Leadership Council of Aging Organizations

THE DIRECT CARE WORKFORCE: A REPORT ON PRACTICES TO PROMOTE QUALITY LONG TERM CARE

Introduction

A quality long-term care system requires a well-trained, respected, and adequately compensated direct care workforce. [1] But providing quality care is threatened by the current high turnover and vacancy rates -- a condition caused by the poor public perception of long-term care and the reality of low wages and difficult working conditions. The result is a chronic shortage of qualified direct care workers in nursing facilities, assisted living facilities and home health agencies.[2]

Current workforce conditions and the difficulty of recruiting direct care workers will grow worse as the number of individuals needing long-term care increases. A recent report estimates that between 2000 and 2040, the number of older people needing home care will increase from 2.2 million to 5.3 million and the number residing in nursing homes will increase from 1.2 million to 2.7 million.[3] To meet this increased need, the number of direct care workers would need to increase by two percent a year, yet during this time period the working-age population is expected to increase by only 0.3% per year.[4]

LCAO Workforce Principles

Addressing the chronic shortage of direct care workers is an important element of creating a better long-term care system. We recognize the complexity of the issue and the need for specific workforce policies to vary depending on the model of care and the characteristics of a particular labor market. However, we believe that a coherent set of core principles that can be applied across the board is indispensable to promoting and shaping a much-needed national debate on a sustainable workforce. These principles fall into three categories and are as follows:

Staffing, Recruitment and Training

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[1] According to Paraprofessional Health Institute, direct-care workers include certified nursing assistants (CNA), nursing assistants, home health aides, home care aides, personal assistants, personal care attendants, and direct support professionals. These workers provide an estimated 70% to 80% of the paid hands-on long-term care and personal assistance received by Americans who are elderly, chronically ill, or living with disabilities. Although there is little doubt that the quality and quantity of care available to our nation's elderly and disabled will be effected by an impending shortage of geriatric and health care professionals broadly defined, this paper focuses primarily on policy issues surrounding the direct care workforce. For more information on direct care workers, see http://www.directcareclearinghouse.org/i_jobs_o.jsp

[2] Institute for the Future of Aging Services, *The Long-Term Care Workforce: Can the Crisis be Fixed?* paper prepared for the National Commission for Quality Long-Term Care, 2007, 9 (hereinafter "*IFAS Report*").

[3] Johnson, R.W., Toohey, D., and Wiener, J.M., *Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions,* The Urban Institute, May 2007, v.

[4] Friedland, R., *Caregivers and Long-Term Care Needs in the 21st Century: Will Public Policy Meet the Challenge?* Georgetown University Long Term Care Financing Project, 2004, 8.

- Nursing homes and other institutional settings should employ sufficient nursing staff (nurses and nurse aides) to provide quality of care and life to residents, create manageable workloads for staff, and increase staff satisfaction and retention. The precise level of nursing staff required to do so may vary depending on the population of the facility and the acuity levels of residents. However, there are identified minimum staffing thresholds below which residents are at significantly greater risk of harm. [5]
- Employers seeking to reduce turnover and increase retention should adopt practices that enhance worker satisfaction, starting with recruitment efforts that better identify the most promising candidates for work in long-term care and continuing with intensive support systems in the early days of employment.
- Direct care workers need stronger initial training standards that include caring for residents and clients with special needs such as developmental disabilities, behavioral health conditions and dementia.
- Employers should provide continuing education that offers opportunities for career advancement and skill development. Meaningful opportunities for advanced learning will improve the quality care and position direct care work as a stepping stone to a career in the caring professions.

Compensation

- Employers should provide family-sustaining wages, affordable health insurance and other benefits sufficient to attract needed long-term care workers. Federal and state efforts to expand health care coverage should include policies specifically designed to provide affordable coverage for long-term care workers.
- Federal and state payment systems for long-term care services should include incentives for providers to increase wages, improve the benefits paid to their workers and staff at appropriate levels as determined by government and academic experts.
- Long-term care employers should follow the lead of employers in other industries that provide additional benefits to help employees meet their financial and family obligations.

Work Environment

- Long-term care workers should be safe on their jobs. Employers have an obligation to minimize their risk of illness or injury, and the federal and state governments have the responsibility to adopt and enforce regulations that protect long-term care workers. These protections should include mandatory ergonomic standards, drafted by the Occupational Safety and Health Administration (OSHA) with input from stakeholders. Workers should also be able to report hazardous conditions without fear of reprisal and should know that they will receive a timely and appropriate response from management. When accidents or near-accidents are reported, management should conduct a thorough investigation. Causes should be identified and programs for prevention created or improved.

[5] Similar concerns exist surrounding the serious shortage of geriatric physicians and social workers who provide essential support and direct care interventions to ensure uncompromised quality of care.

- Culture change, the movement to transform institutional care through client-centered practices, should be encouraged across long-term care settings as a way to improve quality of care and quality of life for the consumer, empower the long-term care workforce, enhance job satisfaction, and reduce staff turnover.
- Direct care workers deserve respect at work, whether in a private home or an institutional setting. Supervisors – generally nurses – tend to set the tone for the treatment of direct care workers and should receive enhanced training to enhance their ability to better manage a diverse workforce.

These are principles that members of LCAO support. Some of these principles and the related examples apply to direct care workers in one setting (either home care or nursing homes), but others are broader (for example, job safety and injury prevention). What unites them is the underlying belief that creating and sustaining a quality direct care workforce can improve the quality of care and quality of life for individuals receiving long-term care.

Long-term care systems are changing. States are seeking ways to rebalance the allocation of resources in state Medicaid programs to expand their home- and community-based services. These are positive developments since they not only expand the workforce but also provide consumers with more autonomy and choice over how and by whom their needs are met. LCAO also supports appropriate safeguards to ensure continued access to needed care, including preservation of basic entitlement and the establishment of standards for quality and safety.

We are also mindful of the serious shortage of health and behavioral health care professionals, such as nurses, geriatricians, social workers, physical and occupational therapists, and dentists. Although these principles and the accompanying report was prepared with direct care workers in mind, we recognize that more attention needs to be given both to the causes of this broader shortage and effective strategies for attracting, retaining and retraining health and behavioral health professionals in the geriatric field in general and in long-term care in particular. Finally, although there has been little study or discussion of the workforce in assisted living, a fast growing segment of long-term care, it is likely that many of the policies and recommendations in this section of the report would also apply to the assisted living workforce.

STAFFING, RECRUITMENT AND TRAINING

A. The Need for Adequate Staffing Levels in Nursing Homes

It is by now well-established that there is a direct relationship between nurse staffing levels and the quality of care in nursing homes. A congressionally authorized study of the appropriateness of nurse staffing ratios in nursing homes, released by the Department of Health and Human Services in 2001 found that the minimum number of hours per day of care below which adverse consequences begin to happen is 4.1 hours a day (nurse staff hours are defined as the combined hours of care provided by RNs, LPN/LVNs and nurse aides).[6] These minimum staffing levels

[6] Abt Associates, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Phase II Final Report, Winter 2001.

have been confirmed by academic studies and a panel of long-term care professionals assembled by the Hartford Institute for Geriatric Nursing,[7] but few nursing homes meet them. The national average for hours of nursing home care in 2004 was only 3.6 hours per resident per day, based on information nursing homes report to the federal government about their staffing levels. Current federal staffing requirements are minimal: (1) a registered nurse at least 8 consecutive hours a day, 7 days a week; (2) 24-hour licensed (RN or LPN/LVN) nursing as necessary to meet the licensed nursing needs of residents; and (3) enough total nursing staff to meet the overall nursing needs of residents. Most states and the District of Columbia have adopted minimum staffing standards that may be stricter than federal standards, but only three states (Florida, Oklahoma and Maine) require staffing levels comparable to the recommended minimum.

Decreasing the workload on nursing staff has other benefits: higher job satisfaction, stronger personal relationships with residents (often cited by residents and staff as the most important aspect of caregiving), higher quality care in all the services necessary to make residents comfortable, and the prevention of otherwise avoidable medical problems. This in turn should reduce turnover, encourage retention and reduces the use of temporary staff services that can compromise quality and harm the morale among permanent staff.

Principle

Nursing homes and other institutional settings should employ sufficient nursing staff (nurses and nurse aides) to provide quality of care and life to its residents, create manageable workloads for staff, and increase staff satisfaction and retention. The precise staffing levels required to do so may vary depending on the population of the facility and the acuity levels of residents. However, there are identified minimum staffing thresholds below which residents are at significantly greater risk of harm.

Examples

Requiring Minimum Staffing Levels and Increasing Medicaid Reimbursement to Achieve Increased Staff.

In 1999, Florida appropriated additional funding "for reimbursing nursing facilities for the cost of hiring additional certified nursing assistants and licensed nurses or for the cost of salary or benefit enhancements to retain such staff in these specific classes" (H.R. 1971). In 2001, Florida enacted a second bill that contained multiple reforms aimed at quality improvement, including a one time increase in RN/LPN staffing and a three step, 70% increase in CNA staffing over a three year period. The state funded the second increase in CNA staffing in 2003, and the final increase was funded in 2006. The Commonwealth Fund is sponsoring a study of the impact of this legislation.

Providing the Public, Policymakers and Regulators Accurate Information about Staffing Levels in Nursing Homes.

In its 2007 Action Plan for Further Improvement of Nursing Home Quality, CMS said it would initiate a process for electronic collection and reporting of nurse staffing data and quality measures by the fall of 2007.

[7] Harrington, C., et al., "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," *The Gerontologist*, Vol. 40, Issue 15-16, 2000.

Better Compensation and Benefits, Enhanced Training and Promotional Opportunities, and an Improved Work Environment.
In some facilities, staffing levels are low because of the difficulty of recruiting and retaining workers. The improvements in training, compensation and the work environment that are recommended in this report can all contribute to making work in long-term care more attractive.

B. Reducing Staff Turnover

High turnover rates plague long-term care occupations. According to 2006 data, annual nursing staff turnover in the United States is approximately 50-75%, with a majority of workers leaving within the first month of employment.[8] Without a stable long-term care workforce, continuity of care is lost and staff-client relationships eroded. In short, there can be no quality care if the workplace has a revolving door.[9]

Principle

Employers seeking to reduce turnover and increase retention should adopt practices that enhance worker satisfaction, starting with recruitment efforts that better identify the most promising candidates for work in long-term care and continuing with intensive support systems in the early days of employment.

Examples

*Mercy Health Partners (2000)***.**
A model program was instituted at four facilities in the network of Mercy Health Partners in southwest Ohio to reduce staff turnover and improve quality. Early data showed Mercy that its staff orientation failures were a big contributor to high turnover and that most CNAs decided to leave within three days. Mercy prepared new recruitment materials that provide a more realistic picture of the job. During staff orientation, a drill on rules and policies was replaced with Mercy's six core values – serve, love, care, be compassionate, be with people, and help others – which put the emphasis on quality care. Mercy also required supervisors to contact new CNAs at least three times during their first three days on the job, and it created a buddy system that paired a new employee with an experienced CNA. In the first year of the program, the four Mercy facilities were able to *eliminate* use of temporary staff and saw an average decline in turnover from 32% to 25%.

*Cooperative Home Care Associates***.**
CHCA is a worker-owned cooperative of over 500 home care workers in the South Bronx, New York, that believes in "quality care through quality jobs." In addition to higher than average wages and benefits, CHCA has adopted numerous other practices to reduce turnover. First, the co-op carefully screens applicants. Second, new hires receive twice the entry-level training of most CNAs and are immediately swept up in the "community" atmosphere of the agency, which emphasizes mutual respect and support for employees at all levels. CHCA's philosophy has paid

[8] Campaign for Advancing Excellence in America's Nursing Homes, 2006, www.nhqualitycampaign.org/files/Goals%20QA9.18.06%20FINAL,%20%20LH.pdf.
[9] Eaton, S.E., *Frontline Caregivers in Nursing Facilities*, Public Policy and Aging Report, 2003 (hereinafter "Eaton Report").

off by limiting its worker turnover to less than 20% a year, compared with an industry average of 40 to 60 percent.[10]

*Cornell Institute for Translational Research on Aging***.**
The institute conducted a study under Better Jobs Better Care that trained "retention specialists" at 16 nursing homes in New York and Connecticut. Over a year, the study compared staff-turnover rates between these facilities and 16 others that did not employ retention specialists. In the first six months, the average turnover rate for the first group declined from 21% to 17%, while the control group saw no change at all. After 12 months, the first group saw an even more dramatic turnover decline to 11%, with no change for the control group. Interviews with CNAs showed that those who worked in facilities with retention specialists perceived a better quality of care than CNAs at other worksites and felt more appreciated by their employers.[11]

C. Raising the Bar for Training Standards Without Closing the Door on Recruitment
Direct care workers typically receive little, and in some cases no, basic training. Federal law requires certified nurse aides in nursing homes to complete 75 hours of basic training and obtain certification. With the exception of Medicare home health aides, there is no federal training requirement for direct care workers in home and community based settings. Some states have passed laws mandating higher standards for nursing assistants and setting training standards for home and community based workers. National and state research and policy analyses consistently suggest that inadequate basic training contributes to high turnover among direct care workers.[12] Turnover usually occurs within the first few months of employment – an indication that the job did not meet the worker's expectations, or that the worker was inadequately prepared to meet job expectations, or both.

Nearly every research and policy report prepared on this workforce recommends strengthening training as a way to improve recruitment and retention, especially for home care and community based workers who typically receive less than half the training required for nursing home workers, even though they increasingly care for people who are eligible for nursing home care.[13] A study by the Margaret Blenker Research Institute under a Better Jobs Better Care grant found that while more training for workers was important, the type of training provided was just as important. Direct care workers wanted more hands-on care, peer mentoring, and a greater emphasis on communications and care of residents or clients with special needs. The research also found that 52% of workers cited lack of staff coverage on their unit as a barrier to attending in-service training.[14]

There is a fundamental need, and public policy imperative, to set basic training standards at the level needed to prepare workers for the realities they will face on the job, thus ensuring quality care and access to care.

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[10] Additional information is available at CHCA's website, www.chcany.org.
[11] Van Ryzin, J., "Workplace Interventions for Retention, Quality and Performance," *futureAge*, March/April 2007.
[12] *IFAS Report; Who Will Care for Us; Federal Workforce Development; Future Supply of LTC Workers;* and *Out of the Shadows.*
[13] Ibid.
[14] Ejaz, F., and Noelker, L., *Tailored and Ongoing Training Can Improve Job Satisfaction*, Better Jobs, Better Care, Institute for the Future of Aging Services, 2006.

Principle

Direct care workers need stronger initial training standards that include caring for residents and clients with special needs such as developmental disabilities, behavioral health conditions and dementia.

Examples

Creating Programs that Support Quality Training Standards.

- Cooperative Care Home Associates in the Bronx is widely recognized for its success in using pedagogical approaches that are adult-learner centered and culturally and linguistically appropriate. Too often, training is disconnected from the experience workers will have on the job, particularly in the areas of dementia, communication, and hands-on skills such as transferring. In addition, most direct care workers are adult learners and they are increasingly foreign born.
- Some states, such as Washington, have addressed the situation of workers who have informal caregiving experience and believe they already have the skills, knowledge, and abilities needed for direct care work, by offering a challenge test which if passed waives basic training requirements.
- Distance learning technologies, peer mentoring programs, partnerships with community colleges, and other approaches that are being experimented with in states such as South Dakota offer promise, particularly in rural areas which present real challenges to any training delivery system.
- The peer mentoring program developed by the Iowa Caregivers Association has been successful in reducing direct care turnover in long-term care organizations. Support for the mentors goes beyond the initial orientation and training, with mentors generally attending weekly meetings, reinforcing their learning and building teamwork.[15]
- To ensure that long-term care staff can better respond to residents' needs, the Alzheimer's Association joined with leaders in dementia care to develop evidence-based dementia care practice recommendations. Phase 1 of these recommendations focuses on the basics of good dementia care, food and fluid consumption, pain management and social engagement. Phase 2 covers wandering, falls and physical restraints. Phase 3 covers end-of-life care practices and issues. To date, more than 30 leading health and senior care organizations have expressed their support and acceptance of one or more phases of the Dementia Care Practice Recommendations. Training programs are available to implement the recommendations.

D. Creating Career Advancement Opportunities and Career Lattices for Direct Care Workers

Direct care jobs in long-term care are often viewed as "dead end" jobs – offering little if any opportunity for significant skill or wage advancement. Research and policy experts consistently cite this as a problem of both recruitment and retention.[16] Job seekers, including youth, may not

[15] Hayunga, M., "Training That Really Works," futureAge, pp 34-39 (March/April 2007).

[16] *IFAS Report*; Stone, R.I., and Wiener J.M, *Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis*, Institute for the Future of Aging Services and the Urban Institute, 2001 (hereinafter "*Who Will Care for Us*"; Raynor, C.R., *Federal Workforce Development: A New Opportunity for Long-Term Care Workers*, Institute on the Future of Aging Services, 2003 (hereinafter "*Federal Workforce Development*"); *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation*, Report to Congress by the Department of Health and

consider direct care jobs absent a better articulated career pathway, and many incumbent workers leave their jobs for the same reason.

By repositioning direct care jobs as a stepping stone to a career in the "caring professions," industry can appeal to untapped labor pools and broaden the universe of job seekers who consider this work. Further, incumbent workers are likely to be retained longer as they complete training and advance up the career ladder. More broadly, the career ladder model can alleviate shortages in nursing, social work, and other high demand professions in long-term care and other health care sectors. Career lattices should be available for direct care workers who want to continue providing direct care and can increase their skill and possible pay. [17]

It is important to note that many direct care workers are committed to their jobs as a career and are not interested in a career ladder. For these workers, developing a career lattice would be more appropriate, along with providing a respectful work environment with better pay for all workers.

Principle

Employers should provide continuing education that offers opportunities for career advancement and skill development. Meaningful opportunities for advanced learning will improve the quality care and position direct care work as a stepping stone to a career in the caring professions.

Examples

Promoting Meaningful Career Ladder Design and Development.

While there are many different ways to design career ladder programs, in the most successful, each "step" in the career ladder builds on previous training and the program provides significant wage and skill progression that prepares workers for jobs that are in high demand. Most career ladder programs either pay directly for participants' training or leverage external resources to support the cost of training. In addition, some career ladder programs provide paid training and wrap-around services such as transportation and day care for participants – important benefits for workers who would otherwise not be able to afford the opportunity costs of participating.

Building Partnerships to Finance Career Ladders and Lattices.

The resources needed to fund a career ladder can be significant. However, investment in training is an effective tool in lowering vacancy and turnover rates and may pay for itself by considerably reducing the direct and indirect costs associated with workforce instability. For this reason, employers may choose to fund all or a portion of the career ladder. Training funds that are

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Human Services and the Department of Labor, 2003 (hereinafter "Future Supply of LTC Workers"); and Miller, E.A., and Mor, V., *Out of the Shadows: Envisioning a Brighter Future for Long-Term Care in America*, report for the National Commission for Quality Long-Term Care, 2006 (hereinafter "*Out of the Shadows*").

[17] We use the word career "lattice" rather than career "ladder," because we recognize that careers do not always follow straight lines. Workers make lateral career moves in and out of occupations, as well as vertical moves. They enter the career lattice at the point that best reflects their background and skills. The lattice design also reinforces the option of drawing candidates to nursing from other branches of healthcare as well as from other fields overlooked as sources of staff. See *How Career Lattices Help Solve the Nursing and Other Workforce Shortages in Health Care – A Guide for Workforce Investment Boards, One-Stop Career Centers, Healthcare Employers, Industry Alliances, and Higher Education Providers*, Council for Adult and Experiential Learning, June 2005.

jointly financed with unions can be designed as single employer or multi-employer partnerships that spread costs and provide a way to leverage local, state, and federal resources (for example, the Local SEIU1199 Employment, Training and Job Security Program and AFSCME's District 1199C Training and Upgrading Fund).[18] In addition, both state workforce development board funding (for example, the Tacoma/Pierce County Workforce Development Council in Washington State) and national and state resources that support worker education and advancement can be leveraged as part of a career ladder. One important example of a state-funded effort is the Extended Care Career Ladder Initiative, a program that was created by the Massachusetts state legislature that supports career ladder and lattice programs in nursing homes and home care agencies across the state. Through strong advocacy by a statewide multi-stakeholder coalition, this program is now a line item in the state budget. Finally, because career ladders often prepare participants to work not only in long-term care but also in hospitals and other health care settings, partnerships across sectors of the health care industry make sense from both a financing and delivery standpoint.[19]

Establishing Certification for Home and Community Based Workers.
Direct care workers in nursing homes (certified nursing assistants or CNAs) have an industry recognized certification, making it easy to build career pathways that articulate this certification into community college and other programs. In contrast, home and community based workers generally have no similar certification requirement. Without industry recognized certification, it is nearly impossible for workers to get any credit for frontline training. In fact, most home care workers cannot even get a job as a nursing assistant without "starting all over." Recognizing these needs and the need for uniform basic training, there are efforts at the state level to develop an industry wide certification for home and community based workers that will allow for career ladder development and improve workforce mobility. Establishing industry certification would be a first step toward building career ladders for this workforce.

Examples
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[18] Information about the Local 1199SEIU program is available at www.1199etjsp.org.
[19] Office of the Inspector General, Department of Health and Human Services, *Nurse Aide Training*, 2002.

the Local SEIU1199 Employment, Training and Job Security Program and AFSCME's District 1199C Training and Upgrading Fund).[20] In addition, both state workforce development board funding (for example, the Tacoma/Pierce County Workforce Development Council in Washington State) and national and state resources that support worker education and advancement can be leveraged as part of a career ladder. One important example of a state-funded effort is the Extended Care Career Ladder Initiative, a program that was created by the Massachusetts state legislature that supports career ladder and lattice programs in nursing homes and home care agencies across the state. Through strong advocacy by a statewide multi-stakeholder coalition, this program is now a line item in the state budget. Finally, because career ladders often prepare participants to work not only in long-term care but also in hospitals and other health care settings, partnerships across sectors of the health care industry make sense from both a financing and delivery standpoint.[21]

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COMPENSATION

A. Wages and Health Insurance

The degree to which the current shortage of long-term care workers is caused by low compensation rates cannot be overemphasized. The decision to leave the field is a rational economic response to the current market for long-term care workers: the median hourly wage for direct care workers in 2003 was $9.20, and because many work only part-time, in 2002 the median annual income for nursing home aides was only $13,287 and for home care aides was only $11,060 (both below the poverty line for a family of four).[22] Improving the economic circumstances of direct care workers is crucial to developing a better long-term care system.

It is ironic that many of the workers who provide hands-on care for some of the frailest and most vulnerable members of our society do not themselves have adequate access to health care. A GAO report in 2001 found that 25 percent of nurse aides in nursing homes had no health care coverage, and of those who did, 10 percent received it through Medicaid.[23] The importance of

[20] Information about the Local 1199SEIU program is available at www.1199etjsp.org.
[21] Office of the Inspector General, Department of Health and Human Services, *Nurse Aide Training*, 2002.
[22] *Out of the Shadows*, 61-62.
[23] *Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern,* U.S. General Accounting Office, May 2001.

health insurance in attracting and retaining direct care workers is demonstrated by survey data showing that the availability of health insurance benefits for part-time workers is the single most important factor, after their commitment to the consumer, in attracting and maintaining workers.[24]

There is also a strong business case for investing in enhanced wages and benefits and other job retention strategies. The high rate of turnover and the difficulty of retaining direct care workers result in substantial direct and indirect costs to providers. For example, the direct cost of replacing a nurse aide has been estimated at $2,500.[25] Many facilities have annual turnover rates for aides as high as 100%, which means that reducing turnover by as little as 20% can result in substantial savings. Providers who invest in wage and benefit increases are likely to find that these improvements pay for themselves through reduced turnover costs.[26]

Principle

Employers should provide family-sustaining wages, affordable health insurance and other benefits sufficient to attract needed long-term care workers. Federal and state efforts to expand health care coverage should include policies specifically designed to provide affordable coverage for long-term care workers.

Examples

Union Representation As An Effective Way To Increase Wages And Improve Benefits.

The use of collective bargaining can be an effective way to improve wages and benefits for direct care workers in a variety of settings. For example, in home care, the introduction of collective bargaining to California's In-Home Supportive Services (IHSS) program had a dramatic effect on wages and health benefits – more than doubling the wages of home care workers, from $5.00 an hour in 1996 to $10.00 per hour in 2002.[27] Similar though less dramatic results have occurred with home care workers in Oregon and Washington State.[28]

Healthcare for Montanans Who Provide Healthcare.

This year Montana enacted legislation that will provide increased Medicaid reimbursements to home care agencies that purchase health insurance for a significant number of their direct care employees. To be eligible for reimbursement, the health insurance coverage must meet a set of quality criteria established by the state. The state has appropriated $2.6 million dollars to pay for the increased reimbursements; when combined with federal matching funds, this funding is expected to provide coverage for 1,000 currently uninsured home care workers. The

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[24] Howes, C., *For Love, Money or Flexibility: Why People Choose to Work in Consumer-Directed Home Care*, presentation at the Academy Health meetings, June 26, 2006.

[25] Seavey, D., *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care, Institute for the Future of Aging Services (2004) (hereinafter "The Cost of Frontline Turnover").

[26] Farrell, D., and Dawson, S., "The Business Case for Investing in Staff Retention: Can You Afford Not To?" *futureAge,* March/April 2007, 8-11.

[27] *IFAS Report,* 7, citing Howes, C., *The Impact of a Large Wage Increase on the Workforce Stability of IHSS Home Care Workers in San Francisco*, Better Jobs Better Care, 2002. See the description of the public authority model in Examples, below.

[28] For additional information on the use of collective bargaining to increase direct care wages and/or benefits, see Seavey, D. and Salter, V., *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefitsfor Personal Care Assistants*, AARP Public Policy Institute, October 2006.

Paraprofessional Healthcare Institute's Health Care for Health Care Workers Initiative hopes to replicate this model in other states.[29]

B. Incentives for Providers to Increase Wages and Improve Benefits

Reimbursement systems, whether by design or omission, can affect compensation for caregivers as well as staffing levels. Facility specific reimbursement systems that fail to distinguish direct or indirect care costs from other facility costs and that reimburse all cost centers up to the same ceiling can create a strong disincentive for higher wages or higher staffing. From a workforce point of view, it is certainly more desirable to have a reimbursement system that devotes a higher proportion of funding to wages and staffing.

By contrast, poorly designed reimbursement systems can create financial barriers for improvements in staffing by capping or otherwise limiting payments for direct care costs at comparatively low levels. It is important that government regulation and reimbursement systems provide incentives to increase wages, raise staffing levels and improve benefits for long-term care workers.

Principle

Federal and state payment systems for long-term care services should include incentives for providers to increase wages, improve the benefits paid to their workers and staff at appropriate levels as determined by government and academic experts.

Examples

Pay For Performance Systems that Incentivize Improvements in Working Conditions.

In theory, pay for performance systems can be designed to provide both direct and indirect incentives for improved working conditions. A direct incentive would use the amount of compensation as a quality measure and an indirect incentive would use retention rates as one of the quality measures that determine the pay for performance reward. Even a pay for performance system that does not explicitly include these factors may provide an incentive for workforce improvements because high quality providers are likely to have more staff, increased compensation and/or a better work environment. However, it is important that the system not penalize residents and workers and worsen conditions at poor performing facilities (for example, pay for performance rewards should be *in addition to* the established reimbursement rate and facilities can be rewarded both for excellence and for significant improvement, as in the Medicare skilled nursing facility demonstration project).

Wage Pass-Through Legislation.

To date, 26 states have experimented with increased Medicaid reimbursements directed to wage and benefit improvements for direct care workers. Wage pass-throughs are generally not a sustainable or effective way of increasing the compensation of direct care workers, since wage increases are not built into the rate structure and most legislation lacks effective accountability and enforcement procedures to ensure that the increased funding is used for its intended purpose.[30] However, with appropriate reforms, this may be an effective way to increase wages and improve benefits.

[29] Email newsletter from the National Clearinghouse on the Direct Care Workforce dated June 11, 2007.
[30] *Out of the Shadows*, 63; and *IFAS Report*, 14.

C. Other Elements of the Compensation Package

While adequate wages and health care coverage are clearly the most important employee benefits for most direct care workers, there are other benefits that can enhance job satisfaction and improve recruiting and retention rates. Direct care workers are no different from other workers in the benefits they want and the support they need to help balance their work and personal lives. In the best workplaces, an employer recognizes these needs and finds ways to respond, thereby improving the odds of maintaining a satisfied staff that will remain on the job. Providing additional benefits makes employees feel valued and rewarded for good work.

Principle

Long-term care employers should follow the lead of employers in other industries that provide additional benefits to help employees meet their financial and family obligations.

Examples

Employers in Many Industries Supplement Wages and Health Insurance with these Valuable Benefits:

- Signing, retention and referral bonuses.
- Subsidized child care and transportation.
- Paid sick days and vacation days.
- Retirement benefits (pensions, 401(k) plans, etc.).
- Tuition assistance.
- Paid registration fees for work-related conferences and stress-reduction classes.
- Workplace savings plans.
- Classes in English as a second language.

WORK ENVIRONMENT

Recent research has pointed to the importance of work environment in recruiting and retaining direct care workers.[31] Surveys show that most workers want a workplace atmosphere of respect, where responsibilities are clear and their skills and efforts are appreciated. Manageable workloads and enlightened supervisory practices contribute greatly to workers' job satisfaction and residents' quality of life, whether they are in an institution or in home and community-based settings.

Long-term care organizations can develop a respectful workplace environment by doing the following:

- Take an inventory of the organization's management style and its relationship with its staff.
- Listen to what workers say about "respect" and provide skills training to supervisors that will enhance their understanding.
- Review existing policies and practices and make changes as needed to ensure that workers feel more respected, valued and heard.

[31] *Respectful Relationships: The Heart of Better Jobs Better Care,* Issue Brief No. 7, Better Jobs, Better Care, Institute for the Future of Aging Services, April 2007 (hereinafter "Issue Brief No. 7").

- See "maximizing human potential" as an important part of the organization's mission.
- Try to understand the needs of non-English speakers and adopt policies to address those needs
- Management should never see this job as complete. The organization must constantly re-assess the workplace environment and try to improve it, for the benefit of the entire staff and the people they serve.[32]

A. Job Safety and Injury Prevention

As a group, nurse aides have consistently ranked among the top job categories for work-related injuries and illnesses. Over the ten year period from 1995 to 2004, the Bureau of Labor Statistics cited nearly 800,000 incidents in which nursing, psychiatric and home health aides became sick or injured on the job and had to take days away from work. One in ten nursing home workers is injured annually – making the work more difficult and demanding than many positions in manufacturing and construction.[33]

Work in nursing homes and in home care, particularly the work of aides, involves constant transferring, lifting, moving and repositioning of patients. Not surprisingly, this places enormous strain on the back, neck and shoulders. As a result, nurse aides suffer more musculoskeletal injuries resulting in lost workdays than any other occupation. High employee turnover and absenteeism due to musculoskeletal injuries significantly compromises the quality of, and continuity of care.

Long-term care workers also lead all occupations as victims of on-the-job assaults, with a rate of 38 per 10,000 nonfatal assaults among nursing and personal care facility workers, compared with a rate of 3 per 10,000 for all private sector workers. Nursing aides and orderlies also suffered the highest proportion (27 percent) of nonfatal workplace assaults resulting in lost workdays, compared to 7 percent for police and corrections officers.

Of course it is important to ensure a safe care environment for those receiving long-term care. It is the moral and financial responsibility of long-term care employers to check appropriate registries and to conduct criminal background checks on potential employees before hiring them to help ensure that individuals with criminal convictions for relevant crimes or histories of abuse are not hired. Worker screening must include appropriate opportunities for workers to appeal any such findings.

Finally, long-term care workers are at risk of a host of blood borne and airborne infectious diseases from hepatitis to HIV to tuberculosis and pandemic flu. The OSHA blood borne pathogens standard requires that workers with potential exposure to blood and bodily fluids receive annual training and equipment to protect them from blood borne disease exposure. As a result of the OHSA requirement that workers be offered free provision of the hepatitis B vaccine, hepatitis B infection rates among healthcare workers have plummeted from more than 17,000 to less than 400 per year. Still, protections against other contagious diseases are largely lacking.

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[32] Issue Brief No. 7, 12-13.

[33] U.S. Department of Labor, Bureau of Labor Statistics, Occupational injury and illness industry data for 2004. Actual rate of injuries per 100 workers in nursing and personal care facilities is 9.7.

Principle

Long-term care workers should be safe on their jobs. Employers have an obligation to minimize their risk of illness or injury, and the federal and state governments have the responsibility to adopt and enforce regulations that protect long-term care workers. These protections should include mandatory ergonomic standards, drafted by OSHA with input from stakeholders. Workers should also be able to report hazardous conditions without fear of reprisal and should know that they will receive a timely and appropriate response from management. When accidents or near-accidents are reported, management should conduct a thorough investigation. Causes should be identified and programs for prevention created or improved.

Examples

Workplace Safety Committees.

Safety and health committees tasked with identifying and analyzing hazards in the workforce can play an important role in reducing injuries and work-acquired illnesses. Committees should include representatives of all segments of the workforce, including rank and file employees (aides, housekeeping workers, food service workers, etc.), who are often in the best position to identify problems and hazards, as well as long-term care consumers. Committees are effective ways to allow workers to report hazardous conditions without fear of reprisal and with the knowledge that their information will receive a timely and appropriate response from management.

Injury Prevention Programs.

Lifting equipment can prevent many back injuries, as can proper training in transferring and repositioning patients. Providers have found that ergonomic programs that incorporate training and equipment can generate substantial savings by reducing injuries and lowering workers compensation premiums. These programs also can make residents and clients feel more secure and result in fewer skin tears, a potentially life threatening condition, but it is important that consumer concerns are addressed when programs are implemented.

Illness Reduction Programs.

While state laws and regulations are spotty, all long-term care workers should be provided education about the benefits of free seasonal flu vaccines, which should be offered every year. If workers are at risk of encountering tuberculosis or other airborne biological threats, the OHSA respirator standard requires initial and annual fit testing of the appropriate respirators for protection, along with training in their use. Planning and training for a potential outbreak of pandemic flu is also important.

Violence and Assault Reduction Programs.

Assault against workers can be prevented by adequate staffing and by training in how to de-escalate potentially violent encounters. OSHA has issued guidelines on establishing a comprehensive violence prevention program that includes the following elements: (1) a visible, high level management commitment to violence prevention; (2) meaningful employee involvement in policy development, such as through joint management and worker committees involved in the overall program implementation; (3) worksite analysis, including regular walk through surveys of all patient care areas and the collection and review of all reports of worker assault; (4) hazard prevention and control including alarm systems and other security measures;

and (5) training and education.[34] Workers need training in understanding and dealing with behaviors of residents who have dementia that may include aggressive actions and inappropriate language.

Reasonable Schedules.
Direct care workers should not be required to consistently work overtime hours – a situation that increases a worker's chance for injury. Overtime should be optional. This may mean changes in staffing so that unreasonable demands are not placed on individual workers.

B. Culture Change
Culture change, often referred to as resident-centered care, clearly has enormous benefits for nursing home residents. But it can also result in a profound transformation in the work environment. Innovative programs, such as the Eden Alternative and Wellspring, humanize facilities by making them more home-like. These programs encourage residents to make their own decisions and see nurse aides as the link between client and management. They believe that if the workforce does not function adequately, the facility cannot function as designed. Nurse aides are considered essential to maintaining quality care and to making the nursing home a better place to live.

Low CNA retention rates are often the result of management practices that seem to devalue direct care work and create a sense of powerlessness. Brandeis University, under a grant from Better Jobs Better Care, found that the management philosophy of 18 nursing facilities was of critical importance to the job satisfaction of direct care workers and that that philosophy was translated to the workers through frontline supervisors. Workers who felt their supervisors trusted their knowledge of resident care and who felt they had control over their work were more likely to express a sense of responsibility toward the residents they cared for and experienced more job satisfaction.[35]

Proponents of the culture change movement recognize that culture change will not produce the desired results unless management finds ways to empower the workforce, for example, by setting up non-hierarchical work teams and adopting self-scheduling. Culture change should not be just another management model imposed from the top down. A key feature of culture change is working with staff and their elected representatives to adopt practices like consistent assignment, where CNAs work with the same residents on a regular basis. This enables CNAs to develop close relationships with residents and become experts in the residents' needs, desires and preferences. Consistent assignment has been shown to significantly increase job satisfaction and create personal relationships between direct care workers and residents that improve the quality of life and care for residents.

Consumer-directed (CD) care – also called self-direction – represents an attempt to take many of same principles found in culture change and apply them to home and community based care. It

[34] OSHA's *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers* are available at www.osha.gov/Publications/OSHA3148/osha3148.html.
[35] Bishop, C., *Improving Institutional Long Term Care for Residents and Workers: The Effect of Leadership, Relationships and Work Design*, Better Jobs Better Care, Institute for the Future of Aging Services, 2006.

is a model of care that allows individuals to identify their own needs and control the process of recruiting, hiring, training, and – when necessary – dismissing the worker they have chosen. The objective of consumer-directed care is to give the person being cared for more control over their community care than they have with agency programs. But consumer-directed care is not one model of care. It is rather a spectrum of options that extends from agency services and care management at one end to cash and vouchers at the other.[36]

Consumer-direction can also help address the shortage of direct care workers, the need for culturally appropriate workers, and the availability of services in rural or other hard-to-reach areas by expanding the pool of available workers.[37] But this only happens if consumers can connect with individuals willing to work and offer wages that will attract workers.

Principle

Culture change, the movement to transform institutional care through client-centered practices, should be encouraged across long-term care settings as a way to improve quality of care and quality of life for the consumer, empower the long-term care workforce, enhance job satisfaction, and reduce staff turnover.

Examples

Leelanau Memorial Health Center.

This non-profit facility in Northport, Michigan, follows the Eden Alternative model and illustrates the benefits of working in a culture change facility. In the late 1990s, it began to minimize or eliminate most traditional management practices and adopted participatory techniques. Today, residents are cared for by self-directing teams. CNAs are trained and encouraged by team coaches and coordinators to make frontline decisions and to contribute ideas on how to make Leelanau a better place to work. To emphasize the importance of frontline care, all staff are cross-trained as CNAs. By employing these practices, Leelanau has reduced annual turnover from 78% to below 20%.

The Greenhouse Project.

Greenhouses take culture change to the next level by altering the facility size, interior design, staffing patterns, and methods of delivering professional services. Each building houses 8 to 10 residents in private bedrooms with private baths that surround a common area that includes an open kitchen, a dining area with one large table, and a sitting area with fireplace. The residents determine their own schedule, and meals are prepared in the house kitchen and are served at one communal table. The direct care providers are CNAs who have been given advanced training and work across traditional job classifications by cooking, cleaning, and doing all work required to maintain the household. They work as a self-managed team and are responsible for scheduling and completing the work and running the household. Nursing care and other professional services are provided by staff members who rotate among the Greenhouses on a campus and can be paged for emergency care.

Local 1199SEIU Quality Care Committee.

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[36] Tilly, J. and Rees, G., *Consumer-Directed Care: A Way to Empower Consumers?,* Alzheimer's Australia Paper 11, May 2007.

[37] Kassner, E., *Consumer-Directed Home and Community-Based Services*, AARP Public Policy Institute. May 2006.

The Quality Care Committee, a program developed by Local 1199SEIU in partnership with the Continuing Care Leadership Coalition, the trade association representing approximately 100 voluntary not-for-profit long-term care facilities, is an important addition to the national culture change movement in New York City – an entity committed to the equal recognition and involvement of direct care staff in the design, leadership and implementation of its programs. Although each of the 40 nursing homes that have participated in the QCC is in a different place in its culture change journey, all have experienced profound changes that have improved conditions for residents and workers alike. The program has attracted the attention of the Commonwealth Fund, which is currently supporting a 15-month study of the QCC experience.

Cash and Counseling

There are many forms of consumer direction that seek to give consumers more control over their home and community services, ranging from having them participate in the development of their own service plans to giving them cash they can use to hire their own attendants. Results from the Cash and Counseling demonstration program show that persons with disabilities and their family caregivers can benefit from having more control over their own services when there are family members available to provide supportive services. However, even with Cash and Counseling, it is still critical to ensure that workforce issues such as wages, benefits and working conditions are addressed.

Agency with Choice

Many consumers receive home care from workers employed by public and private agencies. Typically, these agencies hire, fire and direct the work of the caregiver, with minimal input from the consumer. However, under an alternative model of agency care, consumers are able to select, manage and dismiss their workers. This model can give consumers the benefits of control and choice, combined with the supportive services of an agency, such as emergency back up care.[38] Agency with choice is one of the Medicaid consumer direction options in Colorado. Under the Colorado program, the consumer chooses both the agency and the worker and has the option either to use a current employee of the agency or to have the agency hire a worker identified and chosen by the consumer.[39]

Public Authority as an Effective Way to Connect Workers and Consumers

The public authority model can be an effective way to make consumer-directed programs work more efficiently without changing the essential elements of consumer-directed care, such as the ability of consumers to choose their own worker and determine how and when care will be provided. The public authorities in Washington, Oregon, California and elsewhere not only maintain a registry of available workers, including workers who need additional work hours, they are also empowered to provide consumers with caregiver referrals and offer training for both consumers and caregivers. By giving once disparate workers a collective voice on the job, the public authorities have been able to raise wages and improve the quality of the workforce,

[38] Kafka,B., "Agency with Choice Model. Consumer Choice combined with the advantages of an agency," available at http://www.cpwd-ilc.org/cpwd/update2005/shell03.asp?Title=Agency+with+Choice+Model%2E.

[39] Colorado Department of Health Care Policy and Financing, power point presentation on "Medicaid's Consumer Direction Options," June 2006, available at http://www.chcpf.state.co.us/HCPF/Syschange/Medicaid%20Options.ppt.

giving consumers confidence in the home care program and workers a renewed interest in the field.

C. Nurse Supervision

Surveys show that direct care workers want supervisors who respect their observations about client status and listen to what they have to say. A direct care worker's relationship with an immediate supervisor – generally an RN or LPN – is often the deciding factor as to whether or not he or she stays on the job. Therefore, to ensure good staff relations, it is important for supervisors to receive skills training in how to manage and mentor a large and diverse workforce.[40]

The long-term care workforce is increasingly diverse. For example, Cedar Sinai Park, a continuing care community in Portland, Oregon, employs staff from 27 cultures. Supervisors, on the other hand, remain overwhelmingly Caucasian and generally have higher levels of education. Culture clashes are common between nurse aides and their supervisors, as well as between residents and staff. Language barriers can exacerbate problems.[41]

Also, nurse supervisors don't always understand the personal problems faced by nurse aides – low-income workers who may have overwhelming family and financial responsibilities. A supervisor may link certain behavior to stereotypes, for example, rather than recognize that a worker may lack a support system if a child is sick or a car breaks down. The supervisor's tone, word choice and body language are critical. If a supervisor appears to harbor prejudices or lack understanding, the aide may see a lack of respect and may no longer trust the person in charge. Workers can have a similar reaction if they sense a lack of supervisory support when residents express racial and ethnic biases.

Principle

Direct care workers deserve respect at work, whether in a private home or an institutional setting. Supervisors – generally nurses – tend to set the tone for the treatment of direct care workers and should receive enhanced training to enhance their ability to better manage a diverse workforce.

Examples

Including Training in Supervisory Skills in the Nursing School Curriculum

There is a need for nursing schools to include supervisory and administration training in their curriculums in order to provide nurses with the skills needed for a successful career in long-term care services. The Paraprofessional Healthcare Institute has recently received a grant from the Hartford Foundation to develop a curriculum to teach nurses to be supervisors using coaching skills, a relationship based approach to supervision that builds the worker's own problem solving skills. The first nursing school to use the curriculum, Sharon Regional Health System School of Nursing in Pennsylvania, will begin teaching coaching supervision in the fall of 2007.

[40] See discussion of "Poor Supervision and Job Quality" on the website of the Direct Care Alliance, www.directcarealliance.org/sections/key_issues.htm.

[41] Issue Brief No. 7.

The Center for Nursing and Rehabilitation
The Center for Nursing and Rehabilitation in New York City has developed a peer mentoring program that trains CNAs as "CNA Person Centered Care Mentors." The program consists of an 18-month course that trains CNAs to counsel fellow workers. It can be used to create career ladder opportunities, but almost always leads to greater job satisfaction, both for the new mentor and the CNA who receives the mentor's attention.[42]

Northern New England LEADS
Northern New England LEADS (Leadership, Education and Advocacy for Direct Care and Support) is a program that makes supervisors into staff "coaches" and teaches them better listening skills and ways to help staff become problem solvers. It encourages supervisors to include CNAs in an organization's "culture change leadership team." CNAs at LEADS organizations report that being encouraged to state opinions and make decisions has helped them develop more confidence in their own abilities.[43]

[42] National Clearinghouse on the Direct Care Workforce's Best Practices, available at www.directcareclearinghouse.org/practices/r_pp_det.jsp?res_id=218910.
[43] Issue Brief No. 7, 7.