

SYNOPSIS >> Developing an adequate, well-supported long-term care paraprofessional workforce is not only a growing business and quality issue for providers but also an economic development issue for communities and their local and state governments. Long-term care is one of the fastest-growing fields in the economy and, as such, is a powerful job engine for direct care occupations as well as an important entry point into licensed health-related occupations. However, public workforce investment systems often shy away from investing in these jobs, because of low wages and other job quality issues. Long-term care providers and employers, for their part, often don't know about or are skeptical of the value of engaging with government workforce development initiatives. This Issue Brief examines this reluctance to invest and engage and highlights five examples of successful partnerships between employers and workforce development networks. These partnerships are seeking to change business as usual in order to improve the quality of care, increase the supply of direct care workers and promote greater workforce stability through higher retention and lower turnover.

Engaging the Public Workforce Development System: Strategies for Investing in the Direct Care Workforce

INTRODUCTION

Across the country, the growing need for long-term care services is creating formidable workforce and economic development issues. Most long-term care is provided informally by family members, neighbors and friends. But the pool of available family caregivers is under strain and shrinking due to major changes in the American family experience. These changes include greater geographic dispersion of family members, divorce, fewer children and delayed childbearing, and the greater labor market involvement of women.¹ On the formal side of the labor market, a growing gap is emerging between the supply of long-term care workers and the mounting needs of elderly and people with disabilities for long-term care services. From a workforce development perspective, this is a labor market problem crying out for

attention and resources. In many areas of the country, traditional mechanisms for recruiting, training and retaining direct care workers are no longer adequate to successfully address the high rates of job turnover, the gap between supply and demand and the need for higher quality and more consistent care.

At the same time, federal and state workforce development systems are in an important period of redesign, ironically with an expanded mandate funded by shrinking public funds. With the passage of the Workforce Investment Act (WIA) in 1998, the public workforce development system left behind its focus on training and placing jobseekers, substituting instead a broader vision that *explicitly* emphasizes working with *both* workers and employers in a market-driven context.² The goal is to connect workforce training and development to local

¹ Seavey (June 2005).

² State and local workforce investment systems. U.S. Code, Title 29, Chapter 30, Subchapter 2. Cornell Law School, Legal Information Institute. <http://www4.law.cornell.edu/uscode/29/ch30schll.html>. The prior public workforce development system was under the Job Training Partnership Act (JTPA). Many of the best JTPA providers and local workforce systems were successful because they engaged both employers and job seekers.

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and regional engines of economic growth, an imperative in light of structural changes in the U.S. economy. Many local Workforce Investment Boards (WIBs), which serve as regional planning and funding agencies for public workforce development activities, are beginning to see themselves as playing a critical role in regional economic development. They are adopting an investment strategy approach that seeks to invest public dollars in industries that offer communities long-term economic viability.

As one of the nation's fastest-growing fields, long-term care seems like a good potential match for the investment of public workforce dollars. Yet direct care occupations are often ignored by state and local workforce development programs. With varying relevance in different parts of the country, three major barriers appear to prevent these partnerships from developing:

- The relatively low compensation and training levels of direct care jobs create concern that they will be bad investment vehicles for scarce public dollars.

What is the public workforce development system?

The **Workforce Investment Act (WIA)** of 1998 provides for a more coordinated, locally-driven workforce investment system intended to meet the needs of businesses and job seekers. This system is a partnership between state, local and federal stakeholders that gives states and localities increased authority to implement innovative workforce investment strategies to best serve the needs of the labor market. In contrast to its predecessor (JTPA), WIA considers both employers and job seekers to be "clients" served by the new system and gives the business community a prominent role in workforce investment activities at both the state and local levels.

One-Stop Career Centers are the foundation of the local workforce development system. The goal of this delivery system is to streamline access to numerous workforce investment, educational and other human resource services, rather than requiring individuals and employers to seek workforce information and services at several different locations, which is often costly, discouraging and confusing. The centers typically have trained staff who provide advice, skill assessments, referrals to programs and services and who help individuals through the system until they are prepared to enter employment. Centers may also provide business services such as information about the labor market, customized training for employers, initial screening of job applicants and assistance for employees who are downsized or laid off. Some One-Stop systems provide electronic linkages to job databases and training resources for both job seekers and employers.

Approximately 600 **local workforce areas** exist throughout the country and each has a local **Workforce Investment Board (WIB)** which administers local WIA activities. The WIB selects One-Stop Center operators, identifies eligible training providers, develops links with employers, creates a local plan and oversees the use of funds for employment and training activities. Local WIBs are appointed by chief local elected officials and include representatives from business (which must be the majority), local educational institutions, labor organizations, community-based organizations, economic development agencies and all One-Stop partners. Each state's activities are directed by a State Workforce Investment Board, which oversees the activities of the local WIBs and assists the governor in monitoring and developing the state plan. State WIB members are appointed by the governor and the majority must be composed of business representatives.

Administered primarily by the **U.S. Department of Labor (DOL)**, funding for the WIA public workforce investment system is channeled through a number of different titles and funding streams, which totaled \$5.3 billion in FY 2005. Funds are allocated by formula to the states and most of the funds are then distributed to local workforce investment areas within each state by a similar formula. WIA has three federal funding streams: adults, dislocated workers and youth. In addition, discretionary WIA grants are available at both the state and federal levels, and states often fund their own (non-WIA) workforce development programs. While WIA funds represent a small percentage of total federal and state resources available for workforce development, WIA nonetheless is an important systems-building effort with significant impacts on state and local workforce development communities.

- The health care sector tends to be represented on WIBs by large hospital systems that are adept at capturing funds for use in acute-care, not long-term care, occupations.
- Long-term care providers often do not think to approach or become involved in the public workforce investment system. They often assume that their state’s One-Stop system largely deals with TANF recipients (TANF—Temporary Assistance to Needy Families—is the nation’s welfare-to-work program), who are presumed to be unsuitable candidates for direct care work.³

But as the examples presented in this Issue Brief demonstrate, when these two sets of players do meet, significant areas of mutual interest emerge. The projects detailed in this brief illustrate the kinds of opportunities and potential outcomes that can arise from these intersections. When local or state WIBs or the U.S. Department of Labor (DOL) sees this workforce as the real potential economic engine it is, exciting things can happen.

MAKING THE CASE FOR INVESTING WORKFORCE DOLLARS IN THE DIRECT CARE WORKFORCE⁴

While Workforce Investment Boards across the country are beginning to address the problem of health care worker shortages, many WIBs pass over direct care employment in long-term care in their assessments of high-priority occupations for receiving workforce investment dollars. As noted above, this is because direct care work is often viewed as consisting of dead-end, low-wage jobs that do not allow for family economic self-sufficiency or wage progression.

A strong argument can be made, however, that this is an outmoded perspective. With the exception of one central criterion—wages and benefits (together often used as a crude proxy for job quality)—direct care jobs across the

long-term care continuum currently meet or exceed all the possible standards of being high-priority occupations for workforce investment dollars. These standards include significance or dominance in the sector at issue, relative number of projected job openings and evidence of worker or skill shortages.

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Many localities, in fact, are in need of effective workforce development policies to help close the gaps between the labor market needs of employers and workers and the needs of an aging society. More specifically, the long-term care industry must find ways to make direct care jobs more competitive—making these jobs attractive relative to other job options—so that the industry can meet the projected increases in demand over the next two decades. Investments in job quality, thus, potentially offer significant returns to local communities, in the form of better jobs for local workers and better care for elders and people with disabilities.

Ignoring the quality of direct care jobs can impose fairly substantial economic costs at two different levels: at the state and local government level and on the families of care recipients. In New York City, for example, one in seven low-wage workers are home or community-based direct care workers, and, as a result, the low-quality of direct care jobs fuels economic instability for significant numbers of



³ TANF recipients can in fact be good candidates for direct care work. A recent Mathematica study concluded that “more than half of those on the TANF caseload have the potential to succeed in paraprofessional LTC [long-term care] jobs and that there are many different ways to design and implement successful LTC training programs for TANF recipients.” Jacqueline Kauff, Gretchen Kirby and LaDonna Pavetti (May 2005) “Linking TANF Recipients with Paraprofessional Long-Term Care Jobs,” Issue Brief, No. 8, New York City: Mathematica Policy Research, Inc. Available at www.mathematica-mpr.com.

⁴ This section draws heavily from Seavey, Dawson and Rodat (January 2006).

low-income households.⁵ These jobs create pressure on already overburdened human service and public assistance systems which are called on to make up for compromised job quality. The lack of a stable, well-supported paid direct care workforce also means that caregiving responsibilities lie heavily with family members. They, in turn, may moderate or adjust their work schedules and labor market participation in order to provide informal care to their loved ones. In some areas around the country where these public costs are evident, pressure for improving direct care occupations is mounting from a variety of sources—organized labor, consumers and city living-wage ordinances—providing important opportunities for complementary investments of public workforce dollars.

Perhaps the greatest obstacles to engaging the workforce development system with the labor market and workforce issues faced by long-term care providers are the stereotypes and mindsets that each side tends to bring. On the workforce development side, long-term care does not always have the same stature as, say, the health care field more generally. And direct care work is not necessarily viewed as a viable profession with legitimate career advancement opportunities. Instead, local and state WIBs often are more drawn to focusing on “health care,” which typically leads to an emphasis on “hospitals” as the principal players, and a focus on registered nurse shortages as the most pressing workforce problem. Furthermore, WIBs often find the acute-care sector easier to work with because hospitals usually are part of large institutions with commensurate staff and infrastructure, and they typically offer the potential to affect many jobs and potential career advancement pathways.

From the long-term care side, providers often don’t use a workforce development lens to understand their employment problems. Some see job turnover or “churning” as a normal cost of doing business and are dubious that investing resources upfront in improved selection and recruitment and in better employment

conditions will lead to higher retention. In other words, the business case for making direct care jobs more attractive is often a hard sell because providers are used to high rates of turnover and vacancy.

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In addition, long-term care providers, like many business people, either don’t know about the workforce investment system or are skeptical of the value of partnering with programs and systems sponsored or created by the U.S. Department of Labor (DOL). They associate the DOL with regulatory requirements, or with programs that support disadvantaged job seekers or those with employment barriers. In particular, a not uncommon employer perception is that One-Stops primarily offer welfare-to-work employment services to TANF recipients.

With careful injection of targeted workforce dollars, however, many WIBs can support the efforts of industry stakeholders working to improve direct care work and may even help be a catalyst for these initiatives. The direct care labor market overwhelmingly employs paraprofessionals who receive very low wages, have limited career mobility and work in jobs that often have poor training, support and supervision. These negative features mattered less when the supply of new labor market entrants was more ample. But in an era where the supply of labor is becoming increasingly constrained, these attributes limit the attractiveness and competitiveness of these jobs and lead to poor outcomes, such as high turnover and inadequate client care and services. Both out-

⁵ Seavey, Dawson, and Rodat (January 2006).

comes can be very costly to providers and ultimately to the public since taxpayer dollars supporting Medicaid and Medicare pay for about 60 percent of all long-term care expenditures.⁶

State and local WIBs can play an important role in helping to shape the future of the direct care labor market and the quality of direct care jobs. They can support efforts to customize recruitment and selection for direct care careers, and improved entry-level training. They can also support efforts to help redesign these jobs and to revamp training and credentialing systems for direct care work.

SELECTED WORKFORCE INVESTMENT INITIATIVES FOCUSED ON DIRECT CARE WORKERS

Several exciting efforts are underway across the country to create strong partnerships between the workforce development system and employers of direct care workers with the goals of addressing workforce shortages and poor quality of care.⁷ Five such initiatives are highlighted below:

- ANCOR/DOL One-Stop Pilots (4 states)
- CAEL/DOL Healthcare Lattice Program (9 states) & Paraprofessional Healthcare Institute Home Health Aide Apprenticeship Program (3 states)
- Oregon Assisted Living Facilities Training Consortium
- Pennsylvania Multi-Employer Industry Partnerships
- Northwest Michigan Community Services Network

These projects illustrate the diversity of approaches and collaborations between the workforce investment system and long-term care providers. In terms of **occupations and settings**, the efforts encompass personal care assistants in assisted living facilities, certified nursing assistants in acute care and nursing homes and home care aides working directly in people's homes. Some of these initiatives have important applicability to other direct care

occupations and settings.

The diversity of **funding** streams tapped is wide: two of the highlighted projects received funding from DOL discretionary funds; the Oregon, Pennsylvania and Michigan projects received state WIA funds. All the projects tapped their local WIA resources and programs.

The highlighted projects also exhibit the **diversity of roles that WIBs can play**. In some cases, local WIBs have demonstrated an activist, hands-on approach to guiding the local workforce system, including undertaking a sectoral change approach to the whole health care field. In other cases, local community-based groups or individual providers were the innovators and then succeeded in accessing public funds, through their WIBs, to support their projects.

Finally, some of the initiatives described are **multistate** while others are **local**, but with potential to be replicated in other areas or to the state as a whole.

“State and local WIBs can play an important role in helping to shape the future of the direct care labor market and the quality of direct care jobs.”

Their considerable diversity notwithstanding, the five projects have two important features in common. First, they share an awareness that **traditional training methods and recruitment tools are inadequate** to the task of keeping up with current and future demands for recruitment, training and retention of direct care workers. Each of these initiatives ultimately targets specific industry practices that underlie job quality. Secondly, each project involves **first-ever partnerships between long-term care stakeholders, the workforce investment system and other community institutions** such as community colleges or industry trade associations. Sustaining these partner-



⁶ Seavey (October 2004).

⁷ For a DOL-supported review of several state-based long-term care nursing workforce initiatives, see Biles et al. (September 2005).

ships has been vital to the continued success of these projects.

ANCOR/DOL One-Stop Pilots: Recruiting Direct Support Professionals to Abate Workforce Shortages and Build Pools of Job-Ready Workers

The ANCOR/DOL pilot program brings together key components of the public workforce development system. Its purpose is to develop a One-Stop program model that provides screened and trained direct support candidates to private providers of community-based facilities for people with mental retardation and developmental disabilities. Launched in May 2004, four specific state locations are now underway in Lexington, Ky.; Portland, Maine; Phoenix, Ariz.; and Rochester, N.Y. ANCOR (American Network of Community Options and Resources)—the national trade association for more than 800 providers of services and supports for people with disabilities—serves as the program’s National Business Partner and used its state affiliate network to identify pilot sites. DOL has committed to inform and educate its One-Stop career development network about this model.

The idea behind this pilot program is to use the public workforce system to help build a pool of available workers who have satisfied most pre-employment training requirements and from which providers can fill vacancies expeditiously. Pre-employment training requirements include:

- First aid and CPR training
- Criminal background check
- Fingerprint clearance card
- Motor vehicle records check
- Testing for TB
- Health Insurance Portability and Accountability Act (HIPAA) training
- Universal precautions training and training for lifting and carrying
- And if applicable or needed:
 - Drivers’ training for large passenger vehicles

- Literacy education
- Approval for subsidized child care

The goal is to use the One-Stop system to recruit, screen and test interested candidates into direct support positions within the provider system.

One year into implementation at the four sites, Renee Pietrangelo, CEO of ANCOR, commented on three lessons that have stood out to her. The first is how little the One-Stops at the four sites knew beforehand about the direct support workforce and how few providers had ever drawn on resources available from the public workforce system. A local planning committee member from one of the states captured this initial unfamiliarity this way, “Most employers might ask themselves ‘partnering with the Department of Labor? Are you kidding me? That’s like working with the enemy.’ After all, the only time we hear from them is when someone has complained and an ‘on-site’ investigation is imminent. Fortunately, that stereotype is far from true.”

At the same time, Pietrangelo has found that, once both sides understand one another better, many opportunities for successful partnerships become apparent. “Success has been realized by our workgroups because ANCOR providers teamed up with state and local service providers to recruit workers who match the employers’ needs,” the Louisville Planning Committee reports. “Employers can now access untapped populations such as youth, older workers, welfare recipients, veterans and persons with disabilities who are looking for jobs. Most importantly, we have built relationships with federal, state and local agencies that, if not for this initiative, may not have been possible.”

The final lesson is the importance of having each pilot generate the specifics of program implementation. Each pilot has established a local planning committee, which consists of representatives from service providers, state DOL, local WIBs and state provider associations. Activities undertaken by these committees have included designing weekly provider presentations at One-Stop Centers, holding job fairs for seniors and developing a wide array of materials to attract potential employees—

including public service announcements and career marketing and recruitment materials such as videos, flyers, print ads and posters. Additionally, some sites have partnered with community colleges to allow incumbent workers, who wish to work as direct support professionals, to obtain college credit hours and have their tuition costs covered by WIA funds and employer dollars. The Rochester, N.Y., effort is tapping into a pre-existing apprenticeship program developed by the New York State DOL for the direct support professional job title.

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CAEL/DOL Healthcare Lattice Program and PHI Home Health Aide Apprenticeship: Creating Partnerships to Develop Career Paths for Direct Care Workers

The CAEL/DOL Healthcare Lattice Program addresses shortages of certified nursing assistants (CNAs), licensed practical nurses (LPNs) and registered nurses (RNs). The program helps incumbent and newly hired workers enter and advance in health care careers through a unique education and training program that results in apprenticeship certification by the U.S. Department of Labor (DOL). Initially piloted in 2003 at sites in five states, (Chicago, Ill.; Houston, Texas; Sioux Falls, S.D.; and the states of Maryland and Washington), funding was expanded to four more states in April 2005 (Kentucky, Georgia, Michigan and Virginia). The program draws enrollees from among workers at hospitals and long-term care facilities, high schools and One-Stop Centers; to date, most of the candidates have been generated internally from health care organizations.

The Council for Adult and Experiential Learning (CAEL)—a national, nonprofit organization that promotes adult learning—developed, in collaboration with DOL, the original nursing assistant apprenticeship model, which DOL then certified as a registered apprenticeship program. CAEL also has developed a tool kit that government, public sector and health care entities can use to create similar career lattice programs.

At each site, the public workforce system—and in particular, One-Stops—is available to help screen potential apprentices for basic language, academic and work skills. Trainees are hired as soon as they enter the program, allowing participants to ‘earn while they learn’ in a competency-based apprenticeship that requires 144 hours of clinical and didactic training and 2,000 hours of training on the job. Apprentices must work for a year to obtain DOL apprenticeship certification. As of September 2005, about 450 incumbent workers either had completed or were enrolled in CNA training across the five sites.

“Partnerships among health care employers, local WIBs and One-Stop Career Centers, colleges and DOL Offices of Apprenticeship Training, Employer and Labor Services have proven to be essential to establishing the career lattice programs and sustaining the initiatives over time.”

Lateral and vertical advancement paths are provided. CNAs can move laterally to become mentors, nurse extenders, medicine aides, skilled long-term care nursing assistants or to specialize in geriatrics, restorative care or dementia. Each move comes with a course of study and on-the-job training; successful completion results in an increase in pay and recognized, portable certification for the specific specialty area. CNA apprentices can also move up the ladder by taking courses at educational institutions or through distance learning to become, for example, LPNs, respiratory therapy technicians or pharmacy technicians.

Partnerships among health care employers, local WIBs and One-Stop Career Centers, colleges and DOL Offices of Apprenticeship Training, Employer and Labor Services have proven to be essential to establishing the



career lattice programs and sustaining the initiatives over time. Collaboration is formalized through local advisory committees whose members represent the various stakeholder organizations. Each pilot site also has a local site coordinator who promotes the lattice, recruits partners, builds relationships and assists with all stages of implementation.

Phyllis Snyder, CAEL vice president, comments that one of the most satisfying parts of CAEL's work has been helping develop partnerships between workforce development groups and health care employers. "This work has been about creating these collaborations and partnerships. Often employers know about the existence of workforce development programs, but mental barriers keep them from connecting and they aren't sure the workforce system can meet their needs. On the other hand, the workforce systems sometimes don't understand the needs of health care employers, particularly those that employ entry-level workers involved in direct care. But once the workforce system shows that it can be responsive to these employers and be flexible with its funding, employers come on board. This work is about changing how things are done."

Building on the CAEL effort, DOL funded the Paraprofessional Healthcare Institute to create an apprenticeship model for home health aides in home care agencies. Through this initiative, the home health aide occupation was recently awarded apprenticeship certification status by DOL. A three-state pilot running through early 2006 is underway in Pennsylvania, Indiana and Michigan. Similar to the nursing assistant career lattice, home health aide apprentices receive DOL certification after one year of employment. Specializations include working with consumers with disabilities, mental illness or dementia; hospice and palliative care; and peer mentoring. At each site, the regional offices of both DOL's Employment and Training Administration and its Apprenticeship Training Office are playing strong roles in recruiting employers to participate in the program. To date, local WIBs have not been significantly involved, although the Northern Indiana WIB is seeking state

incumbent worker funds to expand the apprenticeship pilot to two additional home health agencies.

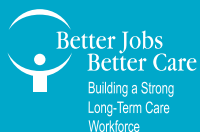
Contact: For the CAEL program, contact Phyllis Snyder, vice president, CAEL, (215) 731-0191, psnyder@cael.org. Visit: www.cael.org/healthcare.htm and see CAEL's *Guidebook for Implementing Career Lattice Programs* at www.cael.org/pdf/publication_pdf/Career_Lattice_guidebook.pdf.

For the home health aide program, contact Vera Salter, director, National Clearinghouse on the Direct Care Worker, Paraprofessional Healthcare Institute, (718) 402-7766, vsalter@paraprofessional.org. See also: www.directcareclearinghouse.org/download/Bul2005-10_Home_Health_Aide.pdf.

Oregon Assisted Living Facilities Training Consortium: Creating Job Profiles and Certification for Personal Care Assistants

In 2002, Portland Community College in Oregon partnered with Cedar Sinai Park and Avamere Health Services to create a training and career model for the assisted living facility segment of long-term care in the Greater Portland Metropolitan Area. The partners developed the Assisted Living Facilities Training Consortium (ALFTC), whose first goal was to create a sustainable, incumbent worker training program (with eventual certification) using industry-based skill standards.

Assisted living facilities constitute the fastest growing segment of the long-term care field in Oregon, but there are no established, recognized skill standards for training the unlicensed, non-certified direct care workers who work in them. As a result, assisted living providers do not have clear and consistent definitions and standards for hiring, training and communicating expectations of personal assistants and medication assistants. This makes it difficult to build meaningful training programs, monitor job performance and provide promotion opportunities (a career ladder). As a result of the minimal training provided, the lack of obvious career ladders and low wages, turnover rates for unlicensed, non-certified direct care workers are high. An Oregon employer survey from 2000 found a 49 percent turnover rate among direct care workers in assisted living,



residential care and nursing facilities within the first 90 days of employment.⁸

The goal of the ALFTC initiative is to create recognized, industry-supported job descriptions and accompanying training programs for direct care workers delivering basic personal care and medication administration services in assisted living facilities. It is expected that this will lead to better trained and equipped workers who will have the opportunity for advancement in position and pay within community-based care in Oregon. This community-based care will include licensed assisted and residential care, and in-home care. Since unlicensed, non-certified direct care workers do not have career pathways, the standardized training and certification process will also enable direct care workers to be better equipped to move between employment settings in community-based care and to enter a variety of allied health care professional training programs. These programs include training to become dental and nursing assistants, nurses, and physical, occupational and respiratory therapists.

Finally, it is also expected that, if adopted statewide, this standardization of job profiles and credentials will reduce recruitment and training costs for employers and contribute to higher quality care for clients through higher worker retention rates and better skills.

State WIA funds provided the seed funding for this project through a competitive grant process for incumbent worker training along with matching in-kind funding from the project's two employer partners. With the assistance of the Institute for Health Professionals and the Customized and Workplace Training Department at Portland Community College, a full curriculum was developed consisting of a set of training modules and a train-the-trainer program. In addition, two job profiles—"resident assistant" and "health care coordinator"—

are being created through a certified job profiles analysis in cooperation with different providers.⁹ These profiles will be tested in various focus groups to arrive at consistent definitions, and then will be available for use by all assisted living employers.

Two assisted living facilities are currently delivering the training to incumbent workers in their facilities, with train-the-trainer sessions bringing designated staff members up to speed on adult education methods and program content. In addition, Portland Community College's Career Pathways Training Program is delivering pre-employment training based upon the ALFTC's curricula. The training has been modified to target non-native English speakers. Partners are sharing what they have learned about this effort to create an integrated workforce development system that responds to industry needs with other long-term care employers at the local, state and national levels.

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Pennsylvania Multi-Employer Industry Partnerships: A Sectoral Economic Development Approach to Investing in the Direct Care Workforce

In 2001, with support from a grant from the Pennsylvania Workforce Investment Board and the U.S. Department of Labor Sectoral Employment Demonstration Project,¹⁰ three local workforce investment boards began a strategic planning exercise to respond to what was determined to be a "massive and long-term" health care workforce shortage. These three boards make up a 10-county labor market area in south-central Pennsylvania.



⁸ Oregon Health Care Association (June 2000) Workforce Shortage Survey: Employer/Administrator Survey. Wilsonville, OR: OHCA.

⁹ The resident assistant position is an entry-level job. The health care coordinator (HCC) position requires a higher level of reading and writing skills, and includes tasks such as the administration and coordination of medications. HCCs also respond when residents fall, or when accidents, injuries or emergencies occur, including triaging to 911.

¹⁰ The Sectoral Employment Demonstration Project funded 39 Workforce Investment Boards to apply sector-based workforce development strategies to their strategic planning and project implementation work. Over half the grantees focused on health care (Urban Institute and Aspen Institute, June 2004).

Among the problems identified were the following:

- Recruitment by employers at all levels was unproductive, often with no candidates applying.
- Competition was intense among employers for good employees.
- The system for skills development was disjointed with barriers and gaps that kept people from moving through it with ease.
- Lack of access to skills training excluded many viable candidates.
- Little or no connection to the public workforce development system existed.

Viewing themselves as representing one, not three, labor markets, the three local WIB boards (Berks, Lancaster and South Central) launched a major regional initiative with 34 local health care employers. Their goals were to:

- Help the workforce system fully understand the health care workforce.
- Increase the supply of qualified and trained health care workers in the regional workforce.
- Connect workers with employers using the CareerLink system (Pennsylvania's One-Stop Service).
- Improve accessibility to career paths available to health care workers.

An intensive, regional communications campaign using television advertising was launched to interest workers in careers in health care. Interested workers were directed to One-Stop Centers that had built-in services needed by workers and employers who were in the initial steps of the direct care career ladder. These services included pre-screening programs for prospective employees, literacy and English as a Second Language programs and a 40-hour foundation skills training program for health care workers. Employers contributed \$1.3 million over three years to the television advertisements, roughly one-quarter of which focused specifically on CNAs. The initial seed money for the campaign came from state WIA funds.

According to a formal evaluation of the initiative, the communications campaign “resulted in thousands of inquiries, and hundreds of participants signed on for health care training programs.”¹¹ While there may have been other contributing factors, vacancy rates for CNAs and home health aides in this region declined from 12-15 percent to 8-10 percent from 2001 to 2003. Every health care education program in Lancaster County doubled its number of graduates from 2001-2004 while maintaining NCLEX pass rates well above the state average (NCLEX is a national entry-level nursing exam).

“While there may have been other contributing factors, vacancy rates for CNAs and home health aides in this region declined from 12-15 percent to 8-10 percent from 2001 to 2003.”

In response to feedback from direct care workers about problematic supervisory practices that contribute to high quit rates, another collaboration between local boards and industry partners was launched. The Central Pennsylvania Workforce Development Corporation and the Lancaster County Workforce Investment Board implemented a retention project focused on changing supervisory practices within nursing homes and home care agencies. With grants from the Pennsylvania Department of Aging and the U.S. Department of Labor and in partnership with the Paraprofessional Healthcare Institute (PHI), four nursing homes in two workforce investment areas received training and technical assistance to implement culture change practices that recognize nursing aides as skilled caregivers. The program provided training in job coaching supervision for frontline managers and organizational development consulting to higher-level managers. Last year, the Lancaster WIB and PHI continued to diffuse these new organizational change and supervisory practices throughout

¹¹ Urban Institute and Aspen Institute (June 2004), p. 26.

Lancaster's long-term care industry by organizing three-day "train-the-trainer" events for nursing homes and home care agencies.

In 2004, the Lancaster County Board and some of its economic development partners formed the Center of Excellence in Long Term Care, whose mission is to encourage innovation and best practices and to help design new training relevant to industry needs. The center has initiated the development of an end-of-life care curriculum for CNAs. A local hospice is designing the training in concert with the National Consensus Project for Palliative Care. Part of the training will be Web-based. The initiative also includes a train-the-trainer component. Eventually, the board hopes to extend end-of-life care training to nurses, pharmacists and clergy.

According to the WIB's executive director, Scott Sheely, also a board member of the Better Jobs Better Care demonstration project in Pennsylvania, the work of the Lancaster County Board within the long-term care field has yielded several important lessons. First, Sheely is convinced of the value of using an *investment* strategy to determine how to use public sector workforce dollars wisely. This requires local workforce investment boards to view themselves as economic development entities and to see themselves as part of an "innovation system," not just part of the public social services system. Sheely and his board are clear that the Lancaster area has a competitive advantage in long-term care and that "direct care workers, health technicians and other allied health occupations constitute a career cluster that is a real winner."

Second, Sheely emphasizes the importance of thinking regionally, across artificial boundaries such as county lines. "Taking a regional perspective on the labor market has been essential to achieving a workable scale for our investments,"¹² and it encourages providers to think beyond their own immediate needs.

Finally, the Lancaster WIB's experience demonstrates the importance of listening to industry experts and building multi-employer

industry partnerships. Partnerships can get needs met more efficiently and effectively than efforts by individual employers. They also can be good vehicles for managers and practitioners to learn from one another and to spread effective practices. Furthermore, because they offer training on a larger scale, they allow training to be purchased at a lower cost per person, thus enabling small employers to offer the

"Taking a regional perspective on the labor market has been essential to achieving a workable scale for our investments,"¹² and it encourages providers to think beyond their own immediate needs."

same training to their workers as larger employers. Sheely comments, "We are very committed to shared training. It has been gratifying to see our funding partners at the federal and state levels finally agree with us that this is the most effective and efficient way to spend these kinds of training dollars...in their commitment to incumbent worker training."

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Northwest Michigan Community Services Network: Engaging WIBs in Funding Innovative Training for Direct Care Workers

Community Services Network (CSN) is a small, nonprofit organization based in Michigan's largely rural, northwest regional peninsula that develops and provides training to direct care workers and other health professionals across



¹² Sheely notes that a large metropolitan area such as Philadelphia might have the opposite scale problem—it might need to segment the occupational focus or the market focus in order to achieve a manageable project scale.

the long-term care continuum. Established in 1999, CSN has distinguished itself in this 12-county region as an innovative, high-quality training provider that strives to improve both training content and the way training is delivered, and delivers training in areas where there are few such opportunities.

“In response to the need for pre-employment training, Northwest Michigan Works! collaborated with CSN in 2000 to develop a 60-hour basic health care training program, which has been provided to nearly 200 people in seven different locations.”

Over the past five years, Northwest Michigan Works!, the region’s local WIB, has convened and surveyed long-term care employers to determine their workforce needs. The top two requests from employers have been for community-based pre- and post-CNA/home health aide training. Employers emphasize the problems posed by high turnover among direct care workers and, in particular, the cost of investing training in new recruits only to have them quit after discovering the realities of direct care work. Pre-training, these employers reason, is needed to help job seekers make better decisions about whether they want to enroll in further formal training. At the other end, post-employment training and incumbent staff development training can play important roles in improving retention and raising care quality.

In response to the need for pre-employment training, Northwest Michigan Works! collaborated with CSN in 2000 to develop a 60-hour basic health care training program, which

to date has been provided to nearly 200 people in seven different locations. The program is designed as a precursor either to employer-specific training or to CNA or other formal training. It covers 10 hours of orientation, including screening and testing in English and math. A 15-hour unit on job readiness and job success skills follows and covers topics such as team work, conflict resolution, confidentiality, work ethic, and consumer rights and responsibilities. These first two units lead to 35 hours of training in specific health care-related topics such as CPR, basic nutrition, vital signs, aging and dementia, and anatomy and physiology.

CSN developed the 35-hour training modules and integrated the three training components; it also delivers the training for the second and third components. The local WIB, in turn, provided the funding to develop the training program and led the design of the first two training modules. It also has been responsible for managing employer relationships, providing the orientation training and staying in contact with trainees to provide job placement support.

CSN went on to help the Northwest Michigan Council of Governments¹³ put together its proposal to become a Regional Skills Alliance (RSA) focused on the health care sector. RSAs are a recent state initiative in Michigan to support workforce policies explicitly linked to economic development policies in priority industry sectors, such as health care and manufacturing; they are accompanied by special state workforce funds and technical assistance. The charge of RSAs in Michigan is to “focus on the workers or potential workers at the lower wage end of the industry and work to improve opportunities in those jobs as well as in jobs at higher levels in the career ladder.”¹⁴ There are now eight health care RSAs in Michigan.

In its RSA proposal, Northwest Michigan focused on the challenge of recruiting and retaining sufficient numbers of entry-level workers to meet the workforce needs of the

¹³ The Northwest Michigan Council of Governments is an \$8 million public agency that facilitates and manages programs related to employment and training, workforce development, economic development and regional planning in the 10-county region of Northwest Michigan.

¹⁴ See “What are Regional Skills Alliances?” at <http://www.michigan.gov/rsa>.

region's long-term care providers. This geographic region is a highly desirable place to live for both families and retirees, but insufficient numbers of youth are choosing to enter the health care sector in general and direct care work in particular. While the region also faces a shortage of RNs, the local WIB chose to focus on entry-level paraprofessionals in part because community colleges are already working to address the RN problem.

Beginning in October 2004, the Northwest Michigan RSA directed funds to develop a series of staff development trainings for incumbent direct care workers and other health pro-

fessionals such as RNs and LPNs. CSN was awarded the bid to develop the training; the content areas were chosen to respond to specific training needs identified in long-term care employer surveys conducted by the local WIB using RSA funds. These interactive, hands-on trainings cover topics such as dementia, body mechanics, elder abuse, stress and time management. From April 2005 through the summer, 34 trainings were conducted in 11 counties and approximately 150 people were trained, most of whom are direct care workers. The Area Agency on Aging is playing an important role in promoting the trainings. WIA

Resources for Workforce Development in Long-Term Care

Biles, Brian and Robert Burke, Kristin McCloskey, Sandra Fitzler (September 2005) *Developing State Partnerships and Initiatives to Address Long Term Care Nursing Workforce Challenges*. Washington, D.C.: American Health Care Association and Employment & Training Administration, U.S. Department of Labor. www.ahca.org/labor/DoLStateWFInitiatives.pdf.

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Office of Apprenticeship Training, Employer & Labor Services, U.S. Department of Labor www.doleta.gov/ATELS_bat.

- List of State Apprenticeship Councils www.doleta.gov/ATELS_bat/statecouncils.cfm.
- Certified Nursing Assistant Career Lattice http://www.doleta.gov/ATELS_bat/pdf/BUL2004-11_Certified_Nursing_Assistant_Career_Lattice.pdf.
- Home Health Aide Apprenticeable Occupation http://www.directcareclearinghouse.org/download/Bul2005-10_Home_Health_Aide.pdf.
- Direct Support Professional Apprenticeable Occupation http://www.directcareclearinghouse.org/download/BUL2002-02_Direct_Support_Spec.pdf.

State WIA Contacts from U.S. Department of Labor, Employment & Training Administration. www.doleta.gov/usworkforce/statecon.cfm.

Local Workforce Boards www.nawb.org/asp/wibdirectory.asp.



Incumbent Worker funds have been used to match the RSA funds and have paid for a good portion of the training initiative.

CSN attempts to fill a critical health care training gap in underserved training areas throughout northwest lower Michigan, a region the size of Connecticut but with a population of only 300,000 living in communities that often are separated by bodies of water. Smaller long-term care employers—such as home care providers or adult foster care homes—have little if any access to community-based, high quality training in their local areas. CSN is able to make its trainings very mobile, bringing them to isolated areas. Recognizing that home care is one of the most neglected long-term care training areas, CSN's next project is to develop a 200-hour training program for home health aides. Currently, Michigan does not license or register home care agencies, so very limited training is available.

“Long-term care providers can help shape the policies that determine the distribution of those resources by assuming leadership roles in their local WIBs.”

Chris Curtin, CSN's director, notes that her organization's involvement with the public workforce system has brought CSN valuable new financial and training resources as well as contacts ranging from community colleges to hospitals with classroom facilities. Because of its experience with direct care workers and advanced training methods, CSN in turn has become an important player in the development of Northwest Michigan's regional workforce strategy for the long-term field. For Curtin, the most satisfying part of CSN's work is bringing higher levels of training to direct care workers whose prior training experience often consists of “watching a video alone in a dark room.” The key to developing a stable workforce in long-term care, says Curtin, “is creating a culture that demonstrates respect for these frontline workers. That respect begins with high-quality training opportunities that

recognize that workers want more skills so they can do a better job.”

Contact: Chris Curtin, director, Community Services Network, (231) 536-0483, ccurtin@voyager.net; Elaine Wood, deputy director, NW Michigan Works!/NW Michigan Council of Governments, (231) 929-5000. Visit: <http://www.nwm.org/>. For more on Michigan's Regional Skill Alliance initiative, see <http://www.michigan.gov/rsa>.

CREATING EFFECTIVE WORKFORCE INVESTMENT INITIATIVES TO SUPPORT DIRECT CARE

While undoubtedly there are other noteworthy efforts across the country that deserve highlighting, the five profiled initiatives illustrate a number of useful lessons and insights about creating effective workforce investment initiatives to support direct care. Key among these are the following:


- A shared understanding is essential that the low level of compensation and training of direct care jobs is not an “innate” characteristic of this work, but rather an attribute that can and must be changed if the long-term care field is to respond successfully to the inexorable growth in demand for its services.
- Effective long-term, structural solutions to alleviating workforce shortages in long-term care ultimately require going beyond doing “more of the same.” They require addressing underlying aspects of industry practice and job structure that cause high rates of turnover and vacancy, and lower the quality of care. In addition to low wages, the chief causes of turnover and vacancy are poor training, ineffective supervisory practices and lack of career ladders.
- Often the first challenges to be overcome in this work have to do either with limited knowledge on the part of state or local WIBs about the long-term care field, or with long-term care employers' limited knowledge of government workforce development initiatives, as well as possible mistrust or negative impressions of these public programs.
- On the workforce development side, long-term care needs to be viewed as a viable field and direct care occupations as skilled jobs whose quality can be raised by interventions.



- On the employer side, long-term care providers need to see the business case for improved recruitment, retention and culture change. They also need to recognize that the public workforce system potentially has useful resources to bring to bear in helping improve these jobs. They can help shape the policies that determine the distribution of those resources by assuming leadership roles in their local WIBs.
- Taking advantage of opportunities for change requires strategic and collaborative approaches among employers, organized labor, direct care worker associations, One-Stop partners, training providers, public education institutions and publicly funded employment intermediaries. Multi-employer and regional approaches are often essential to using resources efficiently and are a way to create incentives for employer participation.
- Being strategic in identifying the most constructive role the local and state WIBs can take requires knowledge of the different roles WIBs can play. These roles include serving as stimulators of successful initiatives, acting as sector intermediaries, providing a vehicle for financing the emerging initiative and developing sector-supportive policies. In some of the initiatives described, the local WIBs were mavericks in their orientation and took sectoral

approaches that linked workforce development and economic development. In other cases, local groups took it upon themselves to convince a local or state WIB to fund an innovative idea.

- These efforts should not be constrained by narrow definitions of what formula-based WIA funds can be used for. Several of the initiatives described in this brief relied on resources provided by state and local WIA funds that are regularly dispersed through competitive grants open to all employment sectors. This suggests the value of an opportunistic and innovative approach to leveraging funding from multiple sources, including national and state discretionary WIA funds, non-WIA state workforce development funds and formula WIA monies.

Above all, the highlighted efforts demonstrate some of the existing, strategic opportunities for investing workforce dollars in direct care occupations. These opportunities can enhance recruitment and job quality by improving training, engaging in job redesign and creating career pathway infrastructures. Careful injection of workforce investment resources into innovative training and job redesign for direct care work can play an important role in re-shaping the future structure and quality of these vital occupations. 



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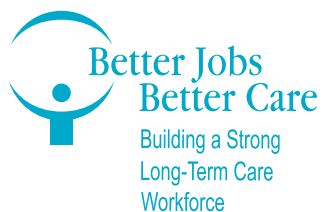
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