Pennsylvania's Care Gap:

Finding Solutions to the Direct-Care Workforce Crisis

By Mark Davis and Steven L. Dawson

Paraprofessional Healthcare INSTITUTE

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The nonprofit *Paraprofessional Healthcare Institute (PHI)* focuses on strengthening the direct-care workforce within our nation's long-term care system through developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. Our work is guided by the belief that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

A recognized leader in long-term care workforce policy, PHI runs the **National Clearinghouse on the Direct Care Workforce** (www.directcareclearinghouse.org), a national information center on the staffing crisis in long-term care. In addition, PHI staffs the national Direct Care Alliance, an advocacy voice representing consumers, workers, and concerned providers who together are creating both quality jobs and quality care within the long-term care sector. Finally, PHI has state-based policy experts working with providers, consumers, and worker/labor organizations in New York, Pennsylvania, Massachusetts, Maine, Michigan, and California.

PHI's workplace practice and caregiving innovations have been developed in cooperation with a federation of direct-care staffing agencies and training programs that includes the highly successful **Cooperative Home Care Associates** of the South Bronx and **Independence Care System,** a nonprofit managed long-term care program for people living with physical disabilities. Through its consulting practice, PHI assists health care providers across the long-term care spectrum to adapt these practices to their specific environments.

PHI's expertise in both industry practice and public policy has made the organization a valued partner to state and federal agencies and industry stakeholders. In affiliation with the Institute for the Future of Aging Services, PHI draws on this dual expertise in its role as designated national technical assistant for the **Better Jobs: Better Care** demonstration project, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies.

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In addition, our thanks go out to the following individuals for their assistance in the development of this paper: Dale Laninga, Pennsylvania Intra-Governmental Council on Long Term Care; Diane Menio, Center for Advocacy for the Rights and Interests of the Elderly; Chris Klejbuk and Beth Greenberg, Pennsylvania Association of Non-Profit Homes for the Aged; Lori Griswold, Griswold Special Care; Mary Anne Kelly, Southwestern Pennsylvania Partnership on Aging; Steven Herzenberg, Keystone Research Center; Tom DeBruin and Howard Harris, Service Employees International Union, 1199P; Carol Williams, Office of the State Auditor General; Karen Kulp, Home Care Associates of Philadelphia; Barbara Piskor, BKP Healthcare Resources; Jennifer Burnett, Pennsylvania Transition to Home; and Eric Failing, Pennsylvania Homecare Association.

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EXECUTIVE SUMMARY

The quality of Pennsylvania's long-term care system depends greatly on the work of over 94,000 direct-care workers who provide daily, hands-on support to the state's elderly and younger residents living with disabilities. These frontline workers (nursing assistants, personal care aides, home care workers, and home health aides) operate at the vital point where the system reaches the individual consumer and the essential caregiving relationship is formed. Though this relationship is obviously critical to the quality of care delivered to consumers, little attention has been paid to the quality of these direct-care jobs. Yet there is clearly a link between the preparation, support, compensation, and respect these workers receive and their ability to deliver compassionate, safe, consumer-centered long-term care services.

Part I: The Direct-Care Crisis in Pennsylvania

Pennsylvania's direct-care workers regularly report dissatisfaction with important aspects of their jobs, such as training, wages and benefits, and working conditions, that interfere with their ability to properly care for consumers. This dissatisfaction, combined with the increasing demand for long-term care in the Commonwealth, has contributed to high turnover rates and the inability of providers to recruit and retain an adequate supply of qualified staff. By early 2001, vacancy rates across Pennsylvania had reached 11 percent, undermining the ability of remaining staff to maintain quality services and, in some cases, forcing providers to limit services to consumers.

Staff vacancies and high turnover harm all three "key stakeholders" within long-term care:

- Workers deal with increased and, at times, unsafe workloads.
- Consumers receive poor care or are denied access to services.
- Providers, who must continuously recruit new workers or resort to the use of temporary agency staff, experience difficulty maintaining quality care as well as higher expenses.

While some thought that these vacancies were a function of an unusually strong economy and increased competition for labor in the late 1990s, the relative softening of economic conditions since 2001 apparently has not eased this situation. Providers, consumers, and workers themselves continue to report that there are not enough frontline workers available to provide safe, quality care to Pennsylvania's long-term care consumers. This is not a temporary problem:

Providers, consumers, and workers themselves report that there are not enough frontline workers available to provide safe, quality care to Pennsylvania's long-term care consumers.

The Commonwealth's demographics indicate that there simply will not be enough workers to meet the needs of all consumers over the next several decades unless direct-care jobs are made desirable enough to attract more people into the profession.

Part II: Dimensions of the Long-Term Care Staffing Crisis

Pennsylvania's long-term care staffing crisis is a function of demographic changes, combined with industry practice and public policies that have contributed to the poor quality of direct-care jobs.

Demographics and the Growing Demand for Long-Term Care Services

Pennsylvania is one of the most rapidly aging states in the nation. While not all elderly people become disabled, a growing elderly population increases the number of people who are likely, at one time or another, to need long-term care. For the decade ending in the year 2000, the number of Pennsylvanians aged 85 and over increased by almost 40 percent, while the number of people who typically fill these jobs (women between the ages of 25 and 54) grew only by about 4 percent. Over the next 25 years, the elderly population is projected to continue to grow by about 40 percent while the state's traditional caregiving population is expected to shrink by 12 percent.

Industry Practice

High turnover and severe shortages of direct-care staff plague long-term care providers irrespective of care setting. Certain aspects of industry practice have been linked to poor recruitment and retention:

1. **Wages & Benefits:** Frontline caregivers generally receive lower wages and are less likely to receive employer-paid benefits than other workers in the United States, even if they remain in the field for an extended period of time. Many direct-care workers' earnings are so low they qualify for public benefits, such as food stamps and Medicaid. Access to health care and other types of benefits is sporadic and, even where offered by employers, beyond the financial reach of workers who earn too little money to contribute to insurance or retirement plans.
2. **Working conditions and workplace culture:** Fundamental flaws in the environment, design, and culture of long-term care work contribute to vacancies and high turnover. Caregiving is physically and emotionally challenging work,

yet workers are given little support. Direct-care workers report that short staffing, negative and punitive supervisory practices, and an overall lack of respect for their skills interfere with their ability to provide quality care to consumers.

3. **Training:** Pennsylvania's direct-care workers report again and again that their training is inadequate for the tasks they must perform. Insufficient time is allotted to cover all the relevant health-related content, to develop interpersonal skills, and to provide practical clinical experience prior to employment. Outside of nurse aide training, there is no standardized curriculum nor are there quality standards for trainers. Workers are often placed in caregiving settings without the mentoring or support necessary to handle unanticipated circumstances. Frontline workers state that they want a core set of skills that prepare them to work with a variety of consumers across settings and the opportunity for continuing education, as in other professions.
4. **Opportunities for career advancement:** Direct-care work provides few opportunities for ongoing skill building or professional development. Career advancement is generally limited to becoming a licensed professional, which requires an investment of time and money that few workers can afford. Also, many frontline workers prefer the closeness of working directly with consumers. Despite the success of genuine career ladder programs in improving retention, such efforts are rare. Lacking ordinary pathways to career advancement, many workers feel they are trapped in dead-end jobs.

Public Policy

As the primary payer and regulator of long-term care, the Commonwealth plays a dominant role in structuring and implementing the system. Policies driving these functions have a direct impact on the quality of direct-care jobs.

1. **Reimbursement policies:** Cost containment measures designed to stem the rapid growth of long-term care spending in Pennsylvania have limited the resources available to invest in improving compensation, training, and working conditions for direct-care workers. The current structure and level of long-term care financing limit the ability of providers to respond to the realities of the labor market.
2. **Quality assurance, workloads, and training:** Pennsylvania has not adequately aligned its regulatory system with the elements of a quality direct-care job. Quality assurance, staffing, and especially training standards fail to address the desire of frontline workers to feel prepared, supported, and able to deliver quality care in a setting that promotes the caregiver-consumer relationship.

Part III: Implications for Quality of Care

While all three key stakeholders in Pennsylvania's long-term care system feel the consequences of the direct-care staffing crisis, it is consumers who suffer most when there are not enough quality caregivers. The emerging care gap contributes to:

- Care without continuity;
- Inadequate and unsafe care; and, in some cases,
- Denial of services altogether.

Part IV: Strategies for Change

The Vision

An effective resolution of the direct-care staffing crisis in Pennsylvania requires that all major stakeholder groups work collaboratively to restructure direct-care employment. This effort must be supported by a parallel effort among key state agencies (Aging, Health, Public Welfare, Education, Labor and Industry) to restructure long-term care public policy around the quality job/quality care connection.

Some impressive efforts by individual organizations to transform long-term care are already underway, but it is essential that out of these distinct initiatives a cohesive statewide stakeholder voice emerge. Consumers, workers, and providers all bring a particular set of issues to the table; policymakers wary of having to balance competing interests are more likely to respond to a unified coalition calling for a renewed vision on behalf of Pennsylvania's frontline caregivers.

Pennsylvania's stakeholders can find common ground if they commit to a long-term care system that guarantees the following:

- **For consumers:** Uninterrupted access to care and services, provided by dependable, qualified caregivers, in the setting of the consumer's choice.
- **For workers:** A quality position as a caregiving professional. This includes self-sufficient wages, family health benefits, adequate and effective training, opportunities for advancement, and a safe, supportive work environment.
- **For providers:** Public policies and resources that support compassionate, client-centered care; effective workplace practices; and the ability to attract and retain an adequate base of skilled, direct-care staff.

Recommendations for Action

Transforming the Commonwealth's long-term care system into one that supports a stable and valued workforce capable of delivering quality care to consumers will require substantive changes in public policy and industry practice.

Public Policy

- Implement long-term care financing systems that promote and support self-sufficient wages and adequate benefits, including health insurance, for direct-care workers.
- Use regulatory and reimbursement systems to encourage, as well as enforce, good workplace practices, including adequate staffing levels. Fund demonstration projects in organizational culture change.
- Set more uniform, versatile, and useful training requirements across long-term care settings. Use federal and state workforce development systems to support better training and skill development.
- Create and fund career ladder programs within the frontline caregiver position.
- Maintain and promote programs that assist low-wage workers, such as tax credits, child care and transportation assistance, and basic health care coverage.

Provider Practice

- Employ wage rates and structures that recognize skills, experience, and the value of services. Commit to the goal of providing a family self-sufficient wage and adequate benefits.
- Redesign the culture of direct-care work around the relationship between the caregiver and the consumer. Establish workplace practices that are supportive, safe, and recognize worker's rights under the law.
- Invest in better training, including: Sufficient hours, relevant content, adequate preparation, and continuing education. Provide workplace orientation, peer mentoring, and on-the-job-training to new workers.
- Create genuine career ladder programs within the direct-care position that include recognition, promotion, and increased compensation.
- Assist direct-care workers in accessing and securing public benefits and other supports available to them.

The Vehicle: A Statewide Stakeholder Approach

As Pennsylvania undertakes its next steps in solving the direct-care workforce crisis, the voices of consumers, providers, workers and their advocates all must be included. As previous analyses of the long-term care workforce crisis in Pennsylvania have recognized, no singular approach that addresses the needs of one stakeholder group without the others will produce sustainable results.

To attract and retain a stable caregiving workforce that can deliver quality care, policymakers and health care providers must make the necessary investment to move to the next level.

To develop and implement a rigorous strategy for immediate action centered on public policy and practice-based reform, stakeholders must begin to transform general understanding and broad-based recommendations into concrete proposals for change. Drawing from the discrete efforts already in place, Pennsylvania's consumer advocates, providers, labor unions, and worker advocates need to cultivate specific efforts targeted at improving compensation, training, caregiving and workplace practices, and career opportunities for the Commonwealth's direct-care workers.

The most effective vehicle for these efforts is a diverse coalition whose members are drawn from these key stakeholder constituencies. This coalition should be a freestanding entity, independent of state government or the primary influence of any one stakeholder group. The coalition could set the stage for concerted, multi-stakeholder advocacy, or provide a base for the emergence of smaller working partnerships. If the diverse members of that group can simultaneously acknowledge their individual agendas and yet advocate in a unified voice, there exists the potential for substantial systemic change.

Part V: Conclusion

The direct-care workforce crisis in Pennsylvania is a complex and multifaceted problem that requires a concerted response by all the key actors across the Commonwealth's long-term care system. If Pennsylvania is to develop a coherent strategy to attract and retain a stable caregiving workforce that can deliver quality care, policymakers and health care providers must be willing to make the necessary financial and philosophical investment to move present initiatives to the next level. It is essential that policymakers review how Pennsylvania designs, regulates, and funds long-term care and equally vital that the industry reinvent how it recruits, trains, and supports its direct-care staff.

We cannot expect to arrive at a new destination by treading the same path. Through collaboration, vision, and openness to change, Pennsylvania can begin to respond to the present challenges and develop a stable frontline workforce that will deliver quality care both now and in the decades to come.

PART I.
OVERVIEW: THE DIRECT-CARE CRISIS IN PENNSYLVANIA

Pennsylvania's Direct-Care Workers

Over 94,000 frontline caregivers in Pennsylvania provide long-term care[1] and support for more than a half million of Pennsylvania's elderly and younger residents living with disabilities, tending to their most intimate and personal needs, such as bathing, dressing, feeding, toileting, and assistance with medication. These hands-on caregivers work in a variety of settings, including nursing homes, personal care homes, private residences, and adult day services centers. What they all share is that they have chosen to dedicate themselves to a profession that is often stressful and difficult. In turn, most paid caregivers report that it is the day-to-day connection with consumers that sustains them.

The relationships that grow out of this ongoing, daily contact are often the most significant, if not the only, source of companionship and connection to the outside world for many who are chronically ill or living with disabilities. Nurturing the quality of these relationships and supporting the ability of frontline workers to provide effective care is vital to maintaining a high quality of life for Pennsylvania's consumers of long-term care services.

The Direct-Care Workforce Crisis

Across Pennsylvania, providers, consumers, and workers are experiencing a crisis in the delivery of long-term care services. Providers' inability to recruit and retain direct-care workers[2] over the last several years has resulted in unparalleled rates of vacancy and turnover among frontline staff. In 2001, over one-half of all long-term care providers statewide reported some degree of staff shortage and, in particular regions (Lehigh Valley and the Northwest), that number exceeded 70 percent (Leon et al. 2001). Vacancy rates averaged around 11 percent statewide, and a significant number of providers, particularly in home care, reported vacancy rates greater than 20 percent.

[1] Long-term care is defined by the Commonwealth as "a wide range of assistance, services or devices provided over an extended period of time and designed to meet medical, personal and social needs in a variety of settings or locations to enable a person to live as independently as possible." Services are available at sites in the community, in consumers' homes, in a residential setting, or in a nursing home (Pennsylvania Department of Aging 2002).

[2] Direct-care workers include nursing assistants, personal care aides, home care workers, and home health aides. Nursing assistants provide basic patient care under direction of nursing staff. They perform duties such as bathing, dressing, grooming, transferring patients, and changing linens. More specifically, personal care aides and home care workers assist elderly or disabled adults with daily living activities including housekeeping, preparing meals, and supervision. Home health aides provide routine personal health care, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the homes of patients or in residential care facilities (U.S. Bureau of Labor Statistics 2000b).

Providers' inability to recruit and retain direct-care workers over the last several years has resulted in unparalleled rates of vacancy and turnover among frontline staff.

The situation within the Commonwealth reflects a national trend. In a recent nationwide survey conducted by the North Carolina Division of Facility Services (1999), 88 percent of the states reported that the recruitment and retention of direct caregivers are major long-term care workforce issues, ones that they expect to persist for an extended period of time as demand for services increases. More than two-thirds of those states reported that they were actively pursuing strategies to address these issues.

Chronic worker vacancies and higher than normal turnover cause a host of problems that affect workers, providers, and consumers of long-term care:

- Workers deal with increased and, at times, unsafe workloads.
- Consumers receive poor care or are denied access to services.
- Providers, who must continuously recruit new workers or resort to the use of temporary agency staff, experience difficulty maintaining quality care as well as higher expenses associated with agency staff and recruitment and training of new workers (PHI 2001; Stone and Wiener 2001; Leon et al. 2001; U.S. GAO 2001).

Providers have responded to these vacancies with a number of strategies. The most common responses have been to increase the use of mandated overtime among staff, to "work short" by maintaining low staff-to-resident ratios in nursing homes, or to decrease the number and length of visits to home care clients. Other responses have included increasing the use of temporary agency (or "pool") staff in facilities or simply limiting the number of persons served in both institutional and community-based settings (Leon et al. 2001; SEIU 2001). Paradoxically, these strategies often exacerbate the problem, for heavier workloads and mandatory overtime only contribute to turnover by increasing burnout among workers. Furthermore, significant reliance on agency staffing reduces the quality of care, since no consistent relationship can be formed between caregiver and consumer.

Continued vacancies and high rates of turnover also have implications for the future of long-term care policy in Pennsylvania. For several reasons, the Commonwealth has made a commitment to the expansion of home- and community-based services for those who are elderly or living with disabilities. Most importantly, Pennsylvanians overwhelmingly report that if they need long-term

care, they want to receive services in their own homes as long as possible (Long-Term Care Council 2002a). In addition, public funding of community-based services has been shown to be more cost-effective per capita when compared to the same services provided in an institution (Long-Term Care Council 2002a). Finally, implementing the Supreme Court's 1999 *Olmstead*[3] decision will require that the state serve more people in need of long-term care services in community-based settings. This move toward home- and community-based care, clearly, will be hampered by worker shortages and high turnover rates (Long-Term Care Council 2002a).

The direct-care staffing crisis is critical to the future of long-term care services in the Commonwealth. This report, thus, explores the multidimensional nature of this staffing crisis, including its basis in demographic changes as well as long-term care industry practice and state public policy. Following this discussion of the root causes of the crisis, we focus on the impact of the crisis, particularly on consumer care, and offer a framework for solutions that calls for the participation of all the system's stakeholders: providers, consumers, workers, and state government.

[3] *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999). The Supreme Court ruled that states must serve individuals living with disabilities in the setting most appropriate to their needs, whether institutional or community-based. As a result of this ruling, states must end any institutional bias in their provision of long-term care services and may be forced to accelerate efforts to provide adequate home- and-community-based care.

PART II:
DIMENSIONS OF THE LONG-TERM CARE STAFFING CRISIS

Pennsylvania's current long-term care staffing crisis is linked to a combination of factors that, left unchecked, will only continue to exacerbate the problem. Some of these factors, such as the demographic distribution of Pennsylvania's caregivers and consumers, are beyond the control of providers and policymakers. However, external factors are only part of the equation. Policies and practices within the long-term care system have undermined the quality of long-term care jobs to such an extent that experienced workers are leaving the profession without sufficient numbers of people willing to replace them. Demographic changes and increased demand for services have functioned in tandem with the poor quality of many direct-care jobs to produce the present crisis, which promises to worsen without a fundamental re-examination and restructuring of how we approach long-term care in the Commonwealth.

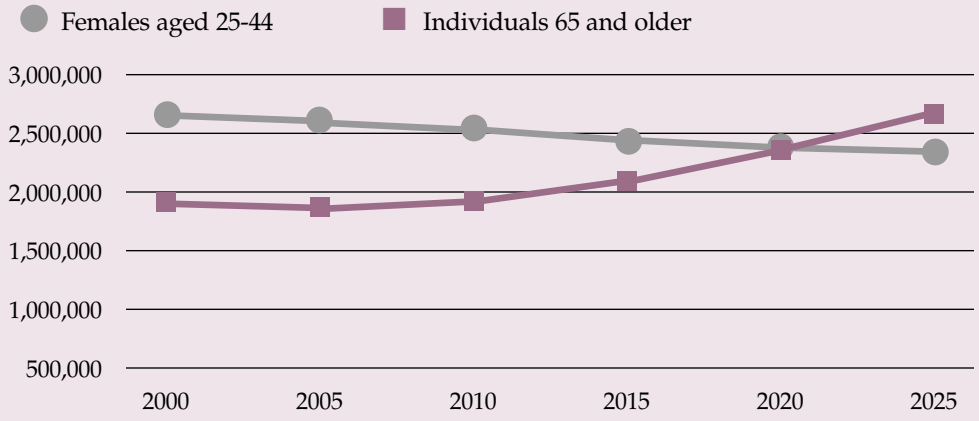
Section A:
Demographics and the Growing Demand for Long-Term Care Services

Demographic changes have contributed to current direct-care worker vacancies both nationally and locally. An aging population has caused a dramatic increase in the demand for caregivers, while the number of individuals who typically fill these jobs (women between the ages of 25 and 54) has changed very little. For the decade ending in the year 2000, the number of Pennsylvanians aged 85 and older increased by almost 40 percent, while the number of women of caregiving age grew only by about 4 percent (PANPHA 2001b; U.S. Census Bureau 2000b). An increasing number of younger (under 65) persons with disabilities also added to the demand for long-term care services during this time period (U.S. Census Bureau 2000a). Demographics, thus, are a significant factor underlying Pennsylvania's current staffing crisis: There simply will not be enough workers to meet the needs of all consumers unless jobs are made desirable enough to attract more people into the profession.

Because Pennsylvania is one of the most rapidly aging states in the nation, this situation is likely to worsen over the coming decades. While not all elderly people become disabled, a growing elderly population increases the number of individuals who will, at one time or another, need long-term care. Direct-care worker positions are consistently listed as "demand occupations" by local

Workforce Investment Boards when designating high-growth occupations in their areas (Pennsylvania Department of Labor and Industry 2002). The latest reports by the Pennsylvania Department of Labor and Industry (2002) show employment opportunities in health care increasing *almost three times as fast* as all other fields combined over the next decade. Almost 40 percent of these job openings will be for direct-care workers. This growth is coupled with an accompanying decline in the population of people who typically provide care: *While the elderly population in Pennsylvania (demand) is projected to grow by 40 percent over the next 25 years, the state's "traditional" caregiving population — women aged 25 to 54 (supply) — is expected to shrink by 12 percent* (U.S. Census Bureau 2002).

Women of Caregiving Age and Elderly in Pennsylvania, 2000-2025



The demand for long-term care is not limited to the elderly or to nursing home residents. The number of children, adolescents, and younger adults with severe long-term health problems has grown substantially over the last two decades and will continue to do so. More than 50,000 children use home health services daily in the United States (PHA 2001). The Commonwealth has also made major efforts to create more balance in the delivery of services by redirecting public funding from institutional to home- and community-based settings. Consequently, the use of programs like attendant care, home health, personal care, and adult day services centers is projected to expand. According to the Pennsylvania Department of Labor and Industry (2002), Pennsylvania will need an additional 41,950 workers in nursing homes, personal care, and home health care between 1998 and 2008.

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Until recently, a strong economy could be blamed for recruitment and retention problems[4]—in a growing economy with low unemployment levels, there is increased competition for a limited pool of workers, and thus, potential frontline caregivers have more choices for employment outside the long-term care industry. Data collected in early 2001, just prior to the economic downturn, underscores this dynamic: nurse aide vacancy rates were around 12 percent, while turnover rates in Pennsylvania nursing homes exceeded 50 percent and were at 78 percent for all facility-based care. Almost 60 percent of providers surveyed reported that it had grown even more difficult over the past year to fill nurse aide positions (AHCA 2002).

With a strong economy, the historical unattractiveness of the direct-care job finally caught up to the industry. The Pennsylvania Intra-Governmental Council on Long-Term Care, in its 2001 report on the direct-care workforce (Leon et al. 2001), found that 35 percent of Pennsylvania providers were experiencing extreme difficulty with recruitment and retention; 68 percent of those reporting serious retention problems and 77 percent of those reporting serious recruitment problems said those difficulties increased in the previous two years. Yet, given the mismatch between the supply of workers and the demand for long-term care services, no matter how the economy expands or contracts over the next several decades, vacancies and turnover in long-term care employment will be a fact of life in Pennsylvania *unless the jobs are made competitively attractive.*

Notably, the recent economic downturn seems to have done little to ease the recruitment and retention crisis: Conversations with providers, consumers, and labor advocates around the Commonwealth reveal that vacancies and turnover are still a very current problem[5]—the numbers cited above have shown no significant improvement. While vacancy rates decreased slightly over the past year (primarily because high unemployment rates created a greater number of people seeking work), turnover rates remained essentially the same (AHCA 2003). This suggests that even in difficult economic times, there is instability in the direct-care workforce. Workers themselves continue to report that one of the major retention issues for them is that "there are never enough workers to help out" (Long-Term Care Council 2001, 2002b).

[4] It should be noted, however, that in a 1999 study, both the state with the lowest unemployment rate (Minnesota at 2.1%) and the state with the highest unemployment rate (West Virginia at 6.8%) indicated that recruitment and retention of direct-care workers were major concerns (NCDFS 1999).

[5] Since August 2001, the author has had periodic conversations with staff from the Pennsylvania Association for Non-Profit Homes for the Aging, Pennsylvania Health Care Association, Pennsylvania Homecare Association, Southwestern Pennsylvania Partnership on Aging, Service Employees International Union, long-term care ombudspersons, as well as individual providers, direct-care workers, and consumers who have reported their experience.

Even if the recent downturn had provided a respite from recruitment and retention problems, it would be a temporary one. Pennsylvania's economy will eventually recover, and as it does, the long-term care system will be forced to deal with a more persistent problem: a growing divide between the number of people needing care and the number of people available to provide it. This demographic shift suggests a looming workforce crisis that resists typical labor market analysis: In the face of the relentless growth in consumer demand, providers cannot count on a slow economy to stabilize the workforce.

Employers and policymakers cannot control the demographic changes that are creating a growing gap between the demand for long-term care services and the supply of workers. Inevitably, the long-term care system will have to broaden the supply of workers beyond those who have traditionally provided care; at the same time, direct-care jobs will need to be restructured to make them more attractive within what will no doubt be an increasingly competitive labor market.

Section B: Industry Practice

High turnover and severe shortages of direct-care staff plague long-term care providers irrespective of care setting. The ability of employers to resolve these problems is intertwined with a number of issues, including the dynamics of providing human services in the private sector and what is often viewed as a limited public investment in long-term care. Public sector issues will be examined in the next section. In this section, we attend to aspects of industry practice that have been linked with poor recruitment and retention, primarily as reported by workers themselves.

Wages and Benefits[6]

National studies on wages and benefits indicate that frontline caregivers, particularly those working in nursing homes and home health, generally receive lower wages and are less likely to receive employer-paid benefits than other workers in the U.S. economy. Approximately one-third of nursing home aides and home care workers in the United States earn less than $20,000 per year compared with about 23 percent of workers generally. Close to 20 percent of long-term care workers have incomes below the poverty level, compared with 11 percent for all workers nationwide (U.S. GAO 2001).

[6] Compensation issues illustrate quite clearly the overlap between public policy and provider practice, given the large role the Commonwealth plays in funding long-term care. Many providers hold the view that if the Commonwealth would fund services in a more timely and sufficient manner, they would offer better wages and benefits. See pages 23-27 for a more complete discussion of reimbursement policy.

MEDIAN HOURLY WAGES OF SELECTED OCCUPATIONS IN PENNSYLVANIA

Occupation	Hourly Wages
Baggage Handlers	$ 10.03
Stock Clerks	$ 9.98
Janitors	$ 8.87
Home Health Aides	$ 8.81
Personal Care Attendants	$ 7.97

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, State Occupational Employment and Wage Estimates, www.bls.gov/oes/2001/oes_pa

Unlike most positions, direct-care workers are not rewarded for remaining in their field over an extended period of time. Direct-care workers and other low-wage workers may actually start out at similar wages in jobs in their respective industries; however, over time, the typical direct-care worker's wage lags well behind that of other low-wage workers. In fact, when adjusted for inflation, he or she sees virtually no increase at all. Even workers who stayed in the *exact same job* for four years or more (a relatively extended time in long-term care) saw only a 14 percent increase in their wages compared with 45 percent for their counterparts in other low-wage jobs (Leon and Marainen 2002).

Many direct-care workers' earnings are so low that they qualify for public benefits such as food stamps and Medicaid. Nationwide, about 5.5 percent of all workers rely on food stamps to feed themselves and their families. Yet more than 13 percent of nurse aides and 15 percent of home care aides require this assistance (U.S. GAO 2001). While approximately 4 percent of all workers in the United States are dependent on Medicaid for health insurance, nearly 10 percent of nurse aides and over 11 percent of home care workers rely on Medicaid coverage. Overall, nurse aides and home health workers are *twice as likely* to receive public benefits as workers in other categories (U.S. GAO 2001, appendix I).

Direct-care workers in Pennsylvania fare no better than their colleagues across the country when it comes to compensation. The average starting hourly wage for a frontline caregiver industry-wide in Pennsylvania in 2001 was $7.29. (Certain segments pay significantly less. For example, personal care home wages started at $6.10 per hour.) The mean *top* hourly wage rate for all long-term care workers was $9.51 (Leon et al. 2001, a-15). Working full time, 40 hours per week, 52 weeks per year, the highest average annual wage is still only a little over $19,000. However, even this optimum scenario is rare since significant numbers of direct-care workers, particularly those working in home care, have difficulty maintaining 40-hour workweeks due to the irregular, part-time structure of the industry. Most make far less than the average worker in Pennsylvania and see their wages compare unfavorably to jobs in retail, fast food service, and factory work (see sidebar).

Recent provider choices demonstrate an acknowledgement that providers must raise wages in order to attract and keep staff. Preliminary feedback from focus groups with direct-care workers revealed that a significant number (80 percent) who reported improved job satisfaction attributed it to significantly

better pay ($ 1-1.25/ hr.)[7] One Pennsylvania union official whose local represents approximately 19,000 members reported that, in general, wage settlements had been better in contracts negotiated with providers in the last year.

However, because they start from a historically low base, recent increases don't go far enough: Pennsylvania's direct-care workers' wages, in 1999, averaged only 62 percent of statewide per capita income—only nine states ranked lower (NCDFS 1999, a-1). Consequently, current wage gains still fail to help the average worker keep pace with the cost of living or with the wages that workers can make in other fields. Based on a recent county-by-county study of the Self-Sufficiency Standard (the amount of income required for a family to adequately meet its basic needs without public or private assistance), the median wage of direct-care workers would be insufficient to support an adult and just one child *in all but one Pennsylvania county* (Pearce and Brooks 2001).[8] Since direct-care workers very often have young children and only one income (U.S. GAO 2001), their wages will rarely cover the full cost of living in the Commonwealth.

Access to employee benefits is also a significant problem for direct-care workers. The percentage of workers in long-term care lacking health insurance is far greater than for other occupations, and in the health care industry, nurse aides and home health aides are the least likely workers to have coverage (U.S. GAO 2001). Furthermore, health care personnel are losing insurance coverage more rapidly than are other workers. Between 1988 and 1998, the percentage of uninsured health care workers making less than $25,000 per year increased from 13.4 percent to 19.1 percent. Overall, "1.36 million health care workers provide care that they and their children cannot expect to receive" (Brady et al. 2002).

Slightly over two-thirds of Pennsylvania's long-term care providers report that they *offer* health insurance to their employees. However, this can be misleading, for

DIRECT-CARE WORKER WAGES AND BENEFITS

- Close to 20 percent of direct-care workers have incomes below the poverty level, compared with 11 percent of workers nationwide.
- 13 percent of nurse aides and 15 percent of home care aides rely on food stamps to feed their families as compared to 5.5 percent of all workers.
- More than 10 percent of direct-care workers rely on Medicaid, as compared to 4 percent of all workers.
- Direct-care workers often cannot afford health insurance: Nationwide, "1.36 million health care workers provide care that they and their children cannot afford to receive."
- The median wage of Pennsylvania direct-care workers—$7.29 per hour—would be insufficient to support an adult and just one child *in all but one of the Commonwealth's counties.*
- Pennsylvania caregivers, in 1999, earned only 62 percent of the state's per capita income.
- Only about half of all long-term care providers in the Commonwealth offer full-time staff paid sick leave.

[7] Preliminary presentation by E4 Exchange to the Pennsylvania Intra-Governmental Council on Long-Term Care, March 7, 2002.

[8] See appendix for the Self-Sufficiency Standard in selected Pennsylvania counties. For more detail, see *The Self-Sufficiency Standard for Pennsylvania* (Pearce and Brooks 2001).

Improving compensation for caregivers is essential, not simply as a function of improving recruitment and retention, but also as a matter of demonstrating how much we as a society value the profession.

less than half of the providers offer these benefits to their part-time staff (Leon et al. 2001, a-22). More than one-third of direct-care workers work part-time or as independent contractors, and therefore may not be eligible for employer-sponsored health coverage (Leon et al. 2001). In addition, workers who are eligible for benefits may not be able to afford them if an employee contribution is required. These individual premiums are often beyond the reach of workers whose wages leave them barely self-sufficient. Many direct caregivers are thus forced to work without health coverage, a great irony given that they serve the health care field.

Health coverage for frontline workers is of particular importance given workers' high exposure to injury and illness on the job (injury and illness rates will be discussed further in the following section). Of additional concern to workers, even if they have health coverage for themselves, is their inability to afford coverage for their families (Long-Term Care Council 2001). Only 31 percent of Pennsylvania providers surveyed contribute to the cost of family coverage. Yet, for both workers and employers, providing family coverage clearly has a positive impact: Providers that make additional contributions toward family health coverage report significantly fewer retention problems (Leon et al. 2001).

Access to other common types of benefits, such as paid sick leave and paid vacation, varies greatly among different types of providers and between full- and part-time workers. For example, most full-time staff in nursing homes receive paid time off. In other settings, however, most notably small personal care homes and unlicensed home care agencies, the number of providers offering this benefit is well below the state average. Overall, only about half of all types of long-term care providers offer even their full-time staff paid sick days. Less than 25 percent offer benefits basic to many jobs such as a retirement plan, dental and vision coverage, or life or disability insurance (Leon et al. 2001, a-22, a-23).

Low wages and uneven benefits contribute to the poor quality of direct-care jobs. Improving compensation for caregivers is essential, not simply as a function of improving recruitment and retention, but also as a matter of demonstrating how much we as a society value the profession. However, as the next section demonstrates, without improvements in other elements of the job, better compensation alone will not solve the long-term care staffing crisis.

Working Conditions and Workplace Culture

Adding to the problem of inadequate compensation are fundamental flaws in the environment, design, and culture of long-term care work that contribute to the current recruitment and retention crisis. The first of these involves the physical demands and emotional stress of caregiving work. Direct-care jobs are typically quite strenuous, requiring the lifting and transferring of clients, long hours of standing and walking, and working with consumers who may be uncooperative or exhibit difficult behaviors.

Direct-care work has one of the highest incidences of workplace injury among all industries in the United States. According to the Bureau of Labor Statistics (U.S. GAO 2001), 13 of every 100 direct-care workers were injured on the job in 1999, a higher rate of injury than that of workers in construction, coal mining, and trucking. Injuries are caused by overexertion as well as assault, most commonly by clients. Nurse aides are the victim of three times as many assaults per year per 10,000 workers than police and private guards (Leon et al. 2001). Long-term care work will only continue to get more physically dangerous as clients' (particularly nursing home residents') needs grow more acute.

According to the Bureau of Labor Statistics, 13 of every 100 direct-care workers were injured on the job in 1999, a higher rate of injury than that of workers in construction, coal mining, and trucking.

"Short staffing," especially in nursing homes, only exacerbates the physical risks already present in caregiving. When direct-care workers "work short," they (and the consumers they serve) are easily injured because they are forced to speed up the pace of the work and to perform tasks alone that require (for the safety of both workers and residents) the assistance of two or even three workers. Since direct-care workers do not have enough time to do things the way they were taught, short staffing can also render training irrelevant. This is a particular problem in facilities where unreasonable workloads force workers to speed up and cut corners to complete their assignments. Finally, fatigue may cause injuries when direct-care workers are forced to work overtime because of insufficient staffing (SEIU 2001).

In home- and community-based settings, workers face different sorts of problems. Third-party payers may restrict the time allotted for a case or the number of visits to a consumer, forcing frontline workers to rush care or move on from a consumer before they feel that the individual's need for services has truly been met. In addition to the short scheduling, the irregular nature of consumers' care needs makes it difficult to piece together steady work hours and a regular

Workers who have changed jobs or left the caregiving profession altogether frequently report the reason as a negative relationship with their direct supervisor.

income. Workers are often told they will be called "if needed," making it hard to plan for other jobs that may supplement their income. Some home care workers resort to "overbooking," scheduling multiple clients for the same time in anticipation that there will be a cancellation. If none occurs, they are forced to call off one or the other.

Frontline caregiving is also emotionally demanding. Every day, workers must try to respond to the needs of chronically ill and cognitively impaired consumers, many of whom have difficulty expressing their needs. Aides must be prepared for the deaths of people with whom they have built emotional connections over months, and possibly, years. When asked to list the most important skills for a caregiver, Pennsylvania's workers ignored technical or physical skills and listed emotional qualities such as being compassionate and empathetic, being a good listener, and having a thick skin (Long-Term Care Council 2001).

The emotional stress of the job is often compounded by an unsupportive work environment with inadequate or no supervision. Workers who have changed jobs or left the caregiving profession altogether frequently report the reason as a negative relationship with their direct supervisor. This is hardly surprising. Professional nursing staff who are overseeing direct-care workers rarely have the benefit of any supervisory training themselves. In nursing homes, many supervising nurses have not performed nurse aide work in years, if ever. Many times, supervision is punitive—aides are simply pushed to work faster rather than given suggestions for working more effectively or for how to handle difficult situations with residents (Eaton 1997). In home care, workers often perform in isolation, without consistent clinical oversight and without the support of colleagues. Home health aides often report not being sure who their supervisor is. Another consistent concern is not being given adequate information to assist the consumer.

Finally, many direct-care workers report that they receive too little respect and feel unappreciated for the important work they do. Although they provide close to 90 percent of the hands-on care to consumers, frontline workers report that they have little or no input into care planning or decision-making related to their clients. Despite a demonstrated positive relationship between worker input and retention, less than half of Pennsylvania's providers report increasing worker participation in care decisions as a strategy to improve retention (Leon et al. 2001).

Training

Adequate preparation is an essential aspect of any quality job. Training becomes even more critical when the work is physically and emotionally demanding and involves the safety and well-being of others. Pennsylvania's frontline caregivers want to provide quality care for the individuals who rely on them. However, workers rarely enter the field with the skills necessary to care for vulnerable consumers who have increasingly complex needs.

Pennsylvania's direct-care workers report again and again that their training is inadequate for the tasks they must perform.

Federal law mandates that nurse aides who work for publicly-funded providers complete at least 75 hours of classroom and clinical training and that they pass an examination for certification. While states are free to set higher standards (over 50 percent of states exceed the minimum for nursing homes), Pennsylvania requires only the minimum. Home health agencies are permitted to use in-house competency evaluations in lieu of formal classroom training and testing (SWPPA 2001). Furthermore, privately reimbursed home care agencies currently have no formal training requirements, nor do licensed personal care homes. When nursing home hours are subtracted, the training average for workers within all other categories of long-term care providers is only 34 hours (Leon et al. 2001).

Pennsylvania's direct-care workers report again and again that their training is inadequate for the tasks they must perform. The cry is not just for more training, but also for more *relevant* and *consistent* training. Insufficient time is spent on "soft" skills such as problem solving and communication with consumers and co-workers (Long-Term Care Council 2001). Few organizations employ qualified trainers with experience in adult learning who can design innovative training methods and curricula that provide workers both the entry-level and continuing education they desire.

The most frequent complaint from workers is that the training ends at the most important point: when their relationship with the consumer begins. Most training takes place prior to the worker going out on the floor or into a client's home. Workers report that no amount of classroom training can simulate the practical realities of caregiving work. As one nurse aide explained, "They taught me how to make a bed but they didn't tell me there would be someone in it, and he would be trying to take a swing at me." [9] This unrealistic orientation is compounded by a lack of ongoing support or mentoring for new direct-care workers.

[9] Conversation with the author (see footnote 5).

By offering no avenue to career growth that is both accessible and affords caregivers the opportunity to remain close to the client, the long-term care industry facilitates workers leaving the field.

Absent the opportunity to receive effective clinical training prior to working with consumers (and adequate support afterwards), many frontline workers simply give up and leave, sometimes within weeks, or even days, of beginning (Long-Term Care Council 2001).

Lack of Opportunities for Career Advancement and Professional Development

Pennsylvania's frontline caregivers typically see their work as a career choice, a profession, not simply a "job." They see themselves as special people who have decided to dedicate their skills to assisting elders and people with disabilities to live more meaningful lives. Often, they have been informal caregivers for neighbors or family and feel a personal call toward their work (Long-Term Care Council 2001).

Unfortunately, unlike other professions, frontline caregiving provides few opportunities for ongoing skill building or professional development. Career advancement is generally limited to becoming licensed, either as a Licensed Practical Nurse (LPN) or as a Registered Nurse (RN), which requires between one and four years of formal education. Moreover, many frontline workers say they prefer to continue to work directly with consumers rather than to take on the administrative responsibilities of licensed nurses.

Thus, by offering no avenue to career growth that is both accessible and affords caregivers the opportunity to remain close to the client, the long-term care industry facilitates workers leaving the field. Provider agencies that have created career pathways for direct-care workers within the position consistently report improved retention. Yet such efforts are rare. Less than 1 percent of Pennsylvania providers report creating career ladder programs as a response to the recruitment and retention crisis (Leon et al. 2001). Lacking pathways to career advancement, many workers feel trapped in what they feel are dead-end jobs.

Pennsylvania's long-term care workforce crisis begins with the demand for services outstripping the supply of workers who traditionally enter the field. In addition, the strong economy (until recently) exacerbated the situation, by giving workers a range of alternative employment options. Close analysis, thus, invariably leads to the uncompetitive aspects of the work: The poor quality of direct-care employment is, after all, *why* people have opted for other jobs.

Fortunately, many frontline workers are not deterred by the inherent difficulties of caregiving. In fact, their relationships with those for whom they care are the only reason that many direct-care workers remain in the field. Workers report that what is driving them from the profession is that it requires them to perform such physically and emotionally difficult work *without adequate preparation, support, respect, or compensation*.

Most of Pennsylvania's long-term care providers are trying to succeed under very difficult circumstances (many feel that they are increasingly asked to do more with less and less funding), and the Commonwealth has a number of good examples of providers making changes in organizational practice and workplace culture. However, the evidence suggests that industry practice *on the whole* has not evolved to a point where workers can expect to find a "just wage," effective training, and an attractive work culture.

Provider practice, albeit critical, is not the sole factor shaping long-term care employment. Job quality is also influenced by state policies governing the structure and financing of the long-term care system. The next section examines the role of government in Pennsylvania's staffing crisis.

Section C:
Public Policy and Its Impact on the Long-Term Care Workforce

While the employment practices cited above have contributed to the poor quality of direct-care positions, they do not operate in isolation. The Commonwealth is the primary payer and regulator of long-term care in Pennsylvania, and the policies driving these functions have a direct and critical impact on the quality of the health care workforce as well as the quality of care that consumers receive.

Long-Term Care Payment Policies

Pennsylvania funds long-term care primarily through its Medical Assistance (MA) program, also called Medicaid. For consumers who are financially and functionally eligible, Medical Assistance pays for nursing home care as an entitlement and for home care services mainly through a variety of waiver programs administered by the Department of Public Welfare (DPW) and the Department of Aging (DOA). Long-term care services are also funded through a variety of other sources, including the state lottery, state general funds, and the federal Older Americans Act. There is increasing pressure on the Commonwealth to limit the costs of these programs: Pennsylvania's long-term care expenditures increased by more than 600 percent between 1986 and 2002 and the Commonwealth currently

Pennsylvania's long-term care expenditures increased by more than 600 percent between 1986 and 2002 and the Commonwealth currently spends two-thirds of its entire Medical Assistance budget on long-term care.

spends two-thirds of its entire Medical Assistance budget on long-term care (Long Term-Care Council 2002a; PANPHA 2002). Medical Assistance supports over 65 percent of the care provided to Pennsylvania's 85,000 nursing home residents (PANPHA 2001b).

While home care services are still primarily funded through the federal Medicare program, due to the expansion of waivers and other state initiatives, MA-financed home care services are expected to exceed Medicare in a matter of years (PHA 2001). Increased demand for MA-reimbursed home care services will also likely be driven by the U.S. Supreme Court's decision in *Olmstead* (1999), which requires states to care for individuals in the most integrated setting possible. In response to *Olmstead*, the Department of Health and Human Services has directed states to ensure the availability of community-based services by evaluating their available long-term care funding streams. States must make certain that their design allows for genuine consumer choice and that their public spending mechanisms do not hinder progress toward a fully-integrated system.

If Pennsylvania's long-term care system were funded like any conventional, privately financed industry, employers facing high rates of worker vacancies and turnover would compete in the typical way for a scarce labor supply. They would adjust prices to find the resources necessary to increase wages and benefits, and otherwise improve job quality, in order to attract and keep workers. However, since the Commonwealth and the federal government are the primary purchasers of services, long-term care must compete in the political arena for public dollars—with health care being only one of a wide array of public needs, and long-term care being only a portion of health care costs (PHI 2003a).

To balance these political choices—especially when state budgets are tight—public payers must implement cost-containment measures that constrict the reimbursement available per client service, per illness/episode, or per visit. Since direct-care labor typically accounts for the majority of costs in long-term care, these measures to a large degree shape the amount of dollars available to invest in workers. Consequently, where consumers and providers might both be willing to pay more to compete effectively for direct-care workers, they must first convince public payers (Pennsylvania, in this case) to adjust their reimbursements accordingly (PHI 2003a).

Many people believe that the Commonwealth's reimbursement policies are woefully out of sync with the current realities of the health care labor market. Reimbursement rates for both nursing and home care are based on retrospective provider cost data (including salaries, health insurance, training and other benefits) that is three to five years old. No mechanism exists for responding to unanticipated changes, such as the current recruitment and retention crisis. Since the historic wage base of direct-care workers becomes the basis upon which future rates are determined, reimbursement for wages and benefits continually lags behind current costs, contributing to the artificial suppression of direct-care wages and benefits.

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Pennsylvania's MA-reimbursement system for nursing homes also lacks rationality in connection to the true cost of providing quality care. While federal Medicare reimbursement is based on an individualized assessment of a consumer's care needs, Medical Assistance is generic. Rates are based on a facility- or agency-wide "case mix" index, determined by looking at an average level of care provided consumers on a random "picture date." Nursing home providers complain that this approach can at times understate the true cost of caring for consumers. Not only does the case mix method fail to account for changes in an individual's care needs throughout the year, it ignores the possibility that consumers with the most complex needs may temporarily be in the hospital, or have yet to be admitted to the facility.

In addition to using an obsolete reimbursement formula, the state has failed to adjust rates for years at a time, leading to generally inadequate funding levels for long-term care. Prior to an increase in the FY 2003 budget, the Commonwealth had not increased MA rates for home care for 11 years. According to the Pennsylvania Homecare Association (2001), home health aide services in 1999 cost an average of $50.53 per visit, but providers received only $37.00 per visit[10] in reimbursement, resulting in a $13.53 *loss* per visit.

Similarly, nursing homes report that despite rate increases, funding has not kept pace with costs, as resident acuity has increased over the last decade. The average MA reimbursement for nursing facilities in 1999 was $126.15 per day while providers report the average cost of care was $142.17 per day, resulting in a loss of more than $16 per day (PANPHA 2001b).

[10] A visit is defined at 55 Pa. Code, sec. 1249.2, as: "A personal contact in the recipient's residence made for the purpose of providing a covered service by a health care worker." Medical Assistance covers either part-time or intermittent care at one fee per visit. As determined by the Department of Public Welfare, a typical home health agency visit should not exceed two hours.

STATE REIMBURSEMENT FOR LONG-TERM CARE SERVICES

- Pennsylvania's long-term care expenditures increased by more than 600 percent between 1986 and 2002.
- Two-thirds of the Commonwealth's Medical Assistance budget is spent on long-term care.
- In 1999, home health aide services cost an average of $50.53 per visit, but providers received only $37.00 (rates increased for the first time in 11 years in the FY03 budget).
- In 1999, the average reimbursement to nursing facilities was $126.15 per day, while the average cost of care was $142.17 per day.
- Prior to a moderate increase in FY 2002, Personal Care Homes received $29 per day for residents whose care cost $60 per day.

Pennsylvania also funds services to residents in many of its almost 1,800 licensed Personal Care Homes (PCHs). PCHs provide supportive residential services to elders, people living with disabilities, and other adults who require assistance with their basic daily activities, but do not need nursing home level care. Through its State Supplement to SSI recipients, the Commonwealth contributes to the care of over 10,000 low-income residents (close to one-fifth of the total in these homes) (PANPHA 2001).

PCHs provide an important function in Pennsylvania's long-term care continuum, serving as a noninstitutional option for individuals who cannot be cared for in their homes or do not have adequate housing. Unfortunately, this system has never been funded in a way that would provide resources to invest in a well-paid, effectively-trained workforce. Unlike a number of states, Pennsylvania does not include personal care home services in its state Medicaid plan. Policymakers are reluctant to include this service as a Medicaid entitlement, fearing they could not then control the total cost of the program. However, were the Commonwealth to restructure its personal care home services as a Medicaid program, it would draw down federal dollars that could cover almost half the cost.

The state's sole reliance on the State Supplement leaves PCH residents inadequately funded. The Supplement provides less than $29.00 per day for resident care and, prior to a $2.00 per day increase in FY 2002, had not been raised since 1993. A recent study found that in an average personal care home in Pennsylvania, it costs approximately $60.00 per day to provide resident care (PANPHA and Shippensburg University 1999). This historic underfunding for residents is mirrored in the paltry investment in caregivers: Without adequate resources, PCH providers rank at or near the bottom of the industry in wages, benefits, and dollars invested in training (Leon et al. 2001).

Quality Assurance, Workloads, and Training

Pennsylvania monitors the quality of its long-term care services through the state Departments of Health (DOH), Aging (DOA), and Public Welfare (DPW). The DPW licenses personal care homes through its Office of Social Programs. The DOH licenses nursing facilities and home health agencies. The DOA administers

and sets standards for home- and community-based service waivers through its 52 Area Agencies on Aging. The Department of Public Welfare also sets conditions (in conjunction with federal requirements) for provider participation in the Medical Assistance program for both institutional and home- and community-based service providers.

Pennsylvania's regulatory and procurement systems pay little attention to measures related to the workforce.

Despite the connection between the quality of frontline caregiving jobs and the quality of care received by consumers, Pennsylvania's regulatory and procurement systems pay little attention to measures related to the workforce. Surveyors for the various licensing agencies are not directed to look at providers' turnover or retention figures, nor are there incentives in place that encourage providers to change the culture and design of the workplace. Many nursing home providers have even cited the survey process as a deterrent to organizational culture change. They fear that progressive practices that do not strictly comply with survey protocols will be found deficient without having been given the opportunity to succeed or fail.

Staffing standards for both nursing and personal care homes often do not reflect the realities of caregiving in those settings and, thus, contribute to unsafe workloads and rushed care. The nursing home standard of 2.3 staff hours per resident per day is far below that recommended by many experts and advocacy groups (NCCNHR 2000), and personal care homes are given significant discretion in determining whether they have sufficient staff to meet consumers' needs. Just as direct-care workers experience the negative effects of "working short," so do consumers and their families: The most common complaints filed with Pennsylvania's Long Term Care Ombudsman program in 2000 were those related to short staffing (U.S. Administration on Aging 2000).

To the degree that the state sets training requirements for long-term care workers, it shares responsibility for the inadequate preparation reported by many frontline caregivers. In contrast to the 75-hour minimum requirement for nurse aides in nursing homes, Pennsylvania requires its barbers and cosmetologists to have 1,250 hours of training (Pennsylvania Department of the Auditor General 1998). At present, training standards tend to focus on minimum entry-level requirements rather than giving workers what they need to perform in a complex and constantly changing care environment. Continuing education or in-service training requirements are minimal for workers delivering skilled care and nonexistent in other settings (e.g., personal care homes).

Home care training requirements are so variable that one expert has referred to the situation as the "wild west."

Direct-care workers consistently state that they want to be viewed as professionals and are willing to work to achieve that status (Long-Term Care Council 2002b). However, currently few mechanisms exist for career growth in long-term care. State agencies responsible for licensing and certification of long-term care providers pay limited attention to continued career growth or development among direct-care workers.

Furthermore, Pennsylvania nurse aides are "deemed competent," as opposed to being licensed or certified as in many other states. Medicare certifies home health aides, but this is mainly for reimbursement purposes, not to establish professional licensure. Credentialing of an occupation, however, has several benefits: It not only lends professional status, but also can establish a base for levels of advancement within that occupation. While Pennsylvania currently licenses occupations ranging from funeral directors to auctioneers, as well as a number of health care professions, it leaves requirements for direct-care workers to be determined within various long-term care regulations.

As a result, training standards tend to be tied to rigid level-of-care or reimbursement designations and to vary widely across provider type. Many workers get little or no formal training at all. For example, personal care homes have no formal requirements for direct-care staff, while nurse aides must have at least 75 hours of training. Furthermore, state licensure regulations allow home health agencies to forgo the 60 hours of classroom training required by the Commonwealth in favor of Medicare's "competency evaluation" standard. This standard requires no set amount of training prior to employment nor is there any objective measure for evaluating "competency."

Home care training requirements are so variable that one expert has referred to the situation as the "wild west." Variation may have some benefits, especially for consumers who wish to direct their own care (some consumers point out that standardized training often makes workers less willing to accommodate individual preferences). However, too little training can also leave workers without the qualifications and confidence they need to do the job well. Consumers' needs change quickly, and workers need the flexibility to respond to individuals who move across systems or who wish to age in place. Too great a disparity in quality and substance of training ignores this fluidity in the long-term care system.

The Commonwealth has significant resources and infrastructure to address some of these training issues through its workforce development system. The federal Workforce Investment Act provides funding through the state and local Workforce Investment Boards (WIBs) to link workers in search of jobs with industries that need workers. Among other services offered under the act are a variety of training programs for entry-level workers and those looking to upgrade their skills so they can move into better paying jobs. WIBs oversee the use of WIA funds and have broad leeway in determining local workforce development policies.

Until very recently, Pennsylvania's WIB had not made long-term care jobs a priority.[11] Part of the problem is that WIA policy is to support quality jobs that pay a living wage and have high retention—characteristics not typical of direct-care work. Several local WIBs, however, have focused on the potential for improvement in long-term care jobs in the Commonwealth. They have seen the growth in Pennsylvania's health care industry (high demand jobs that can't be taken out of the state) and have thrown their resources behind innovative training, peer mentoring, and career ladder programs.

Although the Pennsylvania WIB has begun to shift its focus in response to industry demands, certain categorical and substantive restrictions still remain as obstacles to these resources being used for a range of training and retention initiatives within long-term care. The WIB has only started to explore, for example, the use of WIA and other workforce development dollars for supervisory training and to encourage better organizational practices among providers.

Pennsylvania is at a pivotal point in reconceiving its long-term care public policy. The surge in demand caused by aging baby-boomers, combined with the desire of both older and younger consumers to be served in community-based settings, will require fundamental changes in how the Commonwealth structures, funds, and oversees long-term care services. Although challenging, this situation provides an opportunity for state government to reform its direct-care workforce policies to ensure consistent, quality care.

[11] The Governor's FY2003 budget included $24 million for Critical Job Training Grants, designed to give displaced workers quick access to training, retraining, and education for high-demand jobs and occupations with immediate openings. Of the funded projects, 65 percent were from the health care industry. The Pennsylvania WIB has also convened a task force on Health Care Workforce Shortages to assist in addressing the critical vacancies among workers.

PART III.
THE IMPACT: IMPLICATIONS FOR QUALITY OF CARE

Industry practice and public policy have combined to limit the quality of direct-care jobs in Pennsylvania and have contributed to the unprecedented turnover rates among frontline positions. All three key stakeholders in the long-term care system—workers, providers, and consumers—feel the consequences. *Workers* struggle financially and frequently work under conditions that interfere with their ability to do the best job possible. *Providers* incur the high costs of recruiting and retaining workers as well as lost income from service cuts. But it is *consumers* who suffer the most when there are not enough quality caregivers.

As health care researchers have long understood, there is a direct connection between quality jobs and the quality of client care. Studies have repeatedly confirmed that consumers' perception of the quality of their care is deeply rooted in the quality of their relationship with their caregivers (IOM 1986; PHI 2001; Wilner and Wyatt 1998).[12] Where conditions impede the ability of direct-care workers to perform effectively—or bring about their departure—it is impossible for this relationship to develop. Thus, consumers recognize the need to improve working conditions and to support caregivers, if there is to be a familiar, experienced workforce to meet their needs (Schuylkill County Resident Council Group 2002).

The instability of the direct-care workforce affects consumers in several ways:

- When there are insufficient numbers of staff, workers are forced to serve relatively more clients. Consumers receive rushed and unsafe care. Workers may have to lift or transfer clients without the necessary assistance, resulting in injury to themselves *and* the consumer. Staff may not have time to perform essential daily tasks thoroughly or competently, such as bathing and feeding. Nurse aides report that the first things to be neglected when they are short staffed are range of motion and other restorative nursing care, keeping residents hydrated, and giving residents enough time and assistance with eating (Hawes 2002).
- Stressful working conditions, staff burnout, and inadequate training are all factors generally viewed as causing or contributing to abuse and neglect of consumers. Low staffing levels and inadequate training have been identified as the most significant preventable causes of abuse and neglect in long-term care (Hawes 2002).
- Even when there are sufficient numbers of staff, high turnover interferes with the continuity of care for consumers. Constant replacement of staff precludes

[12] Also see Grace Clement, *Care, Autonomy, and Justice* (1996), for the notion that for a true ethic of care to exist, the relationship between caregiver and care recipient must be based on the autonomy and dignity of each, not just within the relationship, but as valued by society.

the development of relationships that are integral to the individualized care that consumers desire. At its best, caregiving is a personal relationship; it thrives on familiarity and the intimate knowledge of both parties of the other's routines and preferences. Constant churning of staff interrupts this relationship as consumers and new workers must continually reorient to each other.

- Continuous upheaval in the workforce means some consumers won't be served at all. Of Pennsylvania providers, 25 percent report that they have cut back services in response to the recruitment and retention crisis. Cutbacks have been highest among home health providers, with approximately half reporting a reduction in services (PHA 2001; Leon et al. 2001). The lack of access to home- and community-based services is most severe at the very moment when the Commonwealth is looking to meet increasing demand for services in consumers' own homes.

Studies have repeatedly confirmed that consumers' perception of the quality of their care is deeply rooted in the quality of their relationship with their caregivers.

PART IV.
STRATEGIES FOR CHANGE

Section A: The Vision

Pennsylvania stands in a uniquely favorable position to respond to its current long-term care workforce crisis. Various statewide organizations have already collected and analyzed an impressive amount of information in an attempt to move toward genuine solutions.[13] In addition, providers, consumer advocates, and labor are all in agreement about the threats posed to Pennsylvania's long-term care system. This is key: An effective resolution of the direct-care staffing crisis in Pennsylvania requires that all major stakeholder groups work collaboratively to restructure direct-care employment.

Several statewide coalitions have already organized individually around this issue and are moving forward to address the present crisis. The Pennsylvania Intra-Governmental Council on Long-Term Care's Workforce Issues Work Group produced three reports on Pennsylvania's frontline workers and followed them up with a set of recommendations that address a number of issues, including improved compensation and better training. The Work Group continues to meet and has been successful in obtaining funding from the Commonwealth for recruitment and retention initiatives. The Long-Term Care Council's most recent publication reports on follow-up focus group sessions in which frontline workers detail their experiences and concerns regarding caregiving work (Long-Term Care Council 2002b).

The Pennsylvania Culture Change Coalition also focuses on workplace issues, in its efforts to transform the core values underlying the provision of long-term care in the Commonwealth. The Culture Change Coalition has organized providers, consumers, and labor advocates from across Pennsylvania around the values of the Pioneer movement, which recognizes that the primary caregiving relationship is strengthened by practices that dignify and value workers. The Coalition, through its best practices and education committees, is poised to become a primary resource for long-term care providers interested in innovative organizational practices.

[13] The Pennsylvania Intra-Governmental Council on Long-Term Care with the Polisher Research Institute, the Keystone Research Center, the Service Employees International Union, and the Southwestern Pennsylvania Partnership on Aging have all produced reports documenting the direct-care worker crisis in Pennsylvania. In addition, the three major long-term care trade associations representing private nursing homes and home care agencies have all identified workforce recruitment and retention as key policy issues.

In addition to these groups, other local and regional initiatives have emerged to try to find solutions to the workforce crisis in long-term care. These efforts have brought together individual long-term care providers, provider associations, labor unions, workforce development, and community-based organizations to respond to specific regional issues surrounding recruitment and retention.[14] These initiatives demonstrate the potential for innovation when private stakeholders take the lead in designing and implementing solutions that are tailored to a specific component of the workforce problem. For example:

An effective resolution of the direct-care staffing crisis in Pennsylvania requires that all major stakeholder groups work collaboratively to restructure direct-care employment.

- **A nursing home in western Pennsylvania has transformed its workplace practices** to include: a team approach to caregiving, mentoring programs, flexible scheduling, and career ladders for all departments. Turnover in the home has been reduced by 57 percent and for 2001 was only 18 percent. The facility has not used temporary agency staff since October 2000.
- **Three local Workforce Investment Boards covering ten counties in central Pennsylvania initiated a public awareness campaign encouraging people to consider careers in long-term care**. Piecing together diverse funding streams, this group, in partnership with local providers, has created innovative skills training and career ladder programs designed to make long-term care jobs more attractive. For the future, this group is seeking to expand their initiative to include training for frontline supervisors.
- **A labor organization representing health care workers in Philadelphia conducts a multifaceted training program for direct-care workers**. The course is an expanded, 16-week entry-level training program for nurse aides that includes development of job-readiness and "soft" skills (such as problem solving) in addition to more traditional clinical skills.
- **A Philadelphia-area consumer advocacy agency has created several innovative educational initiatives**, including a long-term care ethics resource and a resident abuse-prevention training program. The training program focuses on teaching frontline caregivers how to recognize and resolve the difficult issues

[14] The sum of these efforts has created the potential for Pennsylvania to attract national foundation dollars for initiatives focusing on the direct-care workforce. A consortium of Pennsylvania stakeholders is currently being considered as a grantee under the Robert Wood Johnson Foundation and The Atlantic Philanthropies' "Better Jobs/Better Care" program, which will fund demonstration projects designed to increase recruitment and retention of frontline caregivers.

Policymakers wary of having to balance competing interests are more likely to respond to a unified, coalitional voice calling for a renewed vision on behalf of Pennsylvania's frontline caregivers.

that may contribute to abuse of consumers. This agency has also partnered with a local provider organization to conduct nurse aide support groups in a number of their nursing homes and to have a ready laboratory in which to develop future trainings. The provider, as part of its commitment to direct-care workers, has implemented comprehensive in-house training, career ladders, and mentoring programs for its nursing assistants.

To achieve the vision of a stable, valued, and well-trained direct-care workforce, it is essential that out of these distinct initiatives a cohesive statewide stakeholder advocacy effort emerge. Pennsylvania's diverse geo-politics demand comprehensive, balanced solutions that can synthesize the perspectives of two large urban centers and the variety of small towns and rural centers in between.

Pennsylvania's political culture is characterized by pragmatism, a tendency to favor incremental over rapid change, and a bias toward localized rather than top-down solutions (Pennsylvania Economy League 1997). Thus, fundamental change in long-term care industry practice as well as legislative and regulatory policy is far more likely to occur if all the communities that are affected by the workforce crisis understand their common stake in this issue and are willing to join in crafting practical, yet creative solutions. Consumers, workers, and providers all bring a particular set of issues to this table; policymakers wary of having to balance competing interests are more likely to respond to a unified, coalitional voice calling for a renewed vision on behalf of Pennsylvania's frontline caregivers.

While diverse stakeholder participation is essential, it is equally important to redesign, in concert with one another, the separate policymaking worlds that converge within long-term care. Key state agencies (Aging, Health, Public Welfare, Education, Labor and Industry) must engage in a shared effort to restructure long-term care public policy around the quality job/quality care connection. State financing and regulatory policy should be centered on a core ethic of care that recognizes a stable, competent, and respected caregiving workforce as essential to preserve the dignity and autonomy of Pennsylvania's elderly and people living with disabilities. Effective state action can guide providers toward practices that recognize the dignity of caregiving work, provide fair compensation, and facilitate strong relationships between caregivers and consumers.

These changes should create a long-term care system that guarantees the following:

- **For Consumers:** Uninterrupted access to care and services in the setting of their choice, provided by dependable, qualified caregivers.
- **For Workers:** A quality position as a caregiving professional. This includes self-sufficient wages, family health benefits, adequate and effective training, opportunities for advancement, and a safe, supportive work environment.
- **For Providers:** Public policies that support effective workplace practices and the ability to attract and retain an adequate base of skilled, direct-care staff—as well as the resources to pay for these essentials. Providers can then avoid the unnecessary expenditure of human and financial capital required to replace a constantly churning workforce.

A living wage, the opportunity to succeed, and recognition for a job well done are things all workers want from their employers.

This vision is founded on public and private strategies that advance the essential elements of a high-quality health care job. These elements are not particularly revolutionary in scope or implementation. A living wage, the opportunity to succeed, and recognition for a job well done are things all workers want from their employers.

Section B:
Recommendations for Action

The following recommendations for state public policy and industry practice call for better compensation, restructuring of workplace culture and practice, and improving the status of frontline caregiving. These recommendations should be explored as part of a comprehensive strategy to address the long-term care staffing crisis. No single action alone is going to be a panacea, nor can staffing problems be resolved over the long-term without coordination by diverse stakeholders across all long-term care delivery systems. Working together within this framework, however, key actors in Pennsylvania's long-term care system can marshal the various initiatives already under way to create a stable, quality workforce that will provide better care for consumers both now and in the future.

SUMMARY OF RECOMMENDATIONS

	State Government	Providers
Wages and Benefits	Implement long-term care financing systems that promote and support self-sufficient wages and adequate benefits. Explore wage-specific reimbursement initiatives. Study health insurance status and needs of direct-care workers.	Employ wage rates and structures that recognize skills, experience, and the value of services, toward insuring a family self-sufficient wage. Offer adequate benefits, including health insurance, paid holidays and sick time, child care, and others that improve the value of work.
Workplace Practice and Organizational Culture	Use regulatory and reimbursement systems to encourage, as well as enforce, good workplace practices. Integrate workforce measures into quality of care standards. Set adequate staffing levels. Ban unsafe practices (e.g., mandatory overtime). Fund demonstration projects in organizational culture change.	Redesign the culture of direct-care work around the relationship between the caregiver and the consumer. Establish workplace practices that are supportive, safe, and recognize worker's rights under the law. Provide training for frontline supervisors.
Training	Set more uniform, versatile, and useful training requirements across long-term care settings. Use the workforce development and other public systems to create and fund better training and skills building.	Invest in better training, including: Sufficient hours, relevant content, adequate preparation, and continuing education. Provide workplace orientation, peer mentoring, and on-the-job-training to new workers
Opportunities for Advancement	Create different levels of certification within the frontline caregiver position. Fund career ladder programs. Expand scope of practice so direct-care workers can learn new skills.	Create genuine career ladder programs within the direct-care position that include recognition, promotion, and increased compensation.
Job Supports	Maintain and promote programs that assist low-wage workers (tax credits, child care and transportation assistance, basic health coverage, etc.).	Assist direct-care workers in accessing and securing public benefits and other supports available to them.

1. Improve Wages and Benefits

State Action

As the primary financier of long-term care services, the Commonwealth can influence how resources are used to improve the value of direct-care work. Public financing systems must allocate sufficient resources to providers so that they can pay self-sufficient wages and offer health insurance and other benefits to direct-care workers. The state should:

- **Review its reimbursement structures and regulations** to ensure that all long-term care services—nursing home, personal care homes, and home- and community-based care—are funded in a manner that both reflects current labor market realities and maximizes consumer preferences. Funding levels should support choice across the continuum and eliminate any bias toward institutional over home- and community-based services. Financing sources should encourage parity of compensation across long-term care sectors.
- **Explore (possibly through local or regional demonstration projects) targeted wage enhancement initiatives** that are designed to improve wages and benefits. Examples include dedicated funding for wage increases and establishing wage "floors" for publicly financed services, based on the local self-sufficiency standards. Any initiative of this kind must ensure that dedicated funds actually reach direct-care workers (accountability) and that enhancements are renewed (continuity). In addition, two other important factors shape the efficacy of wage enhancements: The size of the increase needs to be sufficient to make an impact on workers' choices, and the increase must be enacted in collaboration with improvements in other elements of the job (PHI 2003b).
- **Generate an independent study of the health insurance status and needs of direct-care workers**. This could be done as part of a larger examination of all of the Commonwealth's uninsured workers and families. Particular attention should be paid to the barriers faced by long-term care providers in securing group health care coverage for their frontline workforce and the ability of workers to contribute to their premiums.

Industry Practice

Although governmental and other third-party payers largely determine provider revenues across long-term care, providers themselves retain some

Given the link between a quality job and quality care, Pennsylvania ought to use its regulatory and reimbursement systems to advocate for the proposition that maintaining a quality workforce is the best way to serve consumers.

degree of discretion over how total payments are allocated among all their costs, including the cost of direct-care labor. Providers should:

- **Review how their resources are currently allocated to see how to increase wages and benefits**. If providers create more attractive working conditions, they may find that money that currently goes to recruiting and training new workers can shift to supporting a more stable workforce.
- **Commit to compensating direct-care workers in a way that reflects the social and market value of their work**. Though resources may be limited, providers can evaluate priorities and make a commitment to begin implementing incremental wage increases that make a difference to workers.

2. Improve Caregiving and Workplace Practices

State Action

The Commonwealth has the ability to shape workplace practices and the quality of direct-care work through its reimbursement and quality assurance mechanisms. This need not take the form of heavy-handed regulation. Instead, state agencies can encourage effective workplace practices among long-term care providers simply by demonstrating that they are paying attention to job quality. More formal incentives could be established through the public funding system. Given the link between a quality job and quality care, Pennsylvania ought to use its regulatory and reimbursement systems to advocate for the proposition that maintaining a quality workforce is the best way to serve consumers. The Commonwealth should explore the following actions:

- **Incorporate measures of job quality, retention, and longevity into quality assurance standards**, as well as in the state's nursing home, personal care, and home health agency survey process. Publish this information on public websites and in guides that assist consumers and their families when comparing and choosing long-term care services.[15] This effort should include educating regulatory agency staff on issues related to the direct-care workforce.

[15] The Institute for the Future of Aging Services (IFAS) and the Paraprofessional Healthcare Institute (PHI) have developed a web-based database that catalogues innovative recruitment and retention practices among long-term care providers (www.directcareclearinghouse.org/practices).

- **Incorporate workforce-related factors into conditions of participation in Medicaid-waiver programs** to create incentives for providers to focus on practices that increase retention and job quality. The Departments of Aging and Public Welfare, through their local administrative entities, have the authority to determine who may be a provider under the various Medicaid-waiver programs.
- **Set realistic facility staffing levels** that will allow workers to deliver safe, attentive, quality care. In home- and community-based services, structure reimbursements and service delivery so that workers have enough time to serve consumers safely and effectively.
- **Fund demonstration projects and applied research** to explore the implementation and efficacy of organizational culture change. Projects should be inclusive of changes in caregiving and workplace practices such as training, supervision, and career ladders, and have a strong evaluative component so that experiences can be disseminated among stakeholder networks and inform public policy.

The long-term care industry must explore ways to redesign care delivery and the structure of direct-care work.

Industry Practice

The quality of direct-care work is not simply a matter of better compensation. Frontline workers desire a job design that recognizes their skills as well as their special knowledge of the client. Equally as important, workers want support from their supervisors.

The long-term care industry must explore ways to redesign care delivery and the structure of direct-care work. There is strong evidence that providers who are open to genuine change in the culture of long-term care and who institute these types of changes experience improved worker retention (Leon et al. 2001). Long-term care agencies and facilities should:

- **Provide individualized, consumer-centered care** in both nursing homes and community-based settings. Innovations such as care plans written from the perspective of the consumer and consistent assignment of direct caregivers have shown promising results (Eaton 2001).
- **Develop inclusive, supportive management and supervisory practices**. Traditional supervision tends to be based on the "discipline and punish" model; however, workers often respond more positively to

Investment in long-term jobs will enhance economic development and job growth in Pennsylvania by taking advantage of a job sector that is already growing.

coaching approaches that support the development of problem-solving skills while holding the worker accountable to workplace policies.

- **Recognize the primacy of the caregiving relationship**. The caregiver-consumer relationship is at the heart of quality care; thus, the cultures of all long-term care institutions need to support this relationship.
- **Recognize caregivers' skills and intimate knowledge of consumers** by including frontline caregivers in care planning and decision making. Bringing direct caregivers into the care-planning process enriches the discussion. Because of their regular contact with those they care for, direct-care workers are often more aware than licensed staff of changes in the consumer's mental or physical state.

- **Recognize the right of workers to choose freely to join unions or form their own associations**. A supportive workplace culture is a "win-win" for workers and employers. Where workers are organized, employers and labor should seek opportunities to partner to effect positive changes in workplace culture that reduce turnover and improve the quality of care.
- **Provide training for frontline supervisors**. Many frontline supervisors in long-term care have no training in managing direct-care workers. To adequately support these workers, supervisors need to develop communication, problem solving, and coaching skills.

3. Improve Training Standards

State Action

The Commonwealth must ensure that direct-care workers have the necessary preparation and skills to do a good job. Training standards should reflect the increasing complexity of providing long-term care, as well as the fact that frontline caregivers view themselves as professionals. Workers want better (not necessarily more) quality training that is relevant, practical, and consistent.

Inherent in this recommendation is the principle that federal, state, and local education, welfare and workforce development resources should be

maximized to support quality training programs.[16] Additionally, any common long-term care curriculum should be shaped around the dignity of the caregiving relationship, supporting the rights of both workers and consumers. Finally, the right of consumers to direct their own care and educate their attendants must be maintained. To enact these changes, the Commonwealth should:

- **Review and upgrade current training standards**. Expand entry-level training curricula to include soft skills such as problem solving and communication and specialized training in caring for people with dementia. Integrate hands-on experience prior to the first day on the job.
- **Make training requirements more consistent**. Reduce or eliminate the disparity across the long-term care system so that credentials and skills are portable. This would provide workers greater flexibility, while also expanding the pool of potential employees for employers.
- **Use the statewide workforce development system to upgrade training and direct-care workforce systems** as follows:
    - Ease both categorical restrictions on who can be trained with money from the federal Workforce Investment Act (WIA) and substantive restrictions on what money can be used for (e.g., allow money to be used for retention activities like supervisor training as well as entry-level training).
    - Use training funds to encourage model workplace practices. The Commonwealth should only fund training for long-term care providers that pay a living wage and engage in effective retention practices.
    - Have local WIA-funded "One Stop" offices serve as a clearinghouse for information on good employers.

These actions will send a message from the Commonwealth that quality employers will have an advantage in accessing the workforce development system for workers as well as training dollars. Investment in long-term care jobs not only leads to better jobs and better care—investment will also enhance economic development and job growth in Pennsylvania by taking advantage of a job sector that is already growing.

[16] Recent examples include funding through the Department of Public Welfare in 2001 for direct-care worker apprenticeship programs and the Critical Job Training grants provided through the Team Pennsylvania/Career Link program.

Workers must have genuine opportunities for career growth.

Industry Practice

Studies show that quality training has a positive effect on retention (Leon et al. 2001). Providers should invest in employer-based training beyond the basic requirements of long-term care regulation in order to give workers the start they need. On-the-job training and peer mentoring programs are examples of methods used to supplement pre-employment and entry-level training. Employers need to:

- **Recognize the importance of initial training and orientation** and make skills-building and continuing education part of each agency's culture. A strong initial foundation is essential for all direct-care workers, but this needs to be combined with a continuing education program that provides workers opportunities to grow personally and professionally.
- **Employ a dedicated trainer or team of trainers with experience in adult learner-centered education** so that training is relevant, accessible, and consistent. Many direct-care workers enter training with a history of negative experiences in the classroom. Training programs that incorporate active learning, recognize multiple learning styles, and emphasize relevancy provide a strong foundation for success.
- **Focus on soft skills such as communication and problem solving** in addition to clinical training. These skills are essential for workers to establish strong relationships with consumers and their families and the caregiving team.
- **Provide ongoing support for new direct-care workers** through peer mentoring and on-the-job training programs. Direct-care workers often leave their jobs during the first three months of employment. During these early weeks on the job, new workers need support to solve unexpected problems and to deal with the emotional issues that often arise when caring for people with complex physical and emotional needs.

4. Create Opportunities for Career Advancement

State Action

To improve the status of direct-care work and create options for career paths for workers, state government should expand credentialing for front-line workers and help to fund programs that allow workers to advance in

the caregiving profession. Specific actions the Commonwealth could take include the following:

- **Encourage career development by creating levels of certification *within* the frontline position**. This could include establishing a basic level of certification for all direct-care workers and then creating additional job levels with specific training requirements, reimbursement levels, and job titles.
- **Review the present scope of practice rules** to make sure there are no barriers to possible career path programs. Explore the possibility that certain tasks currently performed by nurses could be delegated to direct-care workers, without compromising quality of care or usurping the position of licensed professional staff.
- **Explore development of career ladders** through statewide systems that focus on expanding workers' skills and addressing the needs of industries where demand for workers is high. Current examples include funding for Critical Job Training through the Workforce Investment Boards and the Department of Public Welfare's funding of apprenticeship programs for home- and community-based care.

Industry Practice

In order to retain an experienced, qualified workforce within direct-care practice, providers must structure their organizations so that direct-care workers are viewed as valued professionals. Workers must have genuine opportunities for career growth and development that are recognized within the organization. Providers should:

- **Create career pathways for workers by partnering with government and educational institutions**. Pathways can include development of mentoring and leadership skills or specialized clinical skills. Increased training and skills building should be accompanied by higher compensation and improved job status.

5. Provide job supports

State Action

Given the low pay and few benefits afforded direct-care work, many workers rely on public benefits to fill the gaps. In the long run, public resources must be committed to long-term care so that workers can earn self-sufficient wages. More immediately, however, frontline workers and their

families (as well as all low-income families) need to be able to access programs that help bolster their incomes and support them through the multiple life-challenges they face. It is important that the state:

- **Maintain funding for programs that support low-wage working people**. These include: the Pennsylvania Tax Back Program, Family Savings Accounts, Adult Basic Health Coverage, the Children's Health Insurance Program, and subsidized child care. The Commonwealth should also explore whether programs need to be added, expanded, or better funded.
- **Promote state and federal programs and benefits available to low-wage working people** through Commonwealth agencies (e.g., Public Welfare or Community and Economic Development). One example is the *Public Benefits Resource Guide*, which is being developed by the Pennsylvania Intra-Governmental Council on Long-Term Care.

Industry Practice

Long-term care employers should be encouraged to assist direct-care workers in accessing and securing public benefits and other supports available to them. For example, employers could:

- **Help workers identify resources for income supports, affordable housing, child care services, transportation benefits, and energy assistance**, by developing resource guides that list services and programs that are available locally. An excellent example is the Pennsylvania Association of Non-Profit Homes for the Aging's *Employee Resource Guide* released in the fall of 2001.
- **Establish a quasi-"case management" function to assist employees in accessing supports**, either through the human resources department or by partnering with nonprofit, community-based organizations that provide these services.[17]

Section C:
The Vehicle: A Statewide Stakeholder Approach

Previous analyses of the long-term care workforce crisis in Pennsylvania have recognized that no singular approach will produce sustainable results (Leon et al. 2001; SWPPA 2001). "Workable solutions are possible only if there is close

[17] For an in-depth description of a range of creative employer support activities, see *Finding and Keeping Direct Care Staff* (Paraprofessional Healthcare Institute and the Catholic Health Association 2003).

cooperation between the various government departments and agencies and between the different provider segments within the long-term care industry" (Leon et al. 2001, 56). In addition, the voices of consumers, workers, and their advocates all must be included as Pennsylvania undertakes its next steps in solving this urgent problem.

In order to develop and implement a rigorous strategy for immediate action centered on public policy and practice-based reform, stakeholders must begin to transform general understanding and broad-based recommendations into concrete proposals for change. Drawing from the discrete efforts already in place, Pennsylvania's consumer advocates, providers, labor unions, and worker advocates need to cultivate specific efforts targeted at improving compensation, training, caregiving and workplace practices, and career opportunities for the Commonwealth's direct-care workers.

Stakeholders must begin to transform general understanding and broad-based recommendations into concrete proposals for change.

The most effective vehicle for these efforts is a diverse coalition whose members are drawn from these key stakeholder constituencies. This coalition should be a freestanding entity, independent of state government or the primary influence of any one stakeholder group. The coalition could set the stage for concerted, multi-stakeholder advocacy or provide a base for the emergence of smaller working partnerships.

The most important feature of such a group, however, will be its commitment to establishing common ground. Coalitions often fracture at crucial moments because members find it impossible to let go of their individual agendas in order to advance group goals. In Pennsylvania, a network of individual organizations that is capable of combining their expertise and political clout can wield enormous power. If the diverse members of that group can simultaneously acknowledge their individual agendas and yet advocate in a unified voice, there exists the potential for substantial systemic change.

An excellent example of this type of coalition is Massachusetts' Direct Care Worker Initiative. In 2000 this group of providers, consumers, organized labor, and worker advocates was successful in getting implemented a $42 million "Nursing Home Quality Initiative." This legislation addressed staffing shortages and quality issues by allocating funds for improved wages, training, and career advancement.

Pennsylvania needs a comparable coalition, one whose membership is open to new possibilities and not trumpeting simply one approach. Some early discussions within the Commonwealth involve the possibility of creating a new nonprofit organization with the stated mission of improving the quality of direct-care work. Member agencies, while not abandoning their primary objectives, would all agree that when working within this new organization, workforce issues would guide their individual agendas. Whatever its form, a cohesive yet flexible coalition, building on a strong foundation of work already done, can advance those efforts toward a concrete agenda of advocacy and reform—improving the quality of long-term care by improving the quality of jobs for direct-care workers.

PART V.
CONCLUSION

The direct-care workforce crisis in Pennsylvania is a complex and multifaceted problem that requires a concerted response by all the key actors across the Commonwealth's long-term care system. A number of stakeholder groups (The Intra-Governmental Council on Long-Term Care's Workforce Issues Group, Keystone Research Center, and the Southwestern Pennsylvania Partnership on Aging) have examined the issue and have begun to explore various strategies for improving the recruitment and retention of frontline staff. However, regional dissimilarities combined with a fragmented long-term care system create obstacles to bringing these various efforts together.

If Pennsylvania is to develop a coherent strategy to attract and retain a stable caregiving workforce that can deliver quality care, policymakers and health care providers must be willing to make the necessary financial and philosophical investment to move present initiatives to the next level. It is essential that policymakers review how Pennsylvania designs, regulates, and funds long-term care and equally vital that the industry reinvent how it recruits, trains, and supports its direct-care staff.

It is essential that policymakers review how Pennsylvania designs, regulates, and funds long-term care and equally vital that the industry reinvent how it recruits, trains, and supports its direct-care staff.

We cannot expect to arrive at a new destination by treading the same path. Through collaboration, vision, and openness to change, Pennsylvania can begin to respond to the present challenges and develop a stable frontline workforce that will deliver quality care both now and in the decades to come.

APPENDIX.
SELF-SUFFICIENCY STANDARDS

These four tables represent self-sufficiency standards for: Forest County, Erie County (Edinboro Borough), Delaware County, and Allegheny County (City of Pittsburgh). SOURCE: The Self-Sufficiency Standard for Pennsylvania (Pearce and Brooks 2001).

Forest County

	Adult	Adult + infant	Adult + preschooler	Adult + infant preschooler	Adult + schoolage teenager	Adult + infant + preschooler schoolage	2 Adults + infant preschooler	2 Adults + preschooler schoolage
Monthly Costs								
Housing	$363	$434	$434	$434	$434	$567	$434	$434
Child Care	$0	$455	$365	$821	$240	$1,061	$821	$606
Food	$168	$246	$255	$330	$437	$444	$475	$521
Transportation	$217	$251	$251	$251	$251	$251	$482	$482
Health Care	$79	$201	$179	$222	$227	$243	$278	$256
Miscellaneous	$83	$159	$148	$206	$159	$257	$249	$230
Taxes	$207	$375	$322	$504	$200	$652	$620	$543
Earned Income Tax Credit (-)	$0	($62)	($94)	($19)	($210)	$0	$0	$0
Child Care Tax Credit (-)	$0	($46)	($48)	($80)	($48)	($80)	($80)	($80)
Child Tax Credit (-)	$0	($42)	($42)	($83)	($12)	($125)	($83)	($83)
Self-Sufficiency Wage								
Hourly	$6.35	$11.20	$10.06	$14.69	$9.54	$18.58	$9.07 per adult	$8.26 per adult
Monthly	$1,118	$1,971	$1,770	$2,586	$1,678	$3,271	$3,193	$2,907
Annual	$13,411	$23,657	$21,244	$31,031	$20,141	$39,247	$38,318	$34,889

Allegheny County – City of Pittsburgh

	Adult	Adult + infant	Adult + preschooler	Adult + infant preschooler	Adult + schoolage teenager	Adult + infant + preschooler schoolage	2 Adults + infant preschooler	2 Adults + preschooler schoolage
Monthly Costs								
Housing	$524	$631	$631	$631	$631	$791	$631	$631
Child Care	$0	$519	$519	$1,038	$343	$1,382	$1,038	$862
Food	$168	$246	$255	$330	$437	$444	$475	$521
Transportation	$222	$256	$256	$256	$256	$256	$491	$491
Health Care	$79	$201	$179	$222	$227	$243	$278	$256
Miscellaneous	$99	$185	$184	$248	$189	$312	$291	$276
Taxes	$312	$575	$569	$770	$504	$987	$897	$829
Earned Income Tax Credit (-)	$0	$0	$0	$0	($56)	$0	$0	$0
Child Care Tax Credit (-)	$0	($40)	($40)	($80)	($40)	($80)	($80)	($80)
Child Tax Credit (-)	$0	($42)	($42)	($83)	($83)	($125)	($83)	($83)
Self-Sufficiency Wage								
Hourly	$7.98	$14.38	$14.27	$18.93	$13.69	$23.92	$11.19 per adult	$10.52 per adult
Monthly	$1,404	$2,531	$2,512	$3,333	$2,409	$4,210	$3,937	$3,704
Annual	$16,850	$30,374	$30,139	$39,991	$28,904	$50,522	$47,248	$44,447

Erie County – Edinboro Borough

	Adult	Adult + infant	Adult + preschooler	Adult + infant preschooler	Adult + schoolage teenager	Adult + infant + preschooler schoolage	2 Adults + infant preschooler	2 Adults + preschooler schoolage
Monthly Costs								
Housing	$457	$538	$538	$538	$538	$695	$538	$538
Child Care	$0	$460	$442	$902	$260	$1,162	$902	$702
Food	$168	$246	$255	$330	$437	$444	$475	$521
Transportation	$221	$255	$255	$255	$255	$255	$490	$490
Health Care	$79	$201	$179	$222	$227	$243	$278	$256
Miscellaneous	$93	$170	$167	$225	$172	$280	$268	$251
Taxes	$247	$435	$419	$588	$340	$746	$698	$627
Earned Income Tax Credit (-)	$0	($26)	($36)	$0	($147)	$0	$0	$0
Child Care Tax Credit (-)	$0	($42)	($44)	($80)	($46)	($80)	($80)	($80)
Child Tax Credit (-)	$0	($42)	($42)	($83)	($59)	($125)	($83)	($83)
Self-Sufficiency Wage								
Hourly	$7.19	$12.47	$12.12	$16.46	$11.23	$20.57	$9.90 per adult	$9.15 per adult
Monthly	$1,265	$2,195	$2,133	$2,897	$1,977	$3,621	$3,485	$3,221
Annual	$15,176	$26,339	$25,600	$34,763	$23,719	$43,449	$41,820	$38,657

Delaware County

	Adult	Adult + infant	Adult + preschooler	Adult + infant preschooler	Adult + schoolage teenager	Adult + infant + preschooler schoolage	2 Adults + infant preschooler	2 Adults + preschooler schoolage
Monthly Costs								
Housing	$657	$812	$812	$812	$812	$1,016	$812	$812
Child Care	$0	$546	$572	$1,118	$328	$1,446	$1,118	$900
Food	$168	$246	$255	$330	$437	$444	$475	$521
Transportation	$255	$293	$293	$293	$293	$293	$566	$566
Health Care	$79	$201	$179	$222	$227	$243	$278	$256
Miscellaneous	$116	$210	$211	$278	$210	$344	$325	$306
Taxes	$341	$606	$611	$801	$542	$1,036	$926	$849
Earned Income Tax Credit (-)	$0	$0	$0	$0	$0	$0	$0	$0
Child Care Tax Credit (-)	$0	($40)	($40)	($80)	($40)	($80)	($80)	($80)
Child Tax Credit (-)	$0	($42)	($42)	($83)	($83)	($125)	($83)	($83)
Self-Sufficiency Wage								
Hourly	$9.19	$16.09	$16.21	$20.97	$15.49	$26.24	$12.32 per adult	$11.50 per adult
Monthly	$1,617	$2,832	$2,852	$3,691	$2,726	$4,618	$4,336	$4,046
Annual	$19,400	$33,979	$34,227	$44,289	$32,717	$55,420	$52,030	$48,557

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Additional Publications Available from the Paraprofessional Healthcare Institute

Effective Practice Descriptions

Training Quality Home Health Aides. Spring 2003.
A description of the learner-centered training practices employed by the Cooperative Healthcare Network.

Finding and Keeping Direct Care Staff, by the Catholic Health Association and the Paraprofessional Healthcare Institute. Catholic Health Association, 2003.
This guide provides employers with immediate, concrete suggestions on how to find and keep direct-care staff.

"Introducing Peer Mentoring in Long-Term Care Settings." *Workforce Strategies* No. 2. May 2003.
This publication identifies the benefits of mentoring programs, defines the peer mentor's role, discusses critical mentoring skills, and outlines the key design elements that long-term care organizations need to consider when developing their own peer mentor programs.

"The Right People for the Job: Recruiting Direct-Care Workers for Home- and Community-Based Care," by the Paraprofessional Healthcare Institute and MEDSTAT. *Workforce Tools,* Vol. 1, No. 1. Centers for Medicare and Medicaid Services. Fall 2002. (8 pages.)
This publication provides agencies and individual consumers with straightforward information on how to recruit, assess, and select personal assistance workers and home health aides.

Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision. 2001. (22 pgs.)
An introduction to coaching supervision: how coaching differs from traditional supervisory practice, the skills needed to become an effective coach, and the organizational structures that make coaching effective.

Recruiting Quality Health Care Paraprofessionals. August 2000. (26 pgs.)
A description of the successful recruiting strategies used by the Cooperative Healthcare Network.

Case Studies

We Are the Roots, by Ruth Glasser and Jeremy Brecher. University of California Center for Cooperatives, 2002. (130 pgs.) $10 plus shipping and handling.
We Are the Roots tells the compelling story of Cooperative Home Care Associates (CHCA), a highly successful worker-owned agency in the South Bronx. Through the voices of managers and workers, we learn of CHCA's culture of cooperation, caring, and learning, which has sustained a vibrant community through tremendous growth and change over 17 years.

The Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach, by Anne Inserra, Maureen Conway, and John Rodat. The Aspen Institute, February 2002. (86 pgs.)
The Aspen Institute uses Cooperative Home Care Associates and its affiliation with PHI to demonstrate the success of industry-based workforce development strategies.

Quality Care Partners: A Case Study, by Karen Kahn. August 2000. (24 pgs.)
This case study traces the early development of a home care cooperative, initiated as a sectoral development project, in Manchester, New Hampshire. The study draws attention to key "lessons learned" in the areas of financing, leadership, market analysis, and customer development.

Policy Papers

Long-Term Care Financing and the Long-Term Care Crisis: Causes and Solutions, by Steven L. Dawson and the Paraprofessional Healthcare Institute. 2003.
This paper examines the "care gap" in long-term care and the negative impact of staff shortages on the three primary stakeholders: consumers, providers, and workers. It recommends a national strategy—integrating both federal and state policy into a comprehensive system of long-term support and services—to address the direct-care crisis.

Michigan's Care Gap: Our Emerging Direct-Care Workforce Crisis, by Hollis Turnham and Steven L. Dawson. 2003. (60 pgs.)
This paper provides a detailed analysis of the direct-care workforce crisis in Michigan. In addition to describing the key stakeholders, the demographic changes that underlie the crisis, and the negative impact of poor quality jobs on each stakeholder group, the authors review current initiatives within the state to stabilize the workforce and make recommendations for future actions.

"State Wage Pass-Through Legislation: An Analysis," by the Paraprofessional Healthcare Institute and the Institute for the Future of Aging Services. *Workforce Strategies* No. 1. Department of Health and Human Services, April 2003. (8 pgs.)
In this issue brief, the authors describe the structure of wage pass-through programs in several states; summarize what is known about the impact of these programs on recruitment and retention of direct-care workers, and identify key design elements that states should consider if they choose to implement a wage pass-through.

Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on Implementing California's Public Authorities, by Janet Heinritz-Canterbury. 2002. (46 pgs.)
This paper analyzes the four-stakeholder coalition that successfully passed legislation and implemented the county public authority structure to improve the quality of jobs and services offered by California's In-Home Supportive Services.

Cheating Dignity: The Direct Care Wage Crisis in America, by the Paraprofessional Healthcare Institute. AFSCME, August 2001. (38 pgs.)
This report provides a detailed analysis of how our nation fails to pay our direct-care staff "self-sufficient" wages and benefits, by comparing wages across several service sector occupations.

"Direct Care Health Workers: You Get What You Pay For," by Steven L. Dawson and Rick Surpin. *Generations.* Vol. XXV, No. 1. Spring 2001. (6 pgs.)
This paper examines labor supply and demand and suggests that improving the price of labor, through changes in policy and practice, is the only way to attract workers to long-term care.

Direct Care Health Workers: The Unnecessary Crisis in Long-Term Care, by Steven L. Dawson and Rick Surpin. The Aspen Institute, January 2001. (33 pgs.)
Dawson and Surpin examine the structure of long-term care, its financing, and the current labor crisis, arguing for sectorwide restructuring supported by labor, welfare, and health care policies that work together to support high-quality care for consumers, decent jobs for workers, and a more rational environment for providers.

"The Home Health Aide: Scarce Resource in a Competitive Marketplace," by Steven L. Dawson and Rick Surpin. *Care Management Journals,* Vol. 2, No. 4, Winter 2000. (6 pgs.)
Noting that labor has become a scarce resource, this paper suggests that employers must create higher quality jobs for home care workers to compete successfully for workers in today's economy.

"Toward a Stable and Experienced Caregiving Workforce," by Mary Ann Wilner. *Generations,* Vol. XXIV, No. 3, Fall 2000.
Wilner reviews some of the mechanisms available for establishing a stable workforce for consumer-directed care.

Health Care Workforce Issues in Massachusetts, by Barbara Frank and Steven L. Dawson. Presented at the Massachusetts Health Policy Forum, June 22, 2000. (32 pgs.)
Arguing that the price of labor must rise to attract direct-care workers, Frank and Dawson make a number of key recommendations for changes in state policy and provider practice.

"Who Will Care for Mother Tomorrow?" By Andy Van Kleunen and Mary Ann Wilner. *Journal of Aging & Social Policy.* Vol. 11, No. 2/3, 2000. (11 pgs.)
This essay confronts the caregiving crisis by offering a closer look at paraprofessional caregivers and the nature of their jobs, summarizing some of the public policies that currently shape the quality of those jobs, and proposing some possible steps that policymakers could take to start rebuilding our nation's direct-care workforce.

Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long-Term Care, by Mary Ann Wilner and Ann Wyatt. A conference background paper prepared for the AARP Long-Term Care Initiative. AARP, 1998. (75 pgs.) This paper explores the role of the paraprofessional in long-term care and highlights the relationship between the paid caregiver and the consumer.

Jobs and the Urban Poor: Privately Initiated Sectoral Strategies, by Peggy L. Clark and Steven L. Dawson, et al. The Aspen Institute. November 1995. (41 pgs.) Analyzing four sectoral initiatives, this report proposes a definition for "sectoral employment development," explores thematic issues, and makes recommendations for pursuing sectoral development as an approach to improving employment prospects in urban areas.

Video

HeartWork: A video celebrating the lives and work of direct-care workers. 2001. (43 min.) $149 for video and discussion guide.
HeartWork chronicles the development of an original theater piece created and performed by women who work as home health aides and certified nursing assistants (CNAs). Through music, dance, storytelling, and interviews, the video provides a real, honest, moving and often humorous account of what it means to be a direct caregiver.

To order any of the publications described above, send your request to: National Clearinghouse on the Direct Care Workforce, 349 East 149th Street, 10th floor, Bronx, New York 10451. Email: info@directcareclearinghouse.org. For bulk orders, please call the National Clearinghouse at: 718-402-4138 or toll-free: 866-402-4138. Many of these publications are available on the Internet at: **www.directcareclearinghouse.org** or **www.paraprofessional.org**

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