Strengthening Wisconsin's Long-Term Care Workforce

Final Report

from the

Direct Care Workforce Issues Committee

WI Council on Long Term Care Reform

June 2005

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Executive Summary

The Direct Care Workforce Issues Committee was created in the spring of 2004 by the Wisconsin Council on Long Term Care Reform, which advises the Department of Health and Family Services (DHFS). The committee was charged with recommending public policy changes that DHFS could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of consumers. The Committee's work and this report focus on "direct care workers," the non-licensed professionals who provide personal care, housekeeping, home management tasks, vocational counseling, supervision and emotional support to people with chronic illness and disabilities of all ages, in all settings.

Direct care workers are the backbone of the long-term care system, providing 70 to 80 percent of paid, hands-on care. Conservatively estimated, there are at least 80,000 of these workers in Wisconsin – accounting for one out of three of all health care jobs. They work independently, as well as in hundreds of small and large organizations in every community in the state. These are fast-growing occupations; personal and home care aide jobs, for example, are projected to rank eighth among *all* jobs in terms of predicted growth rate between 2000 and 2010.

Wisconsin, like most other states, is experiencing a shortage of direct care workers in many long-term care settings, placing pressure not only on the formal (paid) system, but also on family caregivers. Without serious intervention, the shortage will worsen as the population ages. Causes of the workforce shortage are multifaceted and interacting, but they are mainly due to high turnover rates and/or low retention rates.

High rates of vacancies and turnover in this workforce has consequences for all four key stakeholder groups within long-term care.

- Consumers and their families may experience inadequate and sometimes unsafe care;
- Workers have higher levels of injury and stress and less supervisory and training support;
- Providers have high costs both to mission and to bottom line; and
- Payers, including taxpayers, make substantial payments for costs that detract from, rather than add to, the quantity and quality of care actually provided.

A growing body of research is concluding that the reasons for workers quitting add up to a failure of employers, supervisors, society as a whole, and sometimes even consumers, to adequately respect and value them and the work that they do. Among the factors associated with recruitment and retention are:

- Hierarchical organizational structure and poor communication and relationships between worker and supervisor
- Low pay and insufficient benefits
- Few opportunities for career advancement
- Poor public image of this work
- Inadequate training, job orientation and mentoring
- Lack of involvement in care planning for their clients and other work-related decisions
- Emotionally and physically hard work and unreasonable workloads

The bottom line is that valuing frontline caregivers can reduce turnover. Demonstration of that respect can take many forms, including better compensation, benefits and career ladders, better training, and improved working conditions that include team approaches to work-related decisions.

Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. The quality of long-term care is dependent on quality caregivers. Public and employer policies should contribute to an environment in which direct care workers can deliver high quality care.

Areas of recommendation

All of our recommendations are based on a review of research and recent efforts in Wisconsin and a number of other states. Some of them would require some upfront investment, but improved retention will save money and improve quality of care in the longer run. Many others are directed toward spending currently available funds more efficiently and effectively. Taken together, we believe they would move Wisconsin toward a more stable and better trained workforce of direct care workers, with the capacity for the growth that will be needed.

Underlying values and principles
We have developed and recommend that DHFS, service providers and other stakeholders in long-term care adopt a statement of principles related to the direct care workforce. These principles are the underpinning for all our other recommendations, and we make specific recommendations to DHFS about how to incorporate these principles in policies and programs.

Data collection, analysis and dissemination
Consistent data about this workforce, including turnover and retention rates, across all long-term care settings and across time is necessary to pinpoint problem areas, focus public and private efforts to resolve problems, and test the extent to which those efforts have a real impact. These data are needed to effectively implement many of the recommendations in this report. We make several specific recommendations for improving the collection, analysis and dissemination of workforce information across settings.

Quality assurance and improvement
A number of studies have shown that a sufficiently large, stable and well-trained direct care workforce is directly correlated with quality of care and quality of life for people receiving long-term care services. We make a number of recommendations, including:

- Integration of workforce-related quality indicators into all DHFS-administered long-term care programs
- Facility licensing requirements that would better assure sufficient staffing
- Better care planning processes to assure that staffing levels meet consumer needs
- Redirection of funds from forfeitures to quality improvement efforts
- Improved county contracting processes
- Improved consumer information about available services

Reimbursement mechanisms
Increased funding is not the only answer to resolving direct care workforce issues, but it is an important goal. Even within current public spending levels, steps can be taken to improve quality of care and job satisfaction of workers, leading to lower turnover rates and higher retention rates. Reimbursement methodologies should reward and promote quality, including a sufficient, well-trained and stable workforce. Our recommendations include:

- A stepped approach to analyzing and revising existing rate structures
- Revision of state and county rate-setting to incorporate incentives for better staffing

Wages and benefits
Research shows that low wages are correlated with high turnover among frontline caregivers and that, in some cases, benefits are even more important than wages in affecting turnover. Given the current shortage and the coming demographic realities, it is imperative that we do all we can to make direct care work in long-term care an attractive career. Investments in wages and benefits – and in other efforts to make these better jobs – are at least partially offset by reducing the costs associated with high turnover. We make a number of recommendations in this area, including:

- Renewed efforts to improve health insurance coverage for workers
- Improved access to benefits, including Workers Compensation, for independent workers

Training, certification and career ladders
Inadequate training leads to higher turnover. Current training requirements for workers vary widely by setting and job title and appear to be inadequate. Workers need opportunities for ca-

reer advancement so that these are not dead end jobs. We make many recommendations related to training, certification and career ladders, including:

- Making initial worker training requirements stronger, more consistent and more portable
- Creating advancement opportunities
- Better in-service training for workers and supervisors
- Ways that DHFS could better support good training opportunities

Working together

Resolving the direct care workforce crisis calls for partnerships among groups with a stake in resolving the problem. The complexity of the problem means that no single person, organization, or sector can resolve the long-term care labor crisis on its own. We recommend several ways that DHFS and counties can encourage multi-stakeholder approaches to working on this issue.

Respect, recognition and teamwork

Many studies have found that a lack of respect and recognition for their work is an important factor in turnover rates of direct care workers. In one study, the degree of nurse aide involvement in resident care planning was superseded only by the condition of the local economy as a factor affecting turnover. To find and keep direct care workers, it is also important to improve the image of this work with the public. We make several recommendations to improve:

- State and county support for provider efforts to better integrate frontline workers into care planning processes
- Support for improving the public image of direct care work

Worker support and safety

Because of their low wages and frequent lack of adequate benefits, direct care workers often need supports. These jobs are also physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with clients who may be disoriented or uncooperative. These jobs have among the highest rates of on-the-job injury, much higher than the construction industry. We recommend a number of strategies for improving worker supports and safety, including:

- Information for workers on public programs they may be eligible for
- Improved supports for independent workers
- Efforts to improve health and safety practices for workers, especially in homes and small residential settings.
- Dissemination of best practices

Self-directing consumer issues

We have included a section on the special issues that arise when consumers self-direct their care and supports, hiring workers directly instead of through an agency. These arrangements can expand the available pool of workers, since some workers may be willing to work for someone they know, but are not interested in agency employment. But these arrangements also raise issues that need attention. We include a number of recommendations, including:

- Strengthening self-directed care mechanisms in county-managed programs
- Improved training for workers, care managers and consumers
- Improved supports for independent workers in these situations

Conclusion

There is no quick fix to the direct care workforce shortage, but progress can be made with small, practical steps, over time, on a number of fronts. With sustained and focused effort, Wisconsin can improve the current situation and avert future crisis. Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs.

Introduction

The Committee on Direct Care Workforce Issues was created in the spring of 2004 by the Wisconsin Council on Long Term Care Reform[1], which advises the Department of Health and Family Services (DHFS). The committee was charged with recommending public policy changes that DHFS could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of long-term care consumers. The committee met monthly from June 2004 to February 2005 to develop a draft report which was reviewed and discussed in several forums, including an invitational discussion involving more than 70 stakeholders, a meeting of the Wisconsin Long Term Care Workforce Alliance, and a large event sponsored by the Milwaukee Aging Consortium. The Committee then met again in June 2005 to finalize its report. Committee members included representatives of service providers, workers, consumers and their advocacy groups, counties, researchers, and others with expertise in workforce issues.[2]

The Committee's work and this report focus on "direct care workers," the non-licensed professionals who provide personal care, housekeeping, home management tasks, vocational counseling, supervision and emotional support to people with chronic illness and disabilities of all ages in any setting. In keeping with our charge (see Appendix 1), the report is also limited to public policy issues which can be impacted by DHFS and the counties with which they contract for long-term care services.

Who are direct care workers?

Direct care workers are the backbone of the long-term care system. After unpaid family members, direct care workers are the most essential component in helping people with long term care needs to maintain function and quality of life. They provide 70 to 80 percent of the paid hands-on long term care and personal assistance received by Americans who are elderly, chronically ill, or living with disabilities (Dawson and Surpin 2001). They have many job titles, including nurse aide, nursing assistant, home health aide, home care aide, personal care worker, personal care attendant, residential aide, supportive home care worker, adult day care aide, rehabilitation aide, and others.

In May 2003, the U.S. Bureau of Labor Statistics (BLS) counted about 68,000 direct care workers in Wisconsin. (US BLS 2003) This number likely seriously underrepresents the actual size of this workforce, particularly in the home care and personal care attendant categories (Turnham and Dawson 2003). For one thing, it does not include independent workers who are self-employed or who have a fiscal agent as an employer of record. The total number of independent workers is not known, although one national study estimates that 29% of the workers providing assistance to Medicare beneficiaries in the home are self-employed (Leon and Franco 1998). We do know that there are at least 4,200 of these independent workers serving participants in Wisconsin's Community Options Program and its related Medicaid waiver programs (WI DHFS 2004b), and an additional unknown number in Family Care and Partnership programs. Thousands more are hired directly by consumers paying privately.

Direct care workers are a substantial segment of the state's health care economy. In 2003, BLS reported that Wisconsin had a total of about 225,000 health care workers. From the same count, about 68,000 – nearly one out of three of these workers – held positions as nurse aides, attendants, home health aides, personal care aides or other direct care workers. (US BLS 2003) A recent study using the PUMS/Census data estimated four times as many home care aides than were identified in previous studies (Montgomery et al, 2005).

It is also a fast growing occupational field. The BLS predicts dramatic growth for all of the key frontline caregiving occupations within health care between 2000 and 2010: nursing aides, orderlies, and attendants projected to grow at a rate of 24 percent; home health aides up 47 percent;

[1] For more information about the WI Council on Long Term Care Reform and its various committees, see http://www.wcltc.state.wi.us/.

[2] See Appendix 1 for the full Committee charge and member list.

and personal and home care aides projected up 63 percent over the decade (Center for Health Workforce Studies 2002; US BLS 2001). Personal and home health aides rank eighth among *all* jobs in terms of predicted growth rate between 2000 and 2010, and nursing aides rank 12th. Health care jobs will grow twice as fast as all jobs. (US BLS, 2001)

Direct care workers work independently, as well as in hundreds of small and large organizations in every community in the state. The formal relationship between the consumer and the worker varies. In some cases, the worker is hired directly by the consumer and functions explicitly at his or her direction. In others, the worker is employed by an agency or facility, which directs and is responsible for the worker. Employers include adult day programs, adult family homes, Community Based Residential Facilities (CBRF), Residential Care Apartment Complexes (RCAC), Home Health Agencies (HHA), Hospice programs, Nursing Homes (including facilities for the developmentally disabled, known as ICFs/MR), Personal Care Agencies (PCA), and Supportive Home Care (SHC) Agencies.

Nationally, nine out of ten direct care workers are women. Their average age is 37 in nursing homes and 41 in home care. Slightly over half are white and non-Hispanic; about one-third are African-American and the rest are Hispanic or other ethnicities. Compared to the general workforce, direct care workers are more likely to be non-white, unmarried, and with children at home (GAO, 2001). The typical direct care worker is a single mother aged 25-54. Over 40% of home care workers and half of those in nursing homes completed their formal education with a high school diploma or a GED. Another 38% of those in home care and 27% of those in nursing homes attended college. Although we do not have comparable data for Wisconsin, several local studies lead us to believe that the demographics of Wisconsin workers are not very different from those of the national workforce, except perhaps for ethnicity in more rural parts of the state.

Dimensions of the problem

Wisconsin, like most other states, is experiencing a shortage of direct care workers in many long-term care sectors, placing pressure not only on the formal (paid) system, but also on family caregivers. Without serious intervention, the shortage of workers is likely to worsen over coming decades. Due to medical advances that allow people with chronic illnesses and disabilities to live longer and the aging of the Baby Boom generation, an unprecedented increase in demand for long-term care will occur over the next several decades. Between 2005 and 2030, the number of Wisconsin residents age 85 and older, those most likely to need long-term care, is projected to grow by nearly 50% percent, from 108,000 to 158,000. At the same time, the population of those who traditionally provide that care (primarily women between the ages of 25 and 54) is projected to decline by about 8,000. In other words, there will be a proportionally far smaller pool of potential workers to support our elders and others with long-term care needs.

Pressure on the paid workforce will be exacerbated by the fact that the current and future generations of older people have fewer adult children available to provide unpaid care than in the past. And more of those adult children are in single-parent and dual-income households, so that they are less available for significant levels of informal (unpaid) caregiving.

Retention is key

Causes of the workforce shortage are multifaceted and interacting, but they are mainly due to high turnover[3] rates and/or low retention[4] rates. Turnover rates for direct care workers in long-term care tend to fluctuate with the economy, going up when the economy is good and people can readily find other jobs. Many long-

[3] The turnover rate measures how many workers are replaced during a given time period, and is usually calculated as the number of workers hired as a percentage of all workers in that category.

[4] The retention rate measures how long workers stay, usually by calculating the percentage of all workers who have worked for an employer for more than a year.

term care providers have a stable core of workers, but suffer from a continuous "revolving door" among new hires. While a certain amount of turnover is inevitable and even healthy, many parts of the long-term care sector experience very high rates that create serious problems.

In Wisconsin, only nursing homes routinely report turnover and retention data. In these settings, rates have been improving in the most recent years for which data are available (2002 and 2003). It is unclear whether this improvement is related to the downturn in the economy in those years or signals a longer-term trend. Both turnover and retention rates tend to be better in facilities for the developmentally disabled than in nursing facilities, and in government-owned facilities, where wages and benefits are better. The highest turnover rates are in for-profit nursing facilities, where turnover of full-time nurse aides was 57% in 2003 and turnover of part-time aides was 84%. In for-profit nursing homes, two-thirds of full-time aides and just over half of part-time aides had worked at the same home for more than one year. Comparable retention rates for government-owned homes were 93% (full-time) and 72% (part-time). (WI DHFS 2004c and 2004d)[5]

> *"We trained 35 people since last year and none are still there." Direct Care Worker*

Information about turnover and retention rates at other types of facilities is sketchier. Various recent Wisconsin studies have found the following:

- Residential Care Apartment Complexes (RCACs): median turnover rate of 22.2% (range from 0% to 100%). Rates are lower in more well-established RCACs. (WHEDA and DHFS 2003)
- Community-based agencies providing vocational and residential services to people with developmental disabilities: an average of 8% of workers had left these agencies in the month previous to the survey. About 58% or surveyed agencies had vacancies at the time of response. (Mulliken 2003)
- Community Based Residential Facilities (CBRFs): Range of turnover rates from 60% to 143%. (Data for 46 facilities.) (Sager 2004)

High turnover rates make recruitment more pressing and retention even harder. High rates of vacancies and turnover in this workforce has consequences for all four key stakeholder groups within long-term care (Dawson and Surpin 2001a, Stone 2001, Turnham and Dawson 2003).

Consumers experience care without continuity, inadequate and sometimes unsafe care, and reduced access to care. (Wunderlich et al. 1996) In turn, these problems place more physical and emotional burden on unpaid family caregivers and create anxiety for those who are trying to arrange formal care. Families with loved ones in nursing homes and assisted living are augmenting the care provided in facilities because of the worker shortage (Stone 2001).

Workers have higher levels of injury and stress and less supervisory and training support when they work in a short-staffed environment. Turnover is directly related to heavy workloads, low wages and benefits, poor working conditions, and other factors (U.S. DHHS/CMS 2001, Harrington et al. 2003). The result is a spiral of instability as more workers leave a workplace that is ever less attractive to potential new staff (Harrington et al. 2003).

Providers have high costs, both direct and indirect. Turnover among direct care staff in long-term care costs U.S. employers about $3,500 per employee, or more than $4 billion a year. (Seavey 2004).

Payers**,** including the taxpayers who pay the highest proportion of long-term care costs, are making substantial payments for costs that de-

[5] For more specific information about turnover and retention rates in nursing homes, see Appendix 3.

tract from, rather than add to, the quantity and quality of care actually provided.

Implications for taxpayers

Public payers contribute the majority of funding for long-term care in Wisconsin and the country. In 2002, Medicaid accounted for 47% of national long-term care spending, while Medicare accounted for 17% (Georgetown 2004). Of those costs, 50 to 70 percent are for direct labor costs (Turnham and Dawson 2003).

In Wisconsin, state taxpayers purchase long-term care services through Medicaid fee-for-service, the Community Options Program and its related home and community-based waiver programs, Family Care, and Partnership programs. The total cost of these programs in 2004 was over $2 billion in state and federal funds. This means that taxpayers paid about $1 billion to $1.4 billion on labor costs in long-term care, mostly for direct care workers. Reductions in turnover could produce real savings that could be better used to improve quality (including jobs with better wages and benefits) and serve more people.

Counties also pay for long-term care, through Community Aids and county tax levy, especially for services for people with developmental disabilities. One recent estimate put the annual county contribution at about $70 million.

What causes high turnover?

The causes of turnover in this workforce are complex. A growing body of research is concluding that the reasons for workers quitting add up to a failure of employers, supervisors, society as a whole, and sometimes even consumers, to adequately respect and value them and the work that they do. Workers repeatedly say that they value their relationships with the people they support and that their work is important. But the work is often very hard and other rewards are few. The committee believes that workers in long-term care should have high quality jobs in good work environments.

A review of the research highlights a variety of factors associated with recruitment and retention problems among this workforce. These include:

- Hierarchical organizational structure and poor communication and relationships between worker and supervisor
- Insufficient benefits
- Low pay
- Few opportunities for career advancement
- Poor public image of the work
- Inadequate training
- Inadequate job orientation and lack of mentoring
- Little or no opportunity for continuing education and development within the position
- Lack of involvement in care planning for their clients and other work-related decisions
- Short staffing; unreasonable workloads
- Emotionally and physically hard work
- Workplace stress and burnout
- Personal life stressors, such as problems with housing, child care and transportation
- Lack of respect from clients' families

The bottom line is that valuing frontline caregivers can reduce turnover.

The relative importance of these factors will vary from individual to individual. People don't usually leave a job for only one reason, but because of general dissatisfaction resulting from multiple causes. Strategies to reduce turnover and increase retention need to address many of these factors to achieve significant change. (Stone 2001, Stone and Wiener 2002, Jervis 2002, Bowers et al. 2003, Eaton 2001, Harahan et al. 2003, Sager 2004, Lageson 2003, Dresser 1999, Landsness 2004, WI DHFS 2004a, and others)

The bottom line is that valuing frontline caregivers can reduce turnover. Demonstration of that respect can take many forms, including better compensation, benefits and career ladders, better training, and improved working conditions that

include team approaches to work-related decisions.

Recommendations for change

There is no quick fix or single solution to the direct care workforce shortage. But progress can be made with small, practical steps, over time, on a number of public policy and provider practice fronts. Our review of research in this area and strategies employed by many other states indicate that with sustained and focused effort, Wisconsin can improve the current situation and avert future crisis. Increased funding is not the only answer to resolving direct care workforce issues, but it is an important goal. Some investment in proven retention strategies is needed up front, but improved retention will save money and improve quality of care in the longer run. And we can spend currently available funds more efficiently and effectively. Within current public spending levels, steps can be taken to improve quality of care and job satisfaction of workers, leading to lower turnover rates and higher retention rates. Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs in Wisconsin.

There is no quick fix or single solution to the direct care workforce shortage. But progress can be made… Our recommendations are intended to point the way toward developing a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with long-term care needs in Wisconsin.

Given our charge, the committee's recommendations are limited to public policy issues within the purview of DHFS. During the course of our deliberations, we learned about promising practices that can and should be considered by private service providers to improve their turnover and retention rates; these are listed in Appendix 10. For ease of reading, our recommendations are divided into a number of policy areas, several of which overlap.

Underlying values and principles

Early in its work, the Committee developed a statement of direct care workforce values and principles. The statement served as a framework for guiding the deliberations of the Committee. We believe its principles would also improve public and private policies and practices if adopted by the Department of Health and Family Services, service providers and other stakeholders in long term care.

This statement was reviewed, modified and adopted unanimously by the Committee's parent Wisconsin Council on Long Term Care Reform in October, 2004. In her response to the Council, Secretary Nelson stated that she would direct Department staff to incorporate appropriate elements into the DHFS Guiding Principles for Long Term Care Redesign. The following statement has been added to these principles under "design" and published on the DHFS web site: "Address labor force issues such as availability, salaries, benefits, and training needed." In addition, the Secretary said that she would direct staff to identify ways that the principles could be incorporated into program operations for a number of programs and proposals. She also promised to share the statement of principles with other state agencies, including the Departments of Workforce Development, Commerce and Public Instruction and the Wisconsin Technical College System.

The statement, as adopted by the Council, is shown below:

Statement of Direct Care Workforce Principles

The Wisconsin Council on Long Term Care Reform recommends that the Department of Health and Family Services, providers and other stakeholders in long term care adopt the following statement of principles as a framework for ensuring that public and private long term care policies and practices promote a sufficient, stable and competent workforce. The Department has a responsibility to promote the creation of good jobs with the long term care funding it administers. These principles should be the basis for any policy that affects paid caregivers for adults and children, including those providing care to a family member.

1. The quality of long-term care is dependent on quality caregivers.
2. Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. Even in difficult economic times, efforts to increase and stabilize this workforce must be a high priority, and all other reform efforts must incorporate and support this goal.
3. Direct care work and the people who do it deserve the respect of public officials, employers, consumers and society.
4. The foundation of direct service work is the relationship with the consumer and his or her family members and/or guardian. Public policies and employers should support these relationships, encouraging continuity and stability of care. Workers and supervisors should be diverse and culturally competent to meet the diverse needs of consumers.
5. Direct care workers should receive a living wage, adequate and affordable health insurance and other benefits. Wages for this work should enable financial self-sufficiency, while reducing dependency on other public programs (such as W-2, food stamps and Medicaid). Restrictions on these other programs should not discourage direct care workers from full participation in this workforce.
6. Workers should have clear opportunities for specialized training and advancement in long term care, including cross-sector career ladders/lattices. Workers should be recognized and rewarded for their skills and experience.
7. Direct care workers and supervisors should receive the training (including training in diversity issues), mentoring, peer support and supportive supervision that will enable them to handle multiple situations.
8. Public and employer policies should contribute to an environment in which direct care workers can deliver high quality care. As the quality of jobs improves, expectations of workers can increase.
9. Direct care workers should be an integral part of the care team. They should have opportunities for input into care planning, and must be included in implementation of the care plan.
10. Direct care workers are the most important source of ideas for resolving the workforce crisis. Direct care workers will be consulted about public and employer policies and practices that impact their work.
11. People who wish to do so should be able to make direct care work a career.

Recommendations

The Department of Health and Family Services, in consultation with affected organizations, workers and consumers, should incorporate items 1 and 4-9 of the statement of principles into the following policies and processes:

- Contracts between DHFS and the various organizations operating Family Care, PACE, Partnership and SSI Managed Care programs, including reporting requirements.
- Family Care and Partnership program reviews, outcome evaluations, and quality improvement projects, including technical assistance from DHFS.
- The Community Options Program (COP) update process.
- Monitoring criteria for program reviews of COP and its related waiver programs: Community Options Program-Waiver (COP-W), Community Integration Programs (CIP IA, CIP IB and CIP II).
- Licensure and certification requirements for all facilities and agencies employing direct care workers, including nursing facilities, community based residential facilities, home health agencies, personal care agencies, licensed adult day care centers, and licensed adult family homes.

In addition, all of these principles should serve as the underpinning of all follow-up work recommended in following sections of this report.

Improving the collection and use of information about the workforce

Although available information indicates a widespread and serious shortage and instability of the direct care workforce, we cannot quantify the problem precisely. The US Bureau of Labor Statistics collects information about the number of direct care workers in broad categories, and their wages. Wisconsin currently collects detailed, consistent and longitudinal data only about nurse aides in nursing homes (nursing facilities and ICFs-MR) and, to a lesser extent, home health agencies. Through the DHFS annual nursing home survey and Medicaid cost reports, we systematically collect and analyze information from nursing homes that allows us to know:

- Number of employees in various categories, by full and part-time
- Turnover rates (for full- and part-time workers)
- Retention rates (for full- and part-time workers)
- Wages and benefits

We have more limited, although consistent and longitudinal data from home health agencies.

Without similar data about workers in other residential and community-based settings, it is difficult to pinpoint problem areas, focus public and private efforts to improve the sufficiency and stability of the direct care workforce, and test the extent to which those efforts have a real impact. Most importantly, these data are needed to inform the development of workforce-related policies that improve the quality of care in all settings. Some of our policy recommendations are fairly general; implementing these as specific policies will require better information than is currently available.

Several other states have begun to collect and analyze data from a variety of providers. North Carolina, for example, annually collects and analyzes basic turnover data on direct care workers in nursing homes, adult care homes and home care agencies, using a standard set of questions. This effort was initiated in 2001.

Recommendations

1. Working with providers, workers, consumers and other stakeholders, DHFS[*] should determine a minimum set of data elements that would be necessary to track the number of workers (head count and FTE) in various worker categories and settings, wages and benefits, and turnover and retention rates.

[*] We encourage DHFS to work collaboratively with the Department of Workforce Development in designing and implementing strategies recommended under items 1, 2, 3, 5 and 6.

2. Working with these stakeholders, DHFS* should develop uniform questions to be asked across employer types and uniform methodologies to be used to analyze data (e.g., turnover calculations). This effort should include uniform definitions of worker categories, so that comparable information can be collected across settings, where job titles may differ.

3. Once developed and field-tested, data should be collected, analyzed and published annually by DHFS* from at least the following providers: nursing homes, home health agencies, community based residential facilities, licensed adult family homes, residential care apartment complexes, personal care agencies, and licensed adult day care centers.

4. Similar data should be collected by counties from certain agencies with which they contract, including supportive home care agencies, fiscal agents who are the employer of record for independent personal care and supportive home care workers, supported living providers, and vocational programs such as sheltered workshops and job coaches. This collection effort should involve agencies for which DHFS does not have a mechanism for collecting information. County collection of data should augment, not duplicate DHFS efforts. These data should be forwarded to DHFS by counties and then incorporated into the overall picture of the direct care workforce published under item 3 above.

5. All data collection and analysis activities should be coordinated across public and private organizations, to minimize duplication of effort for both the collectors and the providers of information. Further, both raw data and analysis of it should be shared widely to make it useful to all stakeholders*.

6. DHFS* should work with the federal Department of Health and Human Services and Bureau of Labor Statistics to explore the possibility of Wisconsin serving as a pilot for the nation in uniform collection and analysis of this information on direct care workers, to assist with the effort to make these data comparable across states.

Quality assurance and quality improvement

A number of studies have shown that a sufficiently large, stable and well-trained direct care workforce is directly correlated with quality of care and quality of life for people receiving long-term care services. While there is little empirical evidence to establish causal links, anecdotes and qualitative studies suggest that problems with attracting and retaining frontline workers may translate into poorer quality and/or unsafe care, major disruptions in the continuity of care, and reduced access to care (Wunderlich et al. 1996). Several studies have observed that inadequate staffing levels are associated with poorer nutrition (Kayser-Jones and Schell 1997). Inadequate staffing has been associated with inadequate feeding assistance, poor skin care, lower activity participation, and less toileting assistance (Spector and Takada 1991; Kayser-Jones 1996, 1997; Kayser-Jones and Schell 1997). More recently and closer to home, a study of nursing homes in south-central Wisconsin found that homes with high staff turnover rates received more complaints and are cited for many more violations and deficiencies than are low-turnover homes. (Hatton and Dresser 2003)

> *"You know the families are paying a fortune, and the people aren't getting the care." CNA*

High turnover disrupts the quality of relationships that are critical to both the client and caregiver, creating "needless opportunities for mistakes and [removing] from the client a sense of dignity and control over herself and her environment" (Dawson and Surpin 2001a). Consumers consistently cite the rapport between themselves and their direct care workers above other potentially important measures of quality care (Wilner 1998).

There is debate over whether quality is best assured through state-imposed, standardized criteria, through the development of an internal quality plan by each facility or agency, or some combination of these. While some basic standards should be uniform, other requirements may be specific to each organization. Many people agree that an approach that centrally defines outcomes and allows regulated entities to develop their own approaches to meeting those outcomes is preferred.

Current state licensing requirements for long-term care providers contain a number of items related to staffing. For example, there are statutory minimum nursing staff-to-resident ratio requirements for nursing homes[6] and a requirement that homes have sufficient staff to meet the needs of residents. The federal requirement that long-term care facilities have "sufficient staff available" is not defined. To determine whether a facility is adequately staffed, surveyors usually look at resident outcomes. Nursing homes are required to post detailed weekly staffing schedules.[7]

> *"I have had many people ask me, 'Why don't you go on to school to be a nurse, why stay "just" a CNA? You are so smart.' To which I reply: 'The work that I do, and the people that I have cared for complete me. They have been my friends, my mentors, my guides, and I have been their legs, their hands, and sometimes their eyes. But never am I "just" their CNA." Beth Hadley, CNA*

Uniform staffing ratio requirements for congregate settings are difficult to establish, since the optimum number of available staff should vary by several variables, including: the needs of the residents, the skill levels of staff, worker responsibilities for non-direct care tasks, assistive technologies that are available and functional, the extent that a team approach to staffing is in place, and regional economic and workforce variables. However, the state should set minimum staffing standards for all facilities and assure that facilities have a plan, available to the public, for staffing levels that will meet the needs of their residents.

Individual care planning, whether by facilities, agencies or counties, should address the staffing needs of each consumer. Direct care workers, despite being closest to the consumer, are not often involved in on-going care planning processes. Questions and information may go from the worker to her supervisor to the care manager and responses back through the chain. It should also be noted that if funding is insufficient to provide all the services that people need, or prior authorization does not allow it, then care plans cannot allow for sufficient staffing and providers cannot meet staffing requirements.

Much of the home and community based long-term care in Wisconsin is purchased by county and other local agencies. The state contracts with counties for administration of the Community Options Program and its related waivers, and with the Family Care and Partnership programs. These local entities, in turn, purchase care through contracts with licensed providers and from those not required to be licensed, and are thus in a position to demand good quality. In addition, care managers in these programs are responsible for helping consumers to choose which agencies will provide care to meet their individual needs, whether in congregate or home care settings.

A policy established by DHFS in 2002 required that county agencies administering the Community Options Program (COP) and the COP and CIP II Waivers incorporate quality standards in their contracts with CBRFs. Model quality performance standards and measures and a checklist for the evaluation of quality in CBRFs were developed by a state-county workgroup and distributed to counties. Some of the quality indicators in the model relate directly to staffing. Counties began incorporating these standards in CBRF contracts in 2003. Objective and consistent criteria and evaluation processes are needed

[6] s. 50.04(2)(d), Wisconsin Statutes
[7] s. 132.63(3)(d), Wisconsin Statutes

within and across counties in order to meaningfully enforce these standards.

Other county efforts are also underway to develop objective tools for measuring the quality of assisted living settings with which they contract. One county, for example, is developing a model using a more objective measurement tool for all populations and all assisted living settings. The Family Care program, operating in five counties, is developing performance-based contracting with service providers. Specific standards, including those related to staffing, are being developed and baseline data collection is underway. Developing and implementing a contracting system that is fully performance-based may take from 3 to 5 years. Efforts are also currently underway in DHFS, through the federally funded Quality Close to Home project, to make quality processes in Family Care and all the waiver programs similar.

When forfeitures are assessed for violations of licensing codes by nursing homes and CBRFs, funds are deposited in the state's School Fund. This constitutionally mandated requirement is premised on the idea that regulators should not benefit from assessing penalties, for example by using these funds to support surveyor salaries. As a result, the current system precludes the use of these funds to improve quality in these or other facilities. A coalition of groups is advocating changing state statutes to allow penalty collections to be used for quality improvement purposes.

To make wise choices about long-term care, consumers need good information about the quality of facilities and agencies, especially information about quality indicators. The California Healthcare Foundation provides a web-based free public service providing comprehensive, consumer-friendly, comparative information on the more than 1,400 nursing homes, 834 home health agencies, and 172 hospice programs in California[8]. In appearance, content and usability, it is said to outperform the CMS system, including pop-up explanations of various terms and functions and comparative ratings across provider type. Depending on the type of long-term care, the site includes information on many factors shown to have an impact on quality of care, including:

- Staffing levels, turnover, and wages;
- Quality measures;
- Complaint, deficiency, and citation rates; and
- Finances and costs.

The federal Centers for Medicare and Medicaid (CMS) provides some information about nursing home and home health agency quality on its web sites respectively titled Nursing Home Compare[9] and Home Health Compare[10] Information includes citations for three years (without detail about seriousness of violations), the degree to which homes meet certain quality measures, and nursing staff hours per day per resident. The Wisconsin DHFS Bureau of Quality Assurance's web pages include considerable information about individual nursing homes, including staffing levels, turnover and retention rates, and citation histories, although navigation is somewhat difficult. Provider profiles are under development for CBRFs, AFHs and RCACs that will include three-year citation histories. Links to consumer checklists for choosing facilities are also available on the DHFS web site, and on the site of the Board on Aging and Long Term Care.

Additional recommendations related to improving quality can be found in the section of this report related to reimbursement mechanisms.

Recommendations

1. Workforce-related outcomes and quality indicators related to a quality workforce should be integrated into all Department-administered long-term care programs (institutional and community-based), including contracts between the Department and counties and other providers. All stakeholders, including providers, workers and consumers, should be actively involved in the development of these indicators. Because data is currently available for Medi-

[8] http://www.calnhs.org/

[9] http://www.medicare.gov/NHCompare/Home.asp

[10] http://www.medicare.gov/HHCompare/Home.asp

caid-funded nursing homes and (to a more limited extent) the Community Integration Program, efforts should start with these programs. As data collection and analysis is expanded as recommended in the data collection section above, efforts can expand to additional programs. Outcomes and indicators should recognize regional workforce and other variables and should include:

- Turnover rates
- Retention rates
- Skill levels of workers and supervisors
- Use of pool staff
- On-the-job injuries
- Extent of overtime required of workers

2. Licensed long-term care facilities should be required through the regulatory process to have a specific process for determining adequate staffing to meet the needs of their residents, taking into account the appropriate use of technology to assist staff and residents. This process should be linked to outcome-based quality assurance processes and should be reviewed and approved by the Bureau of Quality Assurance as part of the initial and renewal licensing process. It should also be publicly available in a format useful to consumers and their families, county care managers, and Aging and Disability Resource Centers. To transition to this requirement, a pilot approach is recommended, to test the variables that should be used and documented.

3. Community Based Residential Facilities, licensed Adult Family Homes and Certified Residential Care Apartment Complexes should be required to post weekly staffing schedules, as nursing homes are already required to do.

4. DHFS should review current minimum staff-to-resident ratio requirements in regulations governing nursing homes, CBRFs and other facilities to assure their adequacy and propose statutory and/or rule changes as needed.

5. DHFS should explore possible changes to assessment and care planning processes required of providers and counties that would more effectively assure adequate staffing levels in all settings to meet consumer outcomes. DHFS should require that care managers in the Community Options Program, the Community Integration Program, Family Care and Partnership consider staffing levels and individual consumers' needs in all placement and contracting decisions. Counties and providers should also involve direct care workers in care planning processes.

6. The committee supports an approach to quality assurance that allows for alternatives to monetary penalties for licensed facilities. We recommend that statutory changes be pursued that would eliminate forfeitures for violations by nursing homes and Community-Based Residential Facilities and allow instead for collection of assessments. Funds from these assessments should be used for grants for quality improvement projects in these facilities and/or for rewarding high quality performance. We further recommend that the state share of recoveries from personal care audits under the Medicaid program be re-directed to quality improvement efforts.

7. DHFS should continue to provide information and technical assistance to counties and work with them to develop meaningful measures and processes for contracting for quality, including workforce quality.

8. DHFS should require that counties incorporate quality standards, including standards related to staffing, into contracts with residential service providers, as has been done under the Community Options Program, COP-Waiver and CIP II.

9. DHFS should incorporate into its Quality Management Plan, currently under development, strategies for insuring that worker feedback is a part of quality improvement

strategies in provider and care management agencies.

10. DHFS should explore the feasibility of providing comprehensive, consumer-friendly, comparative information about nursing homes and other long-term care providers on a web site similar to the one that the California Healthcare Foundation provides. The web site under development through the Comprehensive System Change project would be a good location for a link to this information. Information about the web site should be made available through Aging and Disability Resource Centers, and distributed by a variety of local means such as doctors, hospital discharge planners, and county agencies.

Reimbursement policies

Increased funding is not the only answer to resolving direct care workforce issues, but it is significant. If providers do not receive funding sufficient to pay their workers living wages and provide decent benefits, they will be unable to attract and retain many of those who might otherwise be attracted to this workforce. Moreover, rates must be high enough to enable staffing levels that will promote good quality of care and quality of life. (See quality section.)

Under the current system of reimbursement, substandard providers are often paid the same as excellent ones.

Reimbursement methodologies should reward and promote quality, including a sufficient, well-trained and stable workforce. Under the current system, substandard providers are often paid the same as excellent ones.

Moving toward a system that rewards quality would require careful consideration of a number of factors. Consensus would need to be developed on what indicators of quality would be used. A number of variables would have to be incorporated into the system, including the proportion of Medicaid residents in a given facility, the availability of private foundation funds to supplement lower rates, the varying levels of resident needs, and others. It should also be noted that, unless new funds are added to the system, there would be the potential for decreasing quality of care even further in poorer performing facilities/agencies. Without new funds, rates for poorer performers would need to be decreased in order to reward high performers. However, a reimbursement system that recognized different levels of consumer need and provider performance would provide assurance to citizens and policy-makers that we are purchasing outcomes, not just paying for services.

Medicare-certified home health agencies (HHAs) are reimbursed under a prospective payment system that utilizes data from the Outcome and Assessment Information Set (OASIS). These data elements are core items of a comprehensive assessment for an adult home care patient and also form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.

Most institutional long-term care and some home and community based care in Wisconsin is purchased under the Medicaid fee-for-service program. For most providers, standard reimbursement rates are established by the state for specific covered services, and providers are reimbursed per unit of service provided. Nursing homes are reimbursed under a formula that incorporates a number of factors.

Wisconsin's nursing home reimbursement formula contains no factors directly related to the adequacy or stability of direct care staff. The direct care allowance portion of the formula is based on a facility's historic costs, creating a disincentive to hiring more staff or increasing pay or benefits for existing staff. In addition, reimbursement rates for initial nurse aide training and testing have not been increased since the early 1990's and there is no reimbursement for in-service training.

Other states have begun to revise their nursing home formulas to tie quality measures, including those related to a sufficient and stable workforce, to reimbursement. Iowa, for example, uses ten accountability measures, including nursing hours provided and high employee retention rate, in determining rate increases. Homes can qualify for up to a 3% reimbursement increase (over the direct-care and non-direct-care component median rates) for meeting these measures. Minnesota is considering a more complex system that incorporates seven tiered quality measures, four of which relate directly to staffing: nursing hours per resident day, staff turnover, staff retention, and use of pool staff. Alaska, Michigan, North Carolina and Vermont are also considering nursing home reimbursement strategies to tie quality to reimbursement levels. Arkansas uses a cost based methodology that is responsive increased staffing levels and salary increases for direct-care workers. (PHI and NCDHHS 2004; Minnesota DHS 2004)

Other states provide "bonus" payments for nursing homes that meet certain quality criteria. In 2003, California's Quality Awards Program, for example, began to distribute up to $1500 per employee as staff bonuses to nursing homes that meet or exceed certain quality benchmarks. South Carolina has a Quality Initiative grant program, one requirement for which is monthly submission of data including facilities' turnover rates.

In addition to state efforts in this area, two bills are pending in Congress that would revise Medicare payment mechanisms to reward nursing homes for providing higher direct care staffing levels and better care. H.R. 5403 proposes to develop and test ways of rewarding facilities with higher pay for high performance on certain quality indicators, including higher than average direct care staffing levels. Companion bills S. 2988 and H.R. 5393 would provide an increase of 1 percent in Medicare payments to skilled nursing facilities that performed in the top 20 percent on quality measures. Homes in the top 10 percent would get a 2 percent increase, while those in the bottom 20 percent would get 1 percent less.

In Wisconsin, a large proportion of community-based long term care is purchased by counties using state, federal and county funds under the Community Options Program and its related waiver programs, and through Family Care. Counties purchase assisted living, vocational supports and in-home services from a wide variety of local providers. Community based providers report that current funding levels make achieving quality supports very difficult. Some programs operate under standard rates per client paid by the state; the CIP IB rate has been flat for years and most counties supplement it with county funds. For the most part, county rates are based on standard rates set by providers. Providers receive, and workers are paid, the same rate regardless of the intensity of need of each client. Quality of care differences among providers are not often recognized in these reimbursement systems.

Community Care of Portage County has begun using measurements of the sufficiency of staffing in CBRFs with which it contracts for services to its Family Care members. As in most Family Care programs, rates are individualized, based on each member's needs as documented in the functional screen. Adjustments to these rates are tied to several indicators of quality relating to staffing patterns, with facilities meeting all staffing standards receiving a higher daily rate.

Recommendations

1. DHFS should analyze current rates for providers in all public long-term care programs to determine their adequacy to support an adequate staff-to-client ratio as well as sustaining wage levels and adequate benefits for workers. The most significant problem areas should be identified and ways to improve them recommended. Since data are already available for all nursing homes and some community providers serving people with developmental disabilities, analysis should begin with nursing home and CIP IB rates. Other analysis can be conducted as better information is available from other providers.

2. State rate-setting methodologies should incorporate mechanisms to encourage sufficient and stable staffing, including rewarding high retention and low turnover rates. In developing these methodologies, DHFS should review those being adopted or under consideration in other states.

3. County rate-setting methodologies for contracted service providers should reward a sufficient, stable and well-trained workforce.

4. While rate setting methodologies that reward providers for having a sufficient and stable workforce are being developed, DHFS and counties should explore ways to provide other kinds of public recognition for high-performing providers.

Wages and Benefits

To stem the tide of nursing assistants and other frontline workers leaving the long-term care sector, surveys conducted by Cushman and colleagues (2001) suggest that more competitive wages are needed. In Wisconsin, the federal Bureau of Labor Statistics reported the following median hourly wages in November 2003 for broad categories of direct care workers[11] in both acute care and long-term care settings:

- Nursing aides, orderlies and attendants: $10.66
- Home health aides: $9.44
- Personal and home care aides: $9.14

Even the highest of these was 21% below the median hourly wage of $13.51 for all occupations in the state for that year.

Workers in nursing homes tend to make more per hour than those in home and community settings, as demonstrated by the following information.

- In Milwaukee County (2003): mean hourly wages of $9.83 for workers in home care, $10.58 in nursing homes, and $10.55 in other community care settings. Range in wages of from $5.15 to $15.00 per hour across settings. (Lageson, 2003)
- Nurse aides in nursing homes (statewide in 2003): Median average hourly wage of $11.15. (WI DHFS, 2003)
- Workers providing community services to people with developmental disabilities in 2003: Mean hourly wage of $8.81 in residential services; $9.93 in vocational services. (Mulliken 2003)
- Workers in CBRFs: Mean hourly wage of $8.40 to $8.62 (Sager 2004)
- Independent workers providing services to participants in COP and related Medicaid Waiver programs in 2004 (statewide for responding counties providing mechanisms for consumers to employ their own workers): Mean low wage of $6.85 per hour to mean high wage of $10.50 per hour. (WI DHFS 2004b)

> *Quality care means a living wage, so we don't have to work two and three jobs to make ends meet, robbing us of our strength so we can't deliver our best care. – John Booker, CNA*

Hourly wage rates can be deceiving because many of these workers cannot work full time; statewide, about half of nursing home workers are part-time. A study conducted by the Milwaukee Aging Consortium in 2003 across all long-term care provider types found that 38% of workers fit the BLS definition of part-time (less than 35 hours per week). Home care workers worked the fewest hours (mean of less than 31 hours per week). Nearly 26% of all workers in the study had total annual incomes under $15,000, and another 35% had incomes between 15,000 and 25,000. (Lageson 2003) Another study (Montgomery, et al 2005) found that only 34% of home care workers nationally work full-time and year-round.

[11] See Appendix 3 for BLS definitions of these worker categories.

"I like my work but I don't want to always depend on help from the government to make ends meet." CNA

Even if they can work full time, the wages for most workers are not at a level that can provide a self-sufficient income for a family. The self-sufficiency standard, calculated by the Wisconsin Women's Network for all Wisconsin counties in 2004, offers a realistic measure of the monthly income required to have a safe, decent, basic standard of living. It defines the income that working families need to meet their basic needs without public or private assistance and is calculated using the real costs of goods and services purchased in the regular marketplace. Only basic needs, including a thrifty food plan with no restaurant or take-out meals, are included. The cost of providing basic family needs varies widely by family size and geography. For one adult with a pre-school age child, the self sufficiency wage ranges from $1,364 ($7.75/hour) in Buffalo County to $3,060 ($17.38/hour) in Waukesha County. (Lewis 2004)

The wages of direct care workers tend to fall short of the self-sufficiency standard. For example, in Milwaukee County, a single parent of one preschool-age child would need to work full-time at $15.72 per hour to meet the self-sufficiency standard. Actual mean hourly wages range from $9.83 to $10.58, depending on the setting. Half of the workers surveyed in the Milwaukee Aging Consortium's study had children under the age of 18 living with them and 22% reported caring for other adults in the family. (Lageson 2003) Almost a third of all frontline caregivers in nursing homes (and a quarter of those in home health care) are not married but have children, meaning that they are the household's primary breadwinners (Hatton and Dresser 2003).

Many direct care workers are among the "working poor." They are twice as likely to receive government benefits – such as cash assistance and Food Stamps – as workers in other job categories because their wages are so low. (Citizens for Long Term Care 2003, GAO 2001). In the late 1990s, nursing home aides and home care aides were more likely to be in poverty (16 percent and 22 percent, respectively) than the average population (12-13 percent) (ASPE 2004).

Nationally, one-third of frontline caregivers in nursing homes and one-quarter of their counterparts in home health agencies do not have health insurance, compared to 16 percent of all workers (GAO 2001). More than a quarter (27.5%) of workers from a variety of settings surveyed in Milwaukee County reported having no health insurance. Only 36.5% of workers had health insurance paid by their employer. About 20% had coverage through a spouse's policy or another source, while 12.3% had coverage under Medicaid. (Lageson 2003) In Wisconsin nursing homes, health insurance coverage and other benefits are much better in government-owned facilities. Part of the reason for low health insurance coverage rates is that is difficult for employers to find insurers who will cover their many part-time workers.

"You can't make a career out of something where you don't have benefits." Direct Care Worker

Uninsured direct care workers are less likely to have a regular health care provider, more likely to avoid medical care because they cannot afford it, and report lower health status than their insured co-workers (Hams 2002). Even when health insurance is provided, given the rapidly rising costs of liability and health insurance, employers have to choose between raising wages and continuing current levels of contribution to health care coverage. And many workers are finding the employee share of premiums and co-pays to be overwhelming (Hams 2002).

Most nursing homes and home health care agencies do not offer pension coverage, and only 21 to 25 percent of aides in these settings are covered (GAO 2001). Information about benefits other than health insurance and pensions is lim-

ited. In the Milwaukee Aging Consortium Retention Survey, workers reported having the following benefits other than health insurance: vacation days (63.5%), paid holidays (63.1%), personal days/paid time off (49.2%), sick days (49.2%), dental insurance (33.6%), life insurance (23.8%), shift differential (23%), retirement benefits (18.9%), flexible scheduling (12.7%), and unpaid days off (11.9%). Ten percent or fewer reported having a variety of other benefits. (Lageson 2003) In a recent statewide survey, agencies providing residential and vocational services for people with developmental disabilities reported providing the following benefits other than health insurance: mileage (92% of agencies), savings plans (17%), employee assistance program (28%), 125 plan for pre-tax benefits (55%), car allowance (6%), use of care (16%), tuition reimbursement (38.5%), on-site or off-site child care (5%), and wellness/fitness (12%) (Mulliken 2003).

National research shows that low wages are correlated with high turnover among frontline caregivers (DCA 2002a, Massachusetts Health Policy Forum 2000, Dawson and Surpin 2001a) and that, in some cases, benefits are even more important than wages in affecting turnover (Brown 2002). Data on turnover among frontline caregivers in South Central Wisconsin nursing homes provide further evidence for this point. A 2003 study found that the average hourly wages at high-turnover nursing homes were nearly $1 less than wages at low-turnover homes, and nearly $3 less when benefits were included (Hatton and Dresser 2003). A large wage increase for publicly-funded homecare workers in San Francisco County, California also correlated with reduced turnover and substantial increases in the number of people drawn to these jobs (Howes 2002). And a study of agencies in New York State providing residential care to people with developmental disabilities found that workers stayed longer at agencies with higher rates of insurance coverage (Duffy 2004).

Independent workers may make less than agency-employed workers, and may not have access to any employer-provided benefits. Of particular concern is that they may not be covered by Workers' Compensation to cover medical expenses if they are injured on the job. Another frequent problem is that there is no mechanism in place to provide respite or even back-up if they are ill or have other pressing personal needs. A survey of counties conducted by DHFS in 2004 found that nearly 4,200 independent providers serve COP and waiver participants who hire the workers directly in the 66 responding counties. Of these, 1,585 (38%) are paid family members of the participants. (Wisconsin DHFS 2004b) There is a statutory requirement for the Community Options Program and all its related waiver programs that all counties offer self-directed supports and the opportunity for consumers to hire independent workers through a fiscal agent, but not all counties currently meet this requirement. Counties who do not do so are concerned about liability issues. However, other counties have resolved the liability issue through a number of mechanisms, including assisting to form agencies to act as the employer of record, and helping independent workers to form cooperatives. In other states, efforts have been made to create cooperatives in which both consumers and independent workers are owner-members.

> *"I haven't seen a pay raise in fifteen years." - Direct Support Professional*

Just over half the states (26), including Wisconsin, have funded a wage or benefit pass-through or other increase to benefit direct-care workers (PHI and NCDHHS 2004). Data on the impact of wage pass-through programs on direct care worker recruitment and retention are limited and inconsistent. Findings across the few evaluations completed to date – and the lack of an appropriate comparison group in these studies – do not support the efficacy of wage pass-through programs or of a particular type of wage pass-through approach (PHI 2003). It should also be noted that when pass-throughs are provided in Medicaid fee-for-service rates, they are available only for those hours that are billable to that funding source; the time of many community-based workers is billed to several different

sources during a given time period. If this strategy were used in Wisconsin again, documentation that funds had indeed been used for wages and benefits should be required and funds recouped if this were not demonstrated. Moreover, data should be collected and analyzed to determine the effect on turnover and retention rates.

Some research with CNAs suggests that wage increases may need to be targeted, i.e. to those who stay longer or as rewards for providing good care (Bowers, et al. 2003). Workers in the WETA study reported that they liked their jobs but felt underpaid and underappreciated, especially when their wages had not increased over long years with the same employer (Sager 2004). Workers in the Milwaukee Aging Consortium study who were dissatisfied with wages indicated that a very reasonable increase would suffice. They also wanted to be rewarded for longevity and experience, rather than making about the same as a newly hired worker. (Lageson 2003) The WETA study found similar results (Sager 2004). In Wyoming, a mandated wage increase for direct care workers in developmental disability community based programs required differential minimum wages for new staff and those with 12 months of experience. Increases for full-time staff were substantial (a 51% increase over several years from an average of $9.08 to $13.74 per hour). A study of the impact of these increases found that turnover dropped by nearly one-third in a three month period, from 52% to 37%.

When employees have the resources for basic needs – food, housing, childcare, health care and reliable transportation – their stability in the profession increases. They are less likely to miss work or to leave the profession altogether. Wages and benefits are not the only reason, and sometimes not even the primary reason, that people take and leave jobs, but they are an important factor in job satisfaction. Given the current shortage and the coming demographic realities, it is imperative that we do all we can to make direct care work in long-term care an attractive career. Investments in wages and benefits – and in other efforts to make these better jobs – are at least partially offset by reducing the costs associated with high turnover.

Recommendations

1. DHFS should take a more active role in improving health insurance coverage for direct care workers and other low-income uninsured people. This should include taking a leadership role in forming a multi-agency task force on health insurance reform to analyze current proposals for reform and advising DHFS, the Department of Workforce Development and the Office of the Insurance Commissioner on strategies for broadening coverage. The Paraprofessional Healthcare Institute has offered informally to provide staff assistance with such an effort.

2. DHFS should monitor the progress and success of health insurance cooperatives and pools as potential models for containing health insurance costs and broadening coverage for workers.

3. As outlined in the training section of this report, workers should have opportunities for advancement within the long-term care field, including opportunities for wage and benefit increases.

4. DHFS should continue to encourage and support models such as worker cooperatives and worker-consumer cooperatives that allow independent workers access to better pay and benefits, including Workers Compensation.

5. DHFS should explore ways to improve the availability of respite and back-up for independent workers, including paid family members.

6. DHFS should renew efforts to resolve the issue of liability for counties when they offer consumer-directed services through independent workers who have a fiscal agent as employer of record. When this is resolved, counties should take responsibility for providing workers compensation coverage for independent workers serving participants in their long-term care programs.

7. DHFS should analyze current reimbursement mechanisms to determine the current percentage of rates going into wages and benefits for workers and the amount of new funding that would be needed to provide sustaining wage levels and adequate benefits. The most significant problem areas should be identified and ways to improve them recommended. Since data are already available for nursing homes and community providers serving people with developmental disabilities, analysis should begin with nursing home and CIP IB rates. Other analysis can be conducted as better information is available from other providers.

Training, certification, career ladders and workforce flexibility

From several perspectives, strengthening training for direct care workers is an important strategy in resolving the workforce crisis. People receiving long-term care are living longer with more severe disabilities and workers need the skills, knowledge and confidence to provide good care in a variety of settings. People living in CBRFs and other community settings today have a level of disability at least as severe as those who lived in nursing homes a decade ago. And nursing home residents have a much higher average acuity level (i.e., more complex and serious illness and disability) than in years past. Training that is relevant, meaningful and practical can give workers the tools they need to do a good job, as well as bolstering their investment in this work. There is evidence to suggest that some direct care workers may not be receiving the training they need to do their jobs effectively (PHI 2005).

A growing body of research supports the hypothesis that inadequate training leads to higher turnover (PHI 2005). One national literature review on this subject found that, in general, higher levels of training for direct care workers helped employers find, and especially, keep employees (Pennsylvania 2001). Several studies have found that effective in-service training can improve turnover and retention rates (McCallion et al. 1999, Taylor 2001, Noel et al. 2000).

Although research on the extent to which training impacts quality of care is limited, most providers, consumers and direct care workers would argue that there is a direct connection. Several consumer advocacy groups, including the National Citizens' Coalition for Nursing Home Reform, the Alzheimer's Association, and the World Institute on Disability, have issued calls for higher or different training standards. (PHI 2005)

> *"Training makes it a profession."*
> *DCW*

Current initial and in-service training requirements for workers in Wisconsin vary widely by setting and job title. Specific hourly requirements range from 75 (for certified nurse aides or CNAs) to no specific requirement for many other categories. Requirements for training content range from very specific to very general. Oversight of training is also quite varied. Training requirements and oversight tend to be most stringent in settings that are the most regulated, supervised and "public." They are the loosest in settings that are least regulated and supervised and where workers are often making decisions on their own. Many workers have training beyond the minimum required to work in a particular setting or agency type. (See Appendix 4 for details.)

Turnover prevention begins with initial training. If people entering the field are treated with respect by trainers and adequately trained to perform the "real" job, they are more likely to stay. Many workers say that current training is not "reality based." They say that classroom training is not effective without sufficient clinical training. They especially find on-the-job mentoring, by people who are trained in mentoring, to be very effective. Not only do they learn from experienced workers, but it helps them to build relationships with the organization and other workers. Peer support of this kind helps to build teamwork and workers' confidence in their

skills. Especially in home care, consumers may also serve as mentors.

Mentoring strategies were part of the Iowa CareGivers Association Project (Iowa CareGivers Association, 2000). Evaluation found that facilities that provided CNA in-service trainings, support groups, and CNA mentorship opportunities had an average length of CNA employment of 18.96 months, which was significantly higher than the control group average of 10.01 months. The CNAs in the treatment group also reported greater job satisfaction.

CNAs

About 176,500 CNAs are listed in Wisconsin's nurse aide registry. Of these, 58,500 meet federal requirements to work in a nursing home, home health agency or hospice program. The remaining 117,500 are either working in another long-term care setting or a hospital or are no longer working as a nurse aide. In order to become a CNA, the State of Wisconsin requires 75 hours of training, including 16 hours of clinical experience; this is the minimum required under federal rules. Although the federal Omnibus Budget Act of 1987 raised the training requirements of frontline caregivers in nursing homes and home health agencies, federal regulations for caregiver training still fall short, according to the Direct Care Alliance. In fact, federally mandated training hours for school crossing guards, cosmetologists and even dog groomers are greater than those required for entry-level CNAs and home health aides (Hatton and Dresser 2003).

A 2002 report from the Office of the Inspector General in the U.S. DHHS found that nurse aide training has not kept pace with 1) the medical and personal care needs of today's nursing home residents; or 2) nursing home practices and new technologies. Forty of 49 State Nurse Aide Training and Certification program directors believe that 75 hours of nurse aide training is not sufficient to prepare nurse aides for their first day on the job. Twenty-six states have extended their nurse aide training programs beyond the 75 hours required by Federal law; new requirements range from 80 hours to 175 hours. Wisconsin is one of 21 states with training requirements at the federal minimum of 75 hours. Wisconsin also is among the lower tier of states with respect to requirements for the clinical experience portion of training. At least 27 other states require more than the federally mandated 16 hour requirement, ranging from 24 to 100 hours. (U.S. DHHS/OIG 2002)

The 2002 DHHS/OIG study also found that teaching methods used in initial training programs are often ineffective, and that clinical exposure is too short and unrealistic. They found that training focuses on acquiring skills needed to pass the State exam. Other skills needed for the job may receive only limited coverage during their initial training. In the same study, CNAs, ombudsmen, and other experts had a low opinion of most in-service training, saying the content was often repetitious, not directly relevant, or signed off on without being absorbed.

All initial training programs for CNAs in Wisconsin are approved by the DHFS Bureau of Quality Assurance (BQA). BQA's Office of Caregiver Quality reviews and approves curriculum, instructor qualification, and training site. Training and experience in a non-approved nurse aide training program (e.g., in a CBRF) does not count toward CNA training. The number of approved nurse aide training programs in Wisconsin has declined recently from 230 to 120 programs. A large percentage of facility-based programs are no longer active, and about half of all new CNAs now are trained at technical colleges. The Office of Caregiver Quality does not review and approve curricula for in-service training.

Other worker categories

Training requirements for workers in settings not requiring nurse aide certification range from non-existent to modest (see Appendix 4). Training for workers in home and community settings is often provided by employers, either directly or through contract with another agency. BQA reviews and approves curricula for workers in CBRFs, but not those for workers in other home and community settings. Competency testing is not currently required for workers in any of these settings. In addition to CNA courses, the Wisconsin Technical College System offers courses in other health and long-term care occupations,

including CBRF Caregiver and Community Developmental Disabilities Associate. However, these are offered at only a few campuses. (See Appendix 5.)

> *"When I asked for training on Parkinson's/ Alzheimer's, they told me to just go to the library and get a book." DCW*

Sometimes training in one setting is portable to another setting and sometimes not. Training in any program that has not been approved by BQA for nurse aide training does not count at all toward CNA training. CNA training may or may not count toward training required for other settings. This inconsistency and lack of portability hinders movement of workers from one type of program to another, as well as the flexibility of providers of more than one service to utilize workers across settings. Further, workers who move across settings may be trained over and over on the same topics if they change jobs, using resources that could be better used on enhancing their knowledge and skills. In-service training is often duplicative, with workers funded through several funding sources required to take essentially the same training multiple times in the same year.

Many states are increasing training and staffing requirements for assisted living facilities. A recent (2005) analysis by the National Center for Assisted Living identified several trends:

- There is a general increase in training and continuing education requirements for both administrators and direct care staff;
- More states are permitting trained, supervised, unlicensed staff to administer medications; and
- There continues to be an increase in training and staffing requirements when care is provided to individuals with Alzheimer's disease in a secured or specialty care section.

Higher training requirements in community settings could help make liability insurance more accessible and affordable for employers. At the same time, distinctions should be made between workers in settings where there are many consumers with differing needs, and those who work with only one or two clients in their own homes. Rather than (or in addition to) a set curriculum of classroom training, workers in the latter category may benefit more from shadowing experienced workers and/or receiving training from consumers and family members about each person's needs and preferences.

Consumers who direct their own care sometimes prefer to train their own workers; however, their objections to formal training programs are often based on the way that training is currently conducted. Some states have developed curricula for personal assistants who deliver services under the self-directed model. San Francisco's In-Home Supportive Services public authority, for example, offers a free, voluntary 25-hour initial training for personal assistants serving self-directing consumers. The curriculum addresses communication, health, safety, nutrition, and job readiness (PHI 2005).

<u>Training and testing costs</u>

Part of the reason that turnover is expensive is that training and testing new employees is costly. A recent study reported average CNA training costs of $1,066 at privately operated facilities and $1,604 at government-operated nursing homes, which generally provide substantially more hours of training per student (Pennsylvania 2001).

CNA training is partially funded through the Medicaid program. Under federal Medicaid rules, CNAs who pay for their own training privately are supposed to be reimbursed for their costs if they start work or receive an offer of employment at a nursing home within a year of being certified. The state is supposed to reimburse the worker, through the facility, and facilities are allowed to require that the worker stay a certain amount of time in order to be reimbursed. (PHI 2005) In Wisconsin, the required competency testing for certification as a CNA costs

$100. Often this is paid for by providers, but may be borne by individual CNAs. Wisconsin's nursing home reimbursement rates for initial nurse aide training and testing have not been increased since the early 1990's. The maximum payment for a nursing home for initial training and testing is $286.50 ($225 for training and $61.50 for testing). The facility receives a percentage of this capped amount based on the percentage of resident days that are covered by Medicaid. Even though they receive a reduced payment, facilities are required to reimburse the CNA no less than the full $286.50. Many CNAs who meet the qualifications, however, are never repaid, and even when they are, the payment may not cover all their costs (U.S. DHHS/CMS 2001).There is no similar reimbursement mechanism to cover facility costs for in-service training.

Apart from CNAs in nursing homes, there is no requirement for Medicaid or other public funding reimbursement of training and testing costs for workers. Some states, including Washington, Kansas and Oklahoma, cover the cost of training other kinds of workers, either directly or through their per diem rates for providers. The Massachusetts Extended Care Career Ladder Initiative has promoted collaboration between workforce development agencies, community colleges, and long-term care providers to offer free or subsidized training. The New York State Department of Health has allocated $100 million in surplus TANF funds to educate certain direct care workers. California used $25 million in combined WIA and TANF funds to improve training and retention of front-line workers in long-term care. The U.S. Department of Labor's new High-Growth Job Training Initiative, which targets health services as one of nine fast-growing sectors, is another promising source of support.

Our government needs to start looking at being a nurse aide as career choice and not a dead-end job. - Jennifer Craigue, nursing assistant

<u>Consistency, portability and advancement opportunities</u>

Although much work would be needed to move toward portable credentials and the "universal worker" concept, we could start by making training requirements more portable than they currently are, across settings and funding sources. With the caveat that some flexibility may be needed for family caregivers, basic training for all worker categories could be consistent. Modules could be added for specific skills needed for a particular client population and/or setting, and more advanced skills and specialty needs (e.g., dementia care). Once a worker had received training and demonstrated competency in a particular module, s/he would not have to repeat it to work at a different work site. Instead, training and worker resources could be devoted to expanding knowledge and skills.

Ohio is identifying key core skill competencies for direct-care workers across systems of care, work settings and consumer populations (e.g., nursing homes, MR/DD, home health, physically disabled, etc.) to develop standardized requirements and institute state credential programs for workers. In Pennsylvania, a broad coalition of groups is working to design and test a comprehensive core-training package for direct-care workers across the continuum.

Creating opportunities for advancement would help decrease the shortage of workers, improve job satisfaction, make the job more attractive, and increase diversity. (Salsberg, 2003) Lack of career mobility may make care work a dead-end occupation, both in the perception of potential employees and in fact. Career ladders can take many forms. Tying extended training to career ladders would provide opportunities for advancement that could help keep experienced workers in long-term care. Making training more portable from one long-term care setting to another would also increase opportunities for workers within the field.

The Wisconsin Education, Training and Assistance (WETA) project (Sager 2004) studied the effectiveness of tying expanded training opportunities for workers in CBRFs to increased wages and/or bonuses in their current jobs. North

Carolina's Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance program (WIN A STEP UP) provides financial incentives to workers for completing training modules and staying with an employer for a specified period. The program also provides financial incentives to nursing homes for their participation. It is funded by civil monetary penalty fines collected from nursing homes, which are earmarked for use in improving nursing home quality. (University of North Carolina 2004) Although evaluation is not complete, these approaches show promise for improving turnover and retention rates.

For workers in the developmental disability field, the National Alliance of Direct Support Professionals has developed a national credentialing program based on the Community Support Skills Standards, a group of 12 broad knowledge and skill sets needed by workers. By completing courses through the Internet-based College of Direct Support, workers can advance through several stages, becoming a support professional assistant, licensed support professional, certified direct support professional and then supervisor, while earning first an associate's and then a bachelor's degree. Two initial evaluations of this new program have been positive.

A few states have credentialing programs of their own. The Massachusetts Department of Mental Retardation, for example, offers a 21-credit Direct Support Certificate Program, which is taught at community colleges. Workers who complete the course get an increase in pay. (PHI 2005) The federal Department of Labor has recently approved an apprenticeship program for home health aides, which is being tested in three pilot programs in Michigan, Indiana and Pennsylvania. It will provide a structured career path for career development.

Some states, including Delaware, Colorado, Massachusetts, New York, North Carolina, Virginia, Pennsylvania and Illinois, have or are experimenting with two or three levels of nurse aides. There are several potential benefits to these types of structures. First, they can give CNAs incentives to stay in their jobs by offering higher pay to CNAs in higher tiers. Second, to advance to the next tier, additional training is required, which will result in a larger population of well-trained CNAs. Having CNAs who have an incentive to continue in the profession and receive additional training, has the potential to decrease the high turnover rate and increase the quality of care received by residents. Career ladders are also being developed designed to facilitate movement from nurse aide to higher paying positions, such as LPN or RN.

Some career ladder opportunities may take workers into areas related to, but not direct care work. For instance, one Wisconsin county identified some direct care workers serving COP clients who were particularly skilled at helping people take advantage of educational, recreational, religious and social opportunities. They were given the opportunity to become care manager assistants and county employees, doing community integration work that care managers and direct care workers might not have time to do.

Promising models of training

The Committee reviewed several training models for direct care workers and supervisory staff that have received positive reviews from multiple agencies in Wisconsin. These included (1) training developed by the Wisconsin Council on Developmental Disabilities and the DHFS Bureau of Developmental Disability Services, (2) training done by the Wisconsin Education, Training and Assistance (WETA) project, and MetaStar's Leadership Development training. Summary and contact information about these models is included in Appendices 5-7.

Recommendations

1 Worker categories, career ladders and workforce flexibility

   a Current direct care job categories should be clarified and clustered. Create more flexibility in training requirements and worker categories. Training beyond the basics should be tailored to the setting in which the worker will provide service,

and the needs of the population(s) with which s/he will work.

b Training requirements should be more consistent and portable across care settings. All workers should have the same basic level of training and competency, and once they have demonstrated competency in a particular skill set, should not have to repeat training in that area when they move to another setting or funding source. Elements of this core training should include:

- Safety (worker and consumer)
- Dealing with emergencies
- Universal precautions (infection control)
- Resident/client rights
- Confidentiality
- Communication between:
  - Caregiver and client
  - Health care providers
  - Caregiver and facility/agency
  - Caregiver and nurses/supervisors
- Life skills
- Activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Natural aging vs. disease and disability
- Challenging behaviors
- Balancing workload/coping strategies
- Family involvement and dynamics
- Ethics and boundaries between caregivers and consumers

c Additional modules of training for advanced or special skills should be available and as consistent as practicable across settings serving similar target groups. Completion of these modules and/or equivalent additional experience should result in wage increases and/or bonuses.

d More consistent training could result in the "universal worker" who could follow a consumer from one setting to another. Training for workers in various job categories and settings should be made much more consistent in terms of:

- The number of hours of training required
- Curriculum approval by the state
- Requirements for instructor qualifications
- Competency testing (written test with the option of an oral test when needed, and skills demonstration), conducted by a person or entity other than the trainer

e As a first step toward making training more consistent and portable, DHFS should identify all current training requirements across all settings and funding sources, including those in the Medicaid Waiver Manual, state statutes, administrative rules and federal rules, and develop a work plan for making a transition to a more uniform system.

f To create advancement opportunities, two (or more) levels of nurse aide should be created, with statewide standards and portability. Guaranteed wage increases should be associated with advanced certification. Similar efforts to create career ladders within long-term care should be explored for other worker categories.

g DHFS should explore ways in which providers could be more flexible and efficient in the deployment of staff, so long as quality of care is not compromised.

2 <u>Adequacy of initial training</u>

a DHFS, in cooperation with provider associations, direct care workers and consumers, should invest in improving current training programs for all direct care workers in all long-term care settings.

- Training should focus not only on health and clinical aspects but also worker and consumer safety, communication, problem-solving, critical thinking, individualizing care, interpersonal skills, listening and relationship building, especially for those new to the workforce.
- Training should use adult-centered teaching methodologies and the content should be immediately applicable and practical. Training should demonstrate and expect professionalism on the job.
- Training and testing requirements should relate to state and county expectations for provider quality.
- Training should focus not only on the needs of employers, but also on the needs of workers.
- Training should consider all needs of consumers, not just their health care needs.
- Ensure that those providing the training for entry level workers in all worker categories (not just CNAs) have adequate credentials and experience. Various methods are possible, including rating trainers based on student evaluations, test results and observation of trainees on the job.
- Ensure that sufficient clinical training follows classroom training.

b All current training requirements should be considered bare minimums. Requirements for workers typically employed by Residential Care Apartment Complexes, Supportive Home Care Agencies, Adult Family Homes and Adult Day Care Centers are particularly low or even non-existent and should be strengthened.

c Both classroom and clinical requirements for CNA training should be increased.

d Training for workers in assisted living and in-home settings should provide more emphasis on medication assistance.

e Training for individuals working in consumers' homes should be specific to the individuals for whom they will work and should include training related to each individual's particular needs and preferences This training should take place with that consumer. A worker who is going to work with just one or a few people in their homes may need less generalized classroom training and more instruction from consumers and family members and/or shadowing experienced workers.

f DHFS should encourage and work with providers and other stakeholders to develop a peer mentoring program for direct care workers.

3 <u>In-service training for DCWs and supervisors</u>

a DHFS should review current in-service training requirements for all direct care worker categories to assure that:

- Required hours are adequate
- Content is relevant to actual job duties of workers
- Requirements for trainer qualifications are adequate
- Employers are accountable for providing the training and workers are accountable for taking it
- Requirements for annual training in universal precautions are consistent, so that workers do not have to repeat it to satisfy various funding source requirements.

b DHFS should establish a requirement that in order to maintain active status in the nurse aide registry, CNAs or their employers must provide documentation of completion of required in-service training.

c DHFS should establish requirements or incentives for training of supervisors, with the content emphasis on team-

building, mentoring and problem-solving.

d Training and other efforts are needed to remove cultural barriers (e.g., age, language, ethnicity, literacy levels) between direct care workers and supervisors. This is an essential component of good communication, team-building and job satisfaction in many organizations.

4 Support for training improvement

a DHFS should take a leadership role and designate staff to develop, identify and recognize excellent training for workers and supervisors.

b DHFS should work with researchers to evaluate initial and in-service training for direct care workers and disseminate the results.

c State and county rate-setting methodologies should provide incentives for providers to cover the cost of ongoing training.

d A State-sponsored training initiative should be considered. (A train-the-trainer approach could be employed.) Training approaches used in Wisconsin and other states that should be considered include:

- The training developed and provided for residential and vocational providers of developmental disability services by the Wisconsin Council on Developmental Disabilities and DHFS
- Leadership Development middle management training for nursing homes and home health agencies developed and provided by MetaStar
- Worker and supervisory training developed and provided in the Worker Education, Training and Assistance (WETA) project.
- Mentor training programs such as those developed by the Iowa CareGivers Association project, the Wisconsin Regional Training Partnership, and elsewhere.

e The state should explore ways to fully or partially subsidize the costs of training and testing, as well as other supports such as child care and transportation needed for workers to attend. A revolving loan fund for initial and/or in-service training for workers and supervisors is an alternative approach worth considering.

f DHFS should work with the Department of Workforce Development to increase the use of Workforce Investment Act funds for long-term care worker training and to strengthen apprenticeship programs to make them useful for long-term care workers.

g The state should develop a continuing education curriculum, on-line courses or other training opportunities for administrators, managers and supervisors, and direct care workers, incorporating information about best practices.

The complex interplay of market forces, industry practices, and public policies means that no single person, organization, or sector can resolve the long-term care labor crisis on its own.

Working together

There are no easy solutions to long-term care workforce problems. The complex interplay of market forces, industry practices, and public policies involved in making such changes means that no single person, organization, or sector can resolve the long-term care labor crisis on its own. This calls for partnerships among groups with a stake in resolving the problem. When providers, consumers and workers from both the institutional and the community sides of the long-term care system come together to work collectively on the workforce issue, they can and

have made a difference. (Better Jobs Better Care 2003)

In Wisconsin, the Wisconsin Long Term Care Workforce Alliance is a coalition that includes providers, workers, consumer representatives, educational organizations and state and county governments. Local coalitions with similar representation also exist in several counties, many of them initiated with support from the Community Links grants. The Alliance has received a grant from the Helen Bader Foundation to assist additional counties to form workforce coalitions and to strengthen existing ones.

Recommendations

1. DHFS is encouraged to continue to support, through the Community Links grant program, statewide and local collaborative models of planning and implementation of efforts to improve the direct care workforce. In particular, support is encouraged for the Wisconsin Long Term Care Workforce Alliance and local coalitions of stakeholders working on these issues.
2. DHFS should evaluate and disseminate information about lessons learned from past Community Links projects and continue funding of these projects to support local efforts to address workforce issues and needs.

Respect, recognition and teamwork

Many studies have found that the lack of respect and recognition for their work is an important factor in turnover rates of direct care workers. When frontline caregivers talk about feeling unsupported on the job, they often cite the lack of respect and recognition for the difficult work they do on a daily basis. (Dresser et al. 1999, Hatton and Dresser 2003, Stone 2001, Bowers et al.2003, Eaton 2001, Pennington 2003, Sager 2004, and others) A recently published study found that organizational culture was the strongest predictor of organizational commitment on the part of workers in assisted living facilities. Employee characteristics such as age, gender, and educational level play little if any role in how committed employees are to their employers. High levels of commitment are linked to low rates of turnover. (Sikorska-Simmons 2005)

Demonstrating that workers are valued by their employers, their colleagues, their clients and the broader society can take many different forms. Many of these are in the purview of the private sector, and not a focus of this report.[12] But some concepts are relevant to public policy and practice.

"I love working with the people I care for. I think that of all the jobs out there, this one fits me best." Direct support professional

"I like the fact that I can make a difference in someone's life. . ." Direct support professional

"I feel like I'm a millionaire every time I walk through those doors and it has nothing to do with the money." CNA

Caring and compassionate people are drawn to these jobs, and many find the work rewarding because of the relationships they develop with clients and families (Mulliken 2003, Dresser 1999, Hatton and Dresser 2003, Lageson 2003, Sager 2004 and many others). Two keys to retention are to foster those relationships and to involve frontline workers in the planning and management of care. In one study, the degree of nurse aide involvement in resident care planning was superseded only by the condition of the local economy as a factor affecting turnover. For example, in facilities where nursing staff were perceived to accept aides' advice and suggestions or simply discussed care plans with aides, the turnover was lower than in those facilities where aides were not involved in care planning. (GAO 2001, Banaszak-Holl 1996)

[12] Selected information about promising practices for provider organizations is provided in Appendix 10.

"The case manager spends 10 minutes in a home and makes an assessment. They don't ask us. The case manager thinks, 'We are educated and they (direct care workers) aren't.'"
Direct Care Worker

A number of training programs for middle management in provider organizations emphasize and encourage team approaches to caregiving that involve direct care workers. Three of these that the Committee reviewed are summarized in Appendices 5-7. The training section above also includes several recommendations related to improved training for supervisory staff that can lead to better recognition and involvement of direct care staff.

To find and keep direct care workers, it is also important to improve the image of this work with the public. Iowa, North Carolina, Arkansas, Massachusetts, Pennsylvania, Maryland and Ohio are among the states that have undertaken public recognition and image campaigns. In Wisconsin, several counties have conducted such campaigns, and the WI Long Term Care Workforce Alliance has received a planning grant from the Retirement Research Foundation to design a research project to evaluate the efficacy of this approach. They plan to apply for funds to implement and test several campaigns. See Appendix 9 for sample materials from recent county coalitions' campaigns.

Recommendations

1. DHFS is encouraged to continue to support the efforts of the Wisconsin Long Term Care Workforce Alliance to implement and evaluate campaigns to improve the image of direct care workers among workers, supervisors, employers, consumers and the general public.
2. Publicly funded long-term care programs should include requirements for consumer-centered care planning processes. Direct care workers' input into care planning should be required, to the extent that consumer preferences about how and when that occurs can be met.
3. DHFS should involve direct care workers in all policy and implementation committees or task forces related to long-term care.
4. DHFS, counties, providers and other stakeholders should actively pursue grants and other funding opportunities to encourage innovative projects and demonstration programs designed to flatten hierarchical structures, involve direct care workers in care planning and other workplace-related decisions, and encourage relationships between workers and clients.

"Quality care means respect from our supervisors and other administrative personnel, to help us feel good about the work and the quality of care that we give, and to give us the support we need to do it right." - John Booker, CNA

Better worker support and safety

Because of their low wages and frequent lack of good benefits, direct care workers often need supports to be reliable in their jobs. DHFS-administered Community Links grants have been used to support county efforts to provide worker supports such as child care and transportation to support people during training. Many employers also provide supports; some promising practices in this area are listed in Appendix 10.

Peer support, continuing education and advocacy are sometimes available to workers through direct care worker associations and unions. These connections can be especially important for independent workers. Maine has used grant funds to establish the Personal Assistance Worker Guild. Pennsylvania is assisting to sup-

port a direct care worker association. Worker cooperatives, such as Waushara Cooperative Care, can provide peer support as well as other tangible benefits.

States can also support workers by providing outreach to inform them about benefits that low-income working families may be eligible for. When people register as CNAs in North Carolina, for example, they are automatically placed on a mailing list to receive information about that state's equivalent of Badger Care.

Studies have identified the physical demands of nurse aide work and other aspects of the workplace environment as contributing to retention problems. Nurse aide jobs are physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with patients or residents who may be disoriented or uncooperative. Nursing homes have one of the highest rates of workplace injury, 13 per 100 employees in 1999, compared to the construction industry with 8 per 100 employees (GAO 2001). Workers cite short-staffing as the leading cause of worker injury; when only one worker is available to do a job that should be done by two people, the chance of injury is greatly increased. Direct care workers in other settings also face high risk of injury, especially in home settings, where often only one worker is present and no equipment is available to assist with transfers.

> *"What I'd really like them to do is stop giving me 6-foot-tall people when I'm under 5 feet tall. Someone's going to get hurt." Home Health Aide*

Workers in private homes are also exposed to a variety of other potential safety issues. Clients may be unable to keep walks and driveways cleared of ice and snow or live in high-crime neighborhoods. Pets, guard dogs and wildlife may pose a danger. Individuals other than the client may be present. The client and/or others in the home may be drinking or using illegal drugs. Sexual harassment is another potential threat to worker safety.

The Select Committee on Health Care Workforce Development, a multi-agency group involving key stakeholders and staffed by the Department of Workforce Development, has identified reduction of injuries related to lifting as a top priority. To date, their efforts have focused primarily on institutions and larger residential settings. Considerable attention is given to worker safety issues in larger facilities because of OSHA regulation; less attention has been focused on worker safety in home and small community settings. A faculty member at the University of Wisconsin Extension is working on a project to develop and evaluate promising interventions (training, technology, practices and procedures) to reduce injuries among home care workers (DeClercq 2005). Special one-time grants under the Community Options Program have been used in the past for technology to improve worker safety, as well as consumer safety and independence. For example, grants have been used to purchase lifting devices, cell phones to improve communication and assure safety of workers on the road, and electronic monitoring devices to allow staff to be available only to respond only when needed.

Some workers choose to work overtime in order to increase their income. In other cases, overtime may be required, because another worker does not show up, because of overall vacancies and staff shortages, or because an employer requires overtime in lieu of hiring additional workers. Worker fatigue and/or preoccupation with childcare or other personal conflicts can create unsafe conditions for both workers and consumers if overtime is extensive.

Recommendations

1. As noted in the self-directing consumer issues section of this report, we recommend that DHFS monitor the results of local projects to create registries to match independent workers and consumers. If these prove to have benefits for consumers and for workers, the Department should encourage ex-

pansion to other localities, perhaps through the Community Links grant program.

2. The long-term care sector should be represented on regional Workforce Development Boards and direct care work in long-term care should be a priority for these Boards. Counties should work with these boards and with local Job Centers to assist, where necessary, those workers who are displaced by closure or downsizing of facilities and agencies to transition to other jobs.
3. Current state and local funding for the development of technology to reduce worker injuries should be preserved.
4. DHFS should maintain and systematically disseminate information to long-term care providers about public programs available to low-income families, such as Badger Care and subsidized child care, which could benefit their employees.
5. DHFS should continue to encourage and support the creation of worker associations, worker cooperatives and worker-consumer cooperatives that can provide supports and other concrete benefits for independent workers. DHFS is also encouraged to consult with the UW Extension Small Business Development Center to explore additional ways that workers could organize.
6. DHFS should consult with stakeholders and experts to develop an inclusive set of best practices to improve worker health and safety across all long-term care settings.
7. DHFS is encouraged to work with the Department of Workforce Development and the University of Wisconsin Extension to form a task force to develop and oversee implementation of recommendations to improve safety and supports for worker in home and small residential settings.
8. DHFS should work with the University of Wisconsin Extension on their project to investigate ways to improve the health and safety of home care workers.
9. DHFS should work with providers, workers and other stakeholders, including the Department of Workforce Development, to build the capacity to make training in worker health and safety more available.
10. DHFS should work to develop training curricula that address the unique worker safety issues that are associated with service delivery to consumers in their private homes.
11. DHFS should encourage wider availability of home safety inspections and advice for consumers, which could improve safety for both consumers and workers.
12. DHFS is requested to study the extent to which overtime, especially mandatory overtime, is creating unsafe conditions for consumers and/or workers.
13. All stakeholders, including researchers, providers, workers, counties and DHFS, should work together to better prepare for and coordinate grant applications and other opportunities to demonstrate, evaluate and disseminate information about projects to strengthen and support the direct care workforce.

Self-directing consumer issues

Many of the recommendations in previous sections of this report relate to the majority of publicly funded consumers, who receive services from workers employed by facilities and agencies. There is another group of consumers who direct their own care, using a variety of funding sources including COP and its related waiver programs, Family Care and private funds. (Medicaid fee-for-service funded services must be provided by agencies certified to receive these funds.) These consumers hire, train, supervise and fire the people who support them, and often the workers are self-employed.

Self-directed support mechanisms can broaden the direct care workforce, since people may be willing to work for one or more individuals whom they know, but are not interested in being employed by an agency to serve multiple individuals. But independent workers may earn less than agency-employed workers, and may not have access to any employer-provided benefits.

Of particular concern is that they may not be covered by Workers' Compensation to cover medical expenses if they are injured on the job.

Mechanisms are needed to connect consumers who are looking for workers and workers who are looking for jobs. Special training issues arise in these situations, for consumers, workers and care managers. Other issues that arise include the frequent lack of peer mentoring opportunities for workers and mechanisms for mediating issues between consumers and workers.

Nearly 4,200 independent providers serve COP and waiver participants who hire the workers directly in the 66 counties responding to a recent survey (Wisconsin DHFS 2004b). There is a statutory requirement for the Community Options Program and all its related waiver programs that all counties offer self-directed supports and the opportunity for consumers to hire independent workers through a fiscal agent who acts as the employer of record, but not all counties currently meet this requirement. More specific information about this issue is included in the wages and benefits section of this report.

Additional information and recommendations relating to independent workers are covered in the sections of this report on wages and benefits, training, and worker supports and safety.

Recommendations

1 Support and strengthen self-directed care mechanisms in public homecare programs, to bring in independent workers (family members, neighbors, etc.) who may be willing to work for someone they know. DHFS should enforce the current requirement that all COP and waiver participants have a self-directed care option and the opportunity to hire independent workers through a fiscal agent. In addition, DHFS should help clarify the legal exposure or liability that consumers have as employer of record and work with counties to resolve the issue of county and consumer liability. Counties should provide workers compensation coverage as recommended in the wages and benefits section above, with the infrastructure in place to protect counties, workers and consumers.

2 DHFS should encourage and offer technical assistance to counties to help them develop and provide training to consumers who wish to self-direct their services and perform employer-related tasks themselves. In addition to training, counties or their fiscal agent organizations could set up payroll systems for individual consumers to help them prepare to manage taxes and other employer tasks.

3 Long-term care funding programs should provide mechanisms for continuing to pay consumer-employed workers during short term interruptions in care (e.g., hospital stays).

4 DHFS should explore ways to improve the availability of respite, back-up and peer mentoring support for independent workers, including paid family members. One option might be to expand the role of fiscal agent organizations to include these services.

5 DHFS should encourage and offer technical assistance to counties for creation of mediation mechanisms, perhaps through care managers, of issues that may arise between self-directing consumers and the independent workers they employ.

6 In addition to the recommended improvements in training for workers and supervisors in the training section of this report, specialized training is needed in self-directed support situations:

   a to instruct caregivers about working for people with disabilities, including training on assistive technology as appropriate;

   b to instruct caregivers about the particular needs and preferences of the individuals whom they will be supporting, including training by consumers and their family members;

c to educate case managers about implementing self-directed care programs and about recognizing signs of abuse and neglect; and

d to educate consumers about managing their own care.

7 Training for workers who will be working with one individual should include training related to that consumer's particular needs and preferences. This training should take place with that consumer.

8 DHFS and counties should develop training resources and opportunities for publicly supported consumers, especially those who manage their own care, to help them build skills as an employer/supervisor as they recruit, hire, supervise and evaluate workers. Consumer training should also incorporate interpersonal skills, problem solving, listening and relationship building.

9 DHFS should encourage and offer technical assistance to Aging and Disability Resource Centers, Independent Living Centers and advocacy organizations to provide training resources and opportunities for both public-pay and private-pay consumers, especially those who manage their own care, as outlined in recommendation 8 above.

10 DHFS should monitor the results of local projects to create registries to connect and match independent workers and consumers. If these prove to have benefits for consumers and for workers, the Department should encourage expansion to other localities, perhaps through the Community Links grant program.

"Most people don't know what CNAs really do. They tell you "anybody can be an aide, it takes no brains and no skills. You just have to be able to handle the smells." Oh, does this make me boil!" - Richard J. Sojka, CNA

"There aren't that many jobs where you can get eight thank-you's in a day. I get a paycheck every day and a stipend every two weeks." -CNA

Appendix 1 – Committee Charge and Membership

Preamble: Without a sufficiently large, stable and well-trained workforce of people providing hands-on care, other efforts to reform the long term care system will fail. Even in difficult economic times, efforts to increase and stabilize this workforce must be a high priority, and all other reform efforts must incorporate and support this goal. The Department of Health and Family Services creates many jobs through its substantial funding of various long term care programs and has a responsibility to ensure that those jobs are good jobs.

Charge: After review of current and recent efforts to address issues related to the direct care workforce in long term care, and with a focus on retention issues, develop recommendations to the full Council, within the constraints of tight fiscal conditions, on public policy changes that the Department of Health and Family Services could make to foster a stable and well-trained workforce of direct care workers and growth of the workforce to meet current and future needs of consumers.

Issue areas to be addressed:

1 A recommended statement of principles that could be adopted by the Department, providers and others, explicitly recognizing the value of direct caregivers and their work, and providing a framework for evaluating whether long term care policies and practices support the goal of a sufficient, stable and competent workforce.

2 Describe the current workforce in various care settings, including demographics, and the percentage paid by Medical Assistance and other public sources. Analyze the factors that contribute to high turnover. Analyze options for improving the stability and skill of direct care workers that utilize existing funds or that leverage small amounts of new funding.

3 Quality assurance and improvement programs for facilities and agencies employing direct care workers that include measures of the stability and quality of their direct care employees.

4 Reimbursement policies and methodologies for publicly funded programs that will support and encourage a stable, well-trained workforce of direct care workers.

5 Identify gaps in data collection about the extent and nature of the workforce shortage as it relates to specific settings and populations; make recommendations about how to improve the collection and use of data to tailor remedies to specific problems.

6 Training for supervisors, workers and consumers, and certification requirements for direct care workers that encourage competency, flexibility in the workforce and retention of qualified workers.

7 Strategies for encouraging innovation, culture change and team approaches to care and care management that increase the involvement of direct care workers.

8 Strategies for providing support to direct care workers.

9 Strategies for making the work less physically demanding

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The Committee benefited from the expertise of a number of individuals who regularly attended meetings and contributed information. These included:

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Many other individuals presented information that was of great use to the Committee.

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Appendix 3 – Size and stability of the Wisconsin direct care workforce

Selected Information

In May 2003, the U.S. Bureau of Labor Statistics (BLS) reported about 68,000 direct care workers in Wisconsin, in three categories[13]:

- Nursing Aides, Orderlies, and Attendants – 40,900
- Home Health Aides – 11,680
- Personal and Home Care Aides – 15,160

The number of nursing aides, orderlies and attendants includes some working in acute care and psychiatric hospitals, although it consists mainly of nurse aides in long-term care settings.

These numbers do not count thousands of independent workers who are not employed by facilities or agencies. Nearly 4200 independent workers are funded through COP (WI DHFS, 2004). One national study estimates that 29 percent of the direct care workers providing assistance to Medicare beneficiaries in the home are self-employed (Leon and Franco, 1998).

As of February, 2005, about 176,500 CNAs are listed in the nurse aide registry. Of these, 58,566 meet all federal requirements to work in a federally certified nursing home, home health agency or hospice program. The remaining 117,514 are either working in another long-term care setting or a hospital, or are no longer working as a nurse aide.

Turnover Rates[14] of Nurse Aides in Nursing Facilities (NF) and Facilities for the Developmentally Disabled (FDD)
Wisconsin, 2003[15]

	NF	FDD
Full-time aides		
All facilities	43%	24%
Government	10%	5%
Nonprofit	43%	46%
For-profit	57%	16%
Part-time aides		
All facilities	61%	33%
Government	41%	26%
Nonprofit	51%	36%
For-profit	84%	39%

Retention Rates[16] of Nurse Aides in Nursing Facilities (NF) and Facilities for the Developmentally Disabled (FDD)
Wisconsin, 2003[17]

	NF	FDD
Full-time aides		
All facilities	74%	84%
Government	93%	95%
Nonprofit	74%	71%
For-profit	67%	89%
Part-time aides		
All facilities	64%	74%
Government	72%	77%
Nonprofit	66%	67%
For-profit	56%	82%

[13] Nursing aides, orderlies and attendants: Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.
Home Health Aides: Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility.
Personal and Home Care Aides: Assist elderly or disabled adults with daily living activities at the person's home or in a daytime non-residential facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide meals and supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities.

[14] The turnover rate is calculated as the number of employees in a given category hired during the year as a percentage of all employees in that category.
[15] WI DHFS, 2004c.
[16] The retention rate is the percentage of all employees in a category who have worked there for more than one year.
[17] WI DHFS, 2004d.

Annual turnover rates in selected Community Based Residential Facilities, 2000-2002. CBRFs participating in Worker Education, Training, and Assistance Program (WETA) training and control facilities. (Sager, 2004)

	Pre-WETA	**During WETA**	**Post-WETA**
Comparison Facilities	135%	143%	126%
Training Facilities	84%	74%	60%

Appendix 4 – Summary of Current Wisconsin Training Requirements

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Certified nurse aides (CNAs) Nursing homes (including ICFs/MR) Home Health Agencies Hospice Programs	Initial training: Minimum of 75 hours, including at least 16 hours of classroom instruction and 16 hours in a clinical setting. Very specific curriculum requirements, including basic nursing skills, personal care skills, basic restorative services, rights of clients and dementia care. In-service training: Minimum of 12 hours required every 12 months. Federal requirement that training address each CNA's strengths and weaknesses.	Standardized written and skills competency testing required. (Contracted through Promissor.) DHFS/BQA licenses these organizations, assures compliance with federal regulations, approves all initial training programs, including curriculum, teacher training and experience, and training site, and oversees the nurse aide registry. BQA does not track in-service training.	Except for feeding assistants, all direct care workers in nursing homes, home health agencies and hospice programs must meet at least nurse aide training requirements, pass competency test and be in nurse aide registry. Most facility-based programs offer 80-90 hours of initial training. Technical colleges offer several different training models, including 120-hour, 140-hour and 160-hour.
Medication Aides (CNAs with experience and advanced training) Nursing homes	Initial training: CNA plus individualized training and supervision In-service training Instructor qualifications specified.	Competency testing (challenge test) required. BQA licenses facilities, ensures compliance with federal regulations and oversees training.	Must have CNA training – see above – plus individualized medication aide training.
Feeding Assistants Nursing homes (limited to feeding and hydration assistance)	Initial training: Minimum 8 hours of instruction in one of 3 standardized and approved curricula with specified topics. In-service training: Minimum 1 hour annually.	Standardized, state-approved written and skills exam. BQA licenses facilities and approves training for workers.	
Community Based Residential Facility (CBRF) Workers (5 or more adults; ranges from 5 to 257)	Initial training: Minimum 45 hours specified in 6 modules over 6 months. Instructor qualifications not specified. In-service training: Minimum 12 hours annually relevant to job responsibilities.	Competency currently not required. (May change after HFS 83 rule revisions underway.) BQA licenses facilities and approves training, often provided by facilities.	Nearly half of all CBRF workers are CNAs (Sager, 2004)

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Licensed Adult Family Home Workers (3-4 beds)	Initial training: Minimum 15 hours within first 6 months of providing care. Broad topics specified. Qualified training organizations specified. In-service training: Minimum 8 hours annually approved continuing education on specified, broad topics.	No competency test. BQA licenses homes.	
Certified Adult Family Home Workers (1-2 beds)	Initial training: No specific requirements. In-service training: No specific requirements.	No competency test. Counties certify homes.	
Residential Care Apartment Complex (RCAC) Workers (5 or more adults in apartment units with services) (Requirements shown are for certified RCACs)	Initial training: Minimum hours and instructor qualifications not specified. Topics are specified. In-service training: Not specified.	RCACs self designate. Those serving only private pay tenants may simply register with DHFS/DDES. Certification by BQA is required to qualify for reimbursement from COP/CIP.	Over 60% of workers in RCACs are CNAs. 46% received training provided by RCAC consisting of a median of 40 hours of job shadowing/on-the-job training, 8 hours of classroom training, and 4 hours of other training. (WHEDA and DHFS, 2003).
Adult Day Center Workers (Group adult day service providers)	Initial training: Workers must receive training on specified topics within 90 days of employment. Minimum hours and instructor qualifications not specified. In-service training: Minimum of 10 hours annually after first year of employment.	No competency test. Program certified by BQA, but only if at least one participant is funded through COP/CIP waiver program.	
Family Adult Day Care Workers (Up to 6 adults, depending on severity of disability, served for less than 24 hours per day)	Initial training: Minimum training hours and instructor qualifications not specified. Topic areas are identified. Workers have up to 6 months to obtain training. In-service training: No requirements.	No competency test. Program certified by BQA, but only if at least one participant is funded through COP/CIP waiver program.	

Job title/setting	Wisconsin training requirements	Accountability	Actual training levels (as known)
Personal Care Workers Home Health Agencies Personal Care Agencies (must be county agency or Independent Living Center)	Initial training: *Current rules:* Minimum 40 hours training, at least 25 hours of which in personal, restorative care, or 6 months equivalent experience. Topics specified. *Proposed rules:* No minimum hour or trainer qualification requirements. Topics specified. In-service training: *Current rules:* None specified. *Proposed rules:* Ongoing instruction and evaluation as appropriate to needs of recipient.	RN supervisor to evaluate competency of worker. BQA licenses Home Health Agencies. Bureau of Health Care Financing oversees Personal Care Agencies and conducts periodic audits. Under proposed rule changes, agencies are accountable for assuring that workers have appropriate training.	
Supportive Home Care Workers	Initial training: Minimum 16 hours classroom training, plus minimum 1 hour in home of consumer. Person often is matched with specific client and additional one-to-one training provided. In-service training: None specified	Sign-off by trainer, who may be consumer, that worker is trained and competent. COP-Waiver manual specifies training requirements.	

Appendix 5 – LTC courses in the WI Technical College System

Technical College	Nursing Assistant	Physical Therapy Assistant	Occupational Therapy Assistant	Medication Assistant	CBRF Caregiver	Community Developmental Disabilities Associate	Human Services Associate
Blackhawk	X	X	X	X			
Chippewa Valley	X			X			
Fox Valley	X		X				
Gateway	X	X	X	X			X
Lakeshore	X						
Madison Area	X	X	X	X			X
Mid-State	X			X			
Milwaukee Area	X	X	X				X
Moraine Park	X			X			
Nicolet Area	X			X			
Northcentral	X			X	X		X
Northeast WI	X	X		X			
Southwest WI	X						X
Waukesha Co.	X	X					X
Western WI	X	X	X			X	
WI Indian-head	X		X	X			

Appendix 6 – WCDD/BDDS Training Summary

This training was developed by the Wisconsin Council on Developmental Disabilities and the DHFS Bureau of Developmental Disabilities for staff of agencies providing residential and vocational services. It is designed to support organizations that want to develop a competent and committed workforce. Several different modules provide perspectives on making direct support work more interesting and meaningful by strengthening relationships between direct support workers, the people they assist, and people's families and allies. The various modules allow organizations to explore their work from different angles, and perhaps to discover practices that will improve outcomes for people with developmental disabilities while offering better conditions for the emergence of valued support workers.

The training is designed as a resource for use by organization managers in the course of their everyday work. Each activity takes one to two hours and can be done within a staff meeting. Activities can be sequenced to support a staff retreat or a more intensive training workshop. All the materials to support the activities are included in the module in the form of PowerPoint shows, reproducible instruction manuals, and reproducible handouts. Each activity invites participants to identify specific action steps that will improve the quality of direct support work. An agency team learns to use the module with the guidance of a more experienced leader and then implements the module in its own workplace.

Good work: Finding Meaning in Providing Direct Support. Based on an approach developed by psychologists Howard Gardner, Mihaly Csikszentmihalyi and William Damon, this module invites organizational teams to discover the sources of meaning and the resources for coping with dilemmas and disappointments available to workers. Its ten activities offer a choice of ways to reflect on and celebrate what matters about direct support work.

We Can! Supporting People to Seek Ambitious Goals. Based on the research of Albert Bandura, this module offers a way to encourage people to pursue ambitious goals. It defines the concept of self-efficacy in the context of direct support work and invites participants to review their organizations to identify and strengthen practices that build a sense of competency to achieve goals that require learning and perseverance.

Learning from High Reliability Organizations. Based on organizational psychologist Karl Weick's synthesis of research into organizations that perform effectively when both the human stakes and uncertainty are very high, this module provides four windows for organizational self-assessment focused on the mindful management of risk. It defines ways of organizing that allow staff to avoid failure and detect and make the most of opportunities for success.

Making Sense of Disability. The activities in this module invite participants to think about the ways that beliefs about disability shape the life prospects of the people they assist and the sort of satisfactions available in direct support work. The module uses a variety of historical materials as case studies to build understanding of the roots of the exclusion of people with disabilities and the importance of commitment to acting on better understandings of disability.

Promoting Resiliency. Based on a growing body of research in developmental psychology and sociology, this module focuses on an approach to dealing with health and safety issues by adopting practices that will strengthen people's ability to cope with difficult life events. The module calls for a resiliency check-up that inventories the protective resources available to a person and identifies actions that will improve resiliency.

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Appendix 7 – MetaStar Training Summary

This Leadership Development training was developed by MetaStar, the Quality Improvement Organization (QIO) for Wisconsin. It is being piloted with members of the Kenosha County Long Term Care Workforce Alliance and will be evaluated.

The training, which uses a train-the-trainers approach, is focused on leadership development for middle management of nursing homes and home health agencies. The curriculum consists of four sessions of about 2 ½ hours each, with homework between sessions. MetaStar will provide free assistance with organizing this training for any group of nursing homes and/or home health agencies. Because of the limits of MetaStar's contract with the federal government, they cannot provide training assistance to other types of service providers; however, curriculum materials are free to anyone in Wisconsin who would like to have them.

Module I: Communication

- Communication PowerPoint
- Group Activities related to communications

Module II: Problem Solving and Conflict Management

- Problem solving and conflict management PowerPoint
- Several group activities related to conflict management and effective problem solving

Module III: Leadership: Developing Skills as a Leader

- Developing skills as a leader PowerPoint
- Group activity: Conflict management tools
- Group activity: Leadership styles orientation
- Caught in the act activity sheet

Module IV: Developing Coaching and Mentoring Skills

- Coaching and mentoring skills PowerPoint
- Several group activities related to coaching and mentoring skills

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Appendix 8 – WETA Training Summary

This training was developed, along with related strategies for retention, by the Wisconsin Education, Training, and Assistance Program, a project of the Wisconsin Alzheimer's Institute. The training is no longer available from this source, but the curriculum is available upon request.

Level I Sessions:
Joint sessions for supervisors and direct care workers:

1. Communication and problem solving: "The Power of Perspective: Communication, Problem-Solving and Personalities
   Communication skills' responding to conflict; approaches to interacting with other people
2. Dementia care: "Creating a Caring Environment"
   Understanding of dementia; philosophy of person-centered care; models of effective care
3. Building teams: "Working Together to Meet the Mission: Creating a Cohesive Team"
   Characteristics of effective teams; team roles and stages of development; benefits of teamwork

Sessions for supervisors:

1. Quality of work life: "Creating a Supportive Environment Through Self-Investment"
   Role modeling; stress and time management; staff recognition; fostering teamwork
2. Manager's role in staff performance: "Connections: Positive Management and Staff Performance"
   Effective methods for hiring, orienting, training, performance reviews, and staff feedback
3. Personal and professional development: "Genuine Leadership"
   Leadership strategies; managing change; developing trust between staff and supervisor

Sessions for direct care staff:

1. Quality of work life: "Believe, Resolve, Take Care!"
   Improving self-esteem; conflict resolution; dealing with aggression; stress management
2. Personal and professional development: "Growing and Becoming Positive, Personal and Professional"
   Accountability; productivity; decision-making; time management; goal setting
3. Caregiver's role in quality of care: "Quality of Care: You Make the Difference"
   Techniques for providing quality care; working cooperatively with families; diversity

Level II Sessions
For supervisors:

1. "Digging Deeper into Communication Skills"
   More in-depth training on communication, including communication across generations and cultures
2. "Developing Leaders"
   More in-depth training on leadership skills
3. "Creativity in the Workplace"
   More in-depth training on developing and supporting creativity

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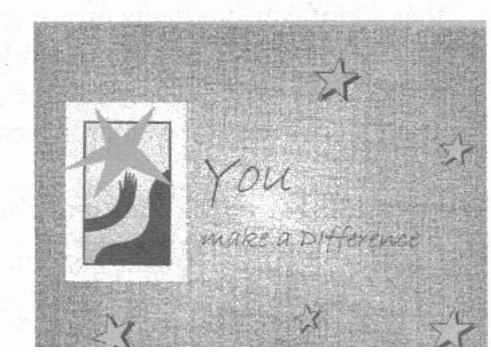
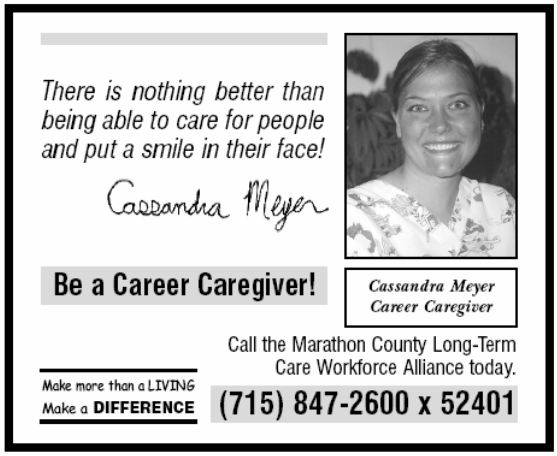
Appendix 9 – Local Image Campaigns

Several local coalitions have conducted public campaigns to improve the image of direct care workers and the work they do. A few selected images from the Kenosha County LTC Workforce Alliance and the Marathon County Long-Term Care Workforce Alliance are shown here.





Appendix 10 – Promising Provider Practices

Although the Committee's charge was to review and make recommendations about public policy within the purview of DHFS, we learned about a number of strategies for improving retention that provider organizations may want to consider. Promising practices that were brought to the attention of the committee and appear to be supported as effective by research include the following. The following is only a beginning list of strategies that employers can undertake to improve retention of workers.

- Improve morale and retention rates by recognizing the valuable contribution of direct care workers to your customers and your organization:
  - Involve workers, who know the consumer best, in care planning.
  - Build respect for frontline workers into organization policies and practices.
  - Thank individual workers for good performance, with words, small gifts, and public praise.
  - Have formal and informal recognition events to reward workers for dedication and quality of care.
- Tie pay and some benefits (e.g., vacation days) to experience, performance and level of training.
- Provide initial and in-service training for all employees that is effective, non-repetitive, and practical. Check to make sure it is absorbed by the trainee.
- Provide training for supervisors in communication, leadership and team-building skills. (Summaries of three of many models are provided above.)
- Relational skills should be supported and nurtured, for both direct care workers and supervisors.
- Encourage continuity in worker assignments within home care and facility-based settings.
- Good screening of workers and good matching of workers with consumers is important to both worker retention and consumer satisfaction.
- Agencies policies should encourage, as much as possible, consumers' choice of home care workers and workers' choice of consumers.
- To assist workers and reduce absenteeism, work with other local organizations and government to make available supports such as child care, health screenings, or a nearby bus stop.
- Consider joining together with other long-term care stakeholders in your community or county to work jointly on direct care workforce issues.
- Keep statistics about your workforce and analyze turnover and retention rates. Try to tie changes in these rates over time to specific strategies you have used, so that you know what works.
- Keep track of the costs of turnover; try to invest some funds in proven strategies for retention, which can be recouped through lower turnover costs.

Appendix 11 – Resources

- The **National Clearinghouse on the Direct Care Workforce** is a web site with a wealth of information about strategies for improving retention, research in this field, and other items of interest. Subscription to their e-newsletter *Quality Jobs/Quality Care* is also available through this site. Links to sponsoring organizations lead to additional information. The address is: http://www.directcareclearinghouse.org/index.jsp

- The **Better Jobs Better Care** web site and e-newsletter also provide timely information, including issue briefs, reports and articles. Connect at http://www.bjbc.org/.

- The **Wisconsin Long Term Care Workforce Alliance** is a statewide coalition across the spectrum of stakeholders, whose mission is to improve the stability and public recognition of the direct care workforce. It also supports local coalitions to work at the community level. Their web site, at http://www.wiworkforcealliance.com/ also includes a news and events section focused on Wisconsin, links to contact information about local coalitions, and more. An e-newsletter is available through this site, along with several community guides, including:
  - Creating Local Coalitions to Address Long Term Care Workforce Issues
  - Improving Public Awareness of Work in Long Term Care
  - Recognizing Direct Care Workers
  - Home Care Cooperatives: Worker Ownership In Focus

- The **Wisconsin Association of Homes and Services for the Aging**'s web site at http://www.wahsa.org/ provides access to several downloadable publications with many ideas for improving workplaces and retention rates. Of particular relevance are:
  - The Gratitude Attitude
  - Enhancing Employment in Long Term Care: A Guide to Retention
  - Models for Practice During the First 90 Days of Employment

- The **Wisconsin Assisted Living Association** (WALA) occasionally offers seminars, open to the public, on workplace philosophy. For a flavor of what this training includes, see the web site at http://www.leadershipthatworks.com/Consulting/FISH!%20Philosophy.htm. Watch WALA's web site at http://www.ewala.org/index.htm for future offerings.

- The **University of Wisconsin Extension** provides an on-line, interactive calculator for determining the direct **costs of staff turnover** to a particular organization. It may be found at http://www.uwex.edu/ces/cced/publicat/turn.html.

- For more information about the **self-sufficiency standard** for various household configurations in each county and tribe of Wisconsin, along with other community-specific information, see another UW Extension web site at http://www.uwex.edu/ces/cced/Indicators_Links.htm#sufficiency.

- Information about the Caregiver Retention Project being conducted by the **Milwaukee Aging Consortium**, including reports of its studies, is available at http://www.milwagingconsortium.org/.