

Addressing Shortages in the Direct Care Workforce:

*The Recruitment and Retention Practices of
California's Not-for-Profit Nursing Homes,
Continuing Care Retirement Communities
and Assisted Living Facilities*

June 2003

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Prepared by the **Institute for the Future of Aging Services**, a policy research center within the American Association of Homes and Services for the Aging, in collaboration with the California Association of Homes and Services for the Aging. The study was supported through a grant from the Center for Health Professions, University of California, San Francisco.

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INTRODUCTION

In February 2001, the Institute for the Future of Aging Services (IFAS), in partnership with the California Association of Homes and Services for the Aging (CAHSA), received a grant from the University of California, San Francisco to examine how California's not-for-profit long-term care community was responding to the labor shortage crisis among direct care workers. IFAS is a policy research institute housed within the American Association of Homes and Services for the Aging. CAHSA is a state membership organization representing not-for-profit nursing homes, continuing care retirement communities (CCRCs), residential care facilities for the elderly (RCFEs) and affordable senior housing in California. The grant was one of a number of awards made by the California Endowment and the California HealthCare Foundation to address shortages in the allied and auxiliary health care workforce.

BACKGROUND

The paraprofessional long-term care workforce—nurse aides, home health and home care aides, personal care workers, and personal care attendants—forms the centerpiece of the formal long-term care system. Nationally, there are approximately two million paraprofessionals or “direct care” workers providing hands-on care, supervision and emotional support to millions of elderly and younger people with chronic illnesses and disabilities. As federal and state policy makers, consumers and long-term care providers focus more attention on quality outcomes in health and long-term care, the need for a prepared, committed and sustainable long-term care workforce has become an increasing priority. At the same time, providers and state agencies responsible for long-term care are reporting unprecedented vacancies and turnover among direct care workers. National data show annual turnover rates ranging from about 45 percent to over 100 percent for nursing homes.¹

In the State of California, there are almost 125,000 nursing home workers including an estimated 47,500 licensed Certified Nursing Assistants (CNA).² According to a survey conducted by the California Department of Health Services in 2002, California’s CNAs are predominantly women, have a high school education, and are likely to have responsibility for a child or other family member. The majority speak English as a second language.³ Within three years of taking a position with a nursing facility, about 60 percent of these aides are no longer working for their initial employer and about 50 percent do not even renew their certification to remain qualified as CNAs.⁴

California is likely to experience significant shortages of direct care workers in the years ahead. A large immigrant population makes the State relatively youthful compared to the United States as a whole. However, the State’s future demographics will be dramatically different. Over the next 20 years, there will be an 80-percent increase in the number of Californians age 65 and older, a rate of increase that is larger than all but four other states. At the same time, the number of women aged 25 to 44 who have traditionally been employed as caregivers in the long-term care industry will be growing substantially smaller. These changing demographics, if left unanswered, could result in a significant future workforce crisis.

¹ General Accounting Office. 2001. *Nursing Workforce: Recruitment and Retention of Nurses and Nurses Aides is a Growing Concern*. Statement of William Scanlon, Director, Health Care Issues. GAO-01-750T.

² Ong, P.M., Rickles, J., Matthias, R., and Benjamin, A.E. 2002. *California Caregivers: Final Labor Market Analysis*. Report to the California Employment Development Department.

³ California Department of Health Services, Licensing and Certification. 2002. *Survey of Certified Nurse Aides*.

⁴ Ong, P.M., et al.

STUDY OBJECTIVES

The objectives of the study carried out by IFAS and CAHSA were threefold:

- To document the difficulties faced by CAHSA members in recruiting and retaining a qualified and committed direct care workforce and the causes of these difficulties—from the perspective of administrators, supervisors and workers;
- To identify recruitment and retention practices employed by CAHSA providers and whether they are perceived as effective in helping to reduce high vacancy and turnover rates among direct care staff; and,
- To describe some of the most promising approaches developed by a select group of providers to improve the workplace environment for workers and residents.

METHODOLOGY

Study data were collected in three ways: a structured mail survey was developed and mailed to all CAHSA nursing homes, continuing care retirement communities (CCRCs) and assisted living facilities (RCFEs); focus groups were held with charge nurses, directors of nursing (DONs), administrators and direct care workers; and, case studies were conducted in three innovative CAHSA facilities.

SURVEY INSTRUMENT

A survey instrument was developed based on a review of the literature and consultation with the project's advisory committee of provider representatives and researchers. The survey instrument was pre-tested in several nursing homes and revised. The survey covered a range of topics including the characteristics of the facility and staffing patterns, vacancy and turnover rates, perceived severity of recruitment and retention problems and the causes of these problems. The survey also asked providers to identify and assess the effectiveness of specific strategies they had put in place to recruit and retain direct care workers including wage and benefit incentives, outreach strategies, job preparation and ongoing education and training, and strategies for improving the workplace environment.

In July 2001, 155 survey forms and a cover letter describing the project were mailed to all not-for-profit nursing homes, continuing care retirement communities, and assisted living facilities in CAHSA's membership. To increase survey response rates, a notice was placed in the CAHSA newsletter alerting members that the survey was forthcoming, a self-addressed, stamped envelope was enclosed with the survey, a gift certificate for a one pound box of candy was sent to facilities that returned the survey, and follow-up calls to non-respondents were conducted. In all, 96 surveys were returned, for a response rate of 64 percent. Administrators or assistant administrators of the facilities filled out nearly one-half of the surveys and almost one-quarter were completed by the facilities' human resources directors. Only four percent were completed by DONs.

FOCUS GROUPS

A total of 14 focus groups were convened. Participants were self-selected and included 73 direct care workers, 13 charge nurses, 8 DONs and 13 administrators. In addition, a telephone call was held with two directors of staff development (DSDs). Focus groups were organized and convened by CAHSA officials and were held in conjunction with the CAHSA annual meeting, as well as in nine CAHSA facilities in various regions of the State. In general, focus group participants were asked to discuss why they entered the long-term care field, what their duties and responsibilities are and how they are involved in facility operations and decision-making, what they like and dislike about the job, why they stay in or leave their jobs, what wage and benefit incentives they most value, the types of support they receive from supervisory staff, their relationships with peers, and how they would improve their jobs.

CASE STUDIES

Case studies were conducted by an IFAS research team in three facilities to document innovative workplace improvement strategies. The facilities selected for inclusion in this part of the study met several criteria. They were not experiencing problems with recruiting and retaining direct care staff (as reported in their responses to the CAHSA survey). They had implemented multiple workforce improvement strategies. They were recommended by an outside source as an innovative facility. Interviews were conducted over a two-day period with the Chief Executive Officer (CEO) of the facility, the DON, the Human Resources Director, the DSD, unit nurses, CNAs and receptionists. The case studies focused on the facilities' hiring practices, management and supervisory approaches, staff development programs, the job duties and responsibilities of direct care and supervisory staff, and job satisfaction.

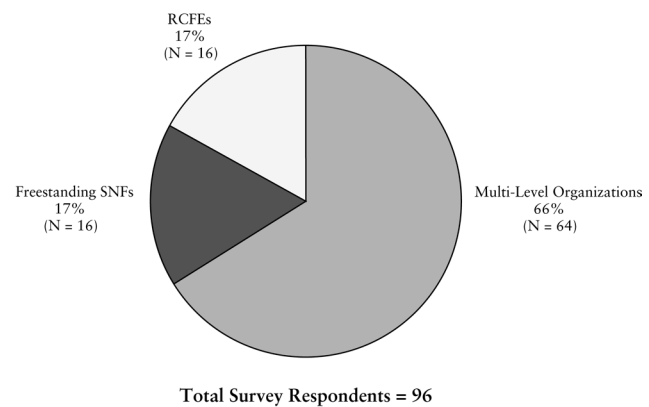
FINDINGS

Most of the findings reported below are taken from the CAHSA survey of recruitment and retention of direct care workers. At various points, we have drawn on the results of the focus groups and case studies to complement these data and to provide contrasting perspectives on a particular issue.

WHO RESPONDED TO THE SURVEY

The majority of facilities responding to the survey were from multi-level organizations which included independent living arrangements, nursing care and assisted living. Seventeen percent of the respondents were from free-standing skilled nursing facilities (SNFs) and 17 percent were from stand-alone residential care facilities for the elderly (RCFEs), typically referred to as assisted living in many other states (Figure 1). SNFs were more likely than other types of facilities to respond to the survey. Of the 22 SNFs belonging to CAHSA, 73 percent returned a survey, while 60 percent of the 106 multi-level organizations and 59 percent of the 27 RCFEs responded (Figure 2).

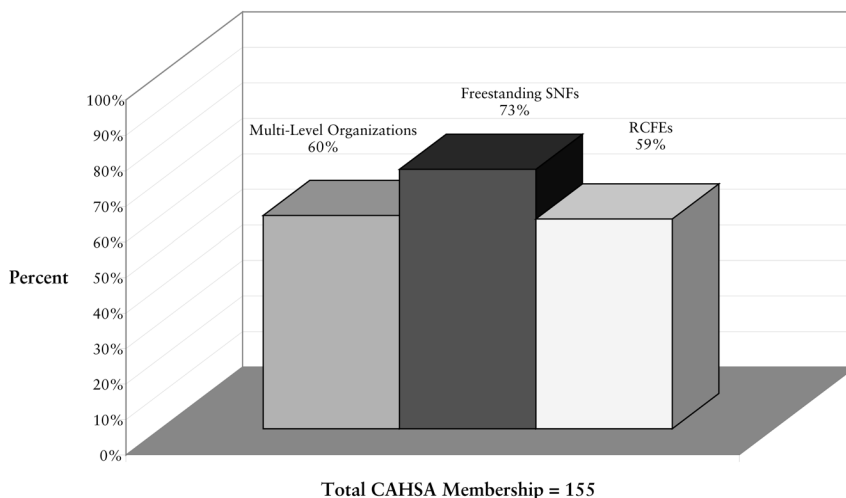
Figure 1
Survey Respondents, By Facility Type



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 2

Proportion of Total CAHSA Membership That Responded to the Survey



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

CHARACTERISTICS OF FACILITY RESPONDENTS

Nearly one-half (44 percent) of the facilities responding to the survey had between 75 and 200 beds and 29 percent reported having 200 beds or more. On average, these facilities employed 43.1 direct care workers. About one-quarter reported using at least one on-call or registry worker, and the majority had at least one vacant position, with SNFs reporting more vacancies (an average of 4.2) and RCFEs reporting the least vacancies (an average of 1.2). A standard starting salary for direct care staff was offered by 36 percent of the facilities, which ranged from \$6.50 to \$12.40 per hour. The average starting salary was higher in multi-level organizations than in free-standing SNFs or RCFEs. Almost two-thirds of respondents reported that they paid more experienced direct care workers higher hourly wages. In addition, slightly over one-half of the facilities reported 10 percent or fewer MediCal/SSI recipients among their residents and less than 10 percent were unionized (Figure 3).

Figure 3
Characteristics of Responding Facilities

	PERCENT
Bed Size	
Less than 75 beds	27%
75 to 200 beds	44%
More than 200 beds	29%
Temporary Workers	
Use on-call or registry workers	24%
Do not use on-call or registry workers	76%
Vacancies	
Have vacancies	65%
Do not have vacancies	35%
Medi-Cal or SSI Residents	
0 to 10 percent	55%
11 to 49 percent	30%
50+ percent	15%
Union Status	
Unionized employees	9%
Non-unionized employees	91%
	AVERAGE
Average Number of Staff	43.1
Avg. # of full-time staff	35.8
Avg. # of part-time staff	7.6
Average Standard Starting Salary	\$8.78
SNF	\$8.41
Multi-level organization	\$9.35
RCFE	\$8.43
Avg. Starting Salary of Facilities that Pay Higher Wages for Experienced Staff	
SNF	\$11.37
Multi-level organization	\$12.31
RCFE	\$11.83

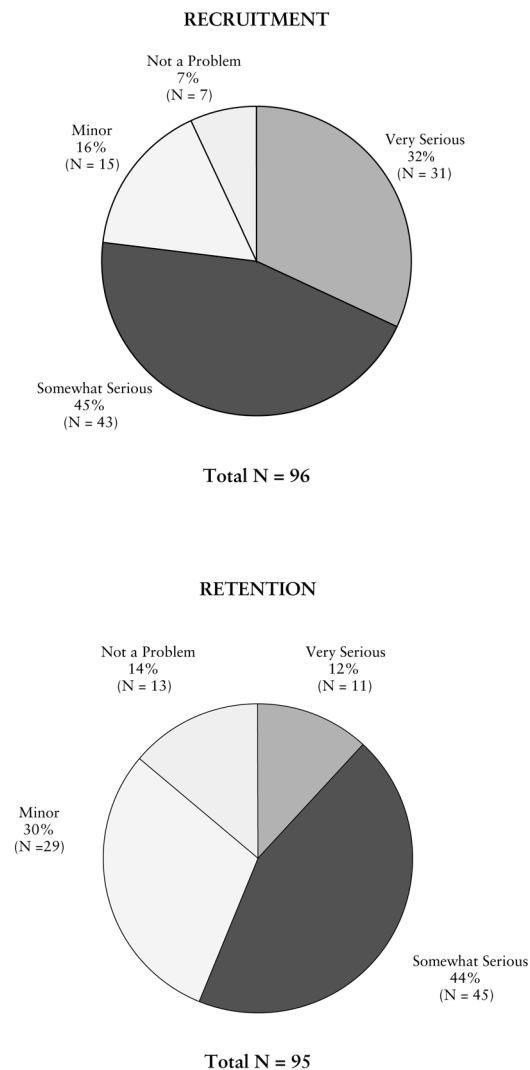
Excludes all cases in which information is unascertained.

SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

SEVERITY OF RECRUITMENT AND RETENTION PROBLEMS

A critical issue for the survey was to document the severity of recruitment and retention problems in CAHSA facilities. We asked respondents to rank the severity of their recruitment and retention problems. While both recruitment and retention of direct care staff were significant issues for CAHSA members, recruitment problems were larger. About 77 percent of survey respondents reported that recruitment was a serious or somewhat serious problem, while 56 percent reported that retention was a similarly serious issue. Conversely, only seven percent reported experiencing no recruitment problems and only 14 percent reported no problems with retention (Figure 4).

Figure 4
Severity of Recruitment and Retention Problems

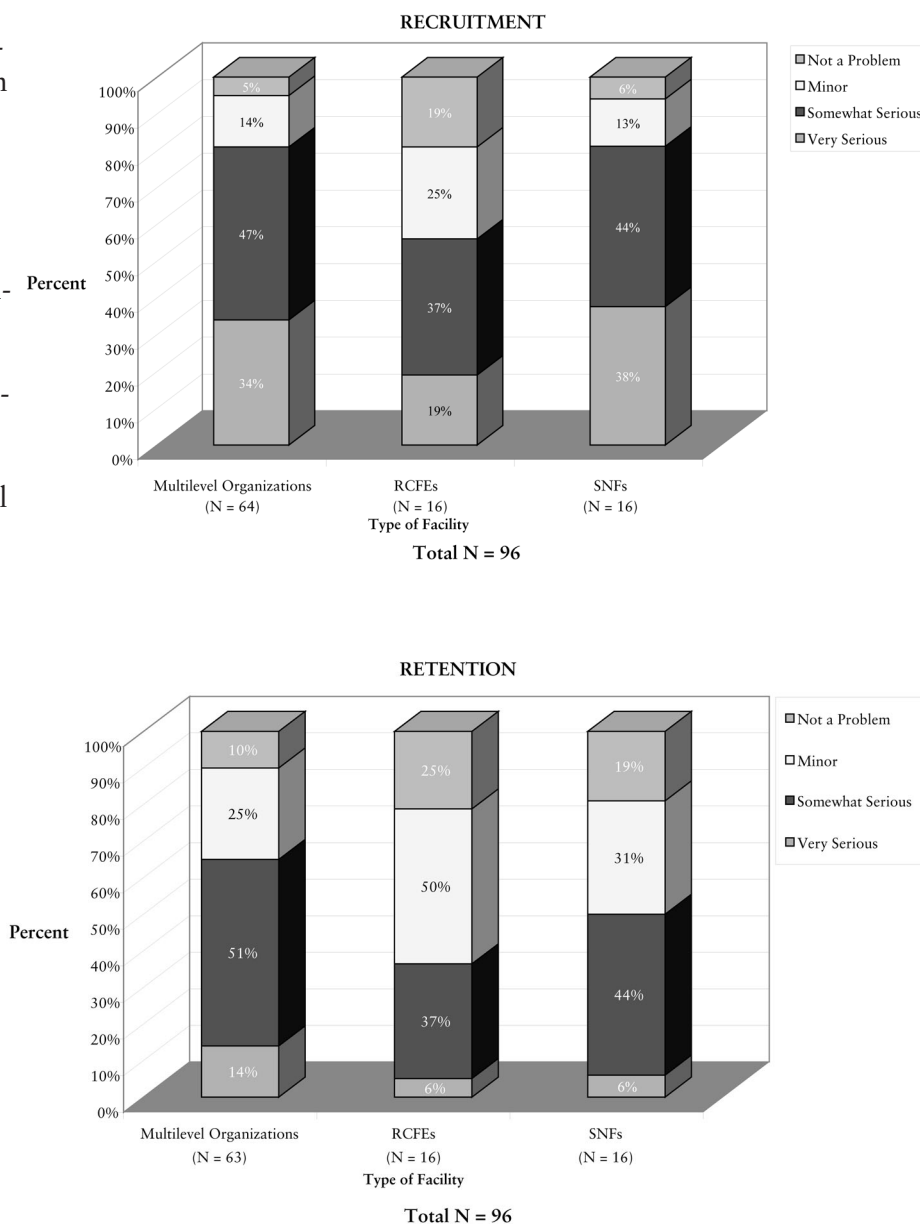


SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

We also asked participants in the two focus groups held with administrators to discuss their perceptions of the relative severity of recruitment versus retention problems. In contrast with our survey respondents, most of whom were themselves facility administrators, administrators in the focus groups were insistent that they received plenty of applications for CNA positions. In their view, the problem was the revolving door nature of the individuals applying for these positions. One administrator noted that out of 15 CNA hires, 12 will leave within 30 days for a job with better pay.

We also looked at whether recruitment and retention problems were perceived differently depending upon the type of facility that was responding to survey. The majority of facility respondents, regardless of whether they were a multi-level organization, a SNF or RCFE, reported that recruitment of direct care staff was a serious or somewhat serious problem. More than one-half of the multi-level organizations and SNFs also reported retention was a serious or somewhat serious problem. However, assisted living facilities (RCFEs) were less likely than the other types of facilities to report these concerns. About 44 percent of RCFEs stated that recruitment was either a minor problem or not a problem at all, and 75 percent said that retention was not really a problem. In contrast, only 19 percent of multi-level organizations and 19 percent of SNFs reported recruitment was not a significant problem and less than one-half reported that retention was a minor problem or not a problem at all (Figure 5).

Figure 5
Severity of Recruitment and Retention Problems, By Facility Type



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

We had no systematic way of explaining why RCFEs perceive the recruitment and retention of direct care staff to be a less significant issue than other types of facilities. Several of the direct care workers participating in the focus groups mentioned that working in an assisted living facility was less stressful than working in a nursing home because there is less regulation and, therefore, fewer paperwork requirements, leaving them more time to spend with residents. Most of the workers in the focus groups also expressed great frustration with the supervisory structure in their nursing homes where they reported to a charge nurse. This hierarchical reporting structure does not exist in assisted living facilities. It is also possible that the case mix of the assisted living facilities is healthier than in the other facilities, placing fewer burdens on staff to address the residents' clinical problems, and leaving more time for socialization with them. Several focus group participants said they knew of CNAs who had accepted lower rates of pay to work in an assisted living facility.

We also looked at whether the number of beds in a facility seemed to influence the perception that recruitment or retention was a significant problem. While the number of beds in a facility did not seem to have an impact on recruitment, it did seem to relate to retention. Over 70 percent of facilities with more than 200 beds reported retention was a significant problem, while 46 percent of facilities with less than 75 beds did. The proportion of Medicaid or SSI recipients in the facility did not appear to affect whether the facility experienced significant recruitment or retention problems. Unionized facilities were somewhat more likely than non-union facilities to report recruitment and retention as significant issues; however, this may be an artifact of the small number of unionized facilities (9) that participated in the survey (Figure 6).

TURNOVER RATES

In addition to asking facility respondents to tell us how they perceived the severity of recruitment and retention problems, we asked them to tell us the actual rate of turnover among direct care staff. Only 60 percent of the facilities responding to the survey were able to provide a turnover rate. Of those, 16 percent reported turnover in excess of 50 percent per year and 18 percent reported turnover rates of 10 percent or less. Facilities that provided turnover data were also asked to tell us how they were calculated. Based on a review of the methods they described, a wide range of techniques were used, making it impossible to compare turnover across facilities. In addition, many of the methodologies described did not appear to be technically sound strategies for producing the desired data.

Figure 6
Impact of Facility Characteristics on Recruitment and Retention

	Percent of Providers Who Have a Serious or Somewhat Serious Problem with:	
	Recruitment	Retention
ALL PROVIDERS	77%	55%
Provider Type		
Skilled Nursing Facility	81%	50%
RCFE	56%	25%
Multi-Level	81%	65%
Number of Beds		
Less than 75 beds	81%	46%
75 to 200 beds	76%	50%
More than 200 beds	75%	71%
Medi-Cal or SSI Residents		
0 to 10 percent	78%	45%
11 to 49 percent	77%	65%
50+ percent	78%	62%
Freestanding Facilities versus Multi-Facility Organizations		
Freestanding	69%	62%
Multi-facility	78%	55%
Union Status		
Unionized employees	89%	67%
Non-unionized employees	76%	53%

Excludes all cases in which the level of the recruitment or retention problem is unascertained.

SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

CAUSES OF RECRUITMENT AND RETENTION PROBLEMS

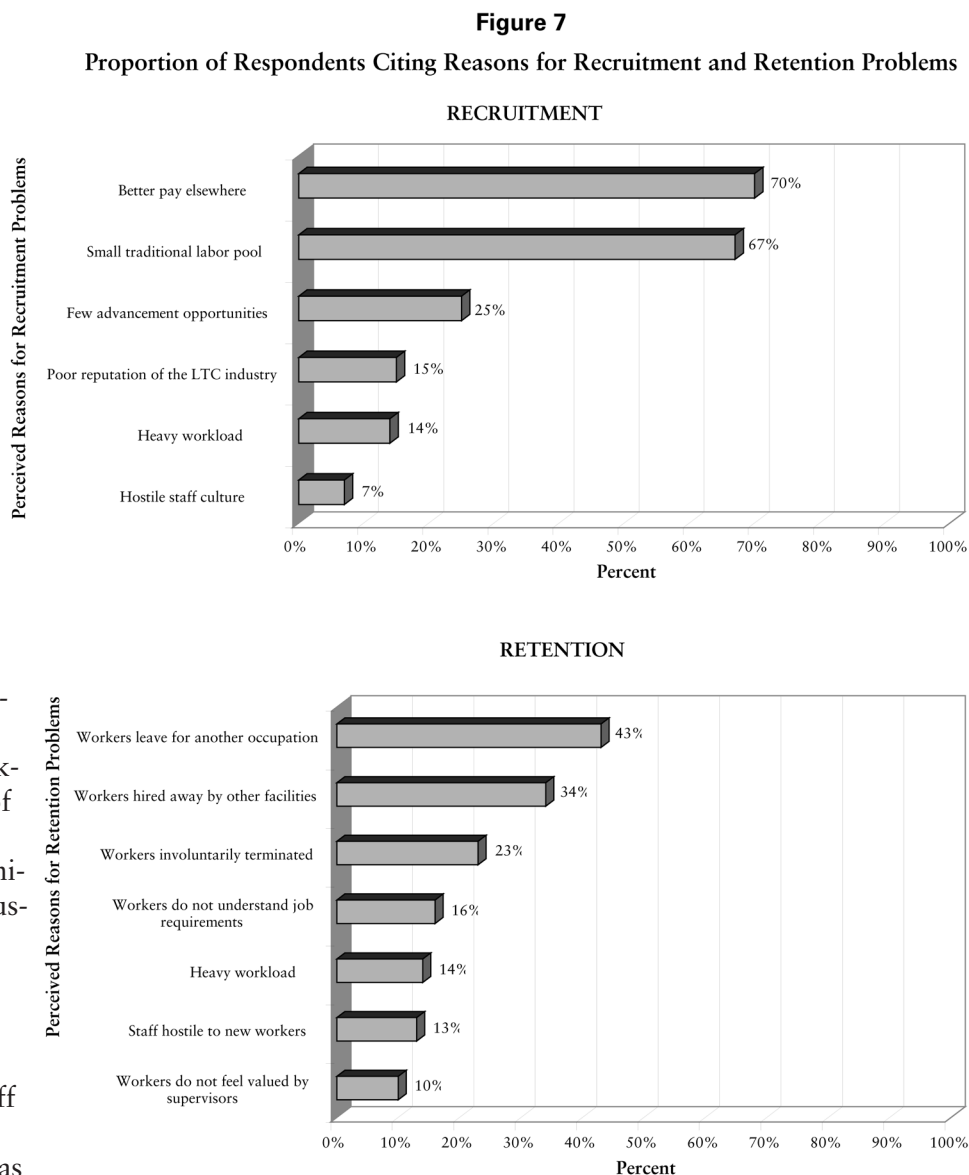
The survey asked respondents to review a list of reasons why they might be experiencing problems with recruitment and retention of direct care staff, and to indicate which of these reasons were most applicable to their own situation. As expected, financial considerations were ranked as being very important. The vast majority of respondents believed that recruitment problems

were caused by workers leaving to go to other fields outside of long-term care because the pay was better (70 percent). However, 67 percent also reported that the traditional labor pool was too small to meet demand. Only small percentages of respondents believed that recruitment problems were attributable to the poor reputation of the long-term care industry or to the heavy workload of the job (Figure 7).

Respondents were also asked to identify other causes for the recruitment problems they faced. A lack of transportation, the high cost of living in the area, the ability of CNAs to receive cash by working private duty jobs, a lack of educational advancement opportunities, and hostile families were among the other causes they cited.

For facilities reporting retention to be a significant problem, the largest proportion—43 percent—believed that staff left to go to another occupation or field where the pay was better, 34 percent thought their

staff was being hired away by another long-term care facility and 23 percent said that workers were involuntarily terminated due to non-performance. Interestingly, in view of findings that emerged from our focus group discussions with direct care workers (to be discussed later), only 10 percent of respondents thought that retention problems could be attributed to direct care staff



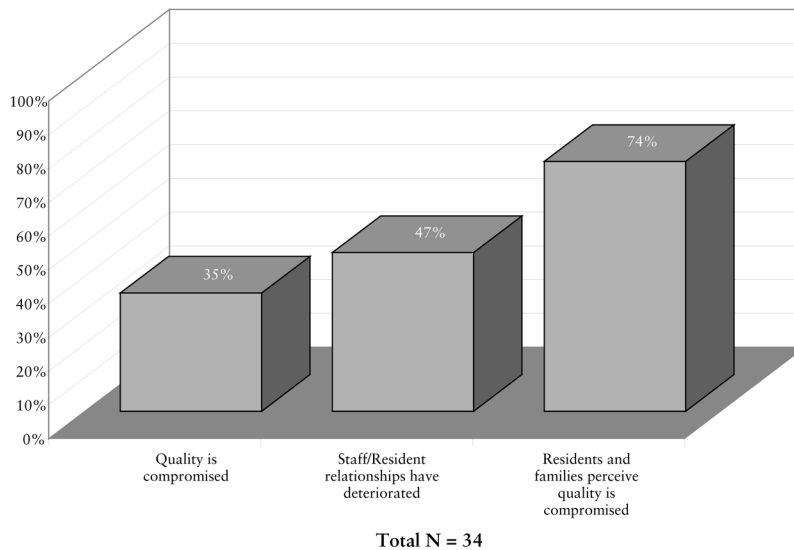
not feeling valued by their supervisors (Figure 7). Other reasons given by survey respondents for their retention problems included transportation difficulties, a desire for better shifts or hours, burn out, the high cost of living in the area, lack of child care, and the inability of aides to accept change.

Focus group participants were also asked to discuss why so many workers leave their jobs. While almost everyone said money was an important consideration, other reasons seemed to receive as much or even more emphasis. Charge nurses in the focus groups said that retention was a problem because CNAs do not receive training that permits them to understand what the job is like. Some of these nurses said they thought some direct care staff left because the job was too difficult or because they did not get along with people. When direct care workers in the focus groups were asked why they left a job or why they thought others leave, their responses often highlighted the role played by charge nurses. Most of these workers agreed that charge nurses did not respect or appreciate the work they carried out and that this was a significant factor in whether facilities were able to retain staff.

Figure 8

Impact of Recruitment and Retention Problems on Quality

Proportion Stating That Quality is Affected In These Ways



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

RECRUITMENT, RETENTION AND QUALITY OF CARE

The survey asked respondents to assess the impact of recruitment and retention problems on the facility's quality of care. Only 35 percent believed that there was an impact on quality. Of those who believed that quality was affected, 74 percent stated that residents and family *perceive* that quality of care is being compromised while 35 percent said that the quality of care is *actually* compromised (Figure 8).

STRATEGIES FOR RECRUITING AND RETAINING WORKERS

A major purpose of the survey was to identify practices used by CAHSA members to recruit and retain direct care staff. The survey asked facilities to identify practices they had implemented in the following areas—wages and benefits, outreach and recruitment, education and training, workplace improvement and labor force expansion—and to assess how well these practices were working. In this section of the report, the results of this analysis are presented.

Wages and Benefits

According to a labor market analysis of direct care workers in California, caregiver occupations fare less well than competing occupations in terms of wages, benefits and opportunities for

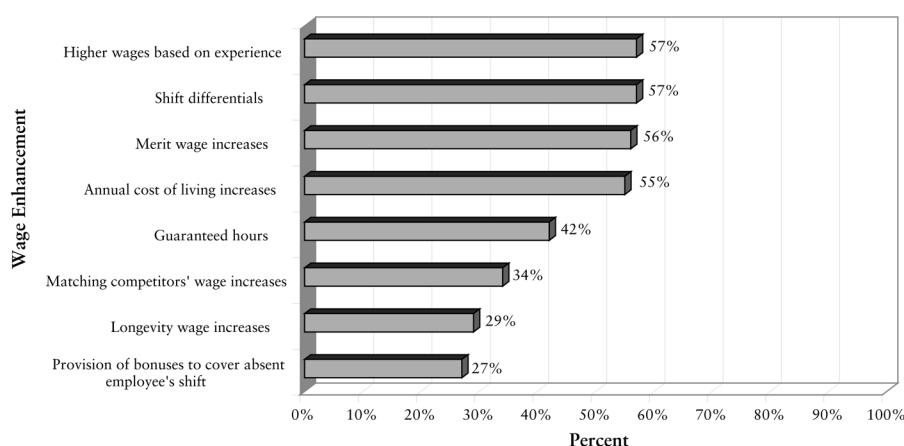
advancement. Occupations in the same labor market which are viewed as similar to CNA work offer 10 percent higher wages.⁵ In fact, as previously stated, 70 percent of respondents to our survey believed that the cause of their recruitment problems could be attributed to better pay in other industries.

Wages

Survey respondents were asked to identify the wage incentives they provided to direct care staff and which of the ones they had implemented made a difference in improving recruitment and retention in their facility. The most prevalent wage incentives offered were higher salaries for difficult shifts (57 percent), higher wages based on experience (57 percent), merit wage increases (56 percent) and annual cost of living increases (55 percent). Somewhat less frequently mentioned incentives were guaranteed hours (42 percent), matching competitors' wage increases (34 percent), longevity wage increases (29 percent), and bonus payments for covering another person's shift (27 percent) (Figure 9). We then asked respondents to rate which of the financial incentives that were offered were most effective. In this case, matching competitors' wages was viewed as being the most effective, where 85 percent of survey respondents who employed this strategy thought it was very effective in improving staff recruitment and retention (Figure 10).

Figure 9

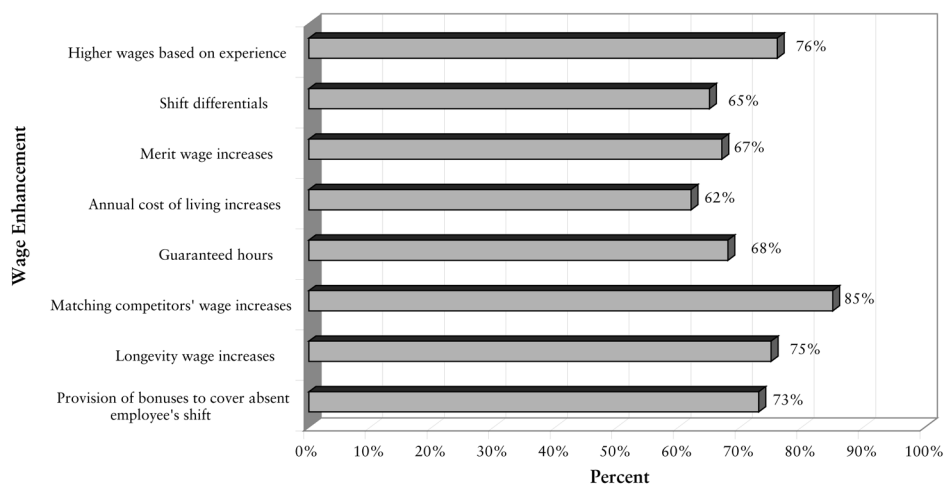
Proportion of Respondents Implementing Selected Wage Enhancements



SOURCE: CAHSA/IFAS, The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 10

Proportion of Respondents Reporting That Wage Enhancements They Use Are Effective



SOURCE: CAHSA/IFAS, The 2001 Direct Care Worker Recruitment and Retention Survey.

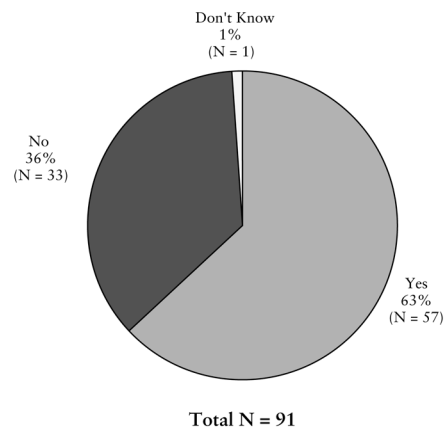
⁵ Ong P.M., et al.

When focus group participants were asked what they would most like to change about their jobs, almost uniformly, they identified higher wages and lower staffing ratios. Interestingly, when CNAs were asked during the focus groups discussions whether they would leave their jobs if they could earn up to \$2.00 an hour more, most said they would not unless their new employer was comparable to their current employer in ways that were important to them, such as keeping their current schedules or maintaining their health insurance.

California's Wage Pass-Through Program

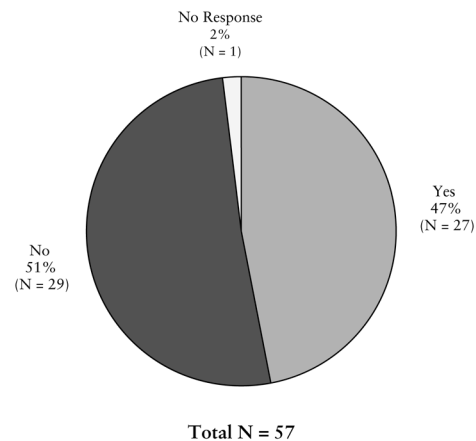
As part of the analysis of the impact of wages on recruitment and retention, survey respondents were asked if they had implemented California's wage pass-through program. The wage pass-through is a special, one-time wage adjustment, provided to facilities based on their Medicaid census, and used by some states, including California, to make direct care jobs more competitive. Of the facilities responding to the survey, 63 percent reported that they had implemented the wage pass-through (Figure 11). About one-half of these facilities believed the wage pass-through had an impact on recruiting and retaining workers because it allowed them to offer more competitive wages. The remaining facilities said it had no impact, citing that they had too few Medi-Cal recipients to affect wages, that the increase was too little, or that they had already provided a raise to their direct care staff prior to the implementation of the pass-through and, therefore, did not derive any benefit from it. The relatively modest impact of the wage pass-through on improving recruitment in the CAHSA facilities where it was implemented is consistent with the census in these facilities which, in general, has fewer Medicaid recipients than other nursing homes in the State (Figure 12).

Figure 11
Proportion of Respondents Implementing the Wage Pass-Through



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 12
Proportion of Respondents Stating That the Wage Pass-Through Is Effective



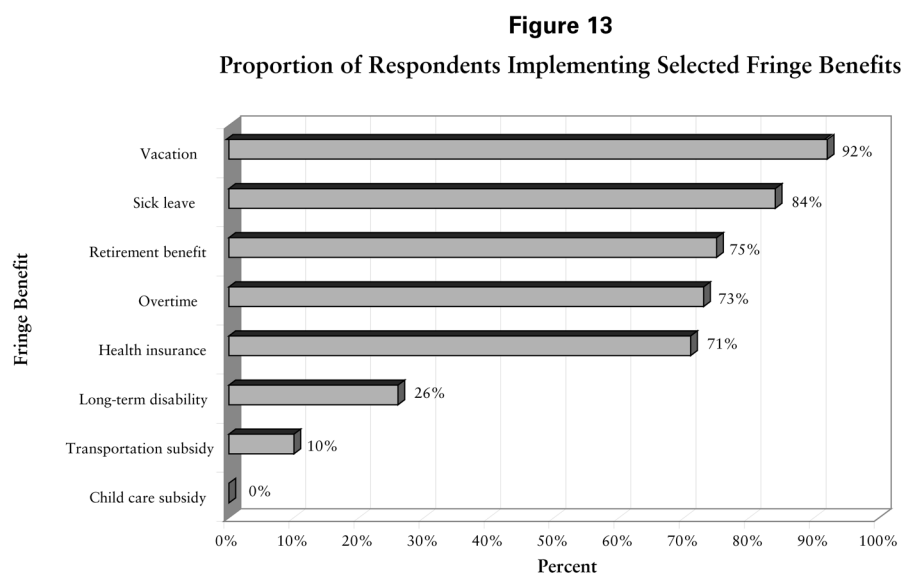
SOURCE: CAHSA/IFAS The 2001 Direct Care Worker Recruitment and Retention Survey.

Benefits

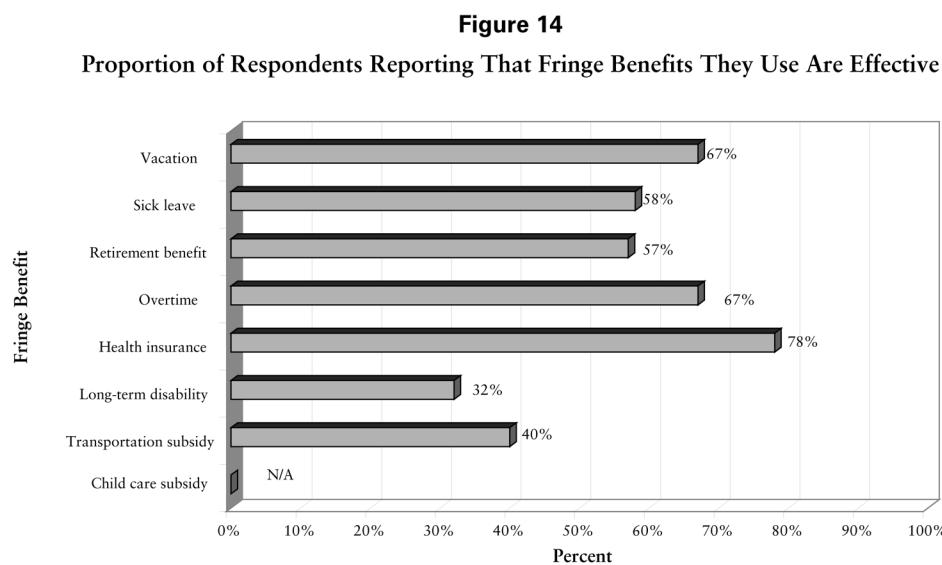
The survey asked respondents to identify the various fringe benefits they offered to employees and to rate their perceived effectiveness in improving staff recruitment and retention. Ninety-two percent of facilities offered a vacation benefit, 84 percent offered sick leave, 75 percent had a retirement benefit, 73 percent provided overtime pay, 71 percent offered a health insurance plan, 26 percent provided a long-term disability benefit, and 10 percent offered a transportation subsidy (Figure 13). Both the survey findings and focus group

results suggest that the availability of health insurance is an important factor in worker retention (Figure 14). While 75 percent of facilities without a health insurance benefit reported that worker retention was a significant problem, only one-half of the facilities who did offer health insurance reported a similar degree of difficulty in retaining staff.

Focus group participants also emphasized that the availability of health insurance was instrumental in the decisions of long-time CNAs to stay in or leave their jobs. While more than 70 percent of survey respondents claimed to be providing health insurance to direct care staff, it is important to note that we do not know how much employees are required to contribute to premium costs or how many aides actually took advantage of the benefit to obtain health insurance. Without such information, the role that health insurance plays in addressing recruitment and retention difficulties among CAHSA members is largely speculative.



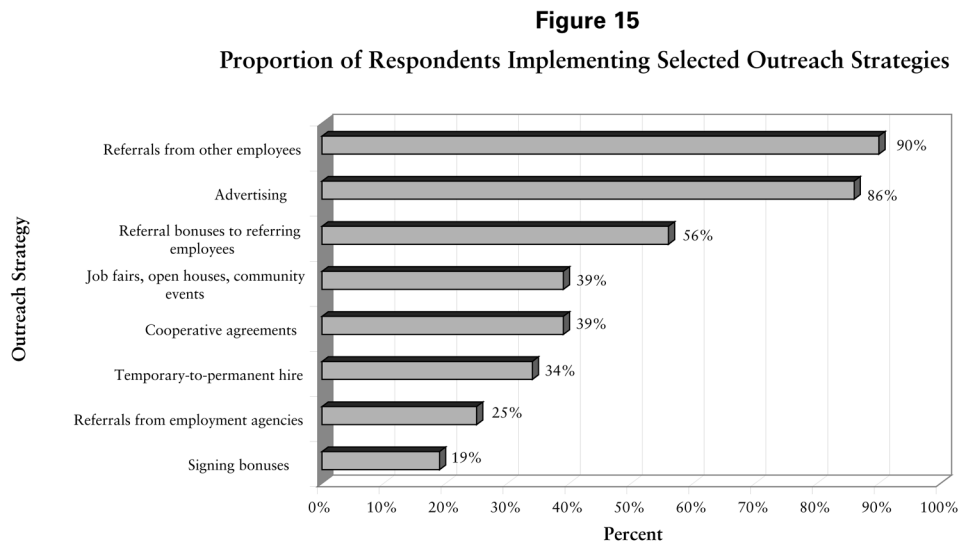
SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.



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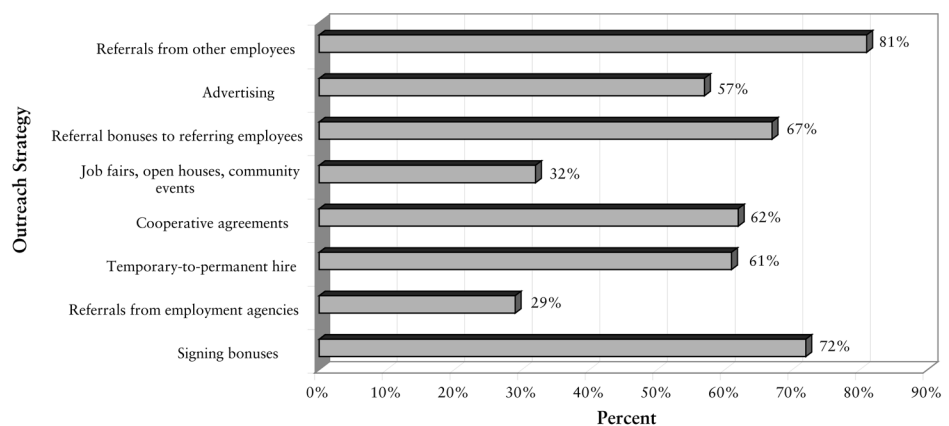
Outreach and Recruitment Strategies

Facility respondents to the survey employed a wide range of strategies to recruit new workers. The most frequently used strategies included referrals from other staff (90 percent), newspaper ads (86 percent), and referral bonuses (56 percent). Much less frequently used recruiting strategies were job fairs and community events to advertise openings, cooperative agreements with community colleges and other educational institutions, moving temporary staff to permanent positions, employment agency referrals, and signing bonuses (Figure 15). Again, survey respondents were asked to rank the effectiveness of the recruitment strategies they had implemented. In this case, staff referrals, referral bonuses, signing bonuses, and cooperative agreements with educational institutions were believed to be very effective in improving staff recruitment. Employment agency referrals and job fairs were rated as least effective (Figure 16).



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 16
Proportion of Respondents Reporting That Outreach Strategies They Use Are Effective



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

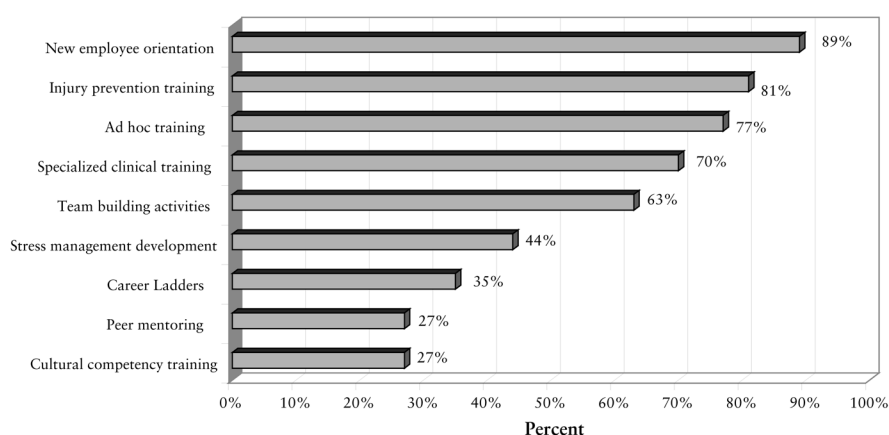
Education, Training and Career Ladder Programs

Both the federal government and the State of California have very detailed training requirements for preparing individuals to become CNAs and for maintaining ongoing certification. Survey respondents were asked if they offered education and training programs to their direct care staff beyond the requirements specified by the government to maintain CNA certification. Almost 90 percent said that they did.

Most of these in-service education and training programs are provided in-house by facility staff. The most frequently mentioned outside source of training was the local Alzheimer's Association. The most commonly cited in-service education and training programs were new employee orientation programs (89 percent), injury prevention (81 percent), ad hoc training to meet the needs of particular residents (77 percent), specialized clinical training (70 percent), and team building (63 percent). Proportionately, fewer facilities offered stress management training (44 percent), career ladder opportunities (35 percent), peer mentoring programs (27 percent) and cultural competency training (27 percent) (Figure 17). Interestingly, when survey respondents were asked to assess the education and training opportunities they offered which were most effective in addressing their recruitment and retention problems, 85 percent mentioned peer mentoring and 81 percent mentioned cultural competency training strategies that were offered relatively infrequently (Figure 18).

Education or Training Program

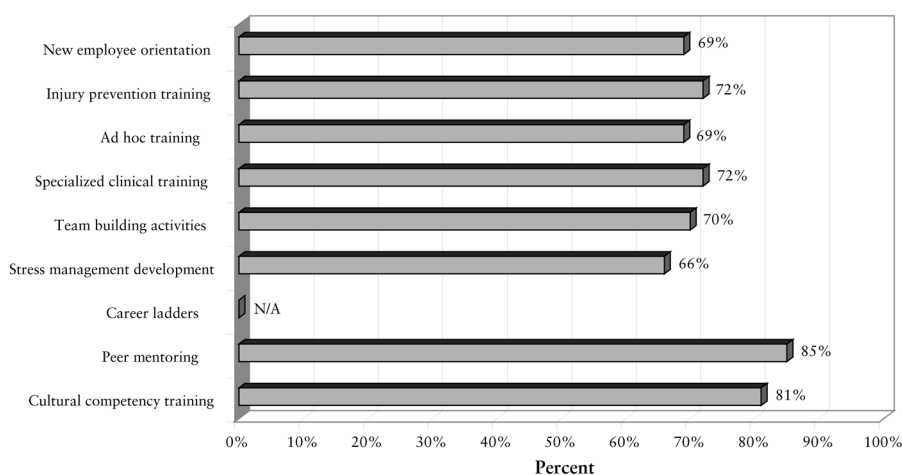
Figure 17
Proportion of Respondents Implementing Selected Education, Training and Career Ladder Programs



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Education or Training Program

Figure 18
Proportion of Respondents Reporting That Education, Training, and Career Ladder Programs They Use Are Effective



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

In general, workers in the focus groups agreed that the in-service educational opportunities provided to them in their facilities were sorely lacking. Long-time CNAs pointed out that while they must participate in these courses to maintain their certification, the content was not very helpful to them in carrying out their jobs. They said that most in-service courses consisted of watching videos or reading books, while they believed they learned best through hands-on training.

Role of the Director of Staff Development

Of particular interest to CAHSA in designing the survey was the role played by the director of staff development (DSD) in educating and training direct care staff. The DSD is a unique position required by the State of California to be implemented in each nursing home to improve training of direct care staff. The DSD position is generally filled on a part-time basis and is responsible for implementing California's in-service training requirements. We asked survey respondents if this position was helpful to them in training direct care staff and, if so, whether they thought the DSD had been instrumental in introducing innovative educational and training opportunities in the facility. Three-quarters of respondents identified the DSD as a helpful training resource, most often citing their role as an educator and trainer at their facilities. In a few cases, DSDs were perceived to be effective mentors and helpful liaisons between management and staff.

Less than one-half of survey respondents believed that the DSD had introduced staff development initiatives that were innovative and effective in improving staff recruitment and retention. While some blamed the rigidity of State in-service education requirements as an impediment to fulfilling the potential of the DSD position, it appears that many facilities simply fail to capitalize on the flexibility that the DSD position can provide. The general perception of the DSDs that were interviewed for this study was that the position was largely used to orient new employees, insure that staff received required in-service hours for recertification, and to provide another nurse "hand" on the floor.

Innovative Uses of the DSD

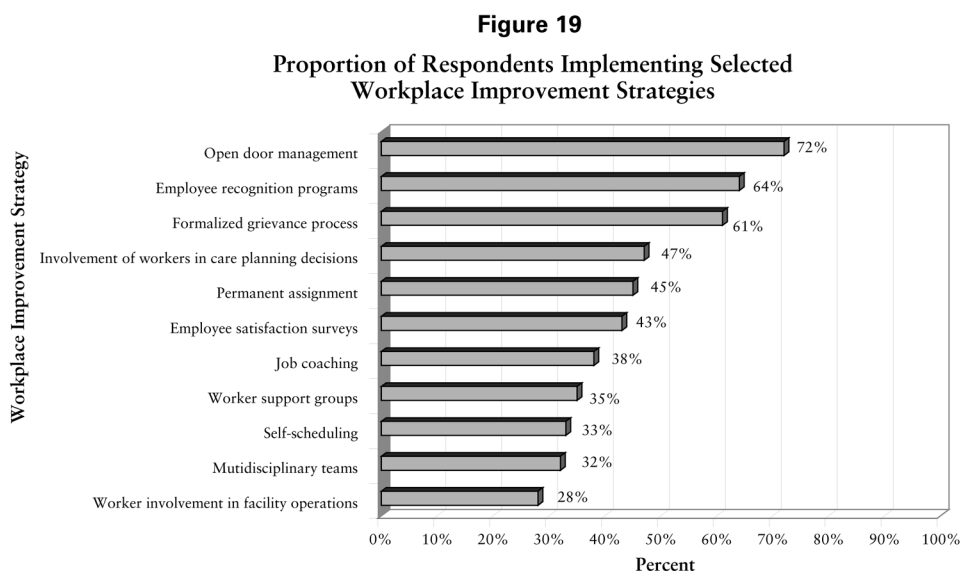
One of our case study sites provided us with a useful example of how the DSD position can be used to help promote creative staff development opportunities. The DSD in this facility, with strong support from the DON and input from direct care staff and other supervisory staff, selects an in-service topic to be worked on each month. The DSD locates several articles on the topic and each staff member is expected to read the article, take a brief examination on the topic and write a short paper on how they will use the information to improve the care they provide. While many CNAs were intimidated by this requirement when it was first introduced because they were afraid of examinations or had difficulty with English and writing papers, staff is now enthusiastically supportive. The DSD was able to work with each CNA individually to assist with both comprehension of the article and writing a paper. After each new topic, the DSD selects one of the best papers to post in the facility. This provides both an incentive to write a good paper and gives other CNAs new ideas about how the information in the article can be used in practice. The CNAs in this facility felt that, in the process, they gained writing skills, English language skills and a sense of confidence in their own ability to learn new things.

The Workplace Environment

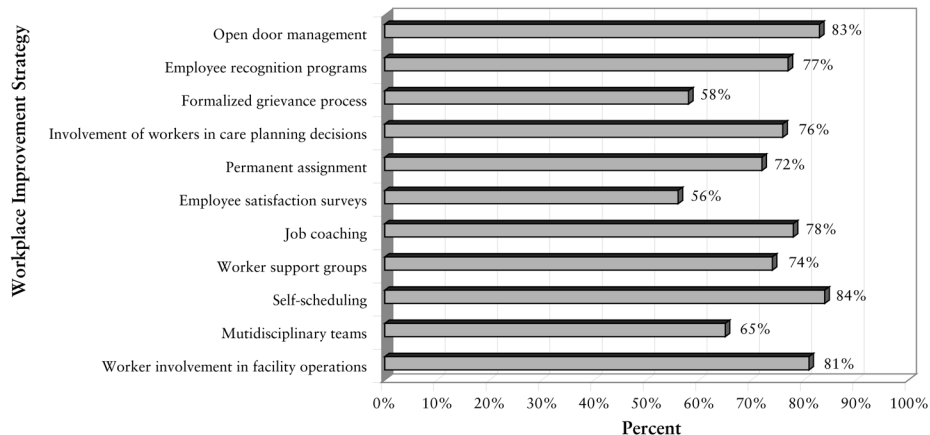
A number of research studies have found that the characteristics of the work environment are as important or more important than wages and benefits in determining how direct care workers view their jobs and whether they are willing to remain in them. We asked respondents to the survey to identify the strategies they were employing to improve the workplace environment for their direct care staff and to assess the effectiveness of each strategy. We also asked focus group participants to talk about the environment in which they worked and what they liked and disliked about their jobs.

Workplace Improvement Strategies Documented in the Survey

Facilities responding to the survey reported that they had implemented a wide variety of strategies to improve the workplace environment for their direct care staff. Almost three-quarters said they used an open door approach to management, 64 percent had implemented employee recognition programs, 61 percent had instituted formalized employee grievance processes and about 50 percent involved direct care staff in resident care planning decisions. Somewhat less than one-half said they had implemented permanent assignment so that direct care staff is assigned to the same residents as much as possible and about the same proportion said they had instituted employee satisfaction surveys. The least commonly mentioned workplace improvement strategies were job coaching, worker support groups, flexible scheduling, use of multidisciplinary teams, and involvement of workers in decisions about facility operations (Figure 19). When asked to rank which of the strategies they had implemented were most effective in addressing recruitment and retention problems, respondents identified open door management, involvement in decisions about facility operations, employee recognition programs, job coaching, and flexible scheduling. Strategies perceived as least effective were formalized employee grievance processes, employee satisfaction surveys and participation of workers on multidisciplinary teams (Figure 20).



SOURCE: CAHSA/IFAS, The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 20**Proportion of Respondents Reporting That Workplace Improvement Strategies They Use Are Effective**

SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Attitudes About the Workplace Expressed in our Focus Groups

In the focus group discussions with CNAs, workers were asked to identify what they most liked about their jobs and what they liked least. Overwhelmingly, CNAs told us that it was their commitment to the residents that kept them in their jobs rather than money. Aides also viewed job security as very important to them (i.e., the knowledge that the position would always be available to them). A surprising number had relatives—mothers, grandmothers or siblings—that had been or were still working as CNAs and stated that their jobs gave them a sense of status and recognition among their peers. Since most of those who are employed as direct care workers have other family responsibilities, it was not surprising that they also placed a high value on flexible scheduling. Some aides told us that they would not give up their current positions, even if they could earn an additional two dollars or more an hour, unless they could keep a work schedule tailored to their own circumstances.

Most CNAs Were Negative About Their Immediate Supervisors

Focus group discussions with direct care staff also underscored the frustrations they felt about the charge nurses to whom they reported. Complaints were generally consistent—charge nurses did not know them, failed to call them by name in some cases, often did not respect them or acknowledge the value of their work, and refused to help even if the aide could not get to a resident in need of help because she was busy taking care of another. They gave many examples to support their perceptions. One worker said she was told by a charge nurse during her orientation that CNAs were only “pretend nurses,” just baby sitters. Another aide told the story of how she was informed by her charge nurse that she only worked as an aide because she could not get another job. This individual subsequently left the facility, got another job, and gave her first pay check to the charge nurse to prove how wrong she was! Another aide told us that once when she needed help lifting a resident, the charge nurse said she was going on a break and left in front of the resident’s family. Many aides in the focus groups thought that charge nurses were a big factor

in whether they were willing to stay in a particular facility. Some even told us that if they knew a particular charge nurse was to be on the floor they would not even come to work that day. When asked what they wanted from charge nurses, focus group participants said they wanted supervisory staff to listen to them, recognize and respect their knowledge of residents, and to be thanked for jobs when they are well done. As one aide told us “you can tell by a charge nurse’s manner and tone in interacting with an aide whether or not they are valued.”

Charge Nurses May Not View Themselves as Managers

Discussions with charge nurses in the focus groups were also revealing. While CNAs see charge nurses as supervisors, charge nurses seem to see themselves mostly as clinicians. They did not identify themselves as managers and, in fact, they did not perform normal management functions such as participating in hiring or firing direct care staff or even identifying staff development needs. Therefore, it was not surprising that these charge nurses did not see a need for management training and did not participate even when it was available. The charge nurses in our focus groups viewed their jobs as being the “eyes and ears” for physicians, administering prescribed medications and treatments, working with families, assigning aides to residents, and scheduling. Administrators in our focus groups—perhaps creating a self-fulfilling prophecy—also told us that nurses do not make good managers and do not receive management training, which was only taught in nursing schools to acute care nurses.

New Job Entrants versus Long-Time Employees

We were interested in learning if aides who were relatively new to the field held the same values about their work as long-time aides. Survey respondents were asked to identify if there were differences between newer aides (those who had been employed for a year or less) and long-time aides. According to the survey, on average, a little over one-quarter of direct care staff had been employed for less than one year, 47 percent had been employed for three or more years, and 22 percent had been employed for 10 or more years. The survey identified several variables—age, prior experience and ethnicity—that might differentiate newer aides from more experienced workers and respondents were asked whether they agreed or disagreed. About one-half believed that long-time workers were more likely to be older than those who had been there for a relatively short period, and to have previously worked with older adults. However, one-half saw no such differences or else said they were unsure. Almost two-thirds said there was no difference in the ethnic background of long-time aides versus newer hires. In response to an open-ended question asking respondents to list other differences they believed distinguished newer from more experienced direct care staff, some thought that newer aides valued money and benefits over the intrinsic rewards of caregiving and that they were less likely to feel loyalty to residents. Others pointed out that newer workers were more able to adapt to change than more experienced workers.

Focus group discussions also yielded some important insights into differences between experienced aides versus more recent hires. Because the self-selection process for the focus groups with direct care staff yielded mostly long-time aides, two focus groups were convened that were limited to aides who had been in the field for one year or less. These CNAs appeared to place a greater emphasis than the long-time aides on the importance of money as the principal reason for becoming a CNA. In addition, these newer aides did not express the same degree of commitment to caregiving as an occupation and did not express the loyalty to residents that we heard from

more experienced aides. While they said they liked their job, newer aides also indicated they would leave to earn more money, either in another facility or another field. Unlike the more experienced aides, they did not appear to attach the same importance to benefits or the security of the job. In general, they did not express negative comments about supervisory staff. Interestingly, the DONs in two of the case study sites said that they would only hire new aides without experience, because these workers were more open to change and did not bring bad habits into the facility.

Staff Involvement in Resident Care Planning

A growing body of research suggests that meaningful participation by direct care workers in resident care planning (i.e., being recognized for their knowledge of residents, having their ideas reflected in care planning and care provision, etc.) is a significant source of job satisfaction. Focus group participants were asked to discuss how they were involved in decision-making within the facility. We only found one of the 73 direct care staff we talked with who had been involved in weekly or monthly case management sessions. None of the aides in the focus groups regularly charted clinical information. Most said they did not discuss clinical information with the residents' families. They said that only management staff attended interdisciplinary conferences and that the CNA was responsible for telling the charge nurse about the resident so that she could take that information to the interdisciplinary conference. Some aides told us they had no connection to upper management at all. Several workers seemed to view staff meetings set up for CNAs to provide input to the facility as a waste of time, because they were used to air complaints without follow-up by management.

Models of Staff Empowerment

The perception of CNA focus group participants about their involvement in care planning and decision-making was in sharp contrast to what we found at the case study sites that were selected because they were not experiencing recruitment or retention problems and were viewed as having adopted innovative management approaches. We asked the direct care staff in these sites to characterize what they liked best about their work environment. They described to us work situations in which the facility's management demonstrated trust in their ability to make decisions on behalf of the residents and clear expectations that they do so.

In one facility, a 33-bed SNF, which is part of a continuum of care that includes independent living apartments and assisted living, this trust was reflected in management's support of a culture that allowed the aide and the resident to identify the activities the resident could benefit from and to leave the unit to pursue them. One example was gardening. CNAs were able to finish their work and leave the unit to take a resident out to look at local gardens, knowing that others would cover their assigned residents while they were gone. They also mentioned other individualized activities they were able to do with residents such as crossword puzzles, cooking, giving manicures, elaborate hairstyling, exercising and going outdoors. Many of the CNAs in this facility placed a high value on the trust that management was willing to place in the CNAs' judgment and commitment to making sure that they could carry out these activities with residents and still complete their other work. It is also important to note that in this facility, the DON was extremely involved in the facility's day-to-day operations and in the personal problems of staff that impinged on their jobs and in resident care. She identified her philosophy as "an open door

policy for all staff.” Her office was centrally located, giving her easy access to the unit and the ability to observe daily activity. She routinely went on rounds with visiting physicians. She identified her role as one of mentor, confidant, advisor, supporter and problem solver.

The work environment of the second case study site, a 200-bed facility with a high percentage of low-income residents, also emphasized both respect and support for staff. In this facility, the management model employed by the DON and unit nurses was one of role modeling, an emphasis on building staff capacity to solve problems, and accountability. The DON believes that all her staff must learn to solve conflicts and problems on their own. She sees her job as providing coaching, mentoring, resources, information and encouragement that enables staff to solve the problems they confront rather than relying on others to solve problems for them. Staff capacity is developed by articulating clear expectations that staff is a part of the problem-solving and decision-making processes, providing quick and clear feedback to staff about good practices and norms of behavior, and creating an environment of mutual respect and encouragement. The DON is committed to insuring that when staff come to her or to their supervisor with a problem, they also come with an idea about how the problem might be solved. If they have not done so, they are asked to participate with her in thinking about possible solutions and the likely consequences of each. As part of this problem-solving exercise, the DON and other supervisors assist the staff person to identify information needed and other staff who should be involved in the problem-solving effort. As in the other site mentioned above, the DON is very visible in the facility and knowledgeable about and involved in the daily care and work. She sees role modeling as her most important function and expressed a belief that this is the most effective way to change behavior in the staff. According to staff, this philosophy is infused throughout the organization. The DON and DSD also actively identify specific talents in all staff and approach them about how they might develop that talent. One of the more tangible outcomes of this emphasis is the operation of a very strong career ladder within the facility. Most of the RNs in the organization started their career in this facility as CNAs, as did many of the LVNs. CNAs are encouraged to go to school, are allowed time off to do so, and consequently, the organization has done a remarkable job of promoting from within. Additionally, this organization allows staff flexibility in scheduling to accommodate personal needs such as child care arrangements or educational classes.

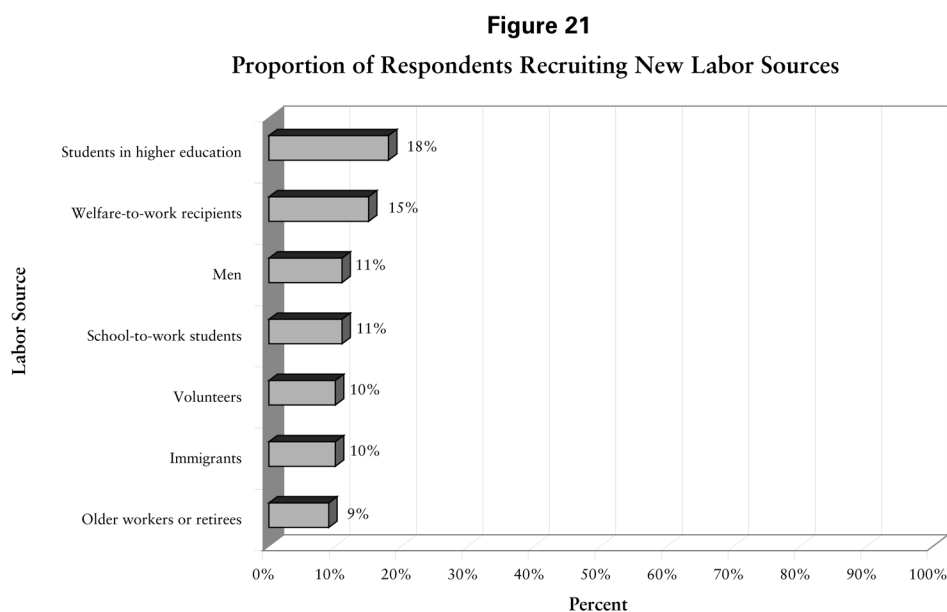
In each of the case study sites, staff regarded their workplace like a family. Recruitment and retention problems were reported to be non-existent even though wages were average or slightly below average in comparison to other CAHSA facilities. Direct care staff and nurses in these facilities reported low levels of work stress even though staffing levels were average. In each facility, the lines between nurses and aides appeared to be blurred with nurses involved in direct care and answering call lights, as well as listening to aides, following through on information and role modeling good practices. Communication and collaboration among all staff appeared to be high. Direct care workers were trusted to make decisions affecting resident care and were held accountable. In each case, the DON was a strong leader, accessible and extensively involved in resident care, and used role modeling, coaching and mentoring as key staff development strategies.

Clearly, there are anomalies raised by differences between the perceptions of workers in the focus groups and survey respondents regarding the environments in which workers are employed and how they are treated by management. It is hard to reconcile the belief of over one-half of the survey respondents that direct care workers are involved in care planning decisions with the state-

ments by over 70 workers in our worker focus groups that they had never been to a case management meeting. It is possible that administrators assume that the normal interactions between charge nurses and direct care workers regarding residents constitute involvement in decision-making about residents. But, the exclusion of aides from care planning meetings and interdisciplinary conferences about residents is significantly at odds with the management philosophies expressed by two of our innovative case study sites. The differences between the views of survey respondents that open door management policies were pervasive with the attitudes expressed by many direct care staff in the focus groups that they were not listened to or respected are stark. Perhaps most importantly is that relatively few survey respondents, most of whom were administrators, believed that retention problems were the result of a lack of respect for direct care staff, compared to the views of workers in our focus groups that this was a critical workforce problem.

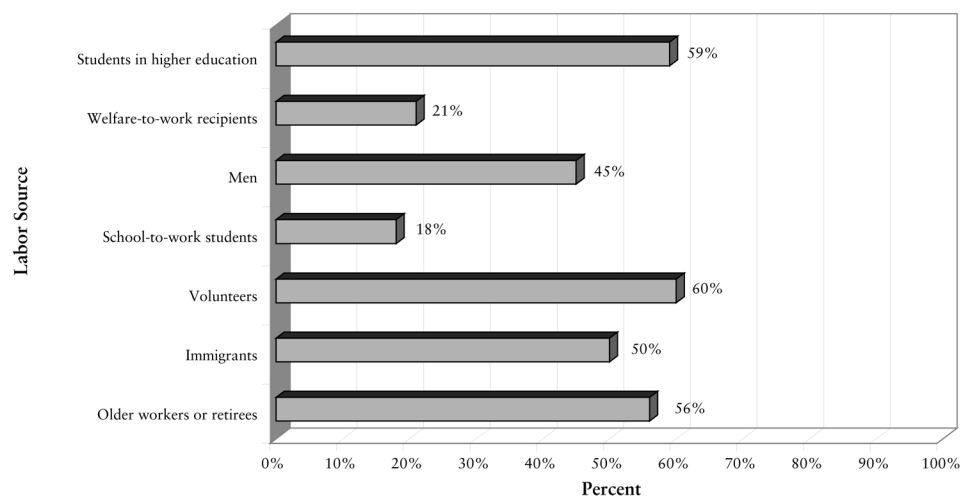
Strategies for Expanding the Labor Pool

The majority of facilities responding to the survey reported that a major cause of recruitment problems was an inadequate labor supply. Yet, while two-thirds of the respondents indicated that the current supply of workers was inadequate, only 38 percent reported that they had sought new sources of labor to fill direct care positions. Of this 38 percent, 18 percent said they had tried to expand their labor pool by recruiting students from community colleges and local institutions of higher education, 15 percent recruited welfare-to-work recipients, 11 percent recruited men, 11 percent recruited students from school-to-work programs, 10 percent recruited volunteers, 10 percent recruited new immigrants and 9 percent recruited older workers or retirees (Figure 21). Recruiting welfare-to-work recipients and students from school-to-work programs were rated as the least useful sources of new labor (Figure 22).



SOURCE: CAHSA/IFAS. The 2001 Direct Care Worker Recruitment and Retention Survey.

Figure 22
Proportion of Respondents Reporting That New Labor Sources They Use Are Effective



SOURCE: CAHSA/IFAS, The 2001 Direct Care Worker Recruitment and Retention Survey.

CONCLUSIONS AND IMPLICATIONS

This study examined the recruitment and retention of direct care workers in California's not-for-profit nursing homes, continuing care retirement communities, and assisted living facilities. The lessons drawn from study results have important implications for providers, workers and policy makers.

- 1. CAHSA members participating in the survey appear, for the most part, to be responding logically to problems with recruitment and retention.** On average, facilities reporting more difficulty with recruitment and retention offered a greater number of financial and benefit incentives and a wider array of education, training and workplace improvement strategies than other facilities. However, no consistently clear patterns emerged from the survey that would suggest the efficacy of a particular strategy, for example, higher wages, over another strategy such as adding a health insurance benefit or offering more comprehensive training, in improving the recruitment and retention of direct care workers.
- 2. The lack of accurate and comparable data on vacancies and turnover makes it almost impossible to evaluate the efficacy of particular strategies employed by CAHSA facilities to improve recruitment and retention.** CAHSA should consider identifying a standard tool for calculating vacancies and turnover and assist its members in implementing it.
- 3. While CAHSA facilities of all types report that they face significant recruitment and retention problems, RCFEs (assisted living facilities) were less likely to report such problems.** There are several possible explanations for why these facilities seem to be experiencing fewer problems, from differences in their management structure and regulatory requirements to their case mix. It would be useful to follow-up and try to explain this finding.
- 4. Health insurance plays an important but difficult-to-quantify role in workforce recruitment and retention.** According to the survey, almost three-quarters of facility respondents provided health insurance to their direct care staff. Both the survey results and focus group feedback suggest that the availability of health insurance plays a role in retaining workers in the facility. However, since data were not collected on how many direct care staff actually participate in the facilities' health plans, it is difficult to assess its real impact. Future work is needed to determine how much direct care workers contribute toward their health care premiums, and actual take-up rates for specific plans.

5. **In-service education and training opportunities do not appear to be highly valued by many direct care staff. The role that could be played in California by the Director of Staff Development in developing and promoting innovative in-service programs has not been widely realized.** In-service requirements should be evaluated for their relevance to the day-to-day needs of workers. Particular attention should be paid to role modeling, mentoring and coaching as positive approaches for disseminating new information and skills. In addition, examples of innovative staff development programs should be shared by and with Directors of Staff Development (DSD). Two of our case study sites provided excellent examples of the powerful role that the DSD can play in staff development.
6. **Workers' negative attitudes towards charge nurses are an important factor in job satisfaction and job retention. However, administrators and nurse supervisors do not seem to appreciate the significance of this problem.** Consistent feedback from direct care staff that they are not valued or respected by their supervisors, coupled with the perception of charge nurses that they are not managers and have no need for management skills, demands attention. Workshops and seminars aimed at bringing charge nurses and direct care workers together to "hear each other out" would seem a good first step. Ultimately, nursing home administrators, DONs, Schools of Nursing and workers should come together to design education and training programs that prepare supervisory nurses to be effective managers who educate and empower rather than disenfranchise the direct care worker.
7. **There appears to be a significant disconnect between the perceptions of survey respondents, who were largely administrators, and direct care staff regarding the involvement of direct care workers in resident care planning.** As part of introducing new management approaches to CAHSA members, special emphasis should be placed on how direct care staff can and should be meaningfully involved in both clinical and quality of life decisions affecting residents.
8. **Differences between long-time employees and more recent hires into direct care roles may be altering the incentives that determine whether the worker will stay in the job or leave.** Attracting new entrants to the field who will become part of a stable workforce is critical for meeting future needs. Additional examination of the values, perspectives and incentives which motivate newer versus long-time workers is important if recruitment and retention strategies are to keep pace with the characteristics of the workforce of the future.

9. **The workplace environment is at least, if not more important than money in determining the job satisfaction of more experienced workers.** Based on our case studies, the attributes of a successful workplace environment appear to include: (1) clearly articulated expectations from management that direct care workers, ancillary staff and nurse supervisors are to be decision-makers and problem-solvers; (2) a timely feedback system as issues and problems are identified; (3) open door management policies that are based on trust, are without repercussions, and which include follow-up that addresses issues that have been raised; (4) blurred lines between CNAs and nurses, two-way accountability, and mutual respect and acknowledgement; (5) management styles which rely on mentoring and role modeling to transfer needed skills; (6) career advancement opportunities and the facility's support to pursue them; and, (7) a DON with strong leadership skills who is visible, accessible and intimately involved with resident care. While the pay-off of such strategies with respect to reducing staff vacancies and turnover and improving quality has not been systematically evaluated, the case study sites in our study that were characterized by many of these qualities, in contrast to the majority of survey respondents, reported no problems with either recruitment or retention. CAHSA's member facilities have much to be proud of with respect to the innovation and leadership skills that reside in many of their staff. CAHSA should facilitate bringing these resources systematically to bear on behalf of all its members to educate and support them in implementing new management approaches.

10. **The DON is a critical linchpin of successful innovation in CAHSA facilities.** Without the leadership of the DON, the successful introduction and implementation of management and organizational arrangements that improve the workplace environment for direct care staff is not likely. State provider associations, national trade associations, professional organizations, unions and schools of nursing should collaborate with one another to develop strategies for attracting and preparing nursing students for these key roles and providing them with the support they need to succeed in them. At the same time, a concerted effort should be made to network the DONs in CAHSA facilities so that they have access to information and technical assistance that helps them to experiment with new management and organizational approaches as well as the support of their colleagues.

11. **California's current shortage of direct care workers is only likely to worsen because of demographic changes.** Increasing the supply of competent and committed workers will require tapping new labor pools such as welfare-to-work recipients, retirees and older workers, volunteers, men, new immigrants and students who may not have traditionally been considered for caregiving occupations. More CAHSA facilities need to become familiar with these potential new labor pools, their specific circumstances, their educational, training and support needs and to market themselves to these groups as potential employers.

Institute for the Future of Aging Services



The Institute for the Future of Aging Services, a policy research center within the American Association of Homes and Services for the Aging, was created in July 1999 to create a bridge among the policy, practice and research communities to advance the development of high-quality aging services.

IFAS provides a forum for the health, supportive services and housing communities to explore and develop policies and programs to meet the needs of an aging society.

American Association of Homes and Services for the Aging



**American Association
of Homes and Services
for the Aging**

The American Association of Homes and Services for the Aging represents more than 5,600 mission-driven, not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community services organizations. AAHSA is committed to advancing the vision of healthy, affordable, ethical aging services for America. The association's mission is to create the future of aging services.

California Association of Homes and Services for the Aging



The California Association of Homes and Services for the Aging's (CAHSA) mission is to advance housing and services for older adults and to support and inspire its members through advocacy, education, research and services enabling them to meet the changing needs of their clients and communities.



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