (Grant, 2002). However, it found no significant differences in staff job satisfaction or job stress. Nursing staff had some difficulty adjusting to the new model, due both to unclear direction about whom they should report to (the Director of Nursing or the Service House Coordinator) and to negative reactions to undertaking housekeeping and meal preparation duties. There was higher than anticipated turnover among care assistants in the program's first year, but after that the workforce stabilized. The implementation experience highlights some key lessons: (1) carefully screening care assistant applicants during recruitment helps to ensure that job tasks are consistent with expectations; (2) care assistants need clear information on whom to report to; and (3) sufficient training helps staff adjust to new roles.

Family and Friends as an Alternative Labor Supply

Cash & Counseling. Cash & Counseling is a national program sponsored by The Robert Wood Johnson Foundation (RWJF), the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS), and the Administration on Aging (AoA) also in HHS. The Cash & Counseling approach provides consumers with a flexible monthly allowance, counseling, and fiscal assistance, which allow them to direct and manage their own personal assistance services and address their own specific needs. Cash & Counseling intends to increase consumer satisfaction, quality, and efficiency in the provision of personal assistance services. A three-state Cash & Counseling Demonstration was implemented to compare the Cash & Counseling consumer-directed model with the traditional agency-directed approach to delivering personal assistance services.

Almost all of the demonstration recipients used the allowance to hire workers, in most cases hiring relatives or acquaintances (Phillips et al., 2003). Hiring family and friends accesses a source of assistance usually unavailable to traditional agencies, since these caregivers are motivated primarily by their relationship with the consumer rather than by employment as an aide. Treatment group members from the Arkansas demonstration were much more likely than control group members to receive paid care (Dale et al., 2002). In fact, consumers in the treatment groups in all demonstration states had difficulty hiring a worker if they did not have a relative or friend to hire (Phillips et al., 2002). These findings speak to the potential value of friends and family as an alternative labor pool for home- and community-based services, and to the need for programs like Cash and Counseling to facilitate linking quality workers with care recipients who do not have access to friends or family who can provide care. The RWJF, ASPE, and AoA have funded an expansion of the Cash & Counseling program through grants and comprehensive technical assistance to additional states that are interested in replicating, and in some states expanding on, this Cash & Counseling model.

DISCUSSION AND CONCLUSIONS

This synthesis of the recent literature on problems and solutions to the LTC direct care workforce dilemma suggests possible candidates for broader replication and remaining gaps where further applied research is needed. Further, the synthesis raises the continuing need to see evaluation as an important component to building the evidence base for what works in the effort to develop a qualified, stable LTC workforce. In this section, we highlight what interventions the evidence shows works, limitations in study designs that impede the development of an evidence base, and on-going or future publicly- and privately-funded efforts that can help contribute to a strong evidence base.

What Works?

Stone (2001) noted the dearth of an evidence base in the literature up to the late 1990s. There have been more applied research and evaluation studies conducted in the past several years, and a number of evaluation efforts are currently in the field or planned for the near future. The designs used to evaluate the interventions described earlier vary in their ability to measure the effect of the intervention on

outcomes of interest (retention and/or turnover). In determining what works among the interventions reviewed, we looked for a pre-post design and use of a comparison group. This quasi-experimental design gives one greater confidence (e.g., compared to no comparison group) that positive effects, if any, are more likely due to the intervention rather than to other competing factors that may have influenced the outcomes of interest. Three interventions reviewed seem appropriate for further replication because relatively robust evaluations (pre-post comparison group design) with clearly defined interventions have shown them to have positive effects on direct care workforce retention and/or turnover: (1) "Growing Strong Roots" peer mentoring for new CNAs; (2) WIN A STEP UP education and payment incentive workforce improvement program; and, (3) the Wellspring model of quality improvement and culture change.

Two additional interventions appear promising but would benefit from further evaluation -- LEAP and Iowa Caregivers Association CNA Recruitment and Retention Project. The LEAP nurse supervisor and direct care worker training plus career ladder model has shown decreased CNA turnover and increased job satisfaction and work empowerment in numerous test facilities. However, the evaluation design does not use comparison groups and different test facilities measure turnover in different ways. LEAP evaluators note that finding truly comparable nursing homes is impossible because even within organizations that have several homes, there are many differences (due to different management, turnover rates, staffing ratios, etc.). With funding from the Health Resources and Services Administration, the LEAP team will follow LEAP-participating organizations over five years and look at organizational characteristics as well as resident indicators to see how these factors relate to worker perceptions and turnover (personal communication with Linda Hollinger-Smith).

The Iowa Caregivers Association CNA Recruitment and Retention Project consisted of a variety of interventions including CNA training, mentoring, and support groups as well as a community-level public awareness campaign and CNA recognition programs. The results from the pre-post comparison group design show a positive significant effect on retention. However, it is unclear whether all treatment facilities received the same set of interventions and, therefore, whether all components are necessary to have the positive outcomes experienced. Further work -- to determine whether particular components of the multi-faceted initiative contributed most to increased retention, or whether treatment facilities receiving different components had different outcomes -- would be helpful in determining whether this initiative (or particular components) is appropriate for replication.

Other promising models -- such as self-managed work teams, WETA, and the Kansas Long-Term Care Workforce Project -- are currently being evaluated, need more refinement based on current results, need better-designed evaluations, or have not measured actual turnover or retention among their outcomes. For other interventions, such as wage and benefits enhancements, more work is needed to determine: (1) how best to target them for optimal workforce outcomes (e.g., amount of wage increase, whether to link them to tenure or performance) and (2) the feasibility of this strategy in light of state budget cuts and Medicaid cuts.

All intervention studies, even those whose outcomes are inconclusive, contribute important lessons on what supports effective implementation. Though the substance of interventions varied, they often pointed to the same set of common implementation requirements. For example, management at all levels must have a sustained commitment to the initiative. In particular, nursing staff who serve as direct care worker supervisors must be committed to working with direct care staff. Staff also need to get clear, consistent messages and expectations about the intervention (i.e., what is being changed and why).

Challenges to Developing a Strong Evidence Base -- What Needs to Be Done?

The evaluation findings reported raise some important issues about the challenges of conducting evaluations in the real world -- namely, measuring longer-term effects, determining the replicability of effective models, the need to measure actual behavioral outcomes, like turnover, and using strong evaluation designs. Well-done evaluation takes time because it takes time for real change to occur with

real people in real settings. Evaluating outcomes before there is sufficient time to expect any difference to occur, or not following up to see if change is sustainable, does not benefit policy or practice to the maximum extent possible.

Not only is it important to evaluate carefully an initial intervention (Beck, 2001), but to invest in replication efforts of interventions that have been shown to work in a particular setting or facility. The devil truly is in the details when it comes to creating workforce change in LTC. The initial Wellspring model showed consistently positive outcomes; subsequent efforts to replicate the model among a different set of nursing homes in Wisconsin did not show similar positive outcomes. Rather than write off this lack of success as a loss, resources are needed to understand *why* the differences occur and what assistance and tools newcomers to Wellspring, or any evidence-based model, need to adapt and implement an effective model in their own context. As Stone (2001) found in the earlier review of evidence, intervention studies still focus on a specific setting. Work is needed to determine whether interventions found effective in one setting (e.g., LEAP in nursing home settings) are transferable to other settings (e.g., assisted living, other residential care settings, home and community-based settings).

In order to know what works to recruit and retain LTC direct care workers, evaluations need to establish whether interventions resulted in significantly decreased turnover and increased retention. These assessments require that evaluators have access to data that measure turnover and retention in the same way across all facilities. Currently, facilities measure these outcomes differently. Further, in some cases, as with the Partners in Caregiving intervention, evaluators do not measure turnover and retention (possibly because of the lack of available outcomes data) and instead look only at intent to quit.

The studies described varied in the type and quality of evaluation designs used. The classic randomized, controlled clinical trial epitomizes the ideal evaluation design, where randomizing study subjects allows the evaluator to determine whether the intervention caused a change in the outcome. In most evaluations conducted in real-life settings -- such as with workforce interventions -- randomized, controlled designs are often impossible. However, pre-post studies that use a valid comparison group composed of study subjects (workers) with similar characteristics in similar facilities to the intervention facilities are generally stronger than studies using no comparison group. Finding an appropriate comparison group and having them provide study data can be challenging. However, having a comparison enables evaluators to rule out some common alternative explanations for intervention findings, thus lending greater credence to the results.

Facilitating the use of evidence-based workforce practices requires more than just better-designed evaluation studies. The results of evaluation studies have not always been heeded. Sometimes, models that have been empirically shown to have positive intended outcomes do not receive wide dissemination or adoption (e.g., Wellspring), while other innovative approaches (e.g., wage pass throughs) with little or no evidence base are replicated more broadly. Resources and attention must also be paid to the effective dissemination of the results of studies to providers, policymakers, third-party payers, and regulators. Providers need training and technical assistance on implementing evidence-based practices (Feldman and Kane, 2003).

On-going and Future Efforts to Build a Strong Evidence Base

At a time when most states have been experiencing continuing challenges with LTC direct care workforce recruitment and retention, the Provider Practice database⁷¹ may be a welcome tool for providers and others looking for answers. IFAS and the Paraprofessional Healthcare Institute developed the database -- a web-based tool containing 40 promising LTC direct care workforce recruitment and retention practices across settings. Although the intent was to include only those practices with an evidence base, most of

⁷¹ The database was funded initially by ASPE and the CMS. The database can be accessed at <http://www.directcareclearinghouse.org/practices/index.jsp>.

the practices in the database have not been evaluated. Ideally, resources should be spent to evaluate these practices and contribute to the evidence base.

States and providers are implementing an array of initiatives, including those being funded by private foundations and the Federal Government. All of these efforts need to be tracked, the range of efforts evaluated, and successful efforts disseminated with careful attention to what is needed to support effective replication. RWJF and the Atlantic Philanthropies recently funded a \$15 million grant program -- Better Jobs Better Care (BJBC) -- to support state-based policy and practice demonstrations in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont. The state demonstrations are being evaluated by researchers at Pennsylvania State University.

BJBC is also funding eight applied research projects designed to advance knowledge about which programs and policies work best to recruit and retain high quality direct care workers in the LTC field. Several applied research grantees will examine organizational innovations and job training models that improve workforce recruitment, retention, and quality. Others will assess the potential of new labor pools, such as older workers and family members and friends, to meet future LTC demands. One study will measure the impact of wage and job benefit enhancements on workforce recruitment and retention. The BJBC program will also provide an opportunity for shared learning across states, providers, and worker organizations and allow wide dissemination of information across LTC settings.

As part of the national New Freedom initiative, HHS awarded nearly \$6 million in September 2003 to five state demonstration projects aimed at helping recruit, train and retain direct service workers. Three of these demonstrations plan to test offering health insurance benefits to workers to determine if that helps keep workers on the job. This Demonstration to Improve the Direct Service Community Workforce will grant \$1.4 million each to the New Mexico Department of Health, the Maine Governor's Office of Health Policy and Finance, and to Pathways for the Future, a service provider in North Carolina. Grants of \$680,500 each will go to the University of Delaware and Volunteers of America in Louisiana for developing educational materials, training of service workers, mentorship programs and other activities. Each of these grants is expected to conduct an evaluation of their efforts.

A number of culture change efforts and accompanying evaluation efforts are currently underway. Two examples include Rosalie Kane's evaluation of the Greenhouse in Tupelo, Mississippi, and Leslie Grant's evaluation of the Beverly Corporation's Resident Centered Care Program.

One of the myriad of challenges faced by those trying to develop evidence-based workforce strategies is the lack of consistent measures, such as turnover. As an example, both the CAHSA-IFAS project team and the LEAP evaluation team found that different LTC facilities use different ways to measure such outcomes as turnover. This challenge suggests the need for a resource of high-quality measures that can be used within and across evaluation studies.

As part of its National Initiative to Improve the Recruitment and Retention of the Paraprofessional Workforce in LTC project, ASPE funded IFAS to develop *Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experiences and Outcomes*.⁷² The Office of Policy in the Department of Labor also contributed to its development. The Guide is intended to help providers, in collaboration with applied researchers, assess worker experiences and track how well their interventions are doing to improve the work environment and keep workers. The Guide includes measures on a variety of topics including retention, turnover, vacancies, worker empowerment, job design, and workload.

ASPE is also funding a national survey of nursing assistants in LTC to examine wages and workers' perceptions of their working conditions, workplace experiences, job responsibilities, and supervisor

⁷² A downloadable copy of the Guide is available at: <http://www.aahsa.org/FutureOfAging/LTCGuide.pdf>.

relationships. The survey will be fielded in the summer of 2004 in conjunction with the National Center for Health Statistics' National Nursing Home Survey. Results are currently planned to be available in December 2004 (PHI and NCDHHS, 2004). ASPE is also sponsoring a symposium in May 2004, of invited stakeholders from LTC and workforce development fields to discuss current available evidence about effective strategies for recruiting and retaining direct care workers.

The past several years have shown that the downturn in the economy has not solved the LTC direct care workforce problem. The challenge is only likely to become greater in the decades to come as societal forces merge to require more direct care workers across the country than are currently projected to be available. Effective workforce policy and practice must be founded on solid evidence. This paper reflects selected evidence-based practices that can be useful as we continue to explore how best to recruit and retain a qualified and committed LTC workforce.

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Recruiting and Retaining a Quality Paraprofessional Long-Term Care Workforce: Building Collaboratives with the Nation's Workforce Investment System⁷³

Michael E. Fishman, Burt Barnow, Asaph Glosser and Karen Gardiner
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INTRODUCTION

This paper sets the stage for an ongoing conversation between representatives of the long-term care sector and the workforce investment system. The long-term care sector provides care to chronically ill, disabled, and elderly persons in a variety of care settings such as individual homes, residential care, nursing homes, and other institutional settings. Long-term care consists of an array of services and supports for persons with functional limitations whose needs range from limited personal assistance to total care. The workforce investment system supports both employers and workers by providing -- at the local level -- labor market information, job placement services, and training.

This conversation is critically important for our nation. In 1995, there were approximately 12.1 million long-term care recipients in the United States (Kaiser Foundation, 1999.) As the baby boom generation ages and technological advances extend life, these numbers will grow rapidly in the coming decades. The elderly population in the United States is expected to increase by over 130 percent between 2000 and 2050 (ASPE, 2003). Much of the formal care for these populations is provided by paraprofessional workers: certified nurse assistants (CNAs), home health aides, and personal and home care aides. For a variety of reasons described later in this paper, there is a growing shortage of these workers.

In addition to the care needs of our nation's elderly and disabled population, there is an economic imperative to support the viability of long-term care services. Spending on institutional and home care for adults -- including Medicare, Medicaid, private long-term care insurance, family resources, and other payers -- is expected to more than double between 2000 and 2025, from \$98 billion to \$208 billion. By 2050, spending is projected to reach \$380 billion (ASPE/Lewin, 2001). The majority of long-term care is provided by unpaid, informal caregivers. Often, formal long-term care services support the care provided by informal caregivers -- typically adult children -- enabling some informal caregivers to enter paid work. Exploring the costs of informal caregiving to employers, MetLife (1997) found that the cost to business through lost productivity as a result of informal caregiving is over \$11 billion per year. In short, developing a long-term care paraprofessional workforce is an economic development issue for communities and individuals. The workforce investment system is well-positioned, through its network of One-Stop Career Centers, to serve as a valuable resource for both long-term care providers and workers.

This paper provides the fundamental context of both the long-term care sector and the workforce investment system in order to build understanding among members of each system. It is not intended to be comprehensive but to provide enough information to stimulate dialogue. **Section II** briefly describes the characteristics of the long-term care paraprofessional workforce. **Section III** outlines the growth in the long-term care sector. **Section IV** discusses workforce shortages from an economic perspective and why they exist in the long-term care sector. **Section V** describes the response of the long-term care sector to the shortage of paraprofessionals. **Section VI** describes the Workforce Investment Act (WIA) and the role of the workforce system. **Section VII** provides some examples of workforce investment initiatives in the long-term care sector. Finally, **Section VIII** presents some opportunities for collaboration.

⁷³ The full paper is available online at <http://aspe.hhs.gov/daltcp/reports/natwis.htm>.

CHARACTERISTICS OF THE LONG-TERM CARE PARAPROFESSIONAL WORKFORCE

Long-Term Care Paraprofessional Occupations

There are over 2.5 million paraprofessional long-term care and health care workers in the United States. As Table 1 indicates, the U.S. Department of Labor's Bureau of Labor Statistics (BLS) data has three occupational categories that include long-term care paraprofessionals: (1) nurse aides, orderlies, and attendants; (2) home health aides; and (3) personal and home care aides. These workers are employed in both long-term care and acute care settings. While they all provide personal care, they have varying levels of supervision, education, and training requirements.

TABLE 1. Long-Term Care Paraprofessional Occupations			
	Nurse Aides, Orderlies, and Attendants	Home Health Aides	Personal and Home Care Aides
Number Employed in 2002 ¹	1,375,000	580,000	608,000
Common Employers	Nursing and residential care facilities; hospitals	Home healthcare agencies; social assistance agencies; nursing and residential care facilities	Home healthcare agencies; individual and family services; private households
Examples of Services Provided	Serve meals; make beds; empty bed pans; bathe patients; take vital signs; observe patients' physical, and mental conditions	Administer oral medication; take vital signs; assist with prescribed exercises; help patients bathe, groom, dress	Housekeeping; routine personal care services; grocery shopping and cooking
Supervision	On-site nursing and medical staff	Periodic check-ins/visits by supervisors (e.g., nurses, physical therapists, social workers, case managers)	Period check-ins/visits by supervisors (e.g., case managers, patients' families, nurses)
Education and Training Requirements	Federal requirements of 75 hours of training (for nurse aides); competency evaluation results in state certification; high school diploma and previous work experience not always required	Per federal rules, if employer receives Medicare reimbursement, must pass competency test (75 hours of classroom and practical training suggested); high school diploma and previous work experience not always required	Dependent on state, some require no formal training; high school diploma and previous work experience not always required
SOURCE: U.S. Department of Labor, Bureau of Labor Statistics (2004). <i>Occupational Outlook Handbook, 2004-2005 Edition</i> . Washington, DC.			
1. Employment numbers from U.S. Department of Labor, Bureau of Labor Statistics. 2002-2012 National Employment Matrix.			

Characteristics of the Long-Term Care Paraprofessional Workforce

Table 2 describes the characteristics of nurse aides in different settings (e.g., nursing home, hospital) compared with other workers. As the table indicates, nurse aides in long-term care settings are more likely

than their counterparts in hospitals to: have a high school education or less, be unmarried with children, have an income below the poverty level, be uninsured, and receive Food Stamps.

When compared with all workers, nurse aides in long-term care settings are disproportionately female, African-American, less educated, unmarried parents, poor, uninsured, and receiving Food Stamps (GAO, 2001).

TABLE 2. Characteristics of Nurse Aides and Other Workers					
	Nursing Home	Home Health Care	Hospitals	Service Worker	All Workers
Mean Age	37.0	41.3	38.7	37.3	44.8
% Female	91	89	80	67	52
% Black	32	34	33	18	12
% Hispanic	12	18	14	22	15
% Immigrant	11	20	13	19	12
% HS Education or less	73	62	54	67	50
% Unmarried with Children under 18	32	25	20	21	11
% Below Poverty	18	19	8	16	11
% Uninsured	25	32	14	31	16
% Receiving Food Stamps	14	15	5	9	6
SOURCE: U.S. General Accounting Office (2001). <i>Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern</i> . GAO-01-750T. Washington, DC.					

Wages

Among the three long-term care paraprofessional occupations presented in Table 1, nurse aides, orderlies, and attendants had the highest median hourly earnings (\$9.59) in 2002. The median annual earnings for this labor category were \$19,960. Wages for nurse aides vary based on the industry setting. The average hourly wages of nurse aides working in hospitals are over one dollar more than their counterparts in community care facilities for the elderly. Median annual nurse aide wages, however, are lower than the median wages for all short-term training occupations (\$21,911) (DOL, 2002).

The median hourly and annual earnings for home health aides were \$8.70 and \$18,090, respectively. The hourly and annual earnings for personal and home care aides were the lowest of the three occupations (\$7.81 and \$16,250, respectively) (DOL, 2002).

Benefits

According to BLS, paraprofessionals generally receive better benefits if they work in a hospital or nursing home as opposed to in home care. For example, nurse aides in hospitals usually qualify for at least one week of paid vacation after one year of service. They are often eligible for medical insurance, pension plans, paid holidays, and sick leave (DOL, 2004). As Table 2 indicates, nurse aides who work in hospitals were more likely to be insured than those in home health care settings or nursing homes.

By comparison, personal and home care aides and home health aides are less likely to receive benefits. They are usually on-call hourly workers, and they are only paid for time spent working in the home (DOL, 2004).

Benefits are also associated with the number of hours worked. Ong et al. (2002) conducted a labor market analysis of California caregivers, including personal and home care aides, home health aides, and nurse aides. One area explored was benefits. The study found that most full-time employees -- but few part-time ones -- were offered benefits.⁷⁴ Most full-time employees were offered vacation time (ranging from 65 percent of home health aides to 95 percent of nurse aides) and sick leave (50 percent to 85 percent). Among part-time workers, the proportion offered vacation time ranged from 10 percent (personal and home care aides) to 30 percent (nurse aides); sick leave was also less common (ranging from 15 percent to 35 percent). The majority of full-time nurse aides and home health aides, and almost half of personal and home care aides, were offered medical and dental insurance, compared with less than one-third of part-time workers (Ong et al., 2002).

The lack of benefits for part-time employees potentially affects a large segment of the paraprofessional workforce. About 30 percent of nurse aides are part-time workers. However, the majority of home health aides and personal and home care aides (over 60 percent) are part-time or temporary employees (Ong et al., 2002).

GROWTH IN THE LONG TERM CARE SECTOR

Between 2000 and 2050, the number of Americans in need of long-term care is predicted to increase about 110 percent, from 13 million to 27 million. A number of factors will contribute to this growth, chief among them the increase in the elderly population, particularly those age 85 and older, and fewer available informal caregivers. The elderly population segment will increase by over 130 percent, from 8 million in 2000 to 19 million in 2050. The growth in the need for care is driving the demand for long-term care workers (ASPE, 2003).

Projected Increase in Paraprofessionals

BLS predicts strong growth in employment among paraprofessionals between 2002 and 2012 (see Table 3). As the Table indicates, the increase in total employment for home health aides (48 percent) and personal and home care aides (40 percent) will be especially strong. Employment among nurse aides is also expected to increase by more than one-quarter. The projected growth for these three occupations is considerably higher than the projections for all short-term training occupations (14 percent) and all occupations (15 percent).⁷⁵

The strong projected growth in home health aides and personal and home care aides reflects a trend in the long-term care system in which services are increasingly provided in home and community-based settings. As noted earlier, these occupations have lower wages and are less likely to receive benefits.

⁷⁴ The study reported benefits offered, as opposed to benefit take-up rates.

⁷⁵ BLS figures likely undercount the number of current workers. BLS data is based on wage and salary employment in residential care, personal care facilities, home health care services, hospitals, temporary help firms and public agencies. Data on self-employed independent providers are collected; however, definitional limitations prevent extracting the subset of workers from these estimates.

TABLE 3. 2002-2012 Employment Projections				
Occupation	Total Employment (000's)		2002-2012 Change in Total Employment	
	2002	2012	Number (000's)	Percent
All occupations	144,014	165,319	21,305	14.8
All occupations requiring short-term training	51,838	59,027	7,193	13.9
<i>Home health aides</i>	<i>580</i>	<i>859</i>	<i>279</i>	<i>48.1</i>
<i>Personal and home care aides</i>	<i>608</i>	<i>854</i>	<i>246</i>	<i>40.5</i>
<i>Nursing aides, orderlies, and attendants</i>	<i>1,375</i>	<i>1,718</i>	<i>343</i>	<i>24.9</i>
Waiters and waitresses	2,097	2,464	367	17.5
Cashiers, except gaming	3,432	3,886	454	13.2
Child care workers	1,211	1,353	142	11.7
Telemarketer	428	406	(21)	-4.9
SOURCE: U.S. Department of Labor, Bureau of Labor Statistics. 2002-2012 <i>National Employment Matrix</i> . Washington, DC.				

Using BLS data, the Department of Health and Human Services (DHHS) estimates that direct care employment will continue to grow, particularly after 2030 when the baby boomers begin to reach 85. Between 2000 and 2050, the estimated number of direct care workers will increase between 200 percent and 242 (Report to Congress, 2003).⁷⁶

Turnover

While demand for paraprofessionals is growing rapidly, the field faces a major problem with turnover. According to GAO (2001), turnover among nurses aides working for home health care agencies and nursing homes is 13 to 18 percent higher than the overall labor force and 20 percent higher than other service workers. Researchers have suggested a number of factors that contribute to above-average turnover rates among paraprofessionals. GAO (2001) highlights substantial physical demands and workplace dangers as factors in high turnover rates. For example, the report notes that nursing homes have a higher rate of workplace injury (13 per 100 employees in 1999) than the construction industry (8 per 100 employees). A survey of home care workers in New York reports that low wages was the most common reason the respondents gave for quitting their last home care job; workers also cited irregular work schedules and lack of benefits and potential for advancement (Long Term Care Policy Coordinating Council, 1990). Research also suggests that employers can reduce turnover by making workers feel more involved in decision-making. For example, Banaszak-Holl and Hines (1996) found that turnover among aides in nursing homes was significantly reduced by aides' involvement in interdisciplinary care plan meetings. High caseloads are also a factor.

It is difficult to establish hard numbers because the extent to which turnover data on paraprofessionals for one or more long-term care settings is collected and analyzed using uniform methodology varies

⁷⁶ In this estimate, "direct care workers" refers to both professionals and paraprofessionals.

tremendously. However, researchers have generally found that turnover rates typically exceed 50 percent (e.g., National Center for Health Workforce Analyses, 2004; PHI and NCDHHS, 2004; GAO, 2001; Stone, 2001).

WORKFORCE SHORTAGES AND WHY THEY EXIST

The term “labor shortage” has no universally agreed upon definition. In this paper, we will adopt DOL’s (1993) slightly modified version of Franke and Sobel’s (1970) definition: “A sustained market disequilibrium between supply and demand in which the quantity of workers demanded exceeds the supply available and willing to work at the prevailing wage and working conditions at a particular place and point in time.” The presence of a market disequilibrium is not an unusual occurrence -- in fact, disequilibria are important for markets to function, as they send signals that affect prices as well as the quantity supplied and demanded.

Much of the economics literature defines labor shortages based on sustained increases in demand that continue at a pace that prevents labor supply from ever catching up. There are, however, other reasons for a shortage of workers. A series of case studies examining labor shortages (DOL, 1993) show how government regulation and institutional rigidities can lead to shortages in some instances. In particular, a shortage can arise when government restrictions prevent the labor market from accommodating an increase of demand; essentially, the government regulations may lead to a temporary disequilibrium becoming a chronic labor shortage.

It is more difficult than one might suspect to identify an occupational shortage. Accurate numbers on the supply of workers and the demand for those workers is not usually readily available, so diagnosis of a shortage must rest on vacancy data, if it exists, or on signals that employers are taking actions to attract more workers into the occupation. Vacancy data are not commonly available, and even when they are, one must look for more vacancies than are “normal” for an occupation to diagnose a vacancy. In previous work, researchers have looked at signs that employers have taken actions consistent with a shortage as a means of ascertaining whether a shortage of long-term care workers is present. Barnow et al. (1998) list a number of the actions employers might be expected to take to alleviate a shortage. They include:

- Increasing recruiting efforts through means such as increased advertising in the usual outlets, advertising in new media, expanding the recruiting area, using public and private employment agencies, and paying bonuses to workers who recruit new employees;
- Increasing use of overtime;
- Reducing the minimum qualifications for the job;
- Restructuring the job to use workers in other occupations;
- Substituting capital for labor in the shortage occupations;
- Training workers for the jobs;
- Improving working conditions;
- Offering signing bonuses to new employees;
- Contracting out work;
- Turning down work.

In addition, when consumers are legally entitled to services, from public or private insurance, a shortage can be inferred by failure to provide such services. Using both direct confirmation and indirect evidence, shortages of long-term care workers have been identified in a number of studies (e.g., Barnow et al., 1998; DOL, 1993; GAO, 2001; Stone, 2001; Stone and Wiener, 2001).

Long-term care occupations might appear to be an unlikely candidate for a shortage. The jobs require short-term training and relatively few technical skills. Thus, under ordinary circumstances, a disequilibrium could be eliminated by increasing wages and inducing workers to enter the field. However, recent studies indicate that shortages do exist and are marked by recruitment and retention problems. These problems

can both contribute to and be symptoms of shortages. For example, a survey of state Medicaid and aging officials conducted in 1999 found that 42 states reported paraprofessional recruitment and/or retention problems. State-level surveys also indicate significant problems. For example, a survey of long-term care providers in Pennsylvania found that 70 percent reported significant recruitment or retention problems. In Massachusetts, nursing home administrators reported an 11 percent frontline worker vacancy rate in 1999 (Stone and Wiener, 2001). A 2001 survey of 155 non-for-profit nursing homes, continuing care retirement communities, and assisted living facilities in California indicated that recruitment was a serious or somewhat serious problem for 77 percent of respondents, while retention was a serious or somewhat serious problem for 56 percent (Harahan et al, 2003). Other evidence of shortages includes high worker caseloads and the reliance of some nursing homes on contracted staff from home health agencies.

However, employers in the long-term care industry often lack the flexibility of other employers. Stone and Wiener (2001) show that the long-term care industry depends to a large extent on government and other third party payments that restrict providers' ability to adjust wages (and other factors that influence their costs) freely. The Medicaid and Medicare programs paid for over one-half of expenditures in the industry in 1995, 37.8 percent and 17.8 percent, respectively, and Medicaid finances about two-thirds of nursing home residents. Stone and Wiener (2001, pg 18) also note that: "For years states have tried to control Medicaid nursing home and home care expenditures by placing limits on reimbursement." Providers have, in the past, used Medicare to make up the difference, but Medicare cuts (Balanced Budget Act of 1997) make this difficult by requiring that reimbursement limits be held to below-inflation rate growth (Stone and Wiener, 2001). Under such circumstances, employers lack the ability to increase wages and take other actions that would alleviate the shortage.

LONG-TERM CARE INDUSTRY'S RESPONSE

According to *Better Jobs Better Care*, a Robert Wood Johnson-funded initiative, numerous factors contribute to the difficulty in recruiting and retaining paraprofessionals.

- Wages are generally low and benefits are poor.
- Job preparation, continuing education, and training frequently fail to prepare these workers for what they face in caring for people with increasingly complex needs.
- Advancement opportunities are often limited.
- Paraprofessionals report that they often do not feel valued or respected by their employers and supervisors.
- Despite having more interaction with patients than many other members of the care team, these workers are often excluded from decision-making involving patient care.

The long-term care sector is trying a number of approaches for dealing with these problems. Broadly speaking, they involve efforts to improve wages and benefits, create opportunities for advancement (e.g., career ladders), and to improve the workplace environment. The major approaches described in the literature are outlined below (Stone and Wiener, 2001).

Improving Wages and Benefits. Efforts include:

- **Provider initiatives that enhance recruitment and retention.** Examples include signing bonuses, retention and referral bonuses, annual raises, subsidized child care, and tuition assistance.
- **Wage pass-through.** As noted above, Medicaid and Medicare reimbursement policies affect the wages of paraprofessional workers. Some states have attempted to increase wages through a wage pass-through (WPT) policy. Under a WPT, some portion of a reimbursement increase for a public source (e.g., Medicaid) is earmarked for increased wages or benefits for front-line workers. A 2003 Paraprofessional Healthcare Institute (PHI) report found mixed results in 21 states that have implemented WPT. Since 2000, there have been formal evaluations of three states' WPT programs.

Although the evaluations found signs of improved wages and/or reduction in turnover, the PHI (2003) report suggests that current data has not made a strong case for the efficacy of these programs.

- **Health insurance coverage.** As noted above, many paraprofessional workers lack medical insurance. Lack of health insurance may discourage workers from entering long-term care jobs or staying in them. Thus, some states are exploring how to expand health insurance coverage. New York, for example, authorized the establishment of a state-funded initiative to cover uninsured home care workers in selected parts of the state.
- **Transportation subsidies.** Home health aides and personal and home care aides spend considerable time traveling from one location to another. Washington State, for example, will reimburse agencies for this commuting time.

Creating Advancement Opportunities. These include:

- **Career ladders.** States and health care providers have created career ladders to encourage workers to enter long-term care jobs and advance within the field (e.g., moving from a CNA to an LPN). For example, Massachusetts developed the Extended Care Career Ladder Initiative in response to the high turnover and vacancies among paraprofessionals (including CNAs) in long-term care facilities (including nursing homes). Providers are partnering with other organizations (e.g., community colleges, unions, community-based organizations, workforce investment agencies) to mount demonstrations.
- **Training.** As noted above, the Federal government requires CNAs to receive 75 hours of training to be certified. About one-third of states mandate extra hours for CNA training. Training could involve basic skills and job supports or specialized training in Alzheimer's and related dementias.

Improving the Workplace Environment. Many providers believe that culture changes designed to empower paraprofessionals will enhance retention. Examples of such efforts include:

- **Wellspring,** a consortium of nursing homes, initiated management change and job redesign. CNAs are part of care teams and are empowered to make decisions that affect quality of life for residents and workers. A nurse practitioner was hired to develop a series of clinical and management training modules and serves as a liaison between management and nursing staff. All staff receive intensive offsite training. Some providers created programs where more senior CNAs mentor or orient new CNAs.
- **Achieve,** an employer-focused demonstration program in Cleveland, aims to increase retention among paraprofessionals by developing a more supportive workplace environment. Achieve is providing frontline supervisory training, lunch and learn education sessions for workers, and on-site case management services for paraprofessional workers. Case managers help paraprofessionals obtain work supports (e.g., transportation, child care) and are available to discuss work-related issues (e.g., problems with supervisors or co-workers) or other issues. Achieve is operated by Towards Employment, a private, non-profit organization.

Developing New Worker Pools. A number of states are trying to broaden the pool of potential workers. Examples of candidates include former welfare recipients, high school students, displaced homemakers, and immigrants. The AFDC Homemaker-Home Health Aid Demonstration, for example, targeted welfare

recipients in seven states for classroom training and practicum experience caring for elderly clients and those with disabilities in nursing homes and private homes.⁷⁷

THE ROLE OF THE WORKFORCE INVESTMENT SYSTEM

The Workforce Investment Act (WIA) was enacted in 1998 to create a more coordinated, locally-driven workforce investment system.⁷⁸ WIA is administered by the U.S. Department of Labor (DOL). Funds are allocated by formula to states, and most of the funds are then distributed to local workforce investment areas by a similar formula. WIA has three funding streams: adult, dislocated workers, and youth. WIA was intended to give states and local areas more control over their programs while, at the same time, establishing a core set of performance standards by which to judge programs.

The WIA legislation included several features that influence the WIA system's ability to help alleviate the shortage of long-term care workers. First, the legislation required that local areas use One-Stop Career Centers to provide services to workers and employers. Second, the law requires, with some exceptions, that One-Stop Career Center customers receive training through voucher-like mechanisms called individual training accounts (ITAs). Third, vendors must place their programs on the state's eligible provider list (EPL) for customers to be permitted to use their ITAs with the vendor. Finally, states and local areas are subject to performance standards that can result in rewards or sanctions depending on how well they do.

In the following sections, the WIA system is described, with particular attention to the issues that affect local programs' ability to work with the long-term care industry to help alleviate shortages. The WIA legislation is currently up for reauthorization. Although both the House and Senate have passed bills, no conference committee has been appointed, and action is considered unlikely this year. The reauthorization may change features such as the type of funding streams, sequencing of services, and rules for the eligible provider lists.

Workforce Investment Boards

WIA gives the business community a prominent role in workforce investment activities at both the state and local levels. At the state level, workforce investment activities are coordinated by state Workforce Investment Boards (WIBs), whose members are appointed by the governor. The majority of the WIB is composed of business representatives. Other members include state legislators, local elected officials, state agency representatives (e.g., employment security), and representatives of other workforce investment constituencies.

At the local level, WIA services are provided through local WIBs. These WIBs are appointed by chief elected officials and include representatives of businesses, educational institutions, unions, community-based organizations, economic development agencies, and other One-Stop Career Center partners. The local WIB is responsible for selecting the One-Stop Career Center operator and designating its partners. Through increased local control, WIA aims to strengthen local economies through the development of workforce investment programs that address the specific needs of area businesses and job seekers. Grounded in strong local partnerships, these programs are intended to build training capacity, link

⁷⁷ An evaluation by Abt Associates found that the training and work experiences led to reductions in recipients' welfare dependency in all seven states. In six of the seven states, the program had a significant impact on increased earnings for participants (Bell and Orr, 1994).

⁷⁸ For additional information about the workforce investment system, see Barnow, B. and King, C. (2003). *The Workforce Investment Act in Eight States: Overview of Findings from a Field Network Study. Interim Report.* Rockefeller Institute of Government.

customers to supportive services, provide quality employment services, and serve as a resource for local employers.

One-Stop Career Centers

WIA mandates the One-Stop Career Center approach to workforce investment. One-Stop Career Centers are required to provide clients with core employment-related services and access to intensive services and training. They can be operated by a number of different entities. Possible operators include: city or county governments, for-profit contractors, nonprofits, community-based organizations, unions, and consortia of organizations.

WIA lists a number of mandatory One-Stop Career Center partners: vocational rehabilitation, Wagner-Peyser Act funded programs (i.e., the employment service), adult education and family literacy, postsecondary vocational education, veterans' services, and unemployment insurance. The legislation also makes reference to optional partners such as the Temporary Assistance for Needy Families (TANF) program and food stamps employment and training programs.

The WIA statute intends for One-Stop Career Centers to provide the entire community with a full range of workforce investment-related services. In addition to providing services to dislocated workers, adults, and youth job seekers, One-Stop Career Centers can provide valuable services to employers. One-Stop Career Centers can refer, recruit, and screen job applicants for employers that are hiring. Businesses that are new to an area might use their facilities to interview prospective employees. Buck (2002) notes that One-Stop Career Centers can give businesses information about federal tax credit programs for hiring disadvantaged workers (e.g., the Work Opportunity Tax Credit). They can work with employers to develop customized training programs to prevent lay-offs or ensure that there is an adequately skilled workforce to fill job openings. With the increased emphasis that WIA puts on labor market information, One-Stop Career Centers can be a valuable resource to employers looking to gain a better understanding of local economic conditions and characteristics of the labor force as well as workers who want to select an appropriate career. Some One-Stop Career Centers have employer representatives who serve as a point-of-contact for businesses in the community and work to ensure that employers are taking full advantage of the services available.

Three Levels of One-Stop Career Center Services

One-Stop Career Centers provide three levels of services to customers -- core services, intensive services, and training.

Core and Intensive Services

One-Stop Career Centers are required to provide core services on-site. Intensive services can either be provided by the One-Stop Career Center or by outside providers upon a referral from the One-Stop Career Center. Table 4 lists some of the core and intensive services available to clients.

TABLE 4. Core and Intensive Services	
Core Services	Intensive Services
<ul style="list-style-type: none"> • Eligibility determination • Outreach, intake, and orientation • Assessment of skills, education, and work experience, and supportive service needs • Job search, placement, and counseling • Labor market information • Information about training providers • Information on and referrals to supportive services • Assistance with Unemployment Insurance issues • Follow-up services 	<ul style="list-style-type: none"> • Comprehensive specialized assessment • Development of individual employment plans • Group and individual counseling • Case management • Short-term prevocational services

Core services are available to the entire community with no restrictions based on income or employment status. Intensive services and training are available to any individual who needs services to obtain or retain employment that leads to self-sufficiency.

Training and Individual Training Accounts

Training services under WIA include:

- Basic skills training
- Occupational skills training
- On-the-job training (OJT)
- Skills upgrades and retraining
- Job readiness training
- Customized training designed in concert with local employers

Clients can only enroll in training programs that provide them training in a demand occupation, as determined by the state’s labor market information unit.

WIA created Individual Training Accounts (ITAs) that allow eligible individuals to enroll with the training provider of their choice. They differ from a pure voucher because local WIBs can, and generally do, put restrictions on how the ITA may be used. Many local WIBs have maximum time and dollar amounts for their ITAs. In addition, some programs further restrict the ITAs by requiring customers to use the lowest cost vendor for their program of interest and/or not allowing customers to enroll in programs where they are unlikely to be successful for any reason including insufficient demand for the skills offered in the program. ITAs are not required for customized training, OJT, training for special populations, and in situations where there are insufficient providers.

States are responsible for certifying a list of eligible training providers from which customers can choose. The list is based on providers’ placement and wage performance for WIA customers and all customers. The list is organized by specific vocational program, so an individual provider can have one or more programs on the list. Local areas can set additional requirements for providers to be eligible to serve their customers. In a study of WIA implementation, Buck (2002) found that data commonly requested by local WIBs as part of the certification process included: program completion rates; unsubsidized employment rates; wages; retention rates; and licensure and certification rates. Given their presence on state and local WIBs, employers are in the position to offer input into the eligible training provider list and occupations approved for training.

Performance Measures

WIA's performance accountability system sets goals for the adult, dislocated worker, and youth programs. The state WIB negotiates the expected level of performance with DOL, and local WIBs negotiate their expected performance with the state WIB. The performance measures for the adult and dislocated worker programs include: entered employment, employment retention, wage gain, and educational/credential attainment. The goals for the youth program are similar, but also include: attainment of a high school diploma; basic skills attainment, occupational skills attainment; work readiness; placement and retention in postsecondary educational training, apprenticeships, the military, or employment.⁷⁹ WIA authorizes the Secretary of DOL to award incentive grants to states for exceeding performance targets and to penalize states that fail to meet their goals in two consecutive years.

EXAMPLES OF WORKFORCE INVESTMENT INITIATIVES

There are numerous examples of workforce investment initiatives designed to recruit, retain, and foster advancement among workers in the long-term care sector. A few examples are described below.

Delaware County (Pennsylvania) Employment Intervention Project

Funded by WIA, this collaboration between educators, employers, and workforce investment agencies involves three phases (Raynor, 2003):

- Phase I, a labor market study of workforce supply and demand, included an assessment of industry and occupational information, demographic information, and employment and training resources. The study identified health care (including long-term care) as a target industry with high growth, easy entry, and career mobility.
- Phase II was creation of an ad-hoc consortium of health and long-term care providers, training providers, and government agencies. The group met quarterly and defined a response to problems facing the health care sector in Delaware County. The consortium developed: (1) *Directory of Healthcare Training Providers* for use by job seekers, guidance counselors, employment training programs, welfare- and WIB-funded programs, schools, social service agencies, and community colleges; (2) *Day Care/Transportation/Healthcare Employer Map* for use by job seekers to find support services near employers.
- Phase III was reduction of direct care vacancies and turnover through a CNA training program. The program targets youth ages 18 to 21 with at least one barrier to employment. It is organized into four components -- employability skills training (e.g., employer expectations) provided by a local community college; literacy/documentation skills, also provided by the community college; career coaching and case management, provided by Women's Association for Women's Alternatives; and a 90-hour training curriculum provided by the community college and Fair Acres Geriatric Center.

⁷⁹ The performance measures for WIA will change as DOL's Employment and Training Administration adopts the common measures developed by the Office of Management and Budget for job training and employment programs. The common measures for adults are entered employment, employment retention in the second and third quarters after first employed, earnings increase from the quarter prior to participation to the first quarter after exit, earnings increase from the first quarter after exit to the third quarter after exit, and efficiency measured as the program appropriation divided by the number of participants. For youth the measures are placement in employment or education, attainment of a degree or certificate, literacy and numeracy gains, and efficiency measured as the program appropriation divided by the number of participants.

California Caregiver Training Initiative

The California Caregiver Training Initiative (CTI) awarded grants to 12 Regional Collaboratives to address shortages in the health care workforce. Each grant was for an 18 to 21 month period. The target audience of the initiative was primarily recruited from local WIA programs (approximately 70 percent of participants) and Welfare-to-Work clients (roughly 30 percent).⁸⁰ The state wanted grantees to develop programs to recruit, train, and retrain healthcare workers while attempting to enhance their earning potential. Most of the collaboratives were headed by local WIBs; prominent partners included employers (e.g., local hospitals, nursing homes), unions, community and four-year colleges, and various community-based organizations (Matthias et al., 2002).

California's Employment Development Department is administering CTI's \$25 million budget. Part of the Governor's Aging with Dignity Initiative, CTI funding comes from a combination of state and federal agencies. The UCLA School of Public Policy and Social Research and the Center for Health Professions at the University of California at San Francisco are conducting the evaluation. The *Process and Implementation Evaluation* gives an overview of the efforts of each of the collaboratives and highlighted initial successes and barriers the grantees faced (Matthias et al., 2002). The report focuses on activities related to recruitment and training.

One of the primary goals of CTI was to improve recruitment efforts. A number of the collaboratives experienced success in recruiting non-traditional populations (e.g., migrant farm workers, non-English speaking home care workers) for caregiver positions. Despite the need for English as a Second Language (ESL) training for some of these potential workers, the collaboratives found that many of these individuals were well-suited to the field due to prior healthcare experience. Recruitment efforts also focused on developing enhanced screening tools to ensure that potential applicants would be able to adjust to a caregiver occupation.

The researchers found that, when developing new training programs, sites that had previous experience working with state licensing boards had an advantage because of their ability to get quick approval for these programs. The collaboratives had access to a coordinated regional training system that was able to meet students' diverse needs -- in large part, because of the strong presence of workforce investment. Students benefited from a combination of intensive case management and the availability of a wide array of training approaches. Many students were particularly pleased with the fast-track training courses they took. The report also stressed the value of being able to use CTI funds for support services for students enrolled in training. However, the availability of some of the most vital services (i.e., transportation and childcare) services varied across sites.

Mennonite Village

Mennonite Village -- a continuing care retirement community in Albany, Oregon -- recognizes the unique challenges associated with working in a long-term care setting and the importance of limiting turnover. In 2003, Mennonite Village had a turnover rate of 16 percent, well below typical rates within the industry. Mennonite Village limits turnover by emphasizing educational opportunities for staff, providing competitive salaries and good benefits packages, and creating an environment where employees are appreciated.

Through an employee scholarship program, eligible employees can apply for funds to take up to two years of college classes at the local community college while working at Mennonite Village. Employees are also eligible for nursing scholarships of up to three years. To further assist with employees' academic aspirations, Mennonite Village offers on-site college counseling and flexible schedules that allow employees to balance academics with work commitments. There are also numerous in-service and other

⁸⁰ Welfare-to-Work was a temporary federal program intended to provide employment and training services to long-term welfare recipients and other highly disadvantaged populations.

formalized training opportunities for employees. For example, Mennonite Village holds an annual CNA seminar. Activities are partially supported by the DOL Employment and Training Administration.

Mennonite Village offers competitive salaries and benefits (100 percent of medical, dental, and vision benefits for full-time employees and 50 percent for part-time workers). In addition, Mennonite Village established an Employee Assistance Fund to provide a safety net for employees facing short-term financial crises. Managers and administrators try to make employees feel appreciated, such as using a group decision-making process so that all employees' views are taken into account. High-performing employees are acknowledged (e.g., the CEO seeks out employees that have been praised by residents and their families). Also, a staff appreciation committee searches for ways to make the work experience more enjoyable.

Direct Caregiver Association

Located in Tucson, Arizona, the Direct Caregiver Association (DCGA) is a consortium of long-term care providers working together to address workforce shortages and turnover among direct caregivers. The providers include nursing homes, assisted living communities, and home care agencies. Since its inception in 2000, DCGA has attempted to expand the workforce and improve retention through activities in four main areas:

- **Recruitment.** DCGA conducts community-wide recruitment to attract a wide spectrum of potential caregivers. The recruitment process includes intensive screening to ensure that potential trainees are committed to providing quality services.
- **Education.** DCGA offers a 200 hour, 12 week comprehensive training in preparation for state CNA certification. DCGA has a 89 percent training retention rate and a 93 percent pass rate on the state CNA certification test. The original curriculum development was funded by the Arizona Department of Commerce. In addition, the Tucson city government supports the training through Community Development Block Grant funding provided by the U.S. Department of Housing and Urban Development. DCGA makes some referrals of prospective trainees to One-Stop Career Centers for financial aid for occupational training. Although training funds available through the WIB have been limited in recent years, some trainees have received ITA funding.
- **Placement.** Graduates of the training have an 86 percent employment rate. Workers' average post-training wages are more than three dollars per hour higher than their pre-training earnings. DCGA works to place trainees in situations that offer room for advancement. For example, approximately one-quarter of trainees will express interest in becoming nurses. Because these trainees can rarely afford this training, DCGA tries to place them with employers that offer educational benefits.
- **Post-employment services.** After placement, workers can access social support and continuing education services through their employers or DCGA's Caregiver Resource Center. DCGA offers over 120 hours of continuing education each year. The Resource Center is supported through a partnership with Goodwill Industries and the city of Tucson. DCGA has made a concerted effort to strengthen its relationship with local workforce investment agencies, attempting to demonstrate to the local WIB the importance of building the long-term care workforce and the advancement opportunities within the field. For example, DCGA recently applied for funding to facilitate increased collaboration between One-Stop Career Centers and community-based organizations. In addition, DCGA and the local One-Stop Career Center, developed a joint strategy to strengthen their relationship.

OPPORTUNITIES FOR COLLABORATION

The long-term care sector and the workforce investment system have mutual interests. The long-term care sector is seeking to recruit and retain qualified paraprofessionals to provide quality services. The

workforce investment system is seeking to identify and focus resources on high demand, high growth sectors in order to both meet the labor force needs of those sectors and channel resources toward the preparation of workers for jobs that offer them opportunities for sustained employment with good wages and benefits. The health sector has been identified nationally by DOL as a high growth area.

Potential areas of collaboration could include:

- **Advertise job openings.** One-Stop Career Centers link employers and workers through the on-line America's Job Bank, which lists job vacancies nationwide. The workforce system can conduct outreach with employers to learn about vacancies. At the same time, providers can contact one-stop career centers as openings arise.
- **Participate on state and local Workforce Investment Boards.** Decisions with regard to priorities and allocation of resources are made by the WIBs. The state WIB sets broad priorities for the state, while the local WIB makes the key decisions locally. Workforce investment can encourage employers to participate on WIBs and long-term care providers can actively seek to become members.
- **Encourage local WIBs to make long-term care training a priority and to include training programs on the eligible provider list.** Long-term care providers and other stakeholders should be prepared to address some obstacles. For one, in some states there is a burden on the vendors/trainers to maintain the data required to be on the eligible provider list. In addition, some states and local areas might not allow training for long-term care jobs because of the low wages. The long-term care industry will need to stress that although the wages are initially low, the training costs are also low; this will be important for the new common performance measure on efficiency.
- **Promote on-the-job training and customized training.** Workforce investment and long-term care providers should work collaboratively to develop sectoral strategies, customized training, and on-the-job training. Employers can overcome the restrictions on Individual Training Accounts and the eligible provider list by agreeing to offer training on-site at the workplace. This may also be very attractive to paraprofessional workers looking to upgrade their skills who often have challenging personal schedules.
- **Identify and work with employer intermediary organizations to recruit, train, and support staff.** There are many skilled intermediary organizations that can be a resource to long-term care providers as they seek to recruit, train, and retain staff. Many of these organizations have experience with the workforce system as well as special populations who can be an important source of labor for the sector.
- **Explore avenues for making jobs more attractive.** This paper presents examples of steps employers can take to develop a supportive workplace environment for paraprofessionals such as training, management redesign and career ladders. These practices can reduce turnover and enable employers to attract and retain their workers.

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Why Workforce Development Should Be Part of the Long-Term Care Quality Debate⁸¹

Robyn I. Stone, DrPH, Steven L. Dawson and Mary Harahan
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INTRODUCTION

Since the Nursing Home Reform Act of 1987, public policy makers, consumers and providers have expressed growing interest in the quality of long-term care in nursing homes and other long-term care settings. The Nursing Home Reform Act, known as "OBRA 87," transformed federal oversight of nursing home quality from its traditional emphasis on structure and process indicators to a focus on maintaining and improving resident outcomes. Since the passage of that landmark federal legislation, consumers, providers, regulators, insurers, and researchers have continuously struggled with how to define measure, assess and ensure long-term care quality.

The purpose of this paper is to introduce a largely overlooked feature of the long-term care system -- direct-care workers -- into the long term care quality debate. For the typical nursing home resident, direct-care staff -- not nurses or doctors -- provide eight out of every ten hours of the care they receive (McDonald, 1994). For home care clients, every hour of non-skilled nursing service is provided by paraprofessional workers. Our thesis is that the quality of long-term care -- the recipients' clinical and functional outcomes and quality of life -- is significantly influenced by the attributes these workers bring to their caregiving jobs, the education and training they receive, and the quality of their jobs. The attitudes, values, skills and knowledge of these workers, how they are compensated and rewarded, and the way their jobs are organized and managed, all have a role to play in determining long-term care quality. Workforce development activities designed to increase the capacity of these individuals to participate effectively in long-term care settings should be integrated into all ongoing and new long-term care quality improvement and quality assurance initiatives.

The paper addresses the following topics:

- The scope of federal quality initiatives to date;
- Why workforce development should be considered an important dimension of long-term care quality;
- The key policy and practice constraints that impede linking workforce development issues and long-term care quality;
- Examples of quality improvement initiatives that have incorporated workforce development activities; and,
- Applied research activities to examine the link between workforce development and long-term care quality.

FEDERAL LONG-TERM CARE QUALITY INITIATIVES

Efforts to develop quality assurance mechanisms and health-related quality of care measures have been pursued more aggressively in the acute care sector than in long-term care (Kane, et al., 1998). While no consensus has emerged with respect to defining long-term care quality, to the extent that quality has been

⁸¹ The full paper is available online at <http://www.futureofaging.org/PublicationFiles/LTC%20Quality%20Debate%20Paper.pdf>.

a focus, the nursing home model has dominated (Noelker and Harel, 2001). During the 1960s and 1970s, regulatory standards in response to perceived quality problems largely addressed structure and process issues (e.g., building safety, staffing levels).

In the early 1990s, as a result of OBRA 87, the federal government identified resident outcomes as a critical dimension of nursing home quality, and began to require nursing homes to report a standardized set of resident level data known as the Minimum Data Set (MDS). The quality indicators that evolved from the MDS are designed to capture clinical processes and outcomes such as the absence of restraints, prevalence of incontinence, decubitus ulcers, pain management and weight loss. For the last several years, the federal government has also required home health agencies to implement a survey -- the "Outcome and Assessment Information Set" (OASIS) -- to measure quality outcomes for adult recipients of Medicare-reimbursed home health services. The OASIS also focuses primarily on the clinical and technical aspects of care.

Not surprisingly, consumer advocates have tended to push federal regulators to define long-term care quality in terms of consumer protections that are intended to ensure resident/client rights and access to appropriate clinical interventions and quality living environments. For the most part, federal regulation of long-term care quality has not focused on the needs or concerns of frontline workers.

OBRA 87 did acknowledge the importance of nurse aides by mandating that they complete 75 hours of prescribed training and pass a competency exam to become certified to work in a Medicare or Medicaid reimbursed nursing home. The content of this training is generally focused on clinical skills and direct patient care tasks and has been criticized for not exposing entry level nurse aides to the communication, decision-making and problem-solving skills they will need to effectively interact with residents. (Direct Care Alliance, 2003). While states are free to add to these certification requirements, about half accept the federal requirement as sufficient (GAO, 2002). OBRA 87 reforms paid little attention to the continuing education needs of direct-care workers, other than to require 12 hours of in-service training per year to address areas of weakness for individual aides. According to the GAO Nurse Aide study, there is no documentation of whether and how facilities comply with federal in-service training requirements. Similar requirements were also applied to home health aides whose employers receive Medicare reimbursement. The qualifications and training requirements for individuals who work as personal care workers or home care aides are not regulated by the federal government, are typically minimal, and vary from state to state.

SOCIAL COMPONENTS OF QUALITY ARE LARGELY MISSING FROM FEDERAL REQUIREMENTS

For many consumers and their families there is another dimension of long-term care, the "social side," that is as important as the clinical aspects in evaluating the quality of care. Social outcomes of long-term care include life satisfaction, sense of autonomy and control, and the quality of relationships between residents/clients and caregivers. Indicators of these social components have proven much more difficult to develop and implement than clinical indicators -- primarily because they are so sensitive to the needs and preferences of the individual recipient of long-term care. These social components, which together help to define quality of life outcomes, do not lend themselves easily to checklists and regulatory scrutiny. While of interest to many researchers, they have not yet captured the attention of policy makers. Kane, who has helped to pioneer the development of nursing home quality of life measures, argues that measuring quality of life is a relatively low priority in nursing homes because of the regulatory focus on markers of poor quality of care, a pervasive sense that nursing homes are powerless to influence quality of life, and impatience with research among those dedicated to culture change (Kane, 2003).

THE CASE FOR LINKING WORKFORCE DEVELOPMENT TO LONG-TERM CARE QUALITY

For purposes of this paper, workforce development is defined as all activities that increase the capacity of individuals to participate effectively in the workforce, thus improving worker performance. It includes activities related to pre-employment education, formal competency and credentialing requirements, recruitment and screening, compensation and benefit incentives, continuing education, and the organization and management of the workplace.

With the exception of entry-level certification requirements, the performance of the direct-care worker has usually been an afterthought in discussions of long-term care quality. However, there is some evidence that this may be changing. The latest Institute of Medicine (IOM) report on long-term care quality identifies workforce development as one of its nine guiding principles and acknowledges that “quality of (long-term) care depends largely on the performance of the caregiving workforce” (Wunderlich and Kohler, 2001). While most of the IOM discussion of workforce issues addressed the importance of achieving minimum staffing levels for nurses and direct-care workers, the report also emphasized that this is a necessary but not sufficient condition for positively affecting the quality of life and quality of care of nursing home residents. The report also identified education and training, supervision, environmental conditions, attitudes and values, job satisfaction and turnover of staff, salaries and benefits, leadership, management, and organizational capacity as other essential elements affecting quality of care.

The central importance of human interaction in long-term care is one of the major reasons why workforce development should be considered an important element of defining and measuring long-term care quality. The non-clinical aspects of long-term care, including assistance with very intimate activities of daily living -- such as bathing, dressing and toileting -- require a high degree of quite personal interaction between the direct-care worker and the care recipient. In the home setting, the worker may be one of the few, or only, sources of social engagement for the client. Furthermore, in addition to addressing clinical and functional concerns, the worker is often attuned to the emotional and spiritual needs of the resident or client. Consequently, the quality of the interaction between the caregiver and care recipient will enhance or impede clinical, functional and quality of life outcomes.

Glass (1991) distinguishes “quality of caring” from “quality of care” and argues that the former is the key to quality of life in nursing homes. Applebaum and Phillips (1990) and Kane and colleagues (1994) have also emphasized the importance of the caregiver/client relationship in home care. Geron (2000) argues that for quality outcomes to be achieved in consumer-directed long-term care, the consumer (who undertakes the role of the employer in this model) must negotiate the terms of the relationship with the direct-care worker (her employee). Both, then, are responsible for the success of the interactions and the ultimate outcomes.

There is a dearth of empirical research linking the performance of direct care workers, and the factors that contribute to effective worker performance, with resident/client level quality of care and quality of life outcomes. Government interest in addressing workforce issues as part of the regulation of long-term care quality has been largely limited to analyzing whether there is a minimum nurse aide to nursing home resident ratio that must be achieved to deliver adequate care (CMS, 2000). Yet there is a growing body of evidence that suggests that other workforce issues are at least as important. A recent study of the not-for-profit nursing home industry in California found that almost all participating facilities had more than adequate staffing ratios (one nurse aide to 6 or 7 residents). In the view of administrators, supervisors and direct-care staff from these facilities, the largest obstacle to delivering high quality care was the need to constantly accommodate vacancies from staff turnover and a revolving door of new staff (Harahan, et al., 2003).

The problem of high turnover and vacancy rates among the nations’ long-term care providers is increasingly well documented. A study of turnover and vacancy rates conducted by the American Health Care Association reported that 52,000 certified nurse assistant (CNAs) positions are vacant nationwide, with annual nurse aide turnover rates exceeding 60 percent in 32 states, and exceeding 100 percent in 10

states (AHCA, 2003). Such turnover and vacancy rates among direct-care staff are generally typical across all long-term care settings and are clear indicators that many frontline workers are dissatisfied with their jobs.

Government and media reports suggest that the high turnover among nurse aides can negatively impact the quality of care and quality of life in nursing homes, assisted living and home care settings (GAO, 1999; IOM, 2000; Leon, 2001). Yet few studies have attempted to draw a direct link between workforce turnover and the quality of care received by long-term care recipients. A variety of researchers (Banaszak-Holl and Hines, 1996; Bowers et al. 2003 Brannon, et al., 1988; Leon, et al., 2001; and Tellis-Nayak, 1988) have examined factors that account for high turnover among direct-care workers. Not surprisingly, most of these studies found that economic conditions and the level of compensation influenced whether individuals stay in or leave their direct care jobs. However, several studies of turnover have singled out the relationship between direct care workers and supervisors as a significant factor in job retention. Bowers' review of the nursing home literature identified empowerment of workers, respect between workers and supervisors, time to spend with residents, collaboration and participation in resident care decision-making, and organization of the work as important determinants of whether a nurse aide stays in or leaves her job -- variables that do not necessarily require providers to find the resources to increase wages and benefits (Bowers, 2003). Several studies of home care workers (Feldman, 1994; Luz, 2001) also found that the relationship between supervisors and aides and the level of aide involvement in care decisions were significant predictors of job satisfaction and lower turnover rates.

In the past few years, researchers have begun to explore more directly the linkages between workforce turnover, workforce development and the clinical quality of long-term care. Eaton documented reductions in mortality, drug use and illness, and increases in resident functioning, and social activities after the introduction of innovative organizational models that emphasized improved working conditions for direct-care staff. These models included working with a full staff instead of the "short staffing" position so many nursing homes find themselves in, as well as an emphasis on working in teams, improved information sharing between nurses and direct-care staff, and enhanced responsibilities for direct care workers (Eaton, 2001). In their evaluation of the Wellspring nursing home quality improvement program, Stone and colleagues found that the intervention reduced nursing staff turnover, including direct-care workers, in comparison to a control group of facilities, and also showed reduced health deficiency citations on federally mandated surveys (Stone, et al., 2002). The Wellspring model includes a focus on both improving clinical competencies and an organizational change process that stresses the use of multidisciplinary resource teams empowered to develop and implement interventions that their members believe will improve quality of care for residents.

In Phase 2 of the CMS nursing home staffing study, researchers found a strong relationship between aide retention in California nursing homes and quality outcomes (CMS, 2002). For short-stay nursing home residents, the study found that retention rates affected electrolyte imbalance and urinary tract infection rates. Aide retention rates affected the functional status and pressure ulcer rates of long-stay residents.

Barry recently completed a study of the relationship between nurse aide empowerment strategies, staff turnover and resident health outcomes in a multi-state sample of nursing homes. She found that nursing homes where the charge nurse delegated more responsibility to aides experienced lower nurse aide turnover, although the impact on resident outcomes (as measured by risk-adjusted pressure ulcer incidence rates and Social Engagement scores taken from the Minimum Data Set) was not significant (Barry, 2002). Findings from this study also suggest that using turnover rates as a quality measure should be considered with caution. Barry found that facilities in her sample with a stable core staff of direct care workers and high turnover among a sub-set of workers, as a result of weeding out inappropriate hires, may produce better psychosocial outcomes than facilities with lower turnover.

BARRIERS TO INTEGRATING WORKFORCE DEVELOPMENT INTO LONG-TERM CARE QUALITY ASSESSMENT AND IMPROVEMENT

The development of the long-term care workforce is not yet a priority in either the regulation of long-term care quality or in the development and implementation of quality improvement initiatives. Below we identify a variety of reasons why providers, policy makers, regulators and consumers may have been slow to accept the central role of workforce development in improving long-term care quality.

1. **Providers Lack Motivation to Invest In Their Workforce.** Third party reimbursement through Medicare and Medicaid creates the framework within which employers determine how much to invest in employing and training direct-care workers. Since the cost of training workers cannot be passed on to the consumers of long-term care in most cases, many providers appear reluctant to invest more in the orientation and continued training of their workers than the government requires. In addition, high turnover among the direct care workforce presumably discourages providers from emphasizing in-service training for fear that their workers will quickly leave for another job with a competing provider.
2. **Economic, Racial and Ethnic Differences between Workers and Employers.** The direct-care workforce is typically populated by low-income women who frequently are from a different ethnic and/or racial background than their supervisors, employers and recipients of care. Barriers of race and class may make it more difficult for providers to understand the needs and concerns of the direct-care workforce or how to turn their workers into high quality performers (Tellis-Nayak and Tellis-Nayak, 1989).
3. **The Hidden Nature of the Relationship between Clients and Workers.** Some of the most important responsibilities of direct-care workers involve an intimate relationship between consumer and caregiver -- one that is typically hidden from regulators, supervisors and family members. What occurs inside more than a million nursing home rooms each day cannot possibly be monitored by harried nurses with multiple supervisory and clinical responsibilities. What occurs within the privacy of home care settings between client and caregiver is even more difficult to monitor, particularly when high proportions of those clients are cognitively impaired. This means that one of the most important dimensions that defines the quality of long-term care -- the quality of the relationship between client and worker -- is extremely difficult to identify measure and evaluate.
4. **Workers Lack A Voice.** Direct-care workers are rarely able to represent their interests to the public, to policy makers and regulators or their employers or to share information and experiences with each other. Few belong to worker associations that can formally give voice to their concerns and support their needs for information and training. This lack of a voice is exacerbated by the negative image many people have of the work that they do -- work that is often perceived as unskilled and unpleasant, and perceived as provided by low-income women who have little opportunity or ability to do anything else. Providers, consumers, and policymakers, therefore, often do not recognize the central role of direct care workers in determining quality of care and quality of life.
5. **The Regulatory System Is Not Designed to Address Workforce Issues.** Direct-care workers are rarely interviewed during regulatory surveys to solicit their insights on quality issues. Anecdotal evidence, for example, indicates that many workers complain about the limited time they are allowed to interact with each resident. Yet, the survey process does not consider this issue in the quality oversight. Surveyors are not required to assess the quality of the work environment and job design as part of the survey process. Ironically, direct-care workers often bear the brunt of negative surveys and are viewed by many, including the mass media, as a major part of the quality problem.

In addition, states Nurse Practice Acts regulate the degree to which nurses can delegate responsibilities to paraprofessionals under nurse supervision. These regulations tend to limit the ability of direct-care workers to undertake greater responsibilities, inadvertently limiting opportunities for empowerment and meaningful career ladders.

6. **Human Resource Management Expertise and Models of Successful Workforce Development are Limited.** Direct-care workers are managed by supervisors, usually nurses, who are largely trained as clinicians rather than human resource managers. In fact, federal law requires nursing homes and home health agencies to employ nurses as supervisors but does not address the management issues in training or certification requirements. Bowers (2000, 2003) has documented the negative feelings that many nurse aides express about the supervision they receive. Other studies have found that many long-term care nurses see themselves as clinicians rather than managers (Harahan, et al., 2003). In addition, most providers have been reluctant to invest in developing new ways of organizing, managing, and training their workers absent any information that such an investment will contribute to a more stable and committed workforce and a higher quality of long-term care for the consumer.

PROMISING PRACTICES

Fortunately, examples of promising workforce development activities are slowly increasing -- perhaps spurred by the workforce shortages facing so many long-term care providers. Several comprehensive models of quality improvement that take account of workforce issues are emerging, including the Deep Culture Change initiatives within the Pioneer Network, the Eden Alternative and the Wellspring Quality Improvement Program in the nursing home arena and Cooperative Home Care Associates, the California Public Authority Model, and the Visiting Nurse Service of New York Learning Collaborative initiative in the home care arena. These models combine improvements in the clinical knowledge and technical skills of workers with organization and management interventions designed to reduce vacancies and turnover and improve job quality.

In addition to the above efforts, many long-term care providers are also experimenting with more discrete elements of workforce development. Such programs include the development and implementation of peer mentoring programs, career ladders, multidisciplinary teams, self-managed teams, as well as job redesign strategies that delegate more responsibility to direct-care staff and actively involve them in care planning and implementation. New programs are also emerging to train long-term care nurses to be supervisors by emphasizing coaching and mentoring rather than command and control strategies. (For a detailed description of these practices see the National Clearinghouse on the Direct-Care Workforce's Provider Practice Data Base).

UNDERSTANDING THE CAUSAL LINKS BETWEEN A QUALITY WORKFORCE AND QUALITY OF CARE/LIFE OUTCOMES

Policy makers and providers need concrete examples of programs and models that successfully link workforce development and long-term care quality improvement to help them make worthwhile and sustainable investments. Currently, The Robert Wood Johnson Foundation and The Atlantic Philanthropies have joined together to fund a \$15 million demonstration and research program -- Better Jobs, Better Care -- to achieve two goals: (1) the implementation of policy and practice changes within five states (Iowa, North Carolina, Oregon, Pennsylvania, Vermont) designed to improve the quality of jobs of direct-care workers; and, (2) the generation of new knowledge through eight applied research and evaluation grants that advance the capacity of the long-term care industry to attract and retain a prepared, committed and sustainable workforce.

This national program will help us better understand the policy, practice and individual-level factors that contribute to quality jobs for direct-care workers and reduce high vacancy and turnover rates. But it will not, in and of itself, demonstrate the impact of workforce development on the quality of long-term care. Rather, understanding the causal links between workforce development and long-term care quality of life and quality of care will require a number of different strategies.

Policy makers, regulators, providers, consumer advocates and the media need to acknowledge the centrality of workforce performance in long-term care quality. The long-term care quality framework must then be broadened to include indicators of workforce quality, such as the attributes and attitudes of workers, the necessary clinical skills and competencies, appropriate communication and problem solving skills, workplace organizational structures and job design that support frontline workers, and the quality of the interactions and relationships between caregivers and care recipients. Specific measures must be developed, tested and refined.

New demonstration and evaluation initiatives should also be designed to assess a wide range of workforce development strategies and their impact on attracting and maintaining a quality workforce and improving quality of care and quality of life for long-term care recipients. The design of such demonstrations should involve researchers with expertise in organizational development, management and job redesign, as well as those skilled in measuring long-term care quality. These demonstrations must be multi-year, acknowledging that changes in quality outcomes can only be measured over a period of several years. They must also be multi-dimensional, acknowledging that workforce quality is determined by a wide range of factors and that no single intervention is likely to be effective. While we have a lot to learn from the natural experiments currently underway in many long-term care settings, the optimal (although most expensive) demonstration design would involve a randomized case-control study to test the effects of various workforce development strategies on care recipient quality outcomes.

POTENTIAL DEMONSTRATION INITIATIVES

New demonstration designs could involve a number of different approaches to test the impact of workforce development on quality of care and quality of life of long-term care recipients. At one end of the continuum, an experiment might be implemented involving a comprehensive approach to workforce development, a large network of participating providers and a randomized design that would permit the impact of the intervention to be compared to the status quo. A broad range of strategies to recruit, select, compensate, train, manage and supervise workers would be identified by researchers, providers and workers from the best available practices. The most promising set of practices would be incorporated into the intervention. The impact of the experiment would be measured using clinical outcomes derived from the Minimum Data Set, and other standardized clinical data quality of life measures as developed for CMS by Rosalie Kane and others as well as measures of workforce retention and job satisfaction, provider costs and measures of implementation burden.

At the other end of the continuum, the impact of interventions that deliberately incorporate workers in quality enforcement and quality assurance activities could be tested. For example, tools could be designed to permit nursing home surveyors to capture the perspectives of a random sample of nurse aides on quality problems in the facility, including the causes of the problems and steps needed to correct them. Plans of correction could then be devised that would take account of worker viewpoints. Comparative analyses of quality outcomes would be conducted to assess the effects of workers input into the quality assurance process.

Demonstrations could be devised that take advantage of the natural variation that exists in wages and benefits for nurse aides within and across particular market areas. High wage, high benefit facilities and agencies could be compared with low wage, low benefit facilities on workforce performance measures such as retention and job satisfaction, and quality of care, quality of life measures. Demonstrations could also be designed to test the quality and cost impacts of interventions that alter the management and supervisory strategies of the long-term care workplace to ensure that supervisors are able to model good care practices and empower nurse aides to make informed decisions about organizing and providing care.

In conclusion, quality assurance and quality improvement activities must recognize the importance of workforce development in long-term care. Given the labor intensive nature of the field, quality of care and quality of life for care recipients will not be achieved without focusing on the quality of their caregivers. We

can begin by integrating a workforce development focus into long-term care quality initiatives at the national and state levels through partnerships between Quality Improvement Organizations (QIOs), provider associations, worker groups and consumer organizations. The new Quality First initiative sponsored by the provider community offers another opportunity to emphasize the role of workforce development in quality. We also need to build an evidence base that demonstrates the links between a quality workforce and quality outcomes and identifies successful strategies for achieving both.

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Selecting a Model or Choosing Your Own Culture⁸²

Robyn I. Stone

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SUMMARY

In this article the author reviews the practical issues related to implementing culture change in nursing homes. The merits of model replications are discussed and the barriers to creating and sustaining culture change in nursing homes are highlighted. This is followed by a description of the various dimensions of culture that must be changed including the approach to clinical training and practice, the nature of management and job design, the approach to caring, and the characteristics of the residential environment. The article then identifies the major elements required to maximize the potential for nursing homes to create and sustain cultural change.

⁸² The full paper is available online at <http://www.haworthpress.com/store/Research.asp>.

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