

# **SPEAKER PRESENTATIONS**

# **Linking Workforce Development to Long-Term Care Quality**

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Robyn I. Stone, Dr.P.H.

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## **WORKFORCE FACTORS INFLUENCING LTC QUALITY**

- Attributes the workers bring to the job
- Education and training
- Quality of the job
  - Compensation and other benefits
  - Job design
  - Organizational and management culture

## **CASE FOR LINKING WORKFORCE DEVELOPMENT AND LTC QUALITY**

- Workforce issues generally afterthought in quality debate
- New interest in workforce/quality links
  - 2001 IOM Nursing Home Quality Report
  - CMS Staffing Quality Study
  - Provider-initiated Quality First
- Central importance of human interaction in LTC
  - Caregiver/care recipient relationships
  - Supervisor/direct care worker relationships
  - Peer relationships

## **BARRIERS TO INTEGRATING WORKFORCE DEVELOPMENT INTO LTC QUALITY ASSESSMENT AND IMPROVEMENT**

- Providers lack motivation to invest in workforce
- Race and class barriers
- Hidden nature of consumer/worker relationship
- Workers lack a strong voice
- Regulatory system does not address workforce issues
- Models of successful workforce development are limited

## **QUALITY IN AGING SERVICES**

- Quality of services/care outcomes
- Quality of “caring”/quality of life
- Quality for whom
  - Residents, home care consumers
  - Families
  - Staff

## **HEALTH DIMENSION OF QUALITY**

- Medical/clinical
- Technical aspects of care
- Quality indicators capture clinical processes and outcomes
  - MDS
  - OASIS

## **SOCIAL DIMENSION OF QUALITY**

- Quality of the physical environment
- Quality of the social supports
- Relationship between care recipients and caregivers
- Measures more sensitive to the needs and preferences
  - Life satisfaction
  - Satisfaction with interactions
  - Sense of autonomy/control

## **QUALITY OF WORKLIFE**

- Key to quality of care and life in aging services
- Focus on staff, particularly direct care workforce
- Interaction between care recipient and caregiver from staff perspective

## **INTEGRATED MODEL IS REQUIRED**

- Good quality aging services combine a focus on both the clinical and social/environment
- Also focuses on work environment and quality outcomes for caregivers
- Clinical and social aspects are intertwined

- Requires organizations that have management structure and philosophy conducive to promoting quality of care and life.
- Appropriate for all settings from independent living to skilled nursing facilities

## **CULTURE CHANGE IN LTC TO IMPROVE QUALITY**

- Focus on where people live and work
- Culture change is comprehensive -- not just one intervention
- Focus on empowering staff and residents/clients

## **ORGANIZATION-LEVEL INTERVENTIONS**

- Flattening management hierarchy
- Creating resident-centered environment
- Mentoring and coaching rather than supervising
- Creating meaningful, rewarding training experiences for all staff
- Focus on intra-staff communication and staff/resident relationships
- Fostering and enhancing community

## **FUTURE OF CULTURE CHANGE**

- Can we move beyond the pioneers?
- What is just rhetorical and what is real?
- Need for evidence-based research
  - What works?
  - Who benefits?
  - What are the costs?
- Building culture change into the Quality Debate
- Making culture change the norm rather than the exception

# **Home Care: Does a Better Workforce = Better Care?**

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A.E. Benjamin

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## **THE BROAD CHALLENGE(S)**

- Expanding demand.
- Worker shortages.
- Worker turnover.
- Worker quality.
- Policy indifference.
- Hidden nature of home care work.

## **HOME HEALTH CARE**

- Stronger arguments, growing data.
- Outcomes data (OASIS, etc.).
- Structure, process (causal links?).

## **PERSONAL ASSISTANCE SERVICES**

- Passionate arguments, little data.
- Defining outcomes
  - Improvement vs. maintenance vs. slowing decline.
- Measuring outcomes.
- Specifying causal chains
  - The worker connection.

## **NEW DEVELOPMENTS -- NEW CHALLENGES**

- Client/consumer as employer.
- Cash/discretionary spending.
- Family and friends as workers.
- Public authorities as C-W link.

## **ASPE STUDY IN CALIFORNIA**

- 1994-98.
- Service outcomes.
- Clients (1,095) and workers (618) in IHSS.
- Two home care models:
  - Agency-based.
  - Consumer-directed.

## **SETTING: IN-HOME SUPPORTIVE SERVICES PROGRAMS (IHSS)**

- Medicaid state plan PAS.
- 200,000+ recipients.
- Up to 283 hours/month.
- Consumer-directed and agency models.

## **CASH & COUNSELING DEMONSTRATION AND EVALUATION**

- 1996-2003.
- Cash (flexible monthly allowance).
- Counseling (supportive services).
- C. flexibility to hire and purchase.
- Setting: Medicaid in Arkansas, Florida, New Jersey.
- Design: Randomized assignment to cash vs. usual Medicaid PAS.

## **WHAT DO CONSUMERS (CLIENTS) REPORT?**

- UCLA
  - More satisfaction.
  - Better quality of life.
  - No differences: Unmet needs, safety concerns.
  - More client empowerment.
  - Less worker turnover.
  - Fewer language problems.

- Cash & Counseling
  - Very good worker performance.
  - Capable and reliable.
  - Less disrespectful.
  - Less worker theft.
  - Fewer unmet needs.
  - Fewer indicators of low-quality care.
  - More QOL satisfaction.

## **POSSIBLE EXPLANATIONS OF BETTER OUTCOMES**

- Matching.
- Familiarity.
- Responsiveness.
- Interpersonal relationships.
- Targeted, informal training.

## **FUNCTIONS OF PUBLIC AUTHORITIES IN CALIFORNIA**

- Bargaining agent.
- Training resource.
- Registry.
- Background screening.
- Quality of care monitoring.

## **PUBLIC AUTHORITIES AND QUALITY OF CARE?**

- Documenting quality issues.
- Enhancing C-W matching.
- Improving C-specific training.
- Addressing interpersonal problems.
- Marketing to improve responsiveness.

## CONCLUSIONS

- Workforce and service quality are related.
- Relationships are complex.
- Expanding choice may be key to enhancing quality.
- Stronger ties between PAs and WIBs may be productive.

<b>WHO ARE THE WORKERS?</b>	
<b>UCLA</b>	<b>Cash &amp; Counseling (Arkansas)</b>
Middle-aged women	Most females age 40-64
Same race/ethnicity	Same race
Family (50%) and friends (25%)	Family and friends (90%)
Half: previous care	Most: previous care
1/3 live with consumer	1/4 live with consumer

<b>WHAT DO WORKERS DO?</b>	
<b>UCLA</b>	<b>Cash &amp; Counseling</b>
Serve one consumer	Serve one consumer
More unpaid hours	More unpaid hours
More flexible scheduling	More non-business
Perform wider range of tasks <ul style="list-style-type: none"> <li>• Health</li> </ul>	Variety of tasks <ul style="list-style-type: none"> <li>• More health care tasks</li> </ul>

<b>WAGES, BENEFITS, WORKING CONDITIONS</b>	
<b>UCLA</b>	<b>Cash &amp; Counseling</b>
Lower wages	Lower wages
Almost no benefits	Almost no benefits
Little formal training	Little formal training
No professional supervision	No professional supervision
Half have another job	Typically part time



HOW DO WORKERS ASSESS THEIR WORK LIVES?	
UCLA	Cash & Counseling -- More satisfied with...
Well-prepared	Job preparation
Well-informed about C's conditions	Information about C's condition
Satisfied with supervision	Feedback on performance
Able to get needed information	Compensation
	Working conditions

**Recent Evidence**

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**Comparing outcomes of PAS models--**

**ASPE**

**UCLA**

**Cash & Counseling Demonstration and Evaluation--**

**RWJF-ASPE**

**U.Maryland & Boston College**

**Mathematica**

# **Recruiting and Retaining a Quality Paraprofessional Workforce: Building Collaboratives with the Workforce Investment System**

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Michael Fishman and Burt Barnow

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## **MOTIVATION FOR PAPER**

- Shortage of long-term care paraprofessional workers exists
- Increasing the supply of these workers can benefit the community and the workers
- Long-term care sector is large and growing rapidly
- Increased collaboration between long-term care sector and workforce investment can solve labor shortage problems and benefit both systems

## **PRESENTATION STRUCTURE**

- Describe briefly:
  - Long-term care paraprofessional workforce
  - Growth in long-term care sector
- Reasons for workforce shortages
- Overview of the workforce investment system
- Long-term care sector response to shortages
- Examples of workforce investment initiatives
- Opportunities for collaboration

## **CHARACTERISTICS OF LONG-TERM CARE PARAPROFESSIONAL WORKFORCE**

- Currently over 2.5 million employed in variety of roles and settings
- More likely than overall workforce to be:
  - Female
  - African-American
  - Less educated
  - Unmarried parents
  - Poor
  - Uninsured
- Wages are low compared to other short-term training occupations
  - Lowest for home health aides and personal and home care aides

- Better benefits if:
  - Employed full time
  - Work in hospital or nursing home
- Many work part-time

## **GROWTH IN LONG-TERM CARE SECTOR**

- Need for long-term care predicted to increase 110 percent between 2000 and 2050
  - From 13 million to 27 million individuals
- Bureau of Labor Statistics (DOL) predicts large increase in paraprofessional occupations between 2002 and 2012
  - 48 percent for home health aides
  - 40 percent for personal and home care aides
  - 25 percent for nursing assistants
- Outpaces predicted increase for all short-term training occupations (14%)
- Growth in demand for paraprofessional workers compounded by high turnover rates

## **WORKFORCE SHORTAGES**

- What is a shortage?
  - A sustained market disequilibrium between supply and demand
- Studies indicate a current shortage in long-term care paraprofessional occupations
- Employers in long-term care sector often lack flexibility to address shortages due to government and third party reimbursement rates

## **OVERVIEW OF THE WORKFORCE INVESTMENT SYSTEM**

- 1998 Workforce Investment Act created more demand-driven workforce investment system
- Workforce Investment Board (WIB), comprised of business leaders and other stakeholders, plays major role in determining local services
- One-Stop Career Centers provide three levels of services: core, intensive, and training
- Core services are available to all, but if funds are limited intensive services and training reserved for low-income customers

## **TRAINING UNDER WIA**

- Most training is done through individual training accounts (ITAs) that are like vouchers
- State and local WIBs restrict training to high-demand occupations

- Only training programs with good records for placement and wages can receive WIA funds
- Performance measures for all WIA programs hold programs accountable for employment, earnings, retention, credentials, and (soon) costs

## **LONG-TERM CARE INDUSTRY'S RESPONSE TO SHORTAGES**

- A number of factors contribute to recruitment and retention problems
  - Low wages
  - Poor working conditions
  - Lack of upward mobility
  - Part-time work with irregular hours
- Approaches for dealing with shortages include:
  - Improving wages and benefits
  - Creating advancement opportunities
  - Improving the workplace environment
  - Developing new worker pools

## **EXAMPLES OF WORKFORCE INVESTMENT INITIATIVES WITH LTC**

- Delaware County Employment Intervention Project
- California Caregiver Training Institute
- Cleveland Achieve
- Mennonite Village
- Tucson Direct Caregiver Association

## **OPPORTUNITIES FOR COLLABORATION**

- Workforce investment can work with long-term care employers:
  - Conduct outreach to employers; ask them to list openings with state and local WIA programs
  - Encourage employers to participate on WIBs and committees
  - Develop sectoral strategies, customized training, and on-the-job training (OJT)
- Long-term care employers can:
  - List openings with state and local WIA programs
  - Participate on state and local WIBs
  - Participate in development and offering of sectoral programs, customized training, and OJT
  - Make jobs more attractive to workforce investment and job seekers by improving pay and retention

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# **Linking Employment, Education, and Economic Development**

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Gay Gilbert

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## **PRESIDENT’S HIGH GROWTH JOB TRAINING INITIATIVE CONCEPT**

Building America’s skilled workforce to provide paths to career enhancing opportunities in high-growth industries and occupations

### **INITIATIVE PROCESS**

- Information Gathering
  - Environmental scan
  - Five Executive Forums
    - American Health Care Association
    - American Association of Homes and Services for the Aging
- Analysis and Planning
  - Workforce Solutions Forums
    - 126 participants
    - 1,001 solutions
    - 84 priority solutions
- Implementation
  - Demonstration projects
    - 22 health care models

### **FOUR MAIN CATEGORIES OF WORKFORCE CHALLENGES**

- Pipeline: Recruitment and Retention
- Skill Development
- Capacity of Education and Training Providers
- Sustainability: Infrastructure, Leadership and Policy

### **DOL ETA LONG-TERM CARE FUNDED MODELS**

- Healthcare Career Lattice: A Model for Enhanced Learning
- Developing Partnerships and Initiatives to Resolve Long-Term Care Workforce Challenges
- Recruitment and Retention of Direct-Care Workers

- Council for Adult and Experiential Learning (CAEL) CNA Apprenticeship Program
- Excelsior College's Hospice Palliative Care Certificate Program

## **DOL ETA HEALTH CARE MODELS**

13 of the remaining 17 models will impact the pipeline of health care workers that could potentially work within the long-term care sector

## **NEXT STEPS**

ETA will continue to explore more innovative projects throughout the year by launching a competitive grant opportunity for the health care industry. This competitive process will allow ETA to fund more new and innovative national models that address the industry's identified workforce challenges.

## **HOW TO FIND THE BUSINESS RELATIONS GROUP**

Gay Gilbert, Director  
Business Relations Group  
U.S. Department of Labor  
Employment and Training Administration  
[businessrelations@dol.gov](mailto:businessrelations@dol.gov)  
(202)693-3949  
[www.doleta.gov](http://www.doleta.gov)  
[www.careervoyages.gov](http://www.careervoyages.gov)

# **Good Samaritan Career Lattice Project**

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Lloyd Schipper

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## **EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY**

- Nation's largest private non-profit long-term care organization
- 240 facilities--25 states--24,000 staff--28,000 residents
- Began in 1923
- Mission

## **SOUTH DAKOTA DEPARTMENT OF LABOR**

- 16 Career Centers (see Figure 1)
- "One Stop" service for Business and Job Seekers
- Our role

## **NEED**

- The Baby Boomer effect
- Average wage of CNA in SD is \$9.03
- SD ranks 7th in % of population 65+ and 3rd in % of population 85+

## **PROJECT GOALS**

- Develop a career lattice offering options for career growth and development
- Improve the image of CNA positions
- Develop enhanced performance standards to improve quality of care
- Decrease CNA turnover rate
- Improve customer satisfaction



## PROJECT STRATEGIES

- Career “lattice” approach
- Apprenticeship and Mentors
- Distance Learning

## CNA LATTICE

Certified Nurse Assistant (CNA)  
Competency Based Model  
Good Samaritan Society

The following examples reflect a performance-based competency driven Nurse Assistant apprenticeship program.

Occupation	Term Hours	Classroom Hours	Completion/ Certificate
CNA I (Level 1)	300-600	34	Certificate of Training
CNA, Advanced (Level 2)	300-600	72	Certificate of Advanced Training
Upon completion of CNA I and CNA, Advanced, an apprentice must select a specialty area to complete their apprenticeship. His/Her Certificate of Completion of Apprenticeship will reflect the specialty area in which they have “Specialized.”			
CNA, Geriatric Specialty (Level 3)	1,000-1,370	88	Certificate of Specialization Geriatric
CNA, Restorative Specialty (Level 3)	1,000-1,300	80	Certificate of Specialization Restorative
CNA, Dementia Specialty (Level 3)	825-1,125	72	Certificate of Specialization Dementia
CNA, Mentor Specialty (Level 3)	600-925	68	Certificate of Proficiency Mentor

## PARTNERS

- USDOL Bureau of Apprenticeship and Training
- CAEL
- Post Secondary Education (USD, SDSU, and LATI)
- South Dakota Career Centers
- Local Good Samaritan Centers

## OUTCOME MEASUREMENTS

- CNA Turnover
- CNA Vacancies
- Quality Indicators/Measures
- Occupancy Rates
- Community Perceptions
- Customer Satisfaction
  - Staff
  - Resident and family

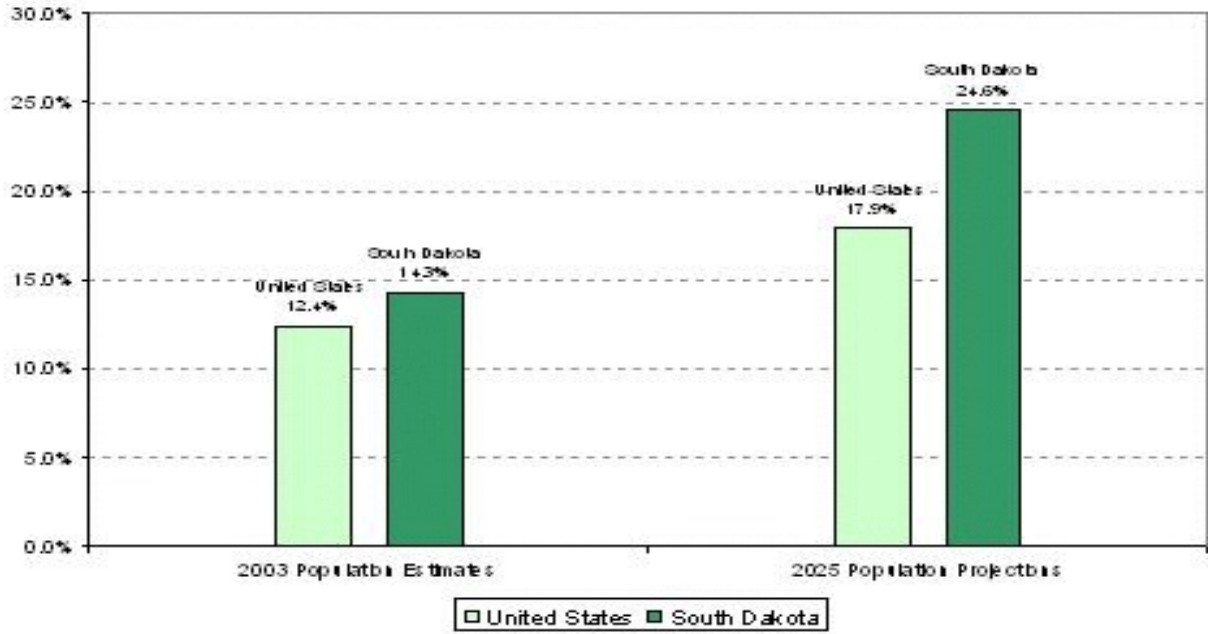
## FUTURE PLANS

- High Growth Initiative Grant
- Walk before you run
- Thank you



# OLDER POPULATION COMPARISON

## Population Age 65 Years and Older Percent of Total Population



# **Healthcare Partnerships in Northern Indiana**

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Juan Manigault

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## **PRESENTATION OVERVIEW**

- Workforce Investment Board
- Workforce Issues
- Healthcare Career Ladder Project
- Healthcare Coalition Project
- Summary

## **REGIONAL OVERVIEW**

- Four county region, which includes Elkhart, Kosciusko, Marshall and St. Joseph Counties in north central Indiana with a population of 576,780. Growing Hispanic population throughout region at 6.79% of total population.
- Educational center with 13 colleges and universities including the University of Notre Dame, Indiana University South Bend and Ivy Tech State College.
- Regional healthcare center with over 2,000 healthcare providers from four major hospital systems to direct care providers. Includes 22 long-term health care providers.
- Diverse mix of industry including: health services, transportation, pharmaceuticals, recreational vehicles/manufactured housing, orthopaedic instrumentation, food services and financial services.

## **BOARD OVERVIEW**

- The federal Workforce Investment Act, requires the establishment of local workforce investment boards, organized around local labor market areas. There are approximately 650 workforce boards in the country.
- The Northern Indiana Workforce Investment Board is comprised of 50 members with a business majority, plus education, organized labor, government, community-organizations and economic development entities.
- Appointed by Local Elected Officials and certified by the Governor.
- \$5+ million direct budget from federal, state, local sources and fees.
- Indirectly impacts a minimum regional budget of over \$15 million from partner organizations through policy and oversight.

## **BOARD FUNCTIONS**

- Assist in the development and growth of the regional economy through strategic planning initiatives, labor market information and convening partnerships that support economic growth through a trained and adaptable workforce.
- Support the development of the incumbent workforce by developing employer-driven strategies that support ongoing training and development.
- Support the development of the emerging (new entrants) workforce by strengthening their academic, career and life skills.
- Develop systems that support economic growth and workforce development.

## **VISION STATEMENT**

To improve the quality of life, raise the standard of living, and enhance the productivity and competitiveness of the region.

## **MISSION STATEMENT**

To define needs, identify resources, and broker relationships that impact regional economic sustainability, business growth and the education and training of a quality workforce.

## **MACRO-LEVEL WORKFORCE ISSUES**

- The Workforce is changing
  - Baby boomers approaching retirement
  - Labor force shortages critical in non-professional and technical positions
- Skill and Knowledge requirements are changing
  - Increasing need for computer literacy, communication skills, decision-making and problem solving skills
- Youth are inadequately prepared for participation in the workforce
  - Youth aspirations aren't consistent with economy and educational performance
  - Graduation rates are too low in urban school districts

## **MACRO-LEVEL NURSING ISSUES**

- RN employment has fallen by 2.4% from 1996 to 2000 in Indiana.
- Increasing number of RN's are 50 years of age or older.
- The average age of long-term care nurses is over 50 years.
- 15% of RN, 13.2% of LPN and 8.5% of QMA positions are vacant in Indiana. Percentages much higher in the long-term healthcare arena.

- The expansion of career opportunities for young people, and particularly women, has reduced the number of individuals pursuing nursing careers since 1983.
- The average age of nurse educators is beginning to exceed age 50.

## **HEALTHCARE CAREER LADDER PROJECT PROCESS**

- Identify healthcare occupations in demand
  - Conduct county focus groups with healthcare providers
  - Conduct one-to-one interviews with primary healthcare providers
  - Identify common skill sets (WorkKeys) needed for entry level positions
  - Determine specific occupations for career ladder development
  - Identify and recruit career ladder employer partners
- Identify healthcare training programs
  - Conduct focus group with employer partners, education/training providers and One-Stop partners
  - Identify barriers in meeting employer need
  - Identify strategies for eliminating training barriers
- Develop an employer driven matrix of career opportunities linked to entry level positions that will demonstrate advancement possibilities throughout the employer partner network.
  - Nurses
  - Therapists
  - Technicians
- Develop matrix of healthcare scholarships, One-Stop training opportunities, on-the-job training and/or employer-paid training opportunities for career ladder advancement.
  - Employer educational advancement programs
  - State training grants
  - WorkOne career scholarships
  - On-the-job training opportunities
  - Post-secondary scholarships
- Engage WIB Youth Council in development of plan to communicate healthcare needs, skill requirements and training opportunities to the emerging workforce.

## **HEALTHCARE COALITION PROJECT**

- Regional Skill Alliances, involving 3 or more employers, are encouraged by the Indiana Department of Workforce Development to support common skills training.
- Workforce Investment Boards are responsible for forming these Alliances, and may apply for up to \$200,000 in training grants to support training activities of participating companies. 10% is reserved for administration with the balance reserved for training costs only.
- Requirements include employer match, which may involve training on company time, and a recognized credential.
- Grants are for one year with the possibility of a no-cost one year extension.
- Initial meeting included representatives from the Workforce Board, Indiana Health Care Association, Ivy Tech State College, and the Indiana Department of Workforce Development.

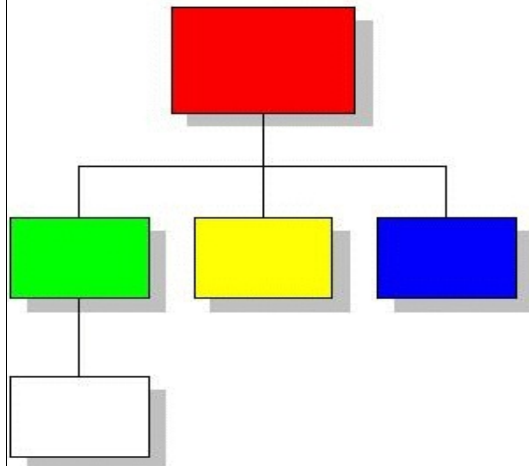
- Basic elements for the training program were agreed to and included:
  - Apply for three \$200,000 grants for St. Joseph County, Elkhart County, and Kosciusko/Marshall Counties.
  - Stagger implementation to coincide with semester enrollment opportunities.
  - Workforce Board will write grants, serve as grant recipient and intermediary, and file all reports.
  - Training program will incorporate elements of the Workforce Board career ladder approach for nursing occupations
  - Indiana Health Care Association will coordinate activities with member institutions in each county, including an initial orientation meeting.
  - Ivy Tech State College and Indiana University South Bend will serve as the primary training institutions for the program.
- Project Guidelines:
  - All participating individuals are incumbent workers at participating long-term health providers.
  - Training program allows dietary, maintenance, and janitorial workers with the basic skills and aptitudes to apply for the program at the CNA/QMA, LPN or ASN level.
  - Existing nurses may apply to pursue the appropriate LPN to ASN, ASN to BSN, or BSN to MSN program.
  - Companies will allow for training on company and use wages and fringe benefits as an allowable match, plus pay for books and travel expenses.
  - Upon successful completion and the awarding of the appropriate credential, individuals will be promoted and receive increases in pay.
- Training Outcomes:
  - 15 certified as QMAs, which includes CNA designation
  - 19 certified as LPNs
  - 12 receive the ASN degree and are eligible to take the state exam to become RNS
  - 2 receive the BSN degree
  - 2 receive the MSN degree
- Total grant of \$208,000, plus matching funds of \$211,000.
- Program begins with the summer semester.
- Next Steps
  - Submit grant application for 2<sup>nd</sup> County in June for implementation in August.
  - Submit grant application for remaining counties in November for implementation in January.

## **SUMMARY**

- Workforce Boards can:
  - Develop partnerships
  - Convene partnership meetings
  - Develop strategic approaches
  - Seek resources
  - Manage grant relationships

## From Organization to Enterprise

### Hierarchical



### Self-Contained Corporation

### Systems Approach



### Value-Creating Enterprise

From The Northbound Train, Karl Albrecht



# **Extended Care Career Ladder Initiative (ECCLI)**

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Charles Bodhi

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## **HISTORICAL PERSPECTIVE ON ECCLI**

- ECCLI - part of the broader Nursing Home Quality Initiative.
- Originally thought of as a career ladder for CNA's.
- Stakeholders worked in partnership to discuss issues in long-term care (LTC) industry.

## **INTENT OF ECCLI LEGISLATION**

- Improve quality of care.
- Promote skills development.
- Improve employee retention.
- Create and institutionalize career ladders and other workplace practices that support and develop workers.

## **ECCLI NUMBERS TO DATE**

- 81 sites have participated in ECCLI.
- Over 4,000 entry-level workers have participated in at least one ECCLI training.
- Over 700 managers have attended some type of leadership training.

## **NEW ROUNDS OF FUNDING**

- Projects beginning April 2004.
- 30 awards being given over 3 rounds of funding.
- Collaboration and partnership across the rounds of funding encouraged.
- 27 additional long-term care facilities involved.

## **ECCLI EVALUATION**

- Baseline Evaluation Report.
- Interim Evaluation Report.

- Report to the ECCLI Statewide Advisory Board
  - Preliminary results from several exploratory analysis:
    - ECCLI participation
    - Participant outcome
    - Patient outcome
    - Employer/facility outcome data
- Study the impact ECCLI has had on quality of patient care evaluation: phase one
  - Contract with Hebrew Centre for the Aged
  - MDS data application
  - Quantitative analysis
  - What effect has ECCLI had on quality of patient care?
- Possible qualitative analysis in near future.

## TECHNICAL ASSISTANCE

- Workforce Investment Boards involved in performance management of Round 4 projects.
- Operational.
- Organizational/culture change.
  - Eden Alternative
  - Tom Zwicker
  - Individual assistance, by site

<b>ECCLI ADVISORY BOARD MEMBERS INCLUDE REPRESENTATIVES FROM THE FOLLOWING ORGANIZATIONS</b>	
Massachusetts Extended Care Federation	Massachusetts Workforce Board Association
Massachusetts AFL-CIO	Massachusetts Department of Transitional Assistance
Paraprofessional Healthcare Institution	Massachusetts Department of Education
Home and Health Care Association	Department of Public Health
Department of Labor and Workforce Development	Executive Office of Health and Human Service
Massachusetts Community Colleges	Jamaica Plain Neighborhood Development Corporation
Massachusetts Council for Home Care Aides	Representation from Senator Mark Montigny's Office
Massachusetts Aging	

# **The Impact of Workforce Improvement Initiatives on Workforce Recruitment and Retention**

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Patsy Harris

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## **INTRODUCTION**

- Collaborative Partnerships (Kinds of...)
- Why Partner
- Potential Workforce Goals or Desired Outcomes of Collaborative Partnerships
- Workforce Improvement Initiatives Case Study Examples

## **COLLABORATIVE PARTNERSHIPS (KINDS OF...)**

- Multi-Stakeholder coalitions (workers, consumers, community-based organizations and employers).
- Sectorial Initiatives (employers, industry leaders, local community colleges).
- Worker Associations (primarily direct care workers).

## **WHY PARTNER...**

- Recognize the power of partnering with leaders/representatives within the social and economic systems that impact not only the recruitment and retention efforts, but understand how these efforts are connected with the overall well-being of the communities in which they exist and operate.
- Intervene and connect low-income workers to better jobs.
- Make and impact policy and practice changes in low-paying industries to increase livable wage and access to benefit opportunities.
- Appreciate the importance of involving employers and industry leaders in the strategic design and mission of the workforce improvement initiatives.

## **POTENTIAL GOALS OR DESIRED OUTCOMES FOR COLLABORATIVE PARTNERSHIPS IN LONG-TERM CARE**

- Improve wages through a concerted ***federal earned income tax credit*** campaign targeting this workforce.
- Secure ***more hours*** of employment.
- Access to ***training***, where to find it, costs, content, job placement and certification, etc.

- Access to **health care coverage** for in-home workers.
- Identify **new approach to supervision** that emphasizes problem solving, communication and critical thinking such as “coaching.”
- Connect workers to existing **supports** for housing, health care, transportation and childcare.

## MULTI-STAKEHOLDER PARTNERSHIPS EXAMPLE

- **Direct Care Alliance:** A national coalition of workers, consumers and employers working together to build a stable and valued direct care workforce.
- **Core Principles:** To shape both public policy and industry practice toward
  - Improving the **quality of jobs** for the direct care staff (nursing home aides, home health aides and personal care attendants), recognizing these workers as the cornerstones of god care and thereby...
  - Improving the **quality of care** for consumers, in particular the elderly, the chronically ill and people living with disabilities.
- Contact information [www.directcarealliance.org](http://www.directcarealliance.org) or email [patsy@directcarealliance.org](mailto:patsy@directcarealliance.org).

## SECTORIAL PARTNERSHIPS EXAMPLE

- **Project QUEST, Inc.**
  - An innovative job training program in San Antonio with a mission to demonstrate the **social and economic benefits** that can be achieved through investments in **long-term training** for those who otherwise would not have the opportunity.
  - Project QUEST defines the skills required to succeed in targeted, hard-to-fill occupations and then **recruits, trains, and develops** adults so that they are **qualified** and ready to fill employers’ needs for **skilled** workers.
  - Contact
- **Jobs For The Future** (Boston, MA)
  - A non-profit research, consulting and advocacy organization working to strengthen our society by creating educational and economic opportunities for those who need it most.
  - JFF works to:
    1. **Understand** the challenges and barriers that keep people from participating full in the economy;
    2. **Accelerate** the adoption of what’s new, what’s needed, and what works in helping youth and adults acquire the skills that employers require; and
    3. **Influence** the policies that drive our nation’s educational and training systems to improve economic opportunities for those who need it most.
  - Contact information [www.jff.org](http://www.jff.org) or [info@jff.org](mailto:info@jff.org).

## WORKER ASSOCIATION PARTNERSHIP EXAMPLE

- **Worker Associations:** Are coalitions developed primarily to assist and empower direct care workers with building support for quality work and quality jobs.

- **Core Principles** for Worker Associations have included: worker empowerment; forming coalitions to build employer support; create opportunities for workers to network; and to promote respect for the worker and the consumer.
- **Some Worker Associations** include: Iowa Caregivers Association, Virginia Association Professional Nursing Assistants, Career Nurse Assistants Programs, Inc., National Association of Geriatric Nursing Assistants.

# Pathways to Better Care: Investing in the Long-Term Care Workforce

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Debra J. Lipson

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## OVERVIEW

- Better Jobs Better Care (BJBC) Goals and Premises
- BJBC Demonstration Projects
  - Policy/practice themes and initial experiences
- National Study of Demonstration Projects
- BJBC Applied Research Projects

## BETTER JOBS BETTER CARE (BJBC) GOAL

- Support changes in long-term care policy and provider practice that:
  - Help to reduce high vacancy and turnover rates among direct care staff across the spectrum of long-term care settings.
  - Improve workforce quality.

## KEY PREMISES OF BJBC

- **Coalitions** of providers, consumers and workers are key to making sustained changes.
- Public **policies** and workplace **practices** should support and **reinforce** each other.
- **More/better research** needed to document the effectiveness of public policies and workplace practices.

## BJBC PROGRAM STRUCTURE

- Co-funded by The Robert Wood Johnson Foundation and The Atlantic Philanthropies.
- National Program Office -- Institute for the Future of Aging Services, providing program direction and technical assistance.
- Technical Assistance partner -- Paraprofessional Healthcare Institute.
- 2 grant programs:
  - Demonstration grants.
  - Applied Research and Evaluation grants.

## **BJBC DEMONSTRATION GRANTS**

- **5 Demonstration grants:**
  - Up to \$1.4 million over 3½ years awarded to coalitions in five states
- **Multi-stakeholder coalitions including:**
  - Long-term care providers, workers and consumers, working with state and local agencies, workforce development agencies, educational institutions, etc.

## **BJBC STATE COALITIONS AND LEAD AGENCIES**

- **Iowa** -- Iowa Caregivers Association
- **North Carolina** -- North Carolina Foundation for Advanced Health Programs
- **Oregon** -- Oregon Technical Assistance Corporation
- **Pennsylvania** -- Center for Advocacy for the Rights and Interests of the Elderly
- **Vermont** -- Community of Vermont Elders

## **BJBC STATE COALITION POLICY INITIATIVES**

- Efforts to link payment, or rewards, to positive workforce development practices and outcomes
- Wage/benefit enhancements and/or wage parity across long-term care provider types.
- DCW Training:
  - State recognition of additional DCW skills.
  - Universal core curriculum for all types of DCWs.
  - Increased access to advanced training.

## **BJBC STATE COALITION WORKPLACE PRACTICE IMPROVEMENTS**

- Organization culture change to empower and value DCWs.
- Peer mentoring, supervisor training programs.
- Promoting/valuing cultural diversity in the workforce.
- Development of innovative curricula and training methods.

## **SYNERGY BETWEEN POLICY AND PRACTICE INITIATIVES**

- State licensing designation and “quality awards” for better DCW workforce inputs/outcomes reinforces provider investment in training.
- State recognition of additional training and skills gives incentives to DCWs to advance or stay in the field, which are reinforced by pay increases and public training subsidies.

## **BJBC NATIONAL DEMONSTRATION STUDY**

- **Penn State University -- Kemper/Brannon**
  - Document and analyze grantee activities, successes and challenges.
  - Assess impact of policy and practice changes on provider organizations, quality of DCW jobs and worker perceptions of quality of care.
- **Management Information System, PSU Survey Research Center**
  - Consistent web-based system to track employee retention, turnover, changes in working conditions in all providers participating in BJBC demonstration activities.

## **BJBC APPLIED RESEARCH AND EVALUATION GRANTS**

- **8 Applied Research and Evaluation Grants awarded**
  - Up to \$500,000 each over 2 years to university and non-profit research institutes.
- Designed to generate **practical, empirical knowledge** about the strategies and practices that work best to attract and retain a high-quality direct care workforce.
- Impact of wage/benefit enhancements.
- Potential to expand labor pool by recruiting family/friends, older workers.
- Organizational and management practices.
- Cultural competency.
- Training needs of CNAs/HHAs.

## **PUBLIC/PROVIDER/POLICYMAKER EDUCATION AND AWARENESS**

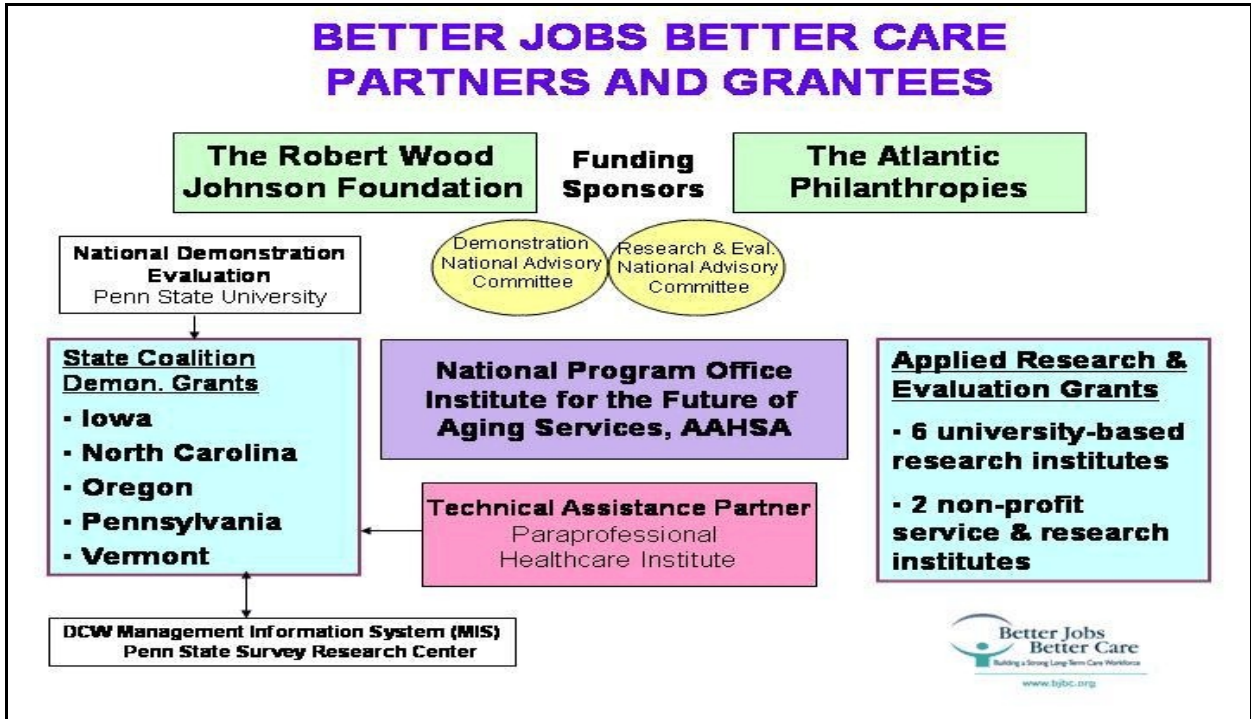
- Dissemination of project findings, results and policy implications
  - Website
  - Newsletter -- *Insights* -- and Issue Briefs
  - Professional conferences
  - Policy seminars in Washington, DC
  - Media briefings, interviews, etc.

## **FOR MORE INFORMATION**

- Visit the BJBC website:
  - <http://www.bjbc.org>
  - See project profiles and descriptions under each type of grant program
  - Download newsletters, issue briefs, etc.
- Contact us or join our mailing list:
  - [bjbc@aaahsa.org](mailto:bjbc@aaahsa.org)
  - 202-508-1216



# BETTER JOBS BETTER CARE PARTNERS AND GRANTEES



# **Workforce Improvement Initiatives to Improve Workforce Retention: What is the Evidence Base?**

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Lauren Harris-Kojetin

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## **PRESENTATION OVERVIEW**

- IFAS
- Why evaluate?
- What has been evaluated recently?
- What works and should be invested in?
- What additional investments are needed to promote long-term care (LTC) direct care workforce improvements that are evidence-based?

## **INSTITUTE FOR THE FUTURE OF AGING SERVICES (IFAS)**

- Independent policy research center within the American Association of Homes and Services for the Aging (AAHSA).
- Conduct research...
  - to improve the quality of aging services
  - to support a quality, stable LTC workforce
  - through partnerships with AAHSA members and other organizations.
- Disseminate findings and evidence-based practice models to AAHSA members and others.

## **WHY EVALUATE?**

- Need to know what works and what does not:
  - Where should limited resources go?
  - Do they really work?
  - Which works best?
  - Was there a change in outcomes of interest?
  - Did the change in outcomes occur because of the initiative or because of something else?
  - How sustainable and replicable are practices?

## **RECENT INSIGHTS ABOUT FRONTLINE LONG-TERM CARE WORKERS: A RESEARCH SYNTHESIS 1999-2003**

- Authors:
  - Lauren Harris-Kojetin, PhD
  - Debra Lipson, MHSA
  - Jean Fielding, MGS
  - Kristen Kiefer, MPP
  - Robyn I. Stone, DrPH
- Funded by ASPE, DHHS

### **A NOTE ON TERMINOLOGY**

- Paraprofessional workers
- Direct care workers
- Frontline workers
  - Nurse aides or Nursing assistants
  - Personal care aides or assistants
  - Home health aides
  - Home care aides
  - Others who provide hands-on assistance with bathing, eating, dressing, and other activities of daily living for persons with disabilities (focus on elderly)

### **TYPES OF INITIATIVES EVALUATED 1999-2003**

- Alternative labor pools
- Career ladders
- Culture change
- Enhanced staff-family communication
- Multi-faceted initiatives
- Peer mentoring
- Self-managed work teams (SMWTs, in process)
- Wage enhancement
- Fifteen interventions reviewed in research synthesis
  - Two have not (yet) had outcome evaluation
  - Two did not measure actual turnover or retention
  - Eight showed non-significant, negative, or inconclusive results or did not use robust quasi-experimental design
  - Three showed significant positive results using a pre-post comparison group design with retention and/or turnover

## WHAT INITIATIVES WORK?

- Pre-post comparison group design
- ▲ retention and/or ▼ turnover of direct care
- Peer mentoring
  - **Growing Strong Roots**
- Multi-faceted initiative
  - **WIN A STEP UP** -- education and payment incentive
- Culture change
  - **Wellspring** -- quality improvement and organizational change process

## GROWING STRONG ROOTS

- Trained, experienced certified nursing assistants (CNAs) matched with new CNAs.
- Training
  - 6-hour project coordinator orientation and manual
  - 6-hour mentor training, manual, and newsletter
  - guide to orienting mentors' supervisors/gaining facility support
  - booster training
- Mentoring active 8 weeks.
- Salary increase for mentor.

## GROWING STRONG ROOTS EVALUATION RESULTS

- Pre-post comparison group design.
- Twelve nursing homes (six treatment, six comparison) in New York state.
- Data collected immediately prior to implementation and 3 months after implementation.
- Statistically significant improvement in retention among those mentored
  - 18 point increase in average retention rate while increase not significant among comparison group.

## **WIN A STEP UP**

- Education and incentive program.
- Ten modules on clinical skills, interpersonal skills, and communication.
- Nurse aides (NAs) get \$70 per completed module.
- Facilities must agree to commit staff time and give either retention bonus (\$75) or wage increase ( $\geq$ \$0.25/hour) 3 months after completion of modules.
- NAs who complete  $\geq$ 7 modules and stay at facility  $\geq$ 3 months after training get matching \$75 bonus from WIN A STEP UP.

## **WIN A STEP UP EVALUATION RESULTS**

- Pilot.
- Pre-post comparison group design.
- Four nursing homes, one home health agency, one adult care home in North Carolina.
- Data collected immediately prior to implementation and several months after implementation.
- Annual turnover rates significantly lower (15%) for NAs in the program compared to those in the matched comparison group (32%).
- Program active in 37 North Carolina nursing homes as of April 2004, with plans to involve 55 nursing homes by July 2005.

## **WELLSPRING INNOVATIVE SOLUTIONS**

- Alliance super structure.
- Clinical training modules.
- Shared advanced practice nurse.
- Nursing coordinator to link components at facility level.
- Care resource teams.
- Systematic collection and use of outcome data.
- Non-hierarchical management philosophy.

## **WELLSPRING EVALUATION RESULTS -- RETENTION**

- Wellspring facilities fared better than other Wisconsin facilities on retention:
  - CNA's: Wellspring retention increased by 6 percent, other homes decreased by 6 percent.

## **WELLSPRING EVALUATION RESULTS -- TURNOVER**

- Wellspring facilities fared better than other Wisconsin homes on turnover.
- RN's: Wellspring exhibited 6 percent lower turnover rates post implementation, while other homes saw a 7 percent increase.
- LPN and CNA turnover rates increased for both Wellspring and other homes, but increase was smaller for Wellspring.

## **GAPS-STRENGTHEN EVIDENCE BASE**

- Evaluate existing models.
  - Distinguish relative role of different model elements in outcomes.
- Develop and test new interventions.
- Strengthen evaluation designs.
  - Measure longer-term effects.
  - Measure variation within facilities (units, shifts).
  - Measure actual behavioral outcomes.
  - Measure outcomes consistently.
  - Use of a comparison group.
- Determine transferability of evidence-based models across settings.

## **GAPS-PROMOTE EVIDENCE BASE**

- Disseminate evidence-based practices for replication more broadly.
- Provide technical assistance to providers to implement and sustain new models.
  - Give on-going feedback to providers.
- Determine how to replicate effective interventions beyond the initial demonstration (inform technical assistance).
  - Assess extent to which replicated models are really being implemented.
- Determine how to sustain interventions.
- "Incentivize" the use of evidence-based models.

# **The National Clearinghouse on the Direct Care Workforce**

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Vera Salter

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## **A NATIONAL RESOURCE CENTER**

- Collect and analyze information about the direct-care workforce.
- Identify knowledge gaps.
- Distribute information to multiple stakeholders.
- Connect people with common interests.
- Respond to requests from users.

## **RESOURCES**

- Library of publications and other resources:
  - National reports on the workforce crisis.
  - Surveys of state initiatives.
  - Curricula and “how to” materials.
  - Worker voices.
- “Best practice” database.
- State resource section.
- Up to 15,000 visits per month.
- *Quality Jobs/Quality Care* e-newsletter with over 1,200 subscribers.

## **PRACTICE PROFILE DATABASE**

- Collaboration between IFAS and PHI, funded by Health and Human Services (ASPE and CMS).
- Objectives:
  - To identify what has worked to improve worker recruitment and retention.
  - Promote cross-learning between innovators.
- Looking for programs that are in place and have shown results.
- Make examples available in a web database.

## **INFORMATION COLLECTION**

- Conversations with experts around the country seeking recommendations.
- Calls for help at conferences and through newsletters.
- Interviews with providers about what they have done.
- Collection of related written material.

## **EXAMPLES OF FINDINGS**

- Screening and recruitment.
- Entry-level training.
- Peer support and mentoring.
- Career advancement.
- Management and supervisory training.
- Comprehensive interventions.
- Wages, benefits and worker support.

## **RECRUITMENT AND ENTRY-LEVEL TRAINING**

Many innovative models that used workforce funds:

- George G. Glenner School of Dementia Care in San Diego.
- Co-operative Home Care Associates in the Bronx, New York (CHCA).
- The Shirley Ware Education Center (SEIU).
- Hope for Health Care in Richmond, Virginia.
- LEAP in Cleveland, Ohio trains people with disabilities.
- Direct CareGiver Association (Arizona).

## **MENTORING AND CAREER ADVANCEMENT**

- WIN A STEP UP -- North Carolina.
- Iowa CareGivers Association: "For those who mentor."



- Luther Manor Nursing Home in Iowa -- facility mentoring program.
- St. Peter Villa in Memphis -- career ladder.

## **MANAGEMENT AND SUPERVISORY TRAINING**

- Mather Lifeways LEAP (IL).
- Co-operative Home Care Associates (CHCA): Coaching Supervision (NY).
- Resthaven Christian Services: Director of CNA position (IL).
- Vinfen: Seld Managed Teams (MA).

## **COMPREHENSIVE INTERVENTIONS**

- Apple Health Care (CT, MA, RI).
- Co-operative Home Care Associates (NY).
- Leelanau Memorial Health Center (MI).
- Mercy Franciscan Health Systems.
- Ararat Nursing (CA).
- Wellspring Innovative Solutions (WI).

## **WAGES, BENEFITS AND SUPPORTS**

- San Francisco IHSS Public Authority.
- Bon Secours wage parity initiative.
- Cooperative Care Waushara Wisconsin.
- Nazareth home wage enhancement program.
- Kahl home employee assistance program.

## **TO ACCESS THE CLEARINGHOUSE**

- [www.directcareclearinghouse.org/practice](http://www.directcareclearinghouse.org/practice)
- 718-402-4138
- Info@directcareclearinghouse.org

## **QUALITY JOBS/QUALITY CARE**

*Quality Jobs/Quality Care* is a free e-mail newsletter that covers issues concerning direct-care workers in long-term care. It's published twice a month by the National Clearinghouse on the Direct Care Workforce ([www.directcareclearinghouse.org](http://www.directcareclearinghouse.org)), which provides reliable, up-to-date information related to the direct-care workforce nationwide. The Clearinghouse is a project of the Paraprofessional Healthcare Institute ([www.paraprofessional.org](http://www.paraprofessional.org)).

# **The Impact of Workforce Initiatives on Recruitment, Training, and Retention**

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Michael Elsas

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## **OVERVIEW**

- CHCA's Philosophy.
- CHCA's Model for Recruitment, Training, and Retention.
- Outcomes.

## **THE PHILOSOPHY**

- To create high-quality jobs for home care workers by offering enhanced training, a supportive work environment, and opportunities for personal and professional growth.
- To improve the quality of care delivered to the chronically ill, elderly and disabled by creating a stable workforce.

## **THE MODEL**

- CHCA's model for recruitment, training, and retention encompasses five elements:
  - Targeted recruitment.
  - Enhanced entry-level training.
  - Supportive services.
  - Opportunities for advancement.
  - Wage and benefit enhancements.

## **TARGETED RECRUITMENT**

- Assessment and Selection
  - 35% of those who interview are enrolled in the training program.
  - 80% complete the program and are hired by CHCA.
- Recruitment Partnerships
  - CHCA has built strategic relationships with human service organizations.

## **ENHANCED TRAINING**

- Adult Learner Centered Training.
- Communication and problem solving.
- Three Months of "On the Job" training.

## **SUPPORT SERVICES**

- Employment Counseling.
- Peer Mentor Program.
- “Coaching As Supervision”

## **PERSONAL AND PROFESSIONAL GROWTH**

- Worker Participation
  - Worker Council.
  - Regional Meetings.
- Leadership Development.
- Policy Action Group.

## **OPPORTUNITIES FOR ADVANCEMENT**

- Senior Aide.
- Peer Mentor.
- Associate Instructor.
- Administrative Staff.

## **WAGES AND BENEFITS**

- Higher Base Wages.
- Wage Differentials.
- Guaranteed Hours Program.
- Benefits
  - Health insurance.
  - 401K.
  - Paid vacation and sick leave.
  - Annual dividends for worker owners.

## **OUTCOMES**

- For individuals hired between July 2002 and June 2003:
  - 84% were employed for at least 90 days.
  - 64% achieved their 365 day employment milestone.
  
- Overall Paraprofessional turnover rate between July 2002 and June 2003 was 23.3%.

# **Nursing Home Workforce and Quality**

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John Schnelle

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## **MAJOR POINTS**

- Staffing numbers are related to quality.
- Staffing low in most homes.
- Training and management interventions will have limited effectiveness.
  - National reports on the workforce crisis.
  - Counter-productive if they imply unrealistic work expectations.
- What should staffing levels be?

## **STAFFING REQUIREMENTS**

- Kramer: 4.1 nurse + aide hours.
- Expert consensus: 4.5 total hours.
- IOM recommendation: 4.1 total hours.
- Simulation: 2.8-3.1 aide hours (CMS study).

## **IF PROJECTIONS CORRECT**

- THEN, Staffing above 4.1.
- Better process implementation related to outcomes.

## **FIELD TEST EVALUATION**

- Directly measured care process implementation in:
  - Homes in upper decile staffing vs. all others.

## **STUDY SAMPLE**

- N=34 homes.
- Lower 90<sup>th</sup> vs. upper 10<sup>th</sup> percentile.
- Total staff hours = 3.1 vs. 4.5.

- Aide hours = 2.3 vs. 2.9.
- Aide report = 9.8 vs. 7.6 ratio.

## **QUALITY ASSESSMENT**

Seven Standardized Measurement Protocols

## **STAFFING CONCLUSIONS**

Different on 13 out of 16 care processes implemented by aides (Schnelle et al, Health Serv Res J 2004).

## **NO OR MARGINAL DIFFERENCE**

- Social interaction during meals.
- Repositioning at night.
- Reported walking assists [low across all homes].
- Licensed nurse/physician driven indicators.

## **WHAT ARE THE SOLUTIONS?**

- Objective analysis of staff requirements to meet regulations.
- Staffing projections (unit level).
- Staff at required levels or reduce care expectations.
- Will increasing staff to required levels be enough?

## **SECOND STEP**

- Accurate and timely information about care delivery.
- Training and management.
- Job design.
- Environmental design.

## **ACCURATE AND USABLE INFORMATION**

- Point of service documentation technology.
- Auditing controls.
- Electronic medical record.

## **TRAINING AND MANAGEMENT MODEL**

- Brief.
- Ongoing.
- Focused on realistic work conditions (see accurate information and staffing requirement slides).
- Quality monitoring between sessions.
- Meaningful incentives.

## **JEWISH HOME NUTRITION PROGRAM**

### Training and Management Model

- 5-minute weekly sessions.
- Focused on specific objectives (talk to resident before assistance).
- Illustrated with video (real residents and aides).
- Quality monitoring between sessions.
- Feedback/Discussion.
- Incentive (employee involvement).

## **CONCLUSIONS**

- Workforce related to quality.
- We should know more about staffing issues than we do.
- First step: Realistic evaluation of staffing requirements.



<b>OUT OF BED/ENGAGEMENT</b>		
	<b>Low Staffing N = 432 Residents</b>	<b>High Staffing N = 125 Residents</b>
% observations out of bed	54	74
% observations engaged	45	52
SOURCE: Bates-Jensen et al., JAGS (in press).		

<b>FEEDING ASSISTANCE</b>			
	<b>Low N = 217</b>	<b>High N = 72</b>	<b>Chart</b>
% residents require assistance and receive $\geq$ 5 minutes	57%	80%	100%
SOURCE: Simmons et al., JAGS 2003.			

<b>INCONTINENCE</b>		
	<b>Low N = 102</b>	<b>High N = 31</b>
Number of toileting assists reported (MDS recall 2+)	1.8	2.8
SOURCE: Schnelle et al., Medical Care 2003.		

# **Long-term Care Paraprofessionals: National and Local Workforce Shortages and Data Needs**

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Jean Moore<sup>1</sup>

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## **THE CENTER FOR HEALTH WORKFORCE STUDIES AT THE UNIVERSITY AT ALBANY**

- Conducts studies of the supply, demand, use and education of the health workforce.
- Committed to collecting and analyzing data to understand workforce dynamics and trends.
- Goal to inform public policies, the health and education sectors and the public.
- One of six regional centers with a cooperative agreement with HRSA/Bureau of Health Professions.

## **OVERVIEW OF PRESENTATION**

- Background on the health workforce.
- Implications of the aging of America on the health care system and its workers.
- Long-term care paraprofessionals: what we know and what we don't know.
- Next steps.

## **CURRENT HEALTH WORKFORCE ISSUES**

- Health worker shortages.
- The squeeze--few new dollars and the high cost of more workers--limit response options.
- Concerns with medical errors and quality.
- Worker and management dissatisfaction.
- Frustration with paperwork and regulation.
- Racial and ethnic imbalances in professions.
- Lack of systematic data on supply and demand for health workers.

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<sup>1</sup> This presentation is available online through the Center for Health Workforce Studies website at <http://chws.albany.edu/index.php?id=12,0,0,1,0,0>.

## **FACTORS CONTRIBUTING TO HEALTH WORKFORCE SHORTAGES**

- Short-term Factors:
  - Competition for workers and the economy.
  - Growing demand.
  - Increased intensity and complexity of services.
  - Educational system cycles and response lags.
- Long-Term Factors:
  - Changing racial/ethnic mix in the US.
  - Expanded career choices for women.
  - The economy and public expectations.
  - Increases in credential requirements.
  - The aging of America: increase in demand.
  - The aging of America: decrease in supply of workers.

## **A STUDY OF THE IMPACT OF AGING ON THE HEALTH WORKFORCE IN THE US**

Recently completed study funded by HRSA

- Aging: Demographics, Models of Care, Family Caregivers, Technology, Reimbursement
- Profile of the Current Workforce:
  - Over 20 health professions.
  - Services to the elderly.
  - Training, education, credentials related to aging.
  - Supply trends/demand projects and gap.
  - Profession-specific issues.

## **THE GROWING ELDERLY POPULATION WILL HAVE A SMALL POOL OF POTENTIAL FAMILY CAREGIVERS**

- Compared to the current elderly, the growing cohort of aging Americans:
  - Have had fewer children than their parents.
  - Are more likely to be divorced.
  - Are more likely to live alone as they enter old age.

## **IMPACT ON HEALTH SERVICES DELIVERY SYSTEM**

- The elderly consumer more health care services than younger age groups.
- The elderly have different health care needs than younger age groups.
- The elderly will have a greater range of health care models to choose from than in the past.
- Access to care will be a greater issue for the elderly.

## **IMPACT OF THE AGING OF AMERICA ON THE HEALTH WORKFORCE**

- Many health professions and occupations do not offer formal credentials focused on the needs of the elderly.
- When such a credential is offered, the number of workers with the credential is typically very small.
- A majority of health care workers in most settings deal with substantial numbers of elderly people whether or not they are specialists.
- Demand for health care professionals to serve the elderly will be affected by:
  - Medicare reimbursement policies.
  - New technologies.
  - New models of care.
  - Changes in profession-specific scope of practice focused on the needs of the elderly.

## **LONG-TERM CARE PARAPROFESSIONALS: NATIONAL AND LOCAL WORKFORCE SHORTAGES AND ASSOCIATED DATA NEEDS**

- Study funded by HRSA's Bureau of Health Professions.
- Objectives of study:
  - Review existing sources of data for states.
  - Compile latest data.
  - Identify strengths and weaknesses of sources.
  - Suggest ways to improve the data.
- Full report is posted to HRSA's website:  
<http://bhpr.hrsa.gov/healthworkforce/reports/nursingandhomeaide.htm>.

## **WHAT IS THE PROBLEM?**

- Shortages of front-line workers serving the elderly, the chronically ill and the disabled.
  - Service reductions due to shortages.
  - Use of temporary workers at higher hourly rates.
- Shortages impact both quality of care and quality of life.
- Between 2000 and 2010, more than 1.2 million long-term care workers will be needed to fill new jobs and to replace those leaving the field.

## **WORKFORCE SHORTAGE ISSUES**

- Supply
  - Demanding work.
  - Jobs often not well designed or supervised.
  - Low pay.
  - Lack of career ladders.

- Demand
  - Aging of population.
  - More types of providers.
  - New technologies.

## **NEED FOR BETTER DATA**

- Workforce planning.
- Policy formulation.
- Patient safety.
- Quality improvement.
- Program evaluation.
- Consumer information.

## **APPROXIMATELY 120,000 ORGANIZATIONS USED LONG-TERM CARE PARAPROFESSIONALS IN 1998**

- Long-Term Care Providers include:
  - Nursing homes.
  - 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).
  - Assisted living facilities.

## **NINE SOURCES OF DATA**

- Bureau of Labor Statistics (BLS)
  - Occupational and Employment Statistics (OES).
  - Current Population Survey (CPS).
  - CPS March Supplement.
  - National Compensation Survey (NCS).
  - Employment Projections.
  - Survey of Occupational Injuries and Illnesses.
- OSCAR (CMS system).
- Decennial Census.
- State CNA registries.

## LIMITATIONS OF THE DATA

- Data exclusions
  - Lack of detail about states or counties.
  - Incomplete coverage of facilities and/or occupations.
- Inconsistencies in definitions.
  - Excessively broad categories.
- Self-reported and unaudited.
- Delays in availability.

## OPTIONS FOR THE FUTURE

- Upgrade CNA registries
  - Cover other providers in addition to nursing homes.
  - Add variables relevant to workforce planning
    - Demographics
    - Workload
  - Add other workers.
  - Coordinate with background checks.
  - Require annual workforce snapshots on a single day.
- Encourage compatible state-level systems
  - Facilitate sharing.
  - Provide bases for comparisons.
- Involve provider associations
  - They have additional information.
  - More and better data is positively correlated with better outcomes.

## IN CONCLUSION

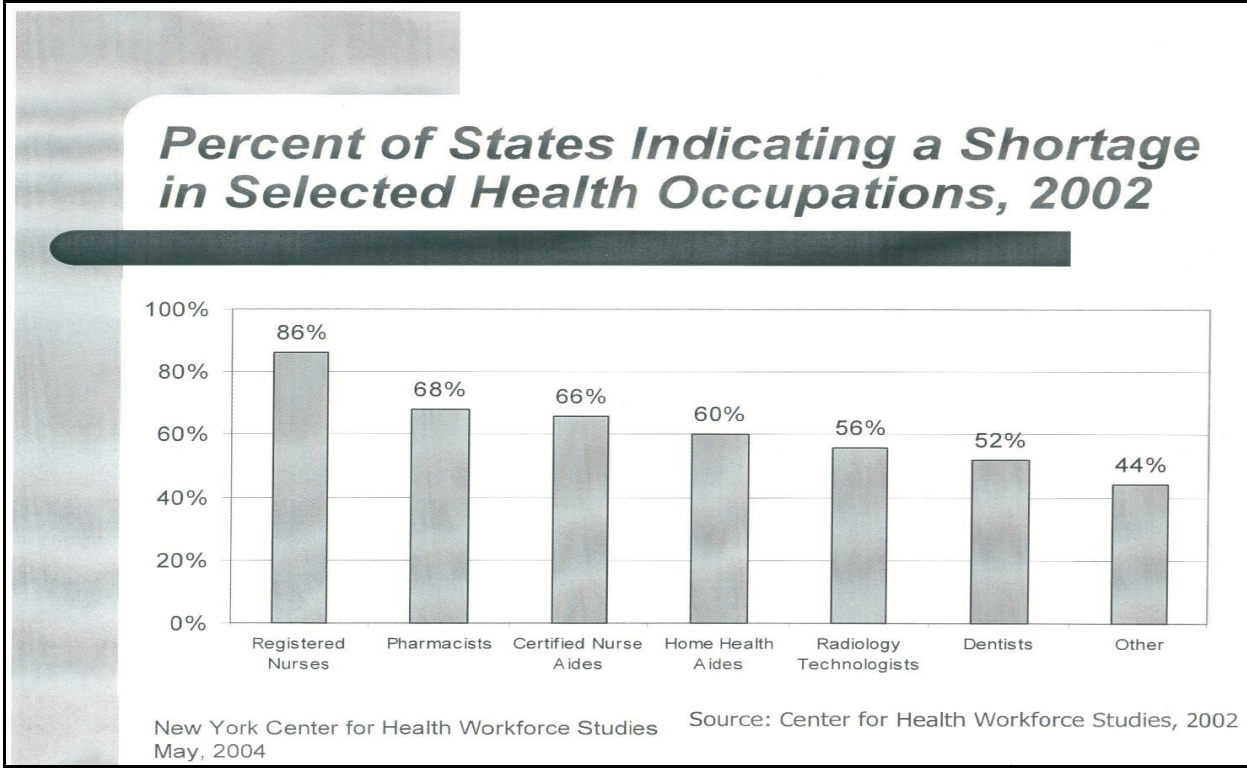
- Informed workforce planning is needed to:
  - Better understand current shortages.
  - Assess impact of present and future initiatives to balance supply and demand.
- Current data systems were limited in their ability to assist in such planning efforts.
- Better data on both providers and workers are needed by planners and policy makers.

<b>IMPACT OF THE AGING OF AMERICA ON THE HEALTH WORKFORCE</b>			
<b>Median Age</b>	<b>1989</b>	<b>1999</b>	<b>Change 1989-1999</b>
Dentists	40.7	44.0	+ 3.3
Dietitians	38.3	40.0	+ 1.7
Health records technologists	35.3	40.3	+ 5.0
Radiologic technicians	34.3	38.0	+ 3.7
Registered nurses	37.3	42.7	+ 5.4
Respiratory therapists	32.3	38.0	+ 5.7
Social workers	38.7	40.3	+ 1.7
Speech therapists	35.7	40.7	+ 5.0
Pharmacists	36.7	41.3	+ 4.6
Total civilian labor force	35.7	38.7	+ 3.0
SOURCE: Bureau of Labor Statistics, Current Population Survey - Annual Demographic Supplement, 1988-2000.			
NOTES: Figures presented are averages of three years' data. Civilian labor force only.			

<b>RECIPIENTS OF LTC IN THE U.S., 1995</b>			
<b>Age Group</b>	<b>Setting of Service</b>		<b>All Settings Combined</b>
	<b>Nursing Home</b>	<b>Home or Community</b>	
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, 1999.			

WORKERS BY INDUSTRY GROUP IN 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%

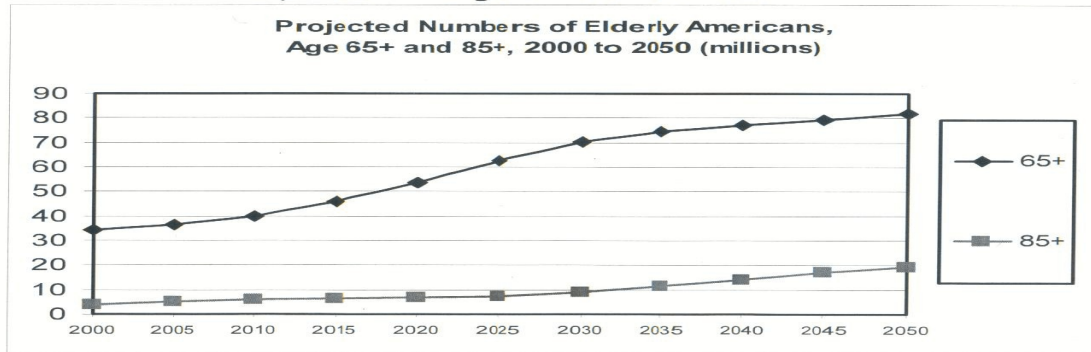
SOURCE: BLS Occupational Employment Survey.





## The Elderly Population in the US Will Grow Dramatically Over the Next 50 Years

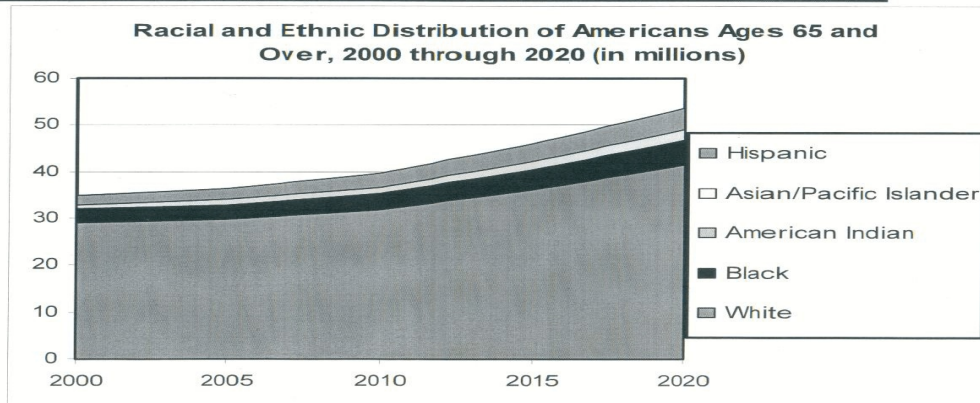
Baby Boomers begin to turn 65 in 2011.



New York Center for Health Workforce Studies  
May, 2004

Source: US Census

## The Elderly Population in the US Will Grow Increasingly Diverse Over the Next 20 Years

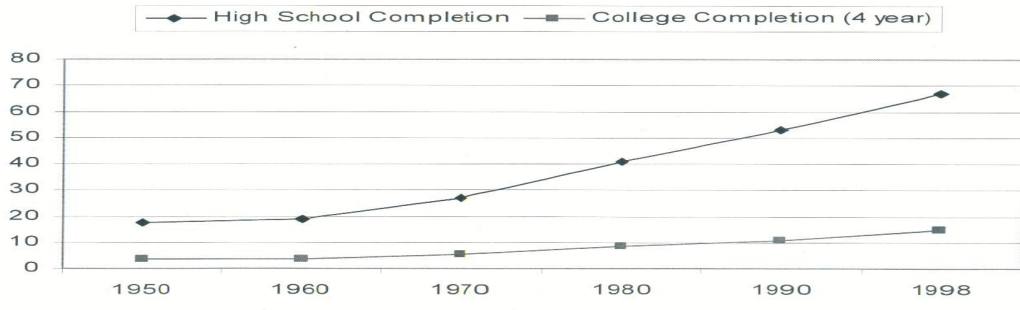


New York Center for Health Workforce Studies  
May, 2004

Source: US Census

## The Elderly Are Better Educated Than in the Past

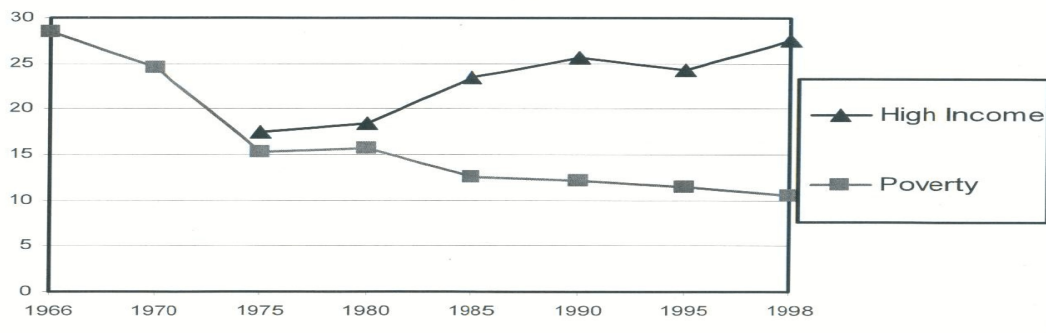
Percentage of the Population Age 65 and Older with High School Diploma and Bachelor's Degree or Higher, 1950 to 1998



Source: Federal Interagency Forum on Aging Related Statistics, 2000  
 New York Center for Health Workforce Studies  
 May, 2004

## The Elderly Are Less Likely to be Poor Than in the Past

Percent of Americans Age 65 and Older Living in Poverty or With High Income



Source: Federal Interagency Forum on Aging Related Statistics, 2000  
 New York Center for Health Workforce Studies  
 May, 2004

## Related Links

Other sections of this conference package include:

- ✓ Symposium Logistics [<http://aspe.hhs.gov/daltcp/reports/04cfpack.pdf>]
- ✓ Background Materials [<http://aspe.hhs.gov/daltcp/reports/04cfpk02.pdf>]

Additional papers written for the Office of the Assistant Secretary for Planning and Evaluation in conjunction with this conference include:

- ✓ Raynor, Charissa R.: ***Federal Workforce Development Programs: A New Opportunity for Recruiting and Retaining Direct Care Workers in the Long-Term Care Field*** (August 2003). [<http://aspe.hhs.gov/daltcp/reports/fedwfdp.htm>]
- ✓ ***Pathway to the Future: How Workforce Development and Quality Jobs Can Promote Quality Care--Symposium Summary*** (July 2004). [<http://aspe.hhs.gov/daltcp/reports/04cfpksum.htm>]
- ✓ Harris-Kojetin, Lauren, Debra Lipson, Jean Fielding, Kristen Kiefer and Robyn I. Stone: ***Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999-2003*** (May 2004). [<http://aspe.hhs.gov/daltcp/reports/insight.htm>]
- ✓ Fishman, Michael E., Burt Barnow, Asaph Glosser and Karen Gardiner: ***Recruiting and Retaining a Quality Paraprofessional Long-Term Care Workforce: Building Collaboratives with the Nation's Workforce Investment System*** (May 21, 2004). [<http://aspe.hhs.gov/daltcp/reports/natwis.htm>]