Rutgers Center for State Health Policy

The Institute for Health, Health Care Policy and Aging Research

A Compendium of Three Discussion Papers:

Strategies for Promoting and Improving the Direct Service Workforce: Applications to Home and Community-Based Services

Elise Scala
Leslie Hendrickson
Carol Regan

May 2008

RUTGERS

This document was prepared by:

Elise Scala of the Health Policy Institute, Muskie School of Public Service, University of Southern Maine.

Leslie Hendrickson, Visiting Professor, Rutgers Center for State Heath Policy.

Carol Regan, Director of Health Care for Health Care Workers Campaign, PHI National.

Prepared for:

Leslie Hendrickson

Robert L. Mollica

The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

Rutgers Center for State Health Policy
55 Commercial Avenue, 3rd Floor
New Brunswick, NJ 08901-1340
Voice: 732-932-3105 - Fax: 732-932-0069
Website: www.cshp.rutgers.edu/cle

This document was developed under Grant No. 11-P-92015/2-01 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

Table of Contents

Summary

This is a compendium of three discussion papers on the topics of direct service workers in long-term care and strategies for improving the quality of their jobs and services. The authors, each with a background that includes consultation and technical assistance on the topics, share the premises that these workers are fundamental to the future and quality of long-term care and that current and projected workforce shortages need to be addressed.

- The first paper, *Home and Community-Based Services: Workforce and Quality Outcomes* describes HCBS programs, the direct service workforce, recommended practices for improving quality, and discusses possible approaches for integrating workforce initiatives into HCBS quality management systems.
- *What is the Impact of Unions on Quality of Care*? discusses effects of unionization on wages, turnover, and quality care and provides an overview of Service Employees International Union (SEIU) initiatives in key states.
- *Health Coverage for Direct Care Workers, Emerging Strategies* discusses work being done to make health insurance benefits more accessible and affordable to individuals working in direct-care and support jobs. The discussion of recent grant-funded projects and initiatives to raise awareness and to implement policies and programs provides a summary of models being used in a number of states.

The papers are not meant to be inclusive for all sectors of the direct care and direct support workforce, nor are they an exhaustive review of the research and demonstration literature. They are meant to provide insight and resource information that highlight current issues and approaches for building and maintaining a quality direct service workforce.

Background

The workforce of personal care, home health aides, and direct support attendants in long-term care, once assumed to be unskilled and readily available, is now recognized as serving an important role, and workers are in short supply. The shift in the value of these frontline service providers coincides with changes in long-term care policies and the expanded use of home and community-based services (HCBS). Personal care and support for hygiene, housekeeping, and the activities of daily living are essential services for many older persons and people with disabilities. These services are fundamental to their choice and capacity to live independently in their homes and community. The demand for these services is surpassing the capacity of long-term care programs to provide a committed, stable pool of direct service workers. Worker shortages and high rates of turnover are raising questions of quality and accountability for public funds and are putting pressures on state program officials to look carefully and take action to remedy the problems.

This is more than a discussion about supply and demand. The shortages are symptomatic of broader problems in the workforce and perplexing issues in the long-term care system. Researchers have identified three problems[1]:

- It is difficult to recruit and retain direct service workers;
- Low status jobs, defined by low wages and poor benefits, reduce workers' job satisfaction; and,
- High levels of turnover and vacancy, and limited training compromise quality.

The federal Centers for Medicare & Medicaid Services (CMS) are leading research, policy, and program implementation efforts to identify effective recruitment and retention interventions. Parallel initiatives are being conducted to implement state-based quality management systems that influence the workforce and could help to address these challenges. This paper explores some of the key questions raised in these efforts:

- What contributes to a quality workforce?
- How do workers contribute to participant outcomes and quality care?
- How can state Medicaid and HCBS program administrators ensure that providers and participants have the necessary staff capacity and capabilities to provide quality services?
- How can service providers increase workers' wages and benefits within the reimbursement rate structure?
- Do higher wages, health insurance benefits, workplace supports, union representation, and training programs reduce turnover rates and help to recruit quality workers?

The compendium provides an overview of direct service workforce challenges and the initiatives being researched and developed to address them. The background information about the workforce is intended to provide states with insights into their workforce issues. Summaries and reference materials about recruitment and retention initiatives are intended to guide states to identify possible strategies to fit their program needs. Discussion paper #1 takes a focused look at HCBS waiver programs as a component of the long-term care system that is experiencing the greatest increases in demand and some of the greatest workforce challenges. Discussion papers #2 and #3 take a focused look at specific categories of interventions, union representation and health insurance coverage, respectively.

[1] Weiner, 2004.

HOME AND COMMUNITY-BASED SERVICES: WORKFORCE AND QUALITY OUTCOMES

Elise Scala, MS
Muskie School of Public Service, University of Southern Maine

Home and Community-Based services (HCBS) waiver programs provide the best example for exploring the role of direct service workers and for understanding the inter-dependant relationship between workforce and program quality. The characteristics of these programs which include; a focus on participant-centered outcomes, heavy reliance on a low-wage, flexible workforce, diversity of job tasks with dispersed and varied work settings, and reliance on Medicaid reimbursement rates; are mirror images of the broader challenges of recruiting and retaining a quality workforce. HCBS personal and home care aides are the lowest paid, most disadvantaged workers in the long-term care system, and yet they provide the most direct, personal, and intimate services. For some participants these are the individuals and services that support their choice to not be institutionalized. It is no longer reasonable to assume that people, whether family members, friends, employed staff, paid or unpaid caregivers, will readily fill-in and cover these vital services, or that low-wage jobs with limited benefits will be the cost-effective approach that can recruit and sustain the qualified and stable workforce needed by HCBS programs.

While every sector of health and long-term care is looking for cost-effective methods to recruit and retain workers, HCBS waiver programs, by design, must balance workforce management across the publicly funded tight rope of participant/consumer choice, access, control, quality, and accountability. This paper is intended for state Medicaid and HCBS program staffs that are working with these issues in their state. The information and insights in the paper will support their efforts to ensure quality participant outcomes and encourage them to explore their workforce issues and integrate workforce development initiatives into their quality management programs. A secondary audience is those responsible for workforce development within a state, whether public or private, who want insight into HCBS workers and program management.

The paper has four objectives:

1. Provide an overview of HCBS programs and the direct service workforce, including the design of the service delivery system and desired outcomes;
2. Describe how the CMS Quality Framework can be adapted to assess the quality of the workforce and its impact on participant outcomes;
3. Provide an overview of the initiatives for managing and improving direct service worker recruitment, retention, and quality; and,
4. Discuss approaches for integrating workforce development initiatives into HCBS quality management systems to ensure participant outcomes.

HCBS Programs, the System of Providers, and the Direct Service Workforce

HCBS Programs

The collective public and privately funded programs known as HCBS are expanding to meet the demands of a growing number of older persons and people with disabilities and to provide needed support services. HCBS programs are based on the recognition that individuals at risk of being placed in long-term care institutions can receive support services in their homes and communities, and preserve their independence and ties to family and friends at a comparable or lower cost in public funds. HCBS waiver programs give states the flexibility to develop and implement creative alternatives to placing eligible individuals in hospitals, nursing facilities, or intermediate care facilities. These alternatives are dependant on the provision of direct care and direct support services.[2]

Nationally, Medicaid HCBS waiver programs are the major public financing mechanism for providing long-term care services in community non-institutional settings,[3] and they are available in all states[4]. These state-administered programs provide services to older persons and people with disabilities, including individuals with physical disabilities, persons with intellectual and development disabilities, medically fragile or technology dependent children, individuals with HIV/AIDS, and individuals with traumatic brain and spinal cord injury.[5]

While the needs of HCBS participants vary widely, personal care attendant and housekeeping services are a predominant support service, since most need assistance with activities of daily living (eating, bathing, toileting, dressing and transferring), and/or instrumental activities of daily living (cooking, cleaning, laundry, household maintenance, transportation, taking medications and money management). Some participants also need skilled nursing services, social service assistance, care coordination, and/or 24-hour services related to a chronic disease or disability. Services are provided in private homes, group homes and assisted living residencies, and in community-based activity centers. According to the U.S. Department of Health and Human Services Primer on Medicaid, the programs give "considerable flexibility to cover virtually all long-term care services that people with disabilities need to live independently in home and community settings."[6]

The twenty-five year history of HCBS waiver programs from 1982 to 2007 details shifts in policies that have contributed to their growth from the early days of deinstitutionalization and advocacy for integration and accommodation, to the current quality movements like culture change, choice, control, and self-direction. The first wave of change in the long-term care system came in the mid 1980s with the authorization of HCBS waiver programs and Medicaid funding for non-institutional care for persons with intellectual and developmental disabilities. While the majority of Medicaid funding for long-term care is directed towards institutional care settings, the percentage

[2] Kaiser, 2007.
[3] Shirk, 2006.
[4] Kaiser, 2007.
[5] Ibid.
[6] U.S. DHHS, 2000; PHI, June 2003.

spent on HCBS more than doubled between 1992 and 2004, from 15% to 36%.[7] In 2004 more than 2.7 million individuals received these services at a cost totaling $31.2 billion.[8]

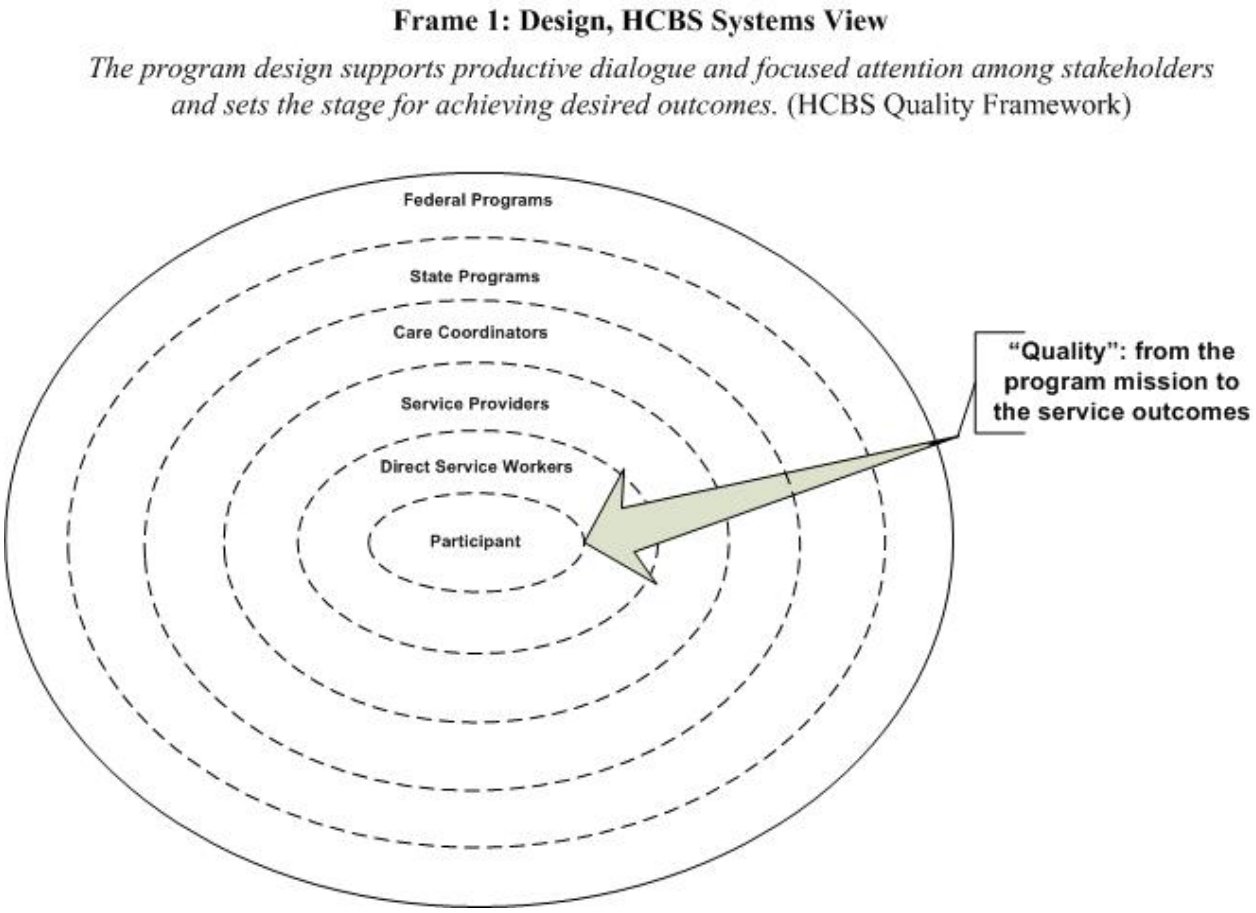
HCBS waiver programs have been credited with giving states the policy support, flexibility, and funding to provide services that are focused on participants' needs and to cover a comprehensive array and range of support needs.[9] Outcomes from the programs appear successful based on measures of increased utilization, reductions in the use of institutional care, expanded options for consumers, and reports of participant satisfaction in the self-directed programs.[10] Long-term care and disability policies for independence and choice, having shifted the center of services from institutions to home and community settings, are converging with the demographics of the aging baby boomers to substantially increase HCBS demand, use, and expenditures.[11] While this growth is consistent with the federal government's goals to rebalance the long-term care delivery system, there are concerns about the capacity of states to meet the rising level of demand for accessible and quality service outcomes.[12]

HCBS Service Provider System

HCBS programs rely on service providers to operate programs and accommodate participants' needs. Frame 1 illustrates the organizational or systems view of HCBS programs, showing the array of administrative programs and service providers as a series of concentric circles. HCBS programs must be able to effectively coordinate the work of program administrators with that of the care coordinators, provider agencies, and direct service workers to produce desired outcomes for participants. The overall HCBS mission is to promote an environment where program policies support the delivery of quality services and bring about the desired outcomes for participants.

[7] Kaiser, 2007.
[8] Ibid.
[9] Wiener, 2004.
[10] Lakin, 2003; Wiener, 2004; AARP, 2005.
[11] Weiner, 2004.
[12] Ibid.

Frame 1: Design, HCBS Systems View



The participant is central in the picture to demonstrate the participant-centered focus of HCBS programs. Direct service workers comprise the most immediate circle of service providers. The network of programs and services delivered by service provider organizations and individual direct service workers (theoretically) engages to meet participants' needs and enables them to live according to their preferences in their home and community. The relationships across HCBS programs and providers, although hierarchical, are dynamic, interactive, and interdependent. Program policies and procedures, service provider capacity, and factors external to the programs all exert some influence on system and service outcomes.

The following operational factors in HCBS programs describe the complexity of the system, including the administrative, funding, staffing, and policy influences at federal and state levels.

Administrative Authority

- States may have separate agencies administering waiver programs and local agencies operating them, as well as other government agencies involved in services, like subcontractors and provider agencies that employ direct service workers;[13]
- State HCBS programs fund local public agencies, health and welfare departments, nonprofit organizations, the aging networks, independent living centers, and community services to provide services such as medical, social, personal care, housekeeping, and transportation needs;[14]
- States have multiple HCBS waiver programs, each designed to serve specific populations, oftentimes administered by different subdivisions of the state government and funded by multiple sources;[15]
- The state Medicaid and HCBS waiver offices oversee the programs and providers to check that eligible consumers have access to and receive the services they need in accordance with federal waiver expectations.[16]

Funding

- HCBS programs are funded by a mixture of state, federal, other public sources such as the Older American Act, Medicare, Social Services Block Grant, Rehabilitation Act funds, general state revenues, and private funding.[17]

Providers

- HCBS programs and individual providers are subject to different structural and operational standards for licensing, accreditation, and regulatory measures and requirements;[18]
- Training requirements and curriculum standards for direct service workers' skills are defined by each state and vary within states based on the occupational title;[19]
- Home health agencies are a principal vendor/employer for home health aides, while the Area Agencies on Aging offer personal care services, transportation, and home-delivered meals to eligible participants;[20]
- Employers of direct care and direct support workers are public and private and operate within their particular mission, purposes, rules, regulations, and personnel requirements. (Nationally the breakdown of organization types are: 43% residential facilities for adults or elderly; 20% home health care agencies; 15% nursing facilities; 11% residential care for non-aged; and in 2006, 8% of the personal and home care aides were self-employed); and,[21]

[13] Booth, January 2005.
[14] Weiner, 2004.
[15] Kaiser, 2007.
[16] Booth, January 2005.
[17] Weiner, 2004.
[18] Booth, January 2002.
[19] PHI, June 2003.
[20] Institute of Medicine, 1996.
[21] Booth et al, 2002.

- It is estimated that two-thirds of HCBS services are provided by informal caregivers, unpaid family members, and friends;[22] 16% of the total caregiver hours are provided by paid staff,[23] and 19% are served by a combination of informal (unpaid) and formal (paid) workers.[24]

The HCBS Direct Service Workforce

Direct service workers have the most direct and consistent contact with participants, providing critical personal and home care support. These workers provide the "frontline" services that support the health, comfort, safety, independence, productivity, and dignity factors that influence participants' quality of life. Broadly described and from the participants' perspective, the direct service workforce includes the immediate circle of care and support people, both paid (formal) and unpaid (informal, family members, and friends). While a significant portion of direct care is provided by informal providers, all indications are that paid workers provide a sizable and growing portion of the coverage.[25] This shift is partly the result of Medicaid and consumer-directed rule changes permitting the payment of family caregivers, making the distinction between the informal and formal workforce less clear.[26]

Nearly two million people are employed in HCBS programs as home health aides, personal and home care assistants, and direct support professionals.[27]

Characteristics of the HCBS Workers

National statistics provide insights into the composition of the direct service workforce and factors that can influence their employment and work environments:[28]

- Ninety percent of the home care workers are women; slightly more male workers are in the MR/DD workforce;
- The average age of home care workers is 41; workers are slightly younger in the MR/DD workforce and slightly older in the informal caregiver workforce (43 years);
- The typical personal and home care aide is a single mother, aged 25-54;
- Ethnicity is about one-half white and one-third African American; the remaining are Hispanic and other ethnicities;
- One-quarter of home care workers are unmarried and living with children;
- Forty-one percent of home care workers have a high school diploma or GED;
- Thirty-eight percent attended college; this is slightly higher in the MR/DD workforce; and,
- Twenty-four percent of home care workers are foreign-born.

[22] Kaye, 2006; Institute of Medicine, 1996.
[23] Kaye, 2006.
[24] Institute of Medicine, 1996.
[25] Wiener, 2004.
[26] PHI, 2003; Penning, 2002.
[27] Baugham, 2006; Bureau of Labor Statistics; PHI, Winter 2004.
[28] US DHHS, 2004; PHI, June 2003; PHI Fact Sheet 2006; Stone, 2001.

Within this group, generalized by the broad title of "direct service workforce," there are numerous occupational titles. People in this workforce are also distinguished by characteristics of their jobs and employment and the needs and goals of the participants they serve. For example, a Personal Assistant employed by a consumer in a Consumer-Directed-Personal Assistance Services (CD-PAS) waiver program may provide direct services to one consumer. This contrasts with the Direct Support Professional (DSP) working in a residential home with multiple adults with developmental disabilities who is employed by a non-profit agency and reports to a supervisor and coordinates services across a staff of co-workers and shifts. Differences in the jobs are also influenced by the regulations, training requirements, and reimbursements that govern the programs and agencies. For example, a DSP may have employment and program requirements for specialized training, and be scheduled and compensated for training. A CD-PAS personal assistant may have no mandatory training requirement. A Certified Nursing Assistant needs to have 75 hours of certified training (OBRA 1987, some states require 150 hours) and participation in the state registry. Home Health Aides working in Medicare programs must complete specialized training and testing.[29]

Characteristics of the Jobs

National statistics provide insights into the jobs and factors that can influence their employment environment:[30]

- Median starting wage: $7.96/hour;
- Median hourly wage: $9.56/hour across all direct care occupations;
- More than 50% of the jobs are part-time;
- Two out of five home care workers lack health insurance coverage;
- No centralized workplace: dispersed work assignments, with workers having greater autonomy and isolation, with limited opportunities for workers to meet with co-workers and supervisors between home visits;
- Payment to workers is structured by fee-for-service rates based on a participant's service hours;
- Direct care work has one of the highest workplace injury rates;
- Training requirements and the provision of training and educational programs on the job varies from none for some consumer-directed, informal, and caretaker/housekeeping jobs to 175 hours of accredited training for home health aides in some states;
- Job preparation, continuing education, and training opportunities are very limited or non-existent for some of the job titles;
- Advancement opportunities are limited and non-existent for some jobs and workers;
- Direct care workers often do not feel valued or respected by their employers and supervisors;
- Despite having more interaction with participants than many other service providers, workers are often excluded from decision-making involving care/support planning;

[29] Bureau of Labor Statistics, 2007.
[30] AARP, 2005; Baughman, 2007; Bureau of Labor Statistics, 2005; Lakin, 2003; PHI Fact Sheet, 2006; Stone and Weiner, 2001; Weiner, 2004; Stone, 2004; Yamada, 2002.

- Direct care work is physically and emotionally demanding and working conditions are often unfavorable;
- Turnover rates are 40-75%, with the first three months post-hire being highest; and,
- Short staffing caused by vacancies and turnover puts a burden on staff.

Although informal (unpaid) caregivers provide a high level of coverage for HCBS participants, the demand across all consumer groups and programs to recruit and employ (paid) direct service workers is increasing.[31] It is predicted that smaller families and more work opportunities for women will reduce the pool of informal caregivers and add to the demand for formal/employed caregivers.[32] This shift, coupled with the rising demand from the aging population, is increasing the need for service providers, especially the direct service workers: the personal and home care aides, direct support assistants, and home health aides.

- Home Health Aide is projected to be the single fastest growing occupation in the U.S. between 2004 and 2014 with a 56% increase projected;[33]
- Personal and Home Care Aide was the fourth-fastest growing occupation in 2006 and is projected to rise 41% through 2014.[34]

HCBS Program Quality and Workforce Performance

HCBS Program Quality

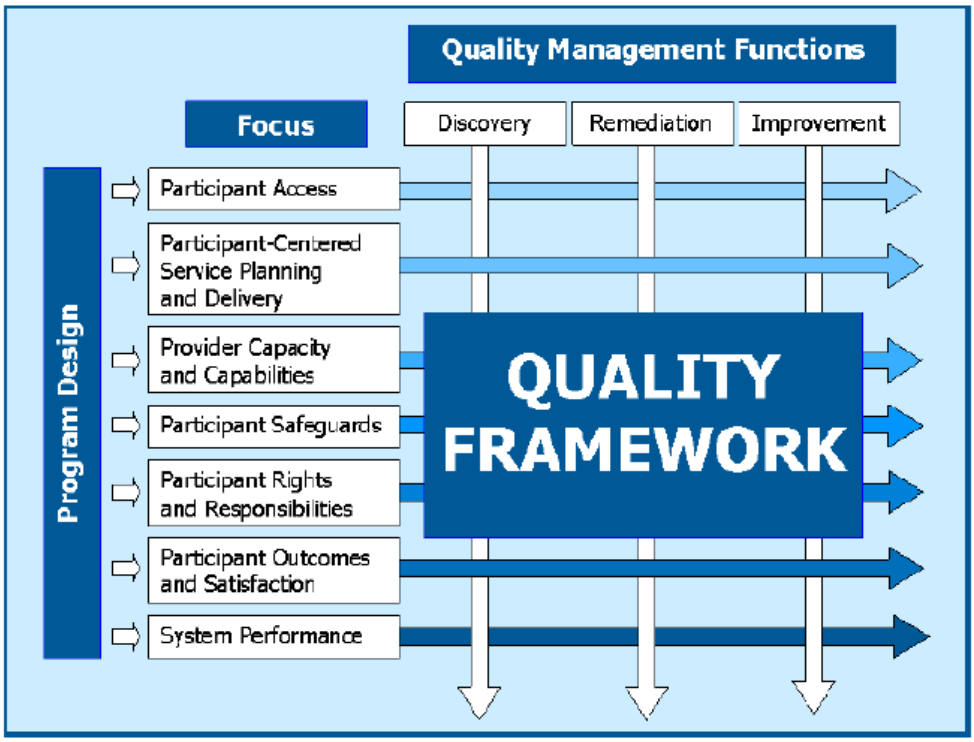
Federal waiver policy places lead responsibility on the state Medicaid agency and HCBS program office to monitor and improve the quality of HCBS waiver programs. This is a significant and challenging role given the dynamics of the service delivery system and the complexity of the programs. The direct service workforce shortages and the underlying system issues that impact quality can undermine and destabilize the ability of HCBS programs to effectively meet the needs of program participants. The workforce issues and their potential influence on participant outcomes require deliberate action. To meet the challenge, state HCBS program managers will need to initiate, be involved in, and possibly lead the effort to address their direct service workforce challenges. A major purpose of this paper is to highlight the information, tools, recommended approaches, research on promising practices, and evidence-based practices and guidance that are available. A summary of the initiatives being implemented to improve workforce recruitment and retention is presented in the next section of this paper and in the accompanying papers in this Compendium.

The Quality Framework was developed by CMS as a tool for states to design their HCBS programs to support desired outcomes in seven focus areas and to develop systems for monitoring performance with respect to each of these areas. Frame 2 shows how program features should be designed to support each focus area, and that the role of quality management is to assure that

[31] Baugham, 2006.
[32] Noelker, 2001; Weiner, 2004.
[33] Bureau of Labor Statistics, 2007.
[34] Ibid.

problems are identified (discovery), individual problems are fixed (remediation), and that system solutions are found (improvement) to prevent the recurrence of problems in each focus area.

Frame 2: HCBS Quality Framework



From the Centers for Medicare and Medicaid Services' HCBS Quality Framework, http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf, retrieved February 26, 2008.

The Framework, while not required by CMS, has been used and adapted by states as a construct for designing their programs and creating quality management systems to assess performance on an ongoing basis. **Quality management** gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes and recommends a process involving these functions [35]:

1. **Discovery:** The deliberate and systematic processes of finding out how the program is operating and using this information to improve program performance;
2. **Remediation:** The process of taking action to remedy a specific problem (at the individual level or the system level) bringing identified areas of weak performance up to minimum standards by understanding and correcting the causes, and preventing future similar problems;
3. **Improvement:** Improving system design flaws that caused or allowed weak performance.

[35] Booth, et al, 2005.

In the following sections, we apply the schema of the Quality Framework to identify quality factors within the workforce and potential opportunities for states to address them.

Workforce Performance

The literature is clear and consistent about the problems in the long-term care workforce that need to be addressed[36]:

1. A shortage or workers
2. High turnover rates
3. Vacancy rates
4. Difficulty recruiting and retaining workers
5. Low levels of training
6. Low status of the jobs
7. Low satisfaction levels

These are problems related to the performance of the workforce that have a direct impact on services and HCBS outcomes. Frame 3 identifies these workforce performance problems as intervening factors in the CMS Quality Framework, and shows the significant influence these problems can have on outcomes and quality. Traditionally state waiver programs have limited analysis of the workforce to the Provider Capacity and Capabilities focus. However, the impact of these workforce problems and underlying issues is not limited to this one area. The problems associated with the workforce influences all the focus areas.

[36] PHI, 2003; Stone et al, 2001; Stone et al, 2004; Weiner et al, 2004; US DHHS, 2004.

Frame 3: Quality Outcomes and Direct Service Workforce Influences

HCBS Focus Areas	Workforce Performance	Quality Outcomes
Participant Access	Quality workers available.	***High Quality:*** Individuals have access to home and community-based services and supports in their communities.
	High turnover, vacancy, workers with limited training.	***Low Quality:*** No services. Workers are not available so participants do not have the support services needed to maintain health and safety in their home/community setting.
Participant Centered Service Planning and Deliver	Agencies train workers; quality workers available; consistent workers; good communications with workers.	***High Quality:*** Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences, and decisions concerning his/her life in the community.
	High turnover, vacancy, workers with limited training.	***Low Quality:*** Poor quality service. Direct service workers change frequently, do not know participant and are not trained, and do not have agency procedures to follow to remedy the issues fast enough. Participant dissatisfied and needs are not being met.
Provider Capacity and Capabilities	Agencies offer competitive salaries and benefits; agencies hire, train, and support workers to deliver quality services; agency has quality management program.	***High Quality:*** There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
	Jobs not competitive and go unfilled; dissatisfied workers; high turnover.	***Low Quality:*** Poor quality services. Agencies are not able to recruit workers and have a revolving door of workers. Training and support is limited and workers are dissatisfied, have limited training and don't stay long. Those who stay struggle or use their own resources to accommodate the situation.
Participant Safeguards	Agency conducts quality recruiting, screening and hiring process; hires quality people; reduced turnover supports skill development, communications and trust; consistent scheduling supports person-centered practices.	***High Quality:*** Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
	Problems filling direct service positions, limited applicant pool and quick hires; limited training; high turnover.	***Low Quality:*** Participant unsure and doesn't feel they can trust workers. Frequent changes in worker means inconsistent direct service support, resulting in workers not being there long enough to get to know them.
Participant Rights and Responsibilities	Reduced turnover supports skill development, communications and trust; consistent scheduling supports person-centered practices.	***High Quality:*** Participants receive support to exercise their rights and in accepting personal responsibilities.
	Problems filling direct service positions; limited applicant pool and quick hires, limited training, high turnover.	***Low Quality:*** Participant unsure and doesn't feel they can trust workers. Frequent changes in worker resulting in inconsistent direct service support. Workers aren't there long enough to get to know them.
Participant Outcomes and Satisfaction	Agency workforce meets service needs; agency gathers feedback from participants and workers; agency recognizes workers; agency/workers are recommended by participant.	***High Quality:*** Participants are satisfied with their services and achieve desired outcomes.
	Low agency and staff moral; agency unable to keep workers on staff and is losing the long-time staff, too.	***Low Quality:*** Participants dissatisfied and service needs partially met or not met. Problems, complaints, looking for alternative support service options.

System Performance	System supports agency and worker needs to sustain high quality services; programs recognize quality providers publicly and in meaningful ways; quality management programs in place and supported as mutually beneficial to system, program and workforce quality.	***High Quality:*** The system supports participants efficiently and effectively and constantly strives to improve quality.
	Poor quality outcomes and dysfunction with programs persist; costs of problems deplete resources and diminish program support and programs.	***Low Quality:*** Agencies go out of business. Poor agencies struggle and stay in business doing the best they can. Direct service work is seen as a poor quality job and the workers are not valued. Participants, advocates are dissatisfied with the system and seek alternative strategies for getting needs met.

Workforce Quality Framework

The long-term care and workforce literature provides a growing evidence base to assess the worker influence and impact on service outcomes and quality. Many sources view workforce problems in broad terms, such as workforce supply and demand issues or challenges in workforce recruitment and retention. These broad assessments, while important indicators of quality, offer little in the way of understanding specific steps that can be taken to improve the situation.

Following the logic of the CMS Quality Framework, three focus areas can be identified for designing a quality workforce. Each focus area can also be described in terms of desired outcomes and the factors and strategies that influence the achievement of quality outcomes. Frame 4 uses the following focus areas as the underpinnings for designing a quality workforce:

1. Job and Workplace Quality
2. Worker Qualifications
3. Workforce Development

Frame 4: Direct Service Workforce Quality Framework

Quality Workforce Focus Areas	Desired Outcome	Workforce Quality Factors
Job and Workplace Quality	The specifications, terms and conditions of the jobs competitively attract and retain qualified workers and contribute to workforce development and quality outcomes. The work environment supports and develops the workers to meet job responsibilities, personal and professional performance goals and standards of excellence, organizational mission, and quality management objectives.	• Wages • Benefits • Work hours • Training and career advancement opportunities • Opportunities to participate in decision making • Employee support programs and links to community resources • Supervisory practices • Management policies and practices

Quality Workforce Focus Areas	Desired Outcome	Workforce Quality Factors
Worker Qualifications	The workers possess the skills, qualifications, abilities, characteristics, and motivation to effectively meet participant, provider, professional, and personal needs and quality outcomes.	• Commitment to caring • Support resources • Training and education, continuing education and Professional development
Workforce Development	The capacity and availability of workers in the community is sufficient to meet participant, provider and community needs over time. Capacity includes committed, stable pool of frontline workers with the knowledge, skills, abilities, and characteristics to provide quality services to people and programs in long-term care.	• Recruitment resources and registry management • Education and training: policies, standards and resources • Public awareness and support • Stakeholder partnerships

State HCBS program offices can use the Workforce Quality Framework as a tool to:

- Learn about how the direct service workforce can influence program and participant quality outcomes;
- Start a discovery process to identify workforce related issues in their programs;
- Review the research literature to identify initiatives that can inform their actions;
- Guide the state's initiatives to select a workforce priority as a quality assurance or quality improvement activity; and,
- Coordinate initiatives with stakeholders to identify workforce issues and establish a quality improvement plan or to revise an existing plan to incorporate workforce quality.

Initiatives for Improving Recruitment, Retention, and Workforce Quality

This section provides a summary of the public and private initiatives implemented to manage and improve direct service worker recruitment, retention, and quality. The list is organized by the workforce quality factors that correspond to areas where initiatives have been implemented, and in some cases evaluated. Topics are discussed in general order of importance based on the relative ranking by employees and evidence of impact on recruitment and retention.

1. Wages
2. Work Hours
3. Benefits
4. Supervisory Practices
5. Opportunities to Participate in Decision-Making
6. Training and Career Advancement Opportunities
7. Employee Support Programs and Links to Community Resources
8. Management Policies and Practices
9. Recruitment Practices
10. Stakeholder Partnerships

Resources used to compile this summary are referenced in the bibliography. In addition, Appendix A provides an expanded list of organizations and experts studying the long-term care direct service workforce. Appendix B provides a list of states where these initiatives are being implemented. Published literature and websites provide extensive information about the workforce, the recruitment and retention problems, and initiatives being implemented to address the challenges. Evidence-based findings from applied research and impact studies are limited, particularly those focused on home care workers. However, findings and reports identify promising practices and provide valuable information about options and influences. Some studies on the retention of nursing assistants, the paraprofessional workforce employed by nursing homes, are cited as they serve as sources for affirming the link between direct care workers and quality. The following summaries and source documents provide an overview of options and specific recommendations for improving practices that support quality workforce and quality service outcomes.

1. Wages

Studies identify wages as a major factor in the recruitment and retention of direct service workers in all settings. Wage rate increases are associated with reduced turnover/increased retention. Some studies found employees report that increased wages positively impact job satisfaction and reduce their intent to leave jobs. The findings, while showing an overall positive impact on wage increases, offer some cautionary observations. For example, the amount of the increase and/or the wage level at which an impact occurred varied. Some studies combined wages with benefits. Others could not distinguish the impact of wage increases from unrelated events occurring during the study period. Findings from these studies can guide organizations and states about factors to take into consideration when designing and implementing wage changes. For example, Dorie Seavey (2006) states that:

1. In most states worker wage rates are determined by employers and not by the state. Medicaid reimbursement rates paid to the agencies are structured by the states and influence an agency's ability to increase wages.
2. Through initiatives supported by state, local, and advocacy groups, seven major strategies have been documented:
    a. Wage pass-through legislation requires provider agencies to use specified dollars or portions of enhanced funding to increase worker wages. Wage floor legislation sets a minimum wage rate for designated workers. Evidence to date on the impact of such legislation is limited, and the legislated actions have generally been found not to correct for "defects in most state reimbursement methods, namely the failure to provide for a built in cost of living adjustment."
    b. Rate enhancements linked to provider performance goals or targets. States have programs providing enhanced rates to agencies that meet defined programmatic, financial, or performance goals related to improved worker retention or quality outcomes. Enhanced rates can be applied to wages or benefits.
    c. New methods for rebasing and updating reimbursement rates for HCBS to account for actual costs and/or competitive market rates. Unlike wage pass-through methods that do not account for employer costs or increases over time, this initiative establishes a reimbursement rate that factors administrative costs into the rate (supervision, benefits,

training, wages, administration, etc.) and sets up a plan to assess cost increases from year to year. Agency rate-setting methods, however, do not themselves increase worker wages, unless specified (see pass-through and wage floor, defined above, section a) since provider agencies typically determine worker wage rates.

d. Litigation against state Medicaid agencies. Medicaid participants and their advocates have filed federal lawsuits challenging state Medicaid HCBS payment policies and rates. Claims allege that Medicaid payment rates are not sufficient and that they set worker wage rates too low to recruit and retain support workers, and therefore, violate federal Medicaid law ensuring access. Similarly, provider associations have challenged state reimbursement rates, claiming that rates do not adequately support their full costs, including the recruitment and retention of a qualified worker.

e. Collective bargaining by workers. The formation of a public authority model and union representation for workers has been responsible for significant wage and benefit increases for In-Home Support Service workers in California, Washington, Oregon, and Michigan. Wage and benefit gains, although less significant, have also been reported in other states as a result of union representation and the resulting collective bargaining conducted with employers and state programs.

f. Living wage ordinances and minimum wage improvements. Wage increases for low-wage workers (including direct services workers) have been achieved through city, county, and/or statewide initiatives. These initiatives have typically targeted private, for-profit employers, and therefore, may not apply to workers employed by non-profit organizations, consumers, or their family members.

Topic Reference Sources: Wages

Baughman et al., 2007; Dawson, 2007; Kaye et al., 2006; Harmuth, 2005; Hewitt et al., 2006; Howes 2002; Howes, 2005; Kadis, 2003; Mickus et al., 2004; PHI, 2003; Seavey et al., 2006; U.S. Department of Labor, 2008; U.S.DHHS/HRSA, 2004; U.S. DHHS, May 2004; Wong, PAS, 2007; Yamada et al., 2006.

2. Work Hours

Most personal and home care workers are part-time and are employed in temporary, per-diem jobs. This status correlates directly to their wage and income rates and eligibility for employer benefits. Some workers are employed by multiple providers; they are doing other jobs or direct care work for multiple agencies/consumers. The per-diem as-needed schedule mirrors the payment structure of personal and home care services that are paid in a fee-for-service payment plan that matches the participants' eligibility and service plans. Positions with residential care and assisted living facilities have more regular schedules to cover the full hours of support needed for 24/7 operations. The variable and often limited hours for home care personal care, on the other hand, are dictated by a participant's approved hours. These hours may change, such as when a participant is hospitalized and the agency/worker is not paid. While some workers like the flexibility and variety these jobs offer, for others the income from these hours is not reliable and, if given the option, these workers would choose to work more hours. These temporary jobs are generally not eligible for sick or vacation time or other benefits.

The low income for many HCBS workers is a direct result of their jobs being limited to part-time hours and the low hourly wage rate. The number of hours worked per week and the stability of the hours varies within this workforce based on the program, for example working with persons who have intellectual disabilities or developmental disabilities vs. older persons and the employers' policies. The low level of job security is further aggravated by payment systems and employer policies that limit payment to the number of hours worked (no client – no hours – no pay). The part-time hours are both a positive and negative factor for workers' provider agencies. The flexible schedule is identified by workers to be a positive characteristic of the job, but reports also indicate that insecure and inconsistent work hours and low income can cause dissatisfaction for workers and lead to turnover. For employers, the part-time temporary status limits payroll costs to match reimbursement schedules. The flexible schedule is offered to workers as a beneficial characteristic of the job, but the agency can experience significant challenges with scheduling when workers use this flexibility and decline assignments. Inconsistent staffing due to uncovered hours or worker turnover has a potential impact on participants and the quality of service. A "guaranteed hours" program can be an effective strategy to ensure stable hours and income for direct services workers while also improving workers' consistency and quality of care.

Topic Reference Sources: Work Hours
Dawson, 2007; Farrell et al., June 2006; Howes, June, 2006; PHI Workforce Strategies, #4; Stone et al., 2001.

3. Benefits

The most frequently discussed employer-based benefit is health insurance. Other benefits associated with employment that are either limited, not offered, not available due to part-time status, or not-affordable to direct service workers include: paid sick time, paid vacation time or personal time, uniforms, travel costs, life insurance, training and development, and retirement savings plans. These benefits, when available, are based on employers' choice, and eligibility is defined by employer policies. Workers' compensation insurance and unemployment insurance are regulated by the states and apply to most employers/employees. The attached discussion paper, the third paper within this Compendium, *Health Coverage for Direct Care Workers, Emerging Strategies,* provides a comprehensive discussion of the initiatives to study the impact of having and not having an employer-sponsored health insurance benefit.

Lack of benefits is reported to discourage people from applying for direct service jobs and for staying in the jobs. Rates of uninsured workers are higher in home care, compared to facility-based care jobs, and are highest in workers who are not employed by agencies. Health insurance coverage has been the subject of many studies, with findings showing significant rates of uninsured and under-insured among direct service workers and issue of access, affordability, and the lack of coverage options. Workers identify health insurance as a key factor in recruitment and retention decisions. Research reports a strong positive link between health insurance benefits and worker retention. State-based and national efforts are underway to study and address this problem.

Topic Reference Sources: Benefits
Dawson, 2007; Feldman, 1990; Health Care for Health Care Workers, 2007; Hewitt, 2001; Lakin, 2003; PHI, June 2003; PHI, April 2006.

4. Supervisory Practices

Studies assessing the value and impact of supervisory practices have focused on relationships, communication, satisfaction, and association with turnover/retention. When workers are surveyed to evaluate the work environment and their level of satisfaction with a job, they are often evaluating the quality of their supervisor. Supervisors are critical to effective hiring, training, and retention, and play a critical role in why people leave their jobs. Employee recognition activities and programs are described within supervisory practices, management policies and practices, and employee support programs. Workers report being more satisfied and more likely to remain in their jobs if they feel personally responsible for their work, and if they receive on-going feedback from their supervisors. Feeling personally responsible is an indicator of respect. Respect is also defined by workers as having discretion about how they do their work. One study cites that trained supervisors are more likely to set expectations and provide feedback to staff about performance. Organizational/cultural change programs include initiatives that address supervisory practices, but these are usually implemented in the nursing facilities. "The underlying hypothesis is that extrinsic rewards (wages) may draw individuals into an organization to work, it is the satisfaction that they receive while on the job that causes them to remain."[37]

Topic Reference Sources: Supervisory Practices
Brannon et al., 2002; BJBC, Respectful Relationships; Dawson, 2007; Feldman et al., 1990; Hewitt et al., 2007; McDonald et al., 2007; PHI, 2003; PHI, 2005; Stone, December 2003; Taylor et al., 2007; U.S. DHHS Recent Findings, May 2004.

5. Opportunities to Participate in Decision-Making

Worker involvement in workplace and care planning discussions and decision-making that affects them and their clients has only recently been acknowledged as an important factor for the workers and their clients/consumers. Some of these opportunities include: self-managed teams in nursing homes where nurse aides provide input into resident care plans; participation on leadership or management teams and/or workplace committees or task forces; or participation on state and national worker associations, unions, and public authorities (CA, MI, OR, WA). Other initiatives described in the literature include: care coordination and team planning; peer mentoring, interactive models of supervision such as the coaching, culture change efforts to engage workers; patient-directed initiatives that include steps to engage workers in order to improve job satisfaction and patient-directed models of care; training programs that include skill development and career development; and, leadership and advocacy activities where workers represent the workforce with policy makers and the public.

Workers report that a lack of respect and recognition for the role they play in enhancing participants' care and quality of life is a major source of dissatisfaction. Nursing facility studies have shown that relationship building, support, and recognition activities have a positive correlation with worker retention. Studies point out that direct workers have more contact with participants than other providers, and are responsible for eight out of every ten caregiving hours. Direct care workers are

[37] Bower, 2001.

more likely to know the client, and to observe changes and issues that should be addressed in care planning and monitoring. A rise in worker associations in the country over the past five years has helped to raise awareness and inform policy decisions on issues of importance to the workers, providers, and consumers.

Topic Reference Sources: Opportunities to Participate in Decision-Making
Barry et al., 2005; Dawson, 2007; Noelker et al., 2004; PHI, June 2003; PHI/CHA, 2003; PHI Workforce Tools, 2004; PHI, 2007; Stone et al., 2001; U.S. Department of Health and Human Services, May 2004; Yeats et al., 2007.

6. Training and Career Advancement Opportunities

Training for workers varies according to job title and is different from state to state, with the exception of Medicare Home Health Aides and facility-based nursing assistants, which are governed by federal requirements. There are no national workforce standards and only a few states have any training requirements for HCBS direct service workers. The training that exists tends to be in the form of orientation and in-service programs with employers deciding on scope and frequency.

Even with the expansion of HCBS programs, there have not been comparable advances in professional worker training programs. Some stakeholders and analysts advocate for standardized competency-based training. In contrast, consumer-directed participants object to standardized training as a perpetuation of the medical care model. Lack of development/training opportunities in these jobs is cited as a key factor in workers' dissatisfaction. Lack of resources and worker turnover make employers reluctant to invest in worker training. PHI reports that employer-based educational programs improve direct service worker retention. The authors recommend a combination of technical and relationship/soft skills classes (communication and interpersonal skills) and a plan to systematically develop and offer training. Employer-based and statewide training plans, with career ladders, opportunities for advancement, and wage increases can enhance job satisfaction by promoting the value and recognition of workers. Some states are developing new job categories, expanding job duties, providing training for existing titles, and are developing comprehensive career ladders as part of a workforce development strategy.

Topic Reference Sources: Training and Career Advancement Opportunities
Dawson, June 2007; Hewitt et al., 2007; McDonald, February 2005; PHI Workforce Strategies, May 2003 and January 2005; PHI, June 2003; Stone et al., 2001; U.S. Department of Health and Human Services, May 2004; Wiener et al., 2004.

7. Employee Support Programs and Links to Community Resources

Providers of all sizes and in all settings have examples of interventions used to support their direct service staff and address needs that influence attendance and retention. These include programs such as mental health services, domestic violence counseling, no-interest loans to cover emergencies, emergency housing support, transportation support, child care stipends or subsidies, reduced cost memberships (from emergency road service to fitness centers), referral services for child care, and employee recognition activities and events. These supports include information and referral services to programs and resources in the community.

Numerous studies reference the limited financial resources and support structures available to direct service workers when emergencies disrupt their lives and affect their capacity to attend to work responsibilities. Employee support programs can help workers to overcome barriers to work (*e.g.,* transportation and child care issues) while also improving employee satisfaction and retention. They can also enhance recruitment by building positive relationships in the community, since existing employees provide valuable word-of-mouth referrals.

Topic Reference Sources: Support Programs and Links to Community Resources
Stone et al., 2001; PHI, 2003; PHI/CHA 2003; U.S. DHHS, May, 2004.

8. Management Policies and Practices

Some employers implement training, in-service programs, and workforce development activities in response to regulatory requirements, while others see their value in saving costs through reduced turnover and improved employee performance. Recruitment and retention initiatives often involve changes in employer policies and/or program standards/requirements.

Nursing facilities and facility-based settings have been the focus of regulatory changes (e.g., training requirement for nursing assistants) and are demonstrating organizational changes, such as culture change strategies. Demonstrations in HCBS programs stress the importance of leadership and support—both financial and programmatic—within organizations. Evaluations of these short-term programs are positive and they cite the need to "institutionalize" training, employee support, and supervisory practices beyond the period of the demonstrations if they are to benefit workers and improve retention. Studies distinguish initiatives, like health insurance benefits, that require policy changes and financial commitments from those that involve organizational behaviors (e.g., including programs to involve workers in decision-making) that are less costly to implement. Incentive programs offered by state administrators designed to encourage employers to implement workforce development and support programs are showing positive outcomes.

Topic Reference Sources: Management Policies and Practices
Better Jobs Better Care, 2004, 2007; Dawson, 2007; Harmuth, June 2006; Hewitt, 2007; Misiorski et al., 2005; PHI/CHA, 2003; PHI, June 2003; Stone et al., 2001.

9. Recruitment Practices

Studies on direct service worker recruitment offer detailed information on the design of programs and assessments of their effectiveness. The literature addresses methods of marketing, recruitment, outreach, expanded applicant pools, screening, and interviewing. Studies calculate the return on investment of these strategies for reducing the high costs of worker turnover. Studies describe programs for involving direct service staff in the screening and hiring process and the value of staff training for those conducting the process. Descriptions in the studies include creative alternative methods for recruiting, like web-based services, and approaches to locating and assessing under-utilized applicant pools, such as older workers, family caregivers, people transitioning off of welfare, and people with disabilities. Studies identified staff recruitment as a serious challenge for organizations. If done through a comprehensive and well managed process, the recruitment process

itself can also contribute to retention. Workers recruited through these programs have a good understanding of the job and encounter fewer unmet expectations that can lead to job dissatisfaction, resignations, and terminations. Training direct service staff to be involved in the hiring process also increases hiring and retention outcomes. Realistic Job Preview, a technique for introducing the job expectations to applicants, has been demonstrated to be effective for reaching select groups and improving retention. Having a reputation as a good employer also attracts workers and increases the likelihood of employees serving as referral sources for new workers. One study reported that the number of months a new hire stays in an organization is approximately 24% higher when inside sources are used.

Topic Reference Sources: Recruitment Practices
Bryant, April 2007; Hewitt et al., 2007; PHI, Workforce Tool, Fall 2002; Seavey, October 2004: Stone, August 2004; University of Minnesota, 2006; Wanous, 1992.

10. Stakeholder Partnerships

The literature describes examples of groups that have been organized to address the direct service workforce shortages and recruitment and retention issues through demonstration projects, policy development, and implementation initiatives. These include public authorities, quality councils, sector initiatives, workforce development groups, workforce coalitions, and collaboratives. Some of these groups were formed in response to policy and others have been legislatively created.

Stakeholder partnerships play important roles in bringing information and divergent views and perspectives together with the hope of developing a consensus strategy. The approaches are varied and include study initiatives that have collected workforce data and prepared reports and presentations. Many states have multi-stakeholder coalitions that involve key decision-makers who have developed consensus strategies, identified priorities, and made recommendations for action or to implement programs: these include wage increases, changes to training programs or standards, and development and/or change of worker state registries. Project reports and studies conclude that a collaborative process is useful for raising awareness and identifying approaches and options for taking on challenging issues that cross stakeholder groups, and it is a necessary step for advancing solutions to workforce issues. While many of these groups were convened during a demonstration project, findings highlight the need to continue their involvement in an ongoing basis.

Topic Reference Sources: Stakeholder Partnerships
Better Jobs Better Care, October 2003; Farrell et al., March-April 2007; Fishman et al., May, 2004; Harris-Kojetin et al., 2004; Heinritz-Canterbury, 2002; Karidis, March-April, 2007; Mills, 2007; PHI Michigan; Salsberg, 2003; Stone et al., 2001; Stone et al., 2003; U.S. Department of Health and Human Services, May 2004 and February 2004.

Conclusions

Having an adequate supply of qualified direct service workers is critical to the success of HCBS programs. All of the desired outcomes identified in the HCBS Quality Framework are influenced directly or indirectly by the performance of direct service workers. Factors that contribute

to the performance of workers specifically, and the workforce in general, include: the quality of the jobs and the work environment of workers; the training and qualifications of workers; and, external initiatives to validate the key role played by direct service workers in the long-term care system and to support a stable and qualified workforce.

HCBS program managers are required to develop quality management strategies to monitor and improve the quality of services provided to program participants. Historically, these strategies have focused on policies and procedures related to the design, operation, and administration of the HCBS programs. Increasingly, HCBS program managers have realized the importance of engaging policy makers in other state departments, stakeholders, and others in broader discussions related to the sustainability of an adequate supply of qualified workers. Issues related to reimbursement, wage rates, health insurance, training, participatory management, and workforce development are issues of concern to HCBS program managers since they impact their program operations and participant outcomes. HCBS quality management strategies need to include and address strategies of workforce quality.

HCBS waiver programs can play important roles in fostering and focusing statewide attention to workforce issues and their relationship to quality. Specifically program managers can:

- Reinforce that workforce and service quality are inter-dependant;
- Participate in state workforce development initiatives and request that HCBS workforce shortages and quality be state priorities;
- Convene the long-term care and workforce development stakeholders to identify opportunities for cross-system collaboration aimed at improving workforce quality;
- Learn from others, such as hospitals and nursing homes, which are encountering similar problems. What's been learned? Is setting up standards and regulatory oversight the way to go? How has the state addressed workforce quality within the Quality Improvement Organizations (QIOs) and Quality First initiatives?
- Engage providers in assessing the scope of the problem and potential solutions;
- Promote policies to support workforce development and sustainability on a statewide and provider level;
- Set expectations for provider agencies to incorporate workforce quality factors in their quality improvement plans and work together to address common concerns and cross-provider issues;
- Develop incentives that will "raise the bar" for provider performance on workforce development;
- Encourage providers and their representative associations to engage with regional and local workforce development initiatives to advocate for support and coordinated training for the HCBS service providers and to expand career opportunities for the direct service workforce; and,
- Find the champions in the workforce and service provider community and engage them in the quality and workforce development vision, policy improvement strategies, and the implementation of quality workplace initiatives.

Appendix A. Workforce Initiatives Resource List

This list was adapted from "Personal Assistance Services and Direct-Support Workforce: A Literature Review" by PHI, June 12, 2003. Updated February 2008

ANCOR (American Network of Community Options and Resources) is a nonprofit trade association representing private providers who provide supports and services to people with disabilities.
www.ancor.org

Association of Developmental Disabilities Providers offers proactive, statewide leadership to improve the social, political, and economic well-being of community organizations that provide services and support to people with developmental disabilities and their families.
www.addp.org

Better Jobs Better Care is a 4-year $15.5 million research and demonstration program, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. The program seeks to achieve changes in long-term care policy and practice that help to reduce high vacancy and turnover rates among direct care staff across the spectrum of long-term care settings and contribute to improved workforce quality. BJBC gives detailed information on all their research and demonstration projects. They also have several newsletters and resources available to the public.
www.bjbc.org

CareCareers.net provides displaced workers with caregiving career opportunities in long-term care.
www.carecareers.net

Center for an Accessible Society is a national organization designed to focus public attention on disability and independent living issues by disseminating information developed through NIDRR-funded research to promote independent living.
www.accessiblesociety.org/about.htm

Center for Health Care Strategies (CHCS), Inc.'s Community Integration Initiative is a major initiative tied to the US Supreme Court's decision in the 1999 Olmstead v L.C. case, awarded planning grants to seven states to improve their community-based long-term care services. The site includes several papers and resources on the community-based workforce.
www.chcs.org

Centers for Medicare and Medicaid Services is the federal agency within the US Department of Health and Human Services that houses the Medicare and Medicaid programs. These programs benefit about 75 million Americans. Under the President's New Freedom Initiative, CMS sponsored numerous grants, demonstrations, and contracts, including a Resource Center, to improve direct service worker recruitment, retention and workforce quality. See NationalDirect Service Workforce Resource Center provides comprehensive information about the community-based direct service

workforce at www.dswresourcecenter.org. The CMS web site extensive has resources and information for consumers about disability and aging issues.
www.cms.hhs.gov/medicaid/consumerag.asp

Center for The **Center for Personal Assistance Services** provides research, training, dissemination and technical assistance on issues of personal assistance services (PAS) in the United States: The relationship between formal and informal PAS and caregiving support, and the role of assistive technology (AT) in complementing PAS; Policies and programs, barriers and new models for PAS in the home and community; PAS Workforce development, recruitment, retention, and benefits; and Workplace models of formal and informal PAS and AT at work.
www.pascenter.org/

Direct Care Alliance, Inc. is a coalition of long-term care consumers, workers, and providers working for reforms in both public policy and workforce practices to ensure a stable, valued, and well-trained direct-care workforce.
www.directcarealliance.org

DisabilityInfo.gov is the online resources for President George W. Bush's New Freedom Initiative. It is a comprehensive online resource specifically designed to provide people with disabilities with the information they need to know quickly. The site provides access to disability-related information and programs available across the government on numerous subjects, including civil rights, education, employment, housing, health, income support, technology, transportation, and community life.
www.disabilityinfo.gov

Empowering Caregivers™ is a site devoted to caregiving, offering information on caregiving practices and resources, message boards, and newsletters.
www.care-givers.com

Family Caregiver Alliance works to address the needs of families and friends providing long-term care by developing services, advocating for public and private support, conducting research, and educating the public. Core services include consultation on long-term care planning, service linkage, legal and PAS and financial consultation, respite services, counseling, and education.
www.caregiver.org

Health Care for Health Care Workers is a national campaign to expand quality health coverage for direct-care workers who are a lifeline for millions of Americans. "Ensuring that direct-care workers have access to health coverage is the right thing to do."
www.coverageiscritical.org

Home and Community-Based Services Resource Network is a partnership between the Assistant Secretary for Planning and Evaluation (ASPE), Centers for Medicare & Medicaid Services (CMS), state agencies that purchase and manage HCBS services, and consumers. The mission of the Resource Network is to work with states, the disability and aging communities, and others who are

committed to high-quality consumer-directed services in integrated settings through cost-effective delivery models.
www.hcbs.org

Human Services Research Institute is active in its efforts to build the capacity of the direct-care workforce and shape a competent direct-service workforce with the skills, knowledge, and values that will help people lead self-determined lives. Toward this end, HSRI staff are engaged in a variety of demonstration, research, and technical activities to help government and human service employers ensure a robust workforce.
www.hsri.org

Independent Living Research Utilization is a national center for information, training, research, and technical assistance in independent living. Since ILRU was established in 1977, it has developed a variety of strategies for collecting, synthesizing, and disseminating information related to the field of independent living.
www.ilru.org

Institute for the Future of Aging Services is a policy research center housed within the American Association of Homes and Services for the Aging whose aim is to help ensure that the needs of older people are met.
www.futureofaging.org

International Center for Disability Resources on the Internet helps caregivers find resources and support worldwide.
www.icdri.org

Iowa Caregiver's Association is a statewide professional association for Certified Nurse Assistants, Home Care Aides, Patient Care Technicians, and other direct care/support workers.
www.iowacaregivers.org

Maine Personal Assistance Services Association (Maine PASA) is committed to the development of all professional personal assistance workers in order to enhance the quality of life and independence of all Maine people.
www.mainepasa.org

Muskie School of Public Service is the research school for the University of Southern Maine. Through its teaching, research and public service, the School is educating leaders, informing policy and practice, and strengthening civic life. In all its activities, the School carries on the values, ideals and contributions of Edmund S. Muskie as exemplified in his long and distinguished career as a public servant for Maine and the nation.
https://muskie.usm.maine.edu

National Alliance for Caregiving is a national organization that disseminates research and information for family caregivers and the professionals who support them.

www.caregiving.org

National Alliance of Direct Support Professionals is a coalition of organizations and individuals committed to strengthening the direct-support workforce.
www.nadsp.org

National Association for Area Agencies on Aging (N4A) is the umbrella organization for the 655 area agencies on aging (AAAs) and more than 230 Title VI Native American aging programs in the US. Through its presence in Washington, DC, N4A advocates on behalf of the local aging agencies to ensure that needed resources and support services are available to older Americans.
www.n4a.org

National Association for Home Care and Hospice is a national organization representing home care agencies, hospices, home care aide organizations, and medical equipment suppliers. It sponsors a national certification program for home care aides through its Home Care University (www.nahc.org/HCU/credent.html).
www.nahc.org

National Clearinghouse on the Direct Care Workforce
Operated by PHI National and provides a comprehensive on-line library for people in search of solutions to the direct-care staffing crisis in long-term care. A project of PHI, the Clearinghouse includes government and research reports, news, issue briefs, fact sheets, and other information on topics such as recruitment, career advancement supervision, workplace culture, and caregiving practices. The Clearinghouse also houses training manuals and how-to guides, a list of direct-care worker associations and listings to other associations, resources, and events. In addition, the Clearinghouse publishes original research and analysis, including fact sheets, an annual survey of state initiatives on the direct-care workforce, news stories, and Quality Care/Quality Jobs, a free weekly on-line newsletter. (See PHI – formally the Paraprofessional Health Care Institute.
www.directcareclearinghouse.org

National Direct Service Workforce Resource Center: created by CMS in 2006 to respond to the large and growing shortage of workers and to support the successful implementation of efforts to improve recruitment and retention of direct support professionals who assist people with disabilities and older adults to live independently and with dignity in the community. This includes direct support professionals, personal care attendants, personal assistance providers, home care aides, home health aides and others.
www.dswresourcecenter.org

National Family Caregivers Association (NFCA) is a grassroots organization created to educate, support, empower, and speak for the family caregivers.
www.nfcacares.org/

National Institute on Disability and Rehabilitation Research's goal is to generate, disseminate, and promote new knowledge to improve the options available to disabled persons.
www.ed.gov/about/offices/list/osers/nidrr/index.html

National Network of Career Nursing Assistants is a nonprofit, educational organization promoting recognition, education, research, advocacy, and peer support development for nursing assistants in nursing homes and other long-term care settings.
www.cna-network.org/

Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the US Department of Health and Human Services on policy development, and is responsible for major activities in the areas of policy coordination, legislation development, strategic planning, policy research and evaluation, and economic analysis. Personal Assistant Services are a key area of their work.
www.aspe.hhs.gov/PIC/

PHI (PHI National, formerly the Paraprofessional Healthcare Institute) focuses on strengthening the direct-care workforce within our nation's long-term care system through developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. (See National Clearinghouse on the Direct Care Workforce.)
www.PHInational.org

PAS Center for Personal Assistance Services provides research, training, dissemination and technical assistance on issues of personal assistance services (PAS) in the United States: the relationship between formal and informal PAS and caregiving support, and the role of assistive technology (AT) in complementing PAS; policies and programs, barriers and new models for PAS in the home and community; PAS Workforce development, recruitment, retention, and benefits; and workplace models of formal and informal PAS and AT at work.
www.pascenter.org

Research and Training Center on Community Living (RTC) is part of the Institute on Community Integration, a University Center for Excellence in Developmental Disabilities in the College of Education and Human Development at the University of Minnesota in Minneapolis. The RTC works with community support systems for people with developmental disabilities and their families, providing research, evaluation, training, and technical assistance. Among other things, it sponsors several websites, publishes a quarterly magazine, and provides organizational support to NADSP. The RTC also helped to develop and maintains the Internet-based College of Direct Support (www.collegeofdirectsupport.com/), where workers can advance through several professional stages while earning first an Associate's and then a Bachelor's degree.
www.rtc.umn.edu

The Center for State Health Policy at Rutgers, (CSHP) has published about 100 papers on home and community based services plus an additional 30 papers on housing. See www.cshp.rutgers.edu/cle/ The Center provides consulting, training, research and evaluation of state health programs and works with multiple states and other organizations.

The Quality Mall houses the "Staffing Store" that provides the browser with easily accessible information on people who provide direct support and other services to people with developmental disabilities.
www.qualitymall.org

Well Spouse Association is a national, not-for-profit membership organization that supports wives, husbands, and partners of the chronically ill and/or disabled.
www.wellspouse.org

Wisconsin Council on Developmental Disabilities is addressing direct-support workforce issues in the state.
www.wcdd.org

Appendix B. Workforce Initiatives by Category and State

Sources: Dawson, S. (June, 2007). Recruitment and Retention of Paraprofessionals: Selected State Initiatives to Improve the Long-Term Care Paraprofessional Workforce, http://www.directcareclearinghouse.org/l_index.jsp.
Harmuth, S. and Dyson, S. (September 2005) Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct Service Workforce, http://www.directcareclearinghouse.org/l_index.jsp.

Initiative	State
Wage Increases	
Reimbursement rate analysis	ME, PA, VT
Increased reimbursement rate	AZ, IL, ME, MD, MN, NJ, OK, WA
Reimbursement usage terms	GA, LA, NV, TX
Wage floor	DC, LA, ME
Wage pass-throughs	DC, LA, MA, RI, SC, VA, WY
Wage and benefit increases	ME, MT, ND, OK, ND, WA
One-time bonus	MT
Collective bargaining increases	CA, MI, ME, OR, WA
Add-ons	SC
State minimum and living wage increases	AZ, CA, CO, FL, MD, MO, MT, NV, NY, OH, OR, VT, WA
Payment Incentives to Employers	
State licensure reimbursement incentive program	NC
Incentive awards	IA, NC, RI, TX, VT
Payment for health benefits for set amount over limited period	NY
Work Groups	
Workforce development	AR, AZ, CO, CT, FL, GA, KY, MD, MA, MI, MN, MT, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, VT, WA, WI, WY
General	AK, DE, IA, MO, NE, VA
Training	
Staff	AK, CA, GA, KS, KY, MA, MI, MN, MT, NV, NJ, NC, RI, VT, VA, WI
Supervisor/administrator	AK, KY, MA, NC, WA
Apprenticeship	IN, KS, MI, PA, WA
Issue-specific only	LA, ME, PA

Licensing, Credential and Training Standards with worker requirements	
Set minimum requirements for training and testing	IL, ME, NC, OR, WA, WI
Minimum staffing ratios	AR, CT, NC, OH
Standard-setting	FL, SC, VA, WA
Reimbursement usage	GA, LA, NV, TX
Staffing levels to be posted	NC
Contracting/procurement standards	PA, WI
Universal core curriculum	PA
Core competencies	DC, NY, OR, PA, VT, WA
Increased minimum requirements for training and testing	DE, VA
Career Ladders	
Expanded skills	MO, NV
Implemented ladder/ladder pilot	MA, TX
Public Awareness	
Targeted population recruitment	AR, MD, MT, NJ, OH, SC, WY
PR materials developed	AR, OH, OK
Monthly or annual recognition of workforce	IA, MO, NH, WI
Focus on culture change	KS
Legislative action	ME
Employee Benefits	
Health insurance	ME, NC, VT, VA, WA
Topic-specific trainings offered	PA, WI
Publications produced	PA
Reimbursements offered (i.e., transportation, daycare	TX
Statewide worker groups	
Worker associations (non-union)	IA, ME, NC, VT, WI
Unions	AZ, CA, CT, DE, FL, IL, IN, KY, ME, MD, MA, MI, MN, MT, NV, NJ, NY, OH, OR, PA, RI, VA, WA, WV, WI
Public authorities	CA, IA, MA, MI, OR, WA
Registry	
Statewide registry added	NJ, VA, WA
Comprehensive registry enhancements	MA, CT, MI, IA

Resources

Administration on Aging. (2007) *Statistics on the aging population.* Retrieved January 28, 2008, from http://www.aoa.gov/prof/Statistics/statistics.asp.

Baughman, R. and Smith, K. (2007) *The labor market for direct care workers*. Boston, MA: New England Public Policy Center at the Federal Reserve Bank of Boston.

Berry, T., Brannon, D. and Mor, V. (2005) Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *Gerontologist 45*(3), 309-317.

Better Jobs Better Care. (2003, October) Multi-stakeholder coalitions: Promoting improvements in the long-term care workforce. *Better Jobs Better Care Issue Brief, 1*.

Better Jobs Better Care. (2004, August) Quality improvement organizations: Recognizing direct care workers' role in nursing home quality improvement. *Better Jobs Better Care Issue Brief, 4.*

Better Jobs Better Care. (2007, April) Respectful relationships: The heart of Better Jobs Better Care. *Better Jobs Better Care Issue Brief 7.*

Better Jobs Better Care. (2005, Summer) *Insights, 7. Testing a Route toward Greater Retention: Can Dedicated Retention Specialists Make a Difference in Direct Care Worker Turnover?*

Bodhi, C. (2004, May) *Extended Care Career Ladder Initiative (ECCLI).* Retrieved March 12, 2008, from http://aspe.hhs.gov/daltcp/reports/04cfpk03.htm#Bodhi1P.

Booth, M. and Fralich, J. (2003, August) *Workbook: Improving the quality of home and community-based services and supports.* Portland, ME: Muskie School of Public Service, University of Southern Maine.

Booth, M. and Fralich, J. (2006, April) *Performance measurement: Managing and using Home and Community-Based Services data for quality improvement.* New Brunswick, NJ: The Community Living Exchange Collaborative at Rutgers Center for State Health Policy and the National Academy for State Health Policy.

Booth, M., Fralich, J. and Bowe, T. (2005, January) *Home and community-based services: Quality management roles and responsibilities.* New Brunswick, NJ: The Community Living Exchange Collaborative at Rutgers Center for State Health Policy and the National Academy for State Health Policy.

Booth, M., Fralich, J. and Bowe, T. (2005, January) *Home and community-based services: Quality management roles and responsibilities.* New Brunswick, NJ: The Community Living Exchange Collaborative at Rutgers Center for State Health Policy and the National Academy for State Health Policy.

Booth, M., Fralich, J., and Nonemaker, S. (2002, January 10) *Quality management and improvement practices for home and community-based care: Literature review*. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy.

Bordieri, J. E. and Peterson, S. L. (1988 September) Job satisfaction of direct care workers in community residential facilities. *Journal of Rehabilitation*, 62-66.

Bowe, T., Booth, M., Bratesman, S. and Fralich, J. (2006, April) *Reporting: Managing and using Home and Community-Based Services data for quality improvement.* New Brunswick, NJ: The Community Living Exchange Collaborative at Rutgers Center for State Health Policy and the National Academy for State Health Policy.

Bowers, B. (2001) *Organizational change and workforce development in long-term care.* Madison, WI: University of Wisconsin.

Bowers, B., Fivitch, B., and Jacobson, N. (2001) Care-as-service, care-as-relating, care-as-comfort: Understanding nursing home residents' definitions of quality. *Gerontologist 41*(4), 539-545.

Bowers, B., Esmond, S. and Jacobson, N. (2000) The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides. *Journal of Nursing Care Quality 14*(4), 55-64.

Bowers, B., Esmond, S., Norton, S. and Holloway, E. (n.d.) *The consumer-provider relationship as care quality mediator.*

Brannon, D., Zinn, J. S., Mor, V., and Davis, J. (2002) An exploration of job, organizational, and environmental factors associated with high and low nursing assistant turnover. *Gerontologist, 42*(2), 159-168.

Bryant, N. (2007, March/April) Where Are the Workers? BJBC Projects Identify Potential Pools of Direct Care Workers. *Future Age*, American Association of Homes and Services for the Aging. 6(2), 40-41.

Bureau of Labor Statistics, U.S. Department of Labor. (2007, December 18) *Occupational outlook handbook, 2008-09 Edition.* Retrieved December 27, 2007, from http://www.bls.gov/oco/.

Castle, N. G. and Engberg, J. (2007 October) The influence of staffing characteristics on quality of care in nursing homes. *Health Research and Educational Trust 42*(5), 1822-1846.

Center on Residential Services and Community Living, University of Minnesota. (1996, July) National voluntary credentialing for direct service workers. *Policy Research Brief 8*(2).

CMS. (n.d.) *HCBS promising practices reports*. Retrieved March 12, 2008, from http://www.cms.hhs.gov/PromisingPractices/HCBSPPR.

Cooper, J. (2002 Mar-Apr). Direct care workers. Reinforcing the numbers, reinforcing commitment. *North Carolina Medical Journal, 63*(2), 116.

Cooperative Home Care Associates. (2004) *Integrated model for recruitment, training, and retention*. Retrieved January 22, 2008, from http://www.directcareclearinghouse.org/practices/r_pp_det.jsp?res_id=48910.

Council on Quality and Leadership. (2005) *Cross-walk between the CMS HCBS quality framework and CQL's quality measures.* Towson, MD: Council on Quality and Leadership.

Cramer, B., Harmuth, S., and Gamble, E. (1999) *Comparing state efforts to address the recruitment and retention of nurse aide and other paraprofessional aide workers.* Raleigh, NC: North Carolina Division of Facility Services.

Dawson, S. (2007, June 28) *Recruitment and retention of paraprofessionals.* Presentation to the Institute of Medicine's Committee on the Future Health Care Workforce for Older Americans.

DeGraff, Alfred H. (2002) *Caregivers and personal assistants: How to find, hire, and manage the people who help you (or your loved one!).* Fort Collins, CO: Saratoga Access Publications.

Direct Care Workforce Study Advisory Group. (2007, January 31) *A study of the direct care workforce in Vermont: Status report*. Waterbury, VT: Vermont Department of Disabilities, Aging, and Independent Living.

Doty, P., Eustis, N. N. and Lindsay Brooke E. (1994, December) *Research agenda: Personal assistance services and related supports.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

Ejaz, F. and Noelker, L. (2006) *Tailored and ongoing training improve job retention.* Washington, DC: Better Jobs Better Care.

Farrell, D. and Dawson, S. (2007, March-April) The business case for investing in staff retention: Can you afford not to? *Future Age,* 8-11.

Farrell, D., McLaughlin, M., Gray, A., Frank, B., and Brady, C. (2006, June) A case for consistent assignment. *Provider,* 47-52.

Feasely, J. (Ed.). (1996) *Health outcomes for older people: Questions for the coming decade*. Washington, DC: National Academy Press, Institute of Medicine.

Feldman, P. H., Sapienza, A. and Kane, N. (1990) *Who cares for them? Workers in the home care industry.* Westport, CN: Greenwood Press.

Fleming, D. (2006, December) *Vermont demonstration project profile: Community of Vermont Elders (COVE).* Washington, DC: Better Jobs Better Care.

Fralich, J., Booth, M., Gray, C., Bowe, T., and Bratesman, S. (2005, April) *Discovery methods for remediation and quality improvement in home and community based services. Discussion paper*. New Brunswick, NJ: The Community Living Exchange Collaborative at Rutgers Center for State Health Policy and the National Academy for State Health Policy.

Fralich, J., and Bratesman, S. (2004, November) *Quality indicators for home and community-based services.* Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy.

Fralich, J., Gray, C., Olsen, L. and Ziller, J. (2005, October 31) *Quality indicators for home and community based-services in Maine.* Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

Frank, B., Harris, A. L., Eaton, S. C. and DuBois, C. (2000) *Health care workforce issues in Massachusetts (Issue Brief No. 9).* Boston, MA: Massachusetts Health Policy Forum.

Friedland, R. B. (2004, July) *Caregivers and long-term care needs for the 21st century: Will public policy meet the challenge?* Washington, DC: Georgetown University.

Gillespie, J. (2003, December) Direct Care Worker Associations and Public Authorities. New Brunswick, NJ: Rutgers/NASHP.

Harmuth, S. (2002, March-April) The direct care workforce crisis in long-term care. *North Carolina Medical Journal, 63*(2), 87-94.

Harmuth, S. (2006, June) *North Carolina Demonstration Project Profile: NC New Organizational Vision Award (NC NOVA).* Washington, DC: Better Jobs Better Care.

Harris-Kojetin, L., Lipson, D., Fielding, J., Kiefer, K., and Stone, R.I. (2004, May) *Recent findings on frontline long-term care workers: A research synthesis 1999-2003*. Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-term Care Policy.

Health Care for Health Care Workers. (2006, January) *Caregivers without coverage: The facts about a critical gap in long-term care (Policy Brief No. 1).* Bronx, NY: PHI.

Health Care for Health Care Workers. (2006, March) *Health insurance coverage for the home care sector: Experience from early DirigoChoice enrollment in Maine*. Bronx: NY: PHI.

Health Care for Health Care Workers. (2006, April) *When caregivers lack coverage: Voices from the front lines*. Bronx, NY: PHI.

Health Care for Health Care Workers. (2007) *Expanding coverage for caregivers: A checklist for state health reform, Policy Brief No. 2.* Bronx, NY: PHI.

Health Care for Heath Care Workers. (2007) *Coverage models from the states: Strategies for expanding health coverage.* Bronx, NY: PHI.

Health Resources and Services Administration. (2004, February) *Nursing aides, home health aides, and related health care occupations: National and local workforce shortages and associated data needs*. Washington, DC: National Center for Health Workforce Analyses, Bureau of Health Professions.

Heinritz-Canterbury, J. (2002) *Collaborating to improve in-home supportive services: Stakeholder perspectives on implementing California's Public Authorities*. Bronx, NY: PHI.

Hewitt, A., Edelstein, S., Seavey, D., Morris, J., and Hoge, M. (2007, November) *Direct support professional work group report*. Raleigh, NC: North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse.

Holzer, H. (2001) *Long term care workers and the low wage labor market: Current characteristics and future trends.* Washington, DC: The Urban Institute and the Institute for the Future of Aging Services.

Howes, C. (2002, November) *The impact of large wage increase on the workforce stability of IHSS home care workers in San Francisco County.* Berkeley, CA: University of California.

Howes, C. (2006, June) *Building a High Quality Home Care Workforce: Wages, Benefits and Flexibility Matter.* Better Jobs Better Care, Institute for the Future of Aging, Washington, DC.

Inserra A., Conway M., and Rodat J. (2002, February) *Cooperative Home Care Associates, A case study of a sectoral employment development approach.* Washington, DC: The Aspen Institute.

Institute for the Future of Aging Services. (2007, January) *The long-term care workforce: Can the crisis be fixed? Problems, causes and options.* Washington, DC: IFAS.

Iowa Direct Care Worker Task Force. (2006, December) Category one: Education and training. *Iowa Direct Care Worker Task Force Report and Recommendations*, 30-37.

Jackson, S. and Seaton, M.A. (2006, October) *Oregon demonstration project profile: Oregon Works! Building a workforce for the 21st century.* Washington, DC: Better Jobs Better Care.

Kadis, J. (2003) *Workplace Planning: How to Recruit and Retain Mental Health Workers*. Community Living Brief Vol 2. Issue 1, Independent Living Research Utilization (ILRU). Rutgers, N.J. http://www.ilru.org/html/publications/newsletters/Briefs/Vol2Iss2.pdf

Kahn, K. (2003, October) Multi-stakeholder coalitions: Promoting improvements in the long-term care workforce. *Better Jobs Better Care Issue Brief*, *1*(1).

Kaiser Commission on Medicaid and the Uninsured. (2007, December) *Medicaid home and community-based service programs: Data update*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Kane, R. L. and Kane, R. A. (2001) What older people want from long-term care, and how they can get it. *Health Affairs, 20*(6), 114-127.

Karidis, A. (2007, March-April) Coalitions harness the power of change. *Future Age,* 26-31.

Kassner, E. (2005, August) *The Medicaid personal care services benefit: Practices in states that offer the optional state plan benefit.* Washington, DC: AARP Public Policy Institute.

Kaye, H. S., Chapman, S., Newcomer, R. J., and Harrington, C. (2006) The personal assistance workforce: Trends in supply and demand. *Health Affairs, 25*(4), 1113-1120.

Kiefer, K. M., Harris-Kojetin, L. H., Brannon, D., Barry, T., Vasey, J., and Lepore, M. (2005, April) *Measuring long-term care work: A guide to selected instruments to examine direct care worker experiences and outcomes.* Washington, DC: U.S. Department of Health and Human Services.

Konrad, T.R. (2002 March-April) Who do we want to care for our mothers? Defining and reinforcing the direct care workforce. *North Carolina Medical Journal, 63*(2), 108-9.

Konrad, T. R. and Craft Morgan, J. (2006) *STEP UP NOW for better jobs and better care: The evaluation of a workforce intervention for direct care workers.* Washington, DC: Better Jobs Better Care.

Lakin, K.C. and Prouty, R. (2003) *Medicaid home and community-based services: The first 20 years*, *Policy Research Brief 14/3.* Minneapolis, MN: University of Minnesota, Institute on Community Integration.

LaPlante, M.P., Kaye, H.S., Kang, T., and Harrington, C. (2004) Unmet Need for Personal Assistance Services: Estimating the Shortfall in Hours of Help and Adverse Consequences. *Journal of Gerontology*, 59-B, S-98.

LaPointe, L. (2002) *New supervisor: Strategies for supporting and managing frontline staff.* Albuquerque, NM: Hartman Publishing.

Leon, J., Marainen, J., and Marcotte, J. (2001, February) *Pennsylvania's frontline workers in long-term care: The provider organization perspective.* Jenkintown, PA: The Polisher Research Institute, Philadelphia Geriatric Center.

Leonard, J. (n.d.) *States use penalty money for worker recruitment and retention.* Retrieved February 26, 2008, from http://www.bjbc.org/page.asp?pgId=165.

Lipson, D. (2005, April) *Linking Payment to Long-Term Care Quality: Can Direct Care Staffing Measures Build the Foundation?* Institute for the Future of Aging, Washington, DC.

Lipson, D. (2005, September) *Building a strong long-term care workforce: Solutions to the paraprofessional crisis.* Institute for the Future of Aging, Washington, DC.

Livingston, J. and Rebeck, D. (2007, January) *A study of the direct care workforce in Vermont: Status report.* Hinesburg, VT: Flint Springs Associates.

Maine Center for Economic Policy. (2007, March) *Study of Maine's direct care workforce: Wages, health coverage, and a worker registry.* Augusta, ME: Maine Department of Health and Human Services.

Maine State Legislature. (2006) *Resolve, to ensure the availability of consumer-directed personal assistance services*. (2006). LD 1991, item 1, 122nd Maine State Legislature.

McDonald, I. (2007, January) *Emerging strategies for providing health coverage to the frontline workforce in long term care.* Bronx, NY: PHI.

McDonald, I. and Davis, G.S. (February 2007) *The SEIU 775 long-term care training, support and career development network: A blueprint for the future.* Bronx, NY: PHI.

McDonald, I. and Kahn, K. (2007, March/April) Respectful Relationships: The Heart of Better Jobs Better Care. *Future Age*, American Association of Homes and Services for the Aging. 6(2), 13-15.

Mickus, M., Luz, C., Hogan, A. (2004) *Voices from the front: Recruitment and retention of paraprofessional workers in long term care across Michigan.* East Lansing, MI: Michigan State University.

Mills, J. (2007, June) *Sector initiatives for Colorado's long-term healthcare industry*. Oakland, CA: National Network of Sector Skills Partners; National Economic Development and Law Center.

Misiorski, S. and Kahn, K. (2005) Changing the culture of long-term care: moving beyond programmatic change. *Journal of Social Work in Long-Term Care*, *3*(3/4), 137-146.

Mollica, R. (2002, December) *Best practices and trade secrets: How to recruit and retain quality staff.* Portland, ME: National Academy for State Health Policy.

Mollica, R. (2006, April) *The deficit reduction act: Home and community-based services state plan option*. Portland, ME: National Academy for State Health Policy.

Montgomery, R. J. V., Lyn Holley, P., Deichert, J., and Kosloski, K. (2005) A profile of home care workers from the 2000 Census: How it changes what we know. *Gerontologist*, *45*(5), 593-600.

Mullan, F. (2002) Time-capsule thinking: The health care workforce, past and future. *Health Affairs, 21*(5), 112-122.

National Center on Caregiving. (2007, March) *Family caregiving: State of the art, future trends conference proceedings.* Chicago, IL: Family Caregiver Alliance.

National Clearinghouse of the Direct Care Workforce. (2006, November) *Fact sheet: Who are direct care workers?* Bronx, NY: PHI.

National Commission on Nursing Workforce for Long-Term Care. (2005, April) *Act now for your tomorrow.* Washington, DC: George Washington University.

Noelker, L.S. (2001, Spring) The backbone of the long-term care workforce. *Generations, 25*(1), 85-91.

Noelker, L. S. and Ejaz, F. K. (2004, November) *Overview: Empowerment of direct care workers.* Washington, DC: Gerontological Society of America.

Noelker, L. S., Ejaz, F. K., Menne, H. L., and Jones, J. A. (2006) The Impact of stress and support on nursing assistant satisfaction with supervision. *Journal of Applied Gerontology*, *25*(4), 307-323.

North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse. (2007, November) *Overview of direct support workforce: Issues and challenges.* Raleigh, NC: North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse.

North Carolina Department of Health and Human Services. *Long Term Care: What training, skills and qualities do direct care workers need?* Retrieved January 2, 2008, from http://www.ncdhhs.gov/ltc/dircare/dcw5.htm.

North Carolina Department of Health and Human Services. Long Term Care: Where do direct care workers provide care? Retrieved January 2, 2008, from http://www.ncdhhs.gov/ltc/dircare/dcw4.htm.

North Carolina Department of Health and Human Services. *Long Term Care: Who are direct care workers?* Retrieved January 2, 2008, from http://www.ncdhhs.gov/ltc/dircare/dcmain.htm.

Ormond, C. (2004, July 21) *A review of minimum staffing ratios for direct-care registered nurses in hospitals.* Portland, ME: University of Southern Maine, Muskie School of Public Service, Institute for Health Policy.

PHI. (2000, August) *Recruiting quality health care paraprofessionals.* Bronx, NY: PHI.

PHI (2002, Fall) The right people for the job: Recruiting direct care workers for home and community-based care. *Workforce Tools*, *1*(1-8).

PHI. (2003, February) *A resource for paraprofessional staffing issues and quality improvement in long-term care.* Orlando, FL: 2003 Technical Conference: Changes, Challenges, and Commitment, A New Era in Healthcare Quality Improvement.

PHI. (2003, April) *Workforce strategies no. 1: State wage pass-through legislation: An analysis.* Bronx, NY: PHI.

PHI. (2003, May) *Workforce strategies no. 2: Introducing peer mentoring in long-term care settings.* Bronx, NY: PHI.

PHI. (2003, June 12) *The personal assistance services and direct-support workforce: A literature review*. Bronx, NY: PHI.

PHI. (2003, August) *Training quality home care workers.* Bronx, NY: PHI.

PHI. (2004, Winter) *The right start.* Workforce Tools 2. Bronx, NY: PHI.

PHI. (2004, Spring) *Direct care worker associations: Empowering workers to improve the quality of home and community-based care.* Workforce Tools 3. Bronx, NY: PHI.

PHI. (2005, January) *Workforce strategies no. 3: The role of training in improving the recruitment and retention of direct-care workers in long-term care*. Bronx, NY: PHI.

PHI. (2005, December) *Creating a culture of retention: A coaching approach to paraprofessional supervision.* Bronx, NY: PHI.

PHI. (2006, April) *CMS direct service workforce demonstration grants: Overview and discussion of health coverage interventions.* Bronx, NY: PHI.

PHI. (2007, July) *Workforce strategies no. 4: The guaranteed hours program: Insuring stable full-time direct care employment.* Bronx, NY: PHI.

PHI and Catholic Health Association. (2003) *Finding and keeping direct care staff.* Bronx, NY: PHI.

PHI Michigan. (n.d.) *Opportunity partnership and empowerment network: A case study of an effective employee retention project.* Lansing, MI: PHI Michigan.

Penning, M. J. (2002) Hydra revisited: Substituting formal for self- and informal in-home care among older adults with disabilities. *Gerontologist, 42*(1), 4-16.

Phillips, C. D., Hawes, C., Lieberman, T. and Koren, M. J. (2007, June) *Where should momma go? Current nursing home performance measurement strategies and a less ambitious approach.* Retrieved January 25, 2008, from http://www.pubmedcentral.nah.gov/articlerender.fcgi?artid=1920506.

Pohlmann, L. (n.d.). *Many of Maine's direct care workers do not have health insurance*. Bronx, NY: Health Care for Health Care Workers and Maine's Direct Care Worker Coalition.

Pohlmann, L. (2006, September) *Meeting Maine's needs for frontline workers in long-term care and service options*. Augusta, ME: Maine Center for Economic Policy.

Potter, S. J., Churilla, A., and Smith, K. (2006, November) An examination of full-time employment in the direct-care workforce. *Journal of Applied Gerontology*, *25*(5), 356-374.

Research and Training Center on Community Living. (2003, March) *Wages of Direct Support Professionals Serving Persons with Intellectual and Developmental Disabilities: A Survey of State Agency and Private Residential Provider Trade Associations.* Minneapolis, MN: University of Minnesota.

Research and Training Center on Community Living. (2003, September) *Medicaid home and community-based services: The first 20 years.* Minneapolis, MN: University of Minnesota.

Rodriguez Banister, K. (2006) *The personal care attendant guide: The art of finding, keeping, or being one*. New York: Demos Medical Publishing.

Rowe, J. (2006, October) *Seasons of change in home and community-based supports: Quality management strategies for self-direction.*

Salsberg, E. (2003, September) *Making sense of the system: How states can use health workforce policies to increase access and improve quality of care.* New York: Milbank Memorial Fund and the Reforming States Group.

Salter, V. and Wilner, M. A. (2006, November) *Conversations about the future of direct care workforce research.* Bronx, NY: PHI.

Schindel, J., Cherner, D., and Health Workforce Solutions. (2006). *Workers who care: A graphical profile of the frontline health and health care workforce*. Princeton, NJ: Robert Wood Johnson Foundation.

Schipper, Lloyd. (2004, May) *Good Samaritan career lattice project.* Retrieved March 12, 2008, from http://aspe.hhs.gov/daltcp/reports/04cfpk03.htm#Schipper1P.

Seavey, D. (2004, October) *The Cost of Front-line Turnover in Long-Term Care*. Washington, DC: Institute for the Future of Aging Services. Retrieved March 12, 2008, from http://www.directcareclearinghouse.org/download/TOCostReport.pdf

Seavey, D. and Salter, V. (2006, October) *Paying for quality care: State and local strategies for improving wages and benefits for personal care assistants.* Washington, DC: AARP Public Policy Institute.

Seavey, D. (2007, March 6) *A workforce perspective on caregiving. Family caregiving: State of the art, future trends, conference proceedings.* Presented by the National Center on Caregiving at Family Caregiver Alliance in Partnership with The American Society on Aging.

Shirk, C. (2006, March 3) *Rebalancing long-term care: The role of the Medicaid Waiver program*. Washington, DC: National Health Policy Forum.

Smith, G. et al. (2000, October) *Understanding Medicaid home and community services*. Washington, DC: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.

Spetz, J. and Adams, S. (2006) How can employment-based benefits help the nurse shortage? *Health Affairs, 25*(1), 212-218.

Stone, R. I. (2000, August) *Long-term care for the elderly with disabilities: Current policy, emerging trends, and implications for the twenty-first century*. New York: Milbank Memorial Fund.

Stone, R. I. (2004, August) The direct care worker: A key dimension of home care policy. *Home Health Care Management and Practice,* 16(5), 339-349.

Stone, R. I. (2004, September) *Supporting the first responder: How to develop and sustain a quality direct care workforce in the long-term services and supports field.* Augusta, ME: Maine Personal Assistance Services Association.

Stone, R. I., Dawson, S., and Harahan, M. (2003, October) *Why workforce development should be part of the long-term care quality debate*. Washington, DC: Institute for the Future of Aging Services and PHI.

Stone, R. I., and Wiener, J. M. (2001, October) *Who will care for us? Addressing the long-term care workforce crisis*. Washington, DC: The Urban Institute and the American Association of Homes and Services for the Aging.

Taylor, M. (2007, September 30) National Training Institute for Frontline Supervisors (NTIFFS) Final Report. Cambridge, MA: Human Services Research Institute.

Teal, C. (2002 March-April) Direct care workers--number one quality indicator in long-term care, a consumer's perspective. *North Carolina Medical Journal, 63*(2), 102-5.

U.S. Department of Health and Human Services. (2004, May) *Recruitment and retention of direct care workers symposium background materials.* Retrieved March 13, 2008, from http://aspe.hhs.gov/daltcp/Reports/04cfpk02.htm.

U.S. Department of Health and Human Services. (2004, May) *Pathway to the Future: How Workforce Development and Quality Jobs Can Promote Quality Care Conference Outline and links to presentations* Retrieved March 13, 2008, from http://aspe.hhs.gov/daltcp/reports/04cfpksum.htm.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-term Care Policy. (2006, May) *Ensuring a qualified long-term care workforce: From pre-employment screens to on-the-job monitoring*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-term Care Policy. (2006, January) *The supply of direct support professionals serving individuals with intellectual disabilities and other developmental disabilities: Report to Congress*. Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services. (2007) *The 2007 HHS poverty guidelines.* Retrieved March 13, 2008, from http://aspe.hhs.gov/poverty/07poverty.shtml.

U.S. Department of Health and Human Services. (2007, September). HHA partnering collaborative evaluation: Practice/Research brief. Retrieved March 12, 2008, from http://aspe.hhs.gov/daltcp/reports/2007/HHAPartrb.htm.

U.S. Department of Labor. (2008, January 1) *Minimum wage laws in the states.* Retrieved March 13, 2008, from http://www.dol.gov/esa/minwage/america.htm.Weiner, J. et al. (2004, July) *Home and community-based services: A synthesis of the literature*. Research Triangle Park, NC: RTI, International.

University of Minnesota. (2006, December) *CMS direct service workforce demonstration: Promising practices in marketing, recruitment and selection interventions*. Minneapolis, MN: University of Minnesota, Research and Training Center on Community Living and The Lewin Group.

Wanous, J.P. (1992). Organizational Entry: Recruitment, Selection, Orientation and Socialization of Newcomers. (2nd Edition). New York: Addison Wesley.

Washington State Department of Personnel. Qualifications catalog: Direct care-Mental health. Retrieved December 27, 2008, from http://www.dop.wa.gov/NR/rdonlyres/BA5484DB-63D4-4D16-A3AD-5B9ACE38C95C/0/QCDirectCareMentalHealthweb.doc.

Washington State Department of Personnel. Qualifications catalog: Direct care-Social services program support. Retrieved December 27, 2007, from http://www.dop.wa.gov/NR/rdonlyres/BCC9634D-82E2-4C37-9164-7229267230BB/0/QCDirectCareSocialServicesProgramsSupportweb.doc.

Weiner, J. et al. (2004, July) *Home and community-based services: A synthesis of the literature*. Research Triangle Park, NC: RTI, International.

Wong, A., Kaye, H. S., and Newcomer, R. (2007, July) *State legislation regarding wages and benefits of home care workers: Thirteen promising practices.* San Francisco, CA: PAS Center for Personal Assistance Services.

Wright, B. (2005, May) *Direct care workers in long-term care, Data Digest 117.* Washington, DC: AARP Public Policy Institute.

Yamada, Y. (2002, April) Profile of home care aides, nursing home aides, and hospital aides: Historical changes and data recommendations. *Gerontologist, 42*(2), 199-206.

Yamada, Y., and Sekiya, M. (2003, December) Licensing and training requirements for direct care workers in Japan: what can the United States and Japan learn from each other? *Journal of Aging and Social Policy*, *15*(4), 113-129.

Yeatts, D. E., Cready, C., Ray, B., DeWitt, A., and Queen, C. (2004) Self-managed work teams in nursing homes: Implementing and empowering nurse aide teams. *Gerontologist, 44*(2), 256-261.

Yeatts, D. E. and Cready, C. M. (2007, June) Consequences of empowered CNA teams in nursing home settings: A longitudinal assessment. *The Gerontologist, 47*(3), 323-39.

Zarrella, E. (2001) *The Self-Sufficiency Standard.* Retrieved March 13, 2008, from http://www.sixstrategies.org/sixstrategies/selfsufficiencystandard.cfm.

WHAT IMPACT HAVE UNIONS MADE ON QUALITY?

Leslie Hendrickson, PhD
Center for State Health Policy, Rutgers University

Unionization of nursing home and home care workers has significantly expanded since the mid 1990s.[1] The Service Employees International Union (SEIU) is the largest and fastest growing union in North America with over 350,000 home care and 150,000 nursing home workers as members. SEIU has a significant membership of health care workers in California, Massachusetts, Michigan, New York, Oregon, and Washington.

State Medicaid staffs work within a multi-agency environment that now increasingly involves working with unions in addition to providers and their associations. The impact of unions is complex influence and not easily characterized. For example, in California, Assembly Bill (AB) 1629 was signed into law on September 29, 2004, which enacted the Medi-Cal Long-Term Care Reimbursement Act. The bill, which was lobbied for by both nursing home providers and unions, increased reimbursement rates paid to nursing homes in California. At the same time, SEIU has joined consumers in lobbing against cuts to the In-Home Support Services (IHSS) program, California's largest in-home services program currently serving about 350,000 persons. In Maine, Massachusetts, and Michigan SEIU has lobbied to increase in-home services.

What is the impact of unionization on the quality of health care provided by nursing home and home and community-based workers? There are three arguable effects from unionization: there is an increase in wages and benefits that effectively lowers staff turnover; quality of care rises as a result of increased reporting and oversight; and, worker performance improves because of support services provided to workers by unions.

[1] For example, between 1994 and 1999 seven counties in California established home health care public authorities and had union elections, the largest adding 74,000 Los Angeles home care workers into SEIU. About 15% of Washington's nursing homes are organized, as measured by licensed beds, with 12% of the 15% being SEIU, the remainder is split between four other unions: the United Food and Commercial Workers (UFCW), the International Brotherhood of Teamsters (IBT), the International Association of Machinists and Aerospace Workers, (IAM), and the Office and Professional Employees International Union (OPEIU). SEIU Healthcare Michigan has 55,000 health care members and it has organized about 25% of Michigan's nursing homes.

Increase in Wages and Benefits

In 2006 there were approximately 787,000 home health workers in the United States, a number that is expected to grow by 49% to 1,171,000 by 2016.[2] Median hourly earnings of home health aides were $9.34 in May 2006, and the median annual wage was $20,100. In 2006 the Federal Poverty Level (FPL) for a family of four was $20,000.[3] These low wages show how close to the poverty level home health workers are and provide ample motivation for seeking work with higher pay.

To the extent that the SEIU and other unions are successful in raising the wages of their members, the increased wages can change the behaviors of workers in ways that affect the quality of care provided to older persons and people with disabilities. Zabin describes the "wage efficiency" economic theory of relative and absolute wage levels, and applies it to the workforce that provides services to persons with developmental disabilities.[4] After reviewing the economic literature, she concludes that the vast majority of research shows that higher wages attract greater numbers of workers and better educated workers, and reduce turnover of workers.

Turnover of care givers has a negative impact on the quality of care, resulting from the loss of the worker's knowledge about the persons being helped. Continuity of care is disrupted and costs are incurred when it is necessary to replace staff and teach them about the persons they are to help. As an illustration of this outcome of increased costs resulting from worker turnover, consider Addus Healthcare. Addus, which began business in 1979, is the largest multi-state agency providing Medicaid personal care services.[5] Addus has signed a contract with SEIU but a factual determination of the impact on Addus and its workers of this contract is beyond the scope of this paper. When interviewed, Addus staff provided the following information:

> Staffs said most newly hired nursing home care aides, personal care workers, and home care aides come to their positions with little or no experience working in nursing facilities or providing direct home care to seniors. Addus has contracts with states that require the company to provide from 12 hours to 30 hours of pre-service training to each new worker, depending on the levels specified by each state's regulatory requirements.
>
> Staffs further said that training includes lectures, educational videos, and some hands-on training. The hands-on training varies by office. Some form of assistive technology is taught in all 95 of the Addus offices. Most offices have some classroom space. About 60% of the offices have hospital beds and instruction can include body mechanics, transferring, safety of ambulation, and use of gait belts. Some Hoyer lifts are used for training, but this activity is limited, as it requires RN supervision that is often unavailable. After training, new aides are usually matched with a supervisor to provide

---

[2] Bureau of Labor Statistics, *Occupational Outlook Handbook, 2006-07 Edition:* See http://www.bls.gov/oco/ocos165.htm See also http://www.bls.gov/oes/current/oes311011.htm

[3] See U.S. Department Health and Human Service poverty guidelines: http://aspe.hhs.gov/poverty/06poverty.shtml

[4] Zabin, C., February 2003.

[5] In 2008, Addus stated that it provides health care services to over 40,000 individuals annually from ninety-five offices in fourteen states. See http://www.addus.com/index.htm.

on-the-job training. For example, potentially dangerous patient bathing procedures would include training that focuses on appropriate methods for tub transfers and other high-risk activities. Training costs can run $2,000 or more per person trained.

To the extent that turnover increases the costs incurred in training new employees, savings can be attained if the rate of turnover decreases. Additionally, reducing the number of persons taking pre-service training by 15% to 30% would create savings for Addus and the low-margin home health care agencies that work with state-set reimbursement rates.

An example of a before and after study showing the effect of wages on turnover is Howes' study of 18,000 home care workers in San Francisco County. Between 1997 and 2002, wages for these workers doubled from $5.00 an hour to $10.00 an hour, over 52 months.[6] Howes found that the effects of the wage increase varied by ethnic group or if there was a familial relationship between the worker and persons being cared for. However, in general the impact of the wage increases was that more persons became home care workers, the number of hours worked increased, the annual retention rate of new care providers rose from 39% to 74%, and the number of workers matched to a consumer of their own ethnicity increased.[7] For example, Howes reported that comparisons of California regional data showed that the higher wages and better health insurance in San Francisco were a causal factor in reducing turnover in San Francisco County among non-family care providers.[8]

In addition to the improved quality of care that lower turnover brings, the increase in the number of workers matched to a consumer of their own ethnicity also has an impact on quality. Howes cites Laura Reif's findings that there were significantly more complaints about poor care provider performance when the provider was from a different ethnic group than the consumer. For example, 16% of consumers matched to a provider of a different ethnicity reported fear of being injured, compared to 1% of consumers in a same-ethnicity match.[9]

Changing Patterns of Care

A second proposed outcome from unionization of workers is a change in the way that care is provided. While there are few studies that have shown a correlation between unionization and quality of care, Swann and Harrington's recent study of 1,155 California nursing homes provides evidence of the impact of unionization on nursing home care.[10] They found that unionized nursing facilities (NFs) received more complaints than did non-unionized nursing facilities: non-unionized NFs had more serious violations, particularly when the proportion of other county facilities unionized was higher. They said their findings suggest that unionization enhances problem reporting, and when there was a high proportion of unionized facilities in a county, the facilities that were non-unionized experienced more serious violations.[11]

---

[6] Howes, C., November 2002; Howes, C., 2004.

[7] Two more examples of before and after studies are: Reich, M., et al, 2002; Wyoming Department of Health, November 2002.

[8] See also Howes, C., 2004.

[9] Reif, L., 2002.

[10] Swan J. and Harrington C., April 2007.

[11] See also the work of Ash, M. and Seago, J.A., 2004.

Union Training Activities

Discussions with SEIU staffs and a review of local union web sites indicates that the amount of training and career development opportunities offered to workers varies by Local, and that Locals do not typically collect research on how many members are provided specific types of company or state training. The training of workers for compliance with state regulations is the responsibility of the agency that hires them. While unions provide training that workers would not otherwise receive, the magnitude of the impact of the training on quality and staff turnover is difficult to measure since this is not a well researched area. There is also little data available on non-union situations where a client in a self-directed program hires and trains a family member or non-union worker.

SEIU 1199 United Healthcare Workers East (SEIU 1199 UHW East) in New York has a Training and Employment Fund (TUF) that provides courses that include specific disease management programs, high school completion courses, skills training, training for employed registered nurses, classes for immigrants, and pre-college and college-level courses. This established local has 230,000 members, has had its training and employment fund for about ten years, and can afford to put on multiple classes.

In 2003 the SEIU 1199 TUF reported:

- 20,000 members completed one or more training programs;
- More than 15,000 members participated in workplace skills training programs;
- Over 2,000 members pursued a nursing degree in Fund-sponsored programs;
- 4,000 members were sponsored in basic education and pre-college programs; and,
- During the 2002-03 school year, the Fund processed 8,673 Tuition Assistance applications.[12]

SEIU local 775NW in Washington has a membership of about 30,500 home care and nursing home workers. The 775NW participates in the SEIU college scholarship program, which provides about 50 awards each year. It does not yet have an educational program where members can take courses through the local. Rather the local has devised a major policy initiative to assign responsibility for a centralized procedure for providing required training to health care workers.[13] This 775NW "Blue Print" calls for one administrative entity to provide a consistent statewide training program, for the state to increase entry-level training requirements for home and community-based workers from 34 hours to 85 hours, and for the establishment of a Certified Home Care Aide (CHCA) designation. Courses would cover both entry-level and advanced material, and the program would be introduced in phases.

---

[12] Information obtained from SEIU staff March 27, 2008 from January 2007 testimony by SEIU to the National Commission for Quality Long-Term Care

[13] SEIU 775NW. (2007 February) *A Blue Print for the Future*. See: http://www.seiu775.org/Admin/Assets/AssetContent/d8663f87-ebff-4552-9164-13d1f01b7ef7/546bfa9e-94e2-495f-9d30-54cc81f55e47/a01d946b-e947-4fe6-b2ef-5833d7b9c6d3/1/3-15-07Blueprint.pdf.

The Blue Print is intended to provide certification for the home care work force. This approach would provide parity with nursing home workers who are certified. The importance of certification is that the home care worker has more mobility to transition from working in home care to nursing facility care, and the worker can more easily qualify to attend a community college to become a registered nurse. A state issued certification may also encourage reciprocity across states. This "professionalization" of the work force would be expected to have a positive impact on quality.

SEIU UHW West has a centralized training program that provides career development or work-related training courses for its 140,000 members. Its Education Department offers disease-specific courses, career development, and CPR training. There is also a SEIU UHW West and Joint Employer Education Fund.[14] Given the absence of data, there is an unproven possibility that these training programs create a more knowledgeable work force and that this could positively impact the quality of care.

In California, training is done locally and is usually offered by county public authorities. Each individual county bargains its own contracts so there is no uniform statewide training. There are no mandatory state training requirements. Training is done in an independent provider mode and the consumer does the hiring and firing of a worker. The Local does not keep track of the total amount of training provided in the 11 counties where there are members. In the county of San Francisco, the Local has worked with the public authority and local community colleges to offer home care training.

The SEIU 503 website in Oregon does not appear to have an educational program or career development classes. Rather training is provided to encourage participation in union activities, such as steward training. In Oregon, the Homecare Commission was created by Ballot Measure 99, which was passed by the voters in 2000. The Commission is charged with providing training opportunities for home care workers, and it also serves as the employer when bargaining with SEIU.[15] As in Washington, the philosophy is to professionalize the workforce, and the Commission's activities are currently focused on creating a statewide registry of home care workers. As with Oregon's SEIU 503, SEIU's Healthcare Michigan provides access to scholarships but does not yet have a training and education program for its 55,000 members.[16]

Measurement of the effect of training by unions is difficult, in part because union locals differ in the manner in which they report on training programs that they offer. However, the cumulative impact of these training activities is presumed to be an increase in professional and personal skills that can contribute to higher levels of quality care.

[14] The SEIU UHW West Education Department catalog may be found at http://www.seiu-uhw.org/documents/education/fall2007cat.pdf.
[15] Courses offered by the Commission's Training Center can be found at http://www.ltcworkers.com/upcomingtraining.shtml.
[16] SEIU staff report that they are in discussions with the Governors' office, the employer of the workers, on how to increase training opportunities.

The Impact of Unions on Quality of Care

There are three arguable impacts that unions have on quality of care: increases in wages and benefits create a larger, more educated, and more stable workforce; changes in how care is provided might produce a better quality care; and, unions create incentives for improved work performance through training and by providing supportive financial and social services to their members. A look at these three effects leads to the proposal of three recommendations.

First, state staffs that are concerned with quality improvement need to develop strategies that ensure increased provider payments are tied to higher wages for workers, and are not absorbed by agency overhead. There is a concern on the part of state staffs that increased payments to providers do not necessarily get passed to workers in the form of higher wages.[17]

Second, Zabin suggests that state quality improvement staffs might consider using a quality-of-care indicator for recording turnover percentages. The current approaches in nursing home and other medical facility licensing that specify minimum staffing ratios could be changed or added to by developing quality indicators based on staff turnover. Simply having bodies present does not necessarily mean good care is being provided. Zabin summarizes her policy position based upon the literature on turnover, saying that while specific metrics have not been developed that relate turnover (or conversely continuity of care) to outcomes, there is no conceptual difference in creating a quality-of-care standard based on a maximum rate of turnover rather than on a minimum staffing ratio for services.[18]

Third, given the variability of training reported within states (*e.g.*, as discussed in the Washington Blue Print) one action that state staffs may consider is to review the number of training hours required and the curriculum that should be taught. Collecting comparative data on what states do and how the level of hours and curriculum are decided upon might illuminate changes that can improve quality.

---

[17] An example of this concern is Harrington et al 2008. An example of an effort to tie provider payment to worker wages is the California WARP language, which was passed by the legislature in the early 2000. This language amended SEC. 43.5 of the California Welfare and Institutions Code. at Section 14110.65 and included the provision that, "Any facility that is paid under the supplemental rate adjustment provided for in this section that the director finds has not provided the salary, wage, and benefit increases provided for shall be liable for the amount of funds paid to the facility by this section but not distributed to employees for salary, wage, and benefit increases, plus, plus a penalty equal to 10 percent of the funds not so distributed. Recoupment of funds from any facility that disagrees with the findings of the director specific to this section and has filed a request for hearing pursuant to Section 14171, shall be deferred until the request for hearing is either rejected or the director's final administrative decision is rendered." See http://www.dhs.ca.gov/publications/forms/pdf/dhs6227.pdf

[18] Zabin, C., 2003.

Resources

Addus Healthcare, Inc. (2006) Retrieved on January 25, 2008, from: http://www.addus.com/index.htm

Ash, M. and Seago, J.A. (2004) The effect of registered nurses' unions on heart-attack mortality. Industrial and Labor Relations Review, 57(3), 422-42.

Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Nursing, Psychiatric, and Home Health Aides, Washington, D. C. Retrieved on march 28, 2008 from http://www.bls.gov/oco/ocos165.htm.

Harrington, C. et.al. (2008, April) Impact of California's Medi-Cal Long Term Care Reimbursement Act On Access, Quality and Costs, Department of Social & Behavioral Sciences, University of California San Francisco, San Francisco, CA. http://www.nccnhr.org/uploads/Harrington-CHCFNHReimbursementPaperMarfinalall.pdf

Howes, C. (2004) Upgrading California's home care workforce: The impact of political action and unionization. The State of California Labor. Berkeley, CA: University of California, Institute for Labor and Employment, Multi-Campus Research Unit. Retrieved on January 20, 2008 from: http://www.irle.ucla.edu/research/scl/pdf04/scl2004ch3.pdf

Howes, C. (2002, November) The impact of a large wage increase on the workforce stability of IHSS home care workers in San Francisco County. Berkeley, CA: University of California, Center for Labor Education Research. Retrieved on January 20, 2008 from: http://www.directcareclearinghouse.org/download/WorkforceStabilityPaper.pdf

McDonald, I. (2007, February) The SEIU 775 long-term care training, support and career development network: A blueprint for the future (prepared for Service Employees International Union). Bronx, NY: PHI. Retrieved on January 28, 2008, from http://www.seiu775.org/Admin/Assets/AssetContent/d8663f87-ebff-4552-9164-13d1f01b7ef7/546bfa9e-94e2-495f-9d30-54cc81f55e47/a01d946b-e947-4fe6-b2ef-5833d7b9c6d3/1/3-15-07Blueprint.pdf

Reich, M., Hall P., and Jacobs, K. (2002) Living wages and economic performance: The San Francisco Airport model. Berkley, CA: University of California, Institute of Industrial Relations.

Reif, L. (2002, July 12-14) Paying for quality: Preliminary analysis of San Francisco in-home supportive services consumer evaluation of quality of care survey findings. Presented at the IAFFE 2002 Conference on Feminist Economics, Los Angeles, CA.

SEIU 775NW. (2007 February) *A blue print for the future*. Retrieved on January 24, 2008, from http://www.seiu775.org/Admin/Assets/AssetContent/d8663f87-ebff-4552-9164-

13d1f01b7ef7/546bfa9e-94e2-495f-9d30-54cc81f55e47/a01d946b-e947-4fe6-b2ef-5833d7b9c6d3/1/3-15-07Blueprint.pdf.

Swan J., and Harrington C. (2007, April) California nursing facility quality and union environments. *Journal of Aging and Health,* 19(2), 183-199.

U.S. Department Health and Human Service. Poverty guidelines. Retrieved on March 28, 2008 from http://aspe.hhs.gov/poverty/06poverty.shtml

Wyoming Department of Health. (2002, November) Report to the Joint Appropriations Committee on the impact of funding for direct staff salary increases in adult developmental disabilities community-based programs (Ref S-2002-749). Cheyenne, WY: Wyoming Department of Health. Retrieved on January 26, 2008, from http://ddd.state.wy.us/Documents/JAC1102.htm

Zabin, C. (2003, February) Labor standards and quality of care in California's services for people with developmental disabilities (expert witness testimony for Sanchez v. Johnson, Case C-00-01593 CW). Retrieved on January 28, 2008, from http://laborcenter.berkeley.edu/disabilities/sanchezvjohnson.pdf

HEALTH CARE COVERAGE FOR DIRECT CARE WORKERS: EMERGING STRATEGIES

Carol Regan, MPH, Director
Health Care for Health Care Workers Campaign, PHI

Background

Health insurance is a highly-valued benefit of employment for most working Americans. Despite the decline in employer-sponsored health insurance, most Americans still get their health insurance coverage from their jobs (62%). Yet for just over half of all direct care workers (52.4%), having a job does not bring with it the benefit of health insurance coverage. While many may receive health coverage from other sources – such as Medicare, Medicaid or their spouses – direct care workers are still twice as likely as the general population to be uninsured (29% vs. 15.8%). The workforce that is the fastest growing – jobs providing personal care services in peoples' homes – is the most likely to lack coverage. Over one in three (35%) home and personal care workers are uninsured.[1]

Several factors explain why so many direct service workers are falling through the holes of our nation's health care system.[2] The large percentage of direct service workers who work for temporary agencies, those who work for small home care agencies, and those who are hired directly by the clients they serve are typically not offered insurance through their employer. Others may be ineligible for benefits because they are part-time workers or new hires where there is often a long waiting period to become eligible. Finally, even those who are offered insurance through their employer may choose not to accept it because they cannot afford the financial burden. High costs are an issue for their employers as well, since they rely heavily on public funds, which vary from state to state and rarely include the costs of paying an adequate wage and health insurance.

The Impact

The lack of affordable health coverage affects workers, employers, and the clients they care for. For direct care workers, going without health insurance can affect their health and their financial stability. Not only do they risk serious illness, but many face insurmountable medical debt. These workers have high rates of chronic medical conditions, such as diabetes or hypertension; conditions that often go untreated and make it nearly impossible to buy health insurance on their own. Additionally, direct care work has the third highest rate of on-the-job injury.[3]

[1] PHI. (2008) *The invisible care gap: Caregivers without health coverage*. Bronx, NY: PHI.
[2] Lipson, D. & Regan, C., 2004, March.
[3] Bureau of Labor Statistics, U.S. Department of Labor, 2006.

For employers, the consequences of having an uninsured workforce are equally serious. Without health insurance, workers delay seeing doctors or are unable to afford medications that help them manage chronic illnesses. As a result, workers miss work or leave jobs altogether because an untreated illness becomes a serious disability. High turnover rates, more than 70% annually in nursing homes and between 40% to 60% in home care agencies, mean quality is compromised when consumers must endure an endless succession of new workers who are unfamiliar with their clinical needs and personal preferences.

The Role of Health Insurance in Recruitment and Retention

The encouraging news is that the long-term care field is now building a growing evidence base concerning the recruitment and retention of a high-quality paraprofessional workforce, including the impact of health insurance on turnover and retention. Researchers have found a strong positive link between employer-sponsored health insurance benefits and worker retention. In fact, the provision of health insurance may be more important than wages in reducing turnover and increasing the supply of direct care workers.

A growing number of studies support these findings:

- Frontline health care workers enrolled in employer health insurance plans have more than twice the tenure of those without employer coverage.[4]
- Health insurance may be even more important than wages in increasing supply of health workers and hours worked.[5]
- Home care workers enrolled in employer-sponsored health plans had a higher retention rate (56%) than workers who were eligible but not enrolled (45%).[6]
- In California, providing health insurance increased the probability of new direct-care workers remaining in their jobs for at least one year by 21 percent.[7]

Finding Solutions

Over the past ten years, the public and private sectors have both experimented with and implemented strategies to insure this workforce. While rising cost of health care has made this challenging, the good news is that solutions do exist. Across the country, state policymakers, employers, clients and their advocates, and unions have been engaging in joint efforts to make health care coverage for direct care workers accessible and affordable. The federal Centers for Medicare & Medicaid Services (CMS) recognized the need to improve the quality of direct care jobs and stabilize this workforce to improve the quality of care and meet the caregiving needs of the future. In an effort to better understand this issue, it launched the Demonstration to Improve the Direct Service Community Workforce in 2003. Through this demonstration program, six

[4] Duffy, N., 2004.
[5] Rodin, H.A., (006.
[6] RTZ Associates, Inc., 2005.
[7] Howes, C., 2005.

grantees received funds to provide health coverage and test the impact on recruitment and retention.[8]

While the interventions differ somewhat, they generally fall into a three broad categories:

1. Subsidizing premiums of employer-sponsored insurance (ESI);
2. Creating purchasing pools for small employers or independent providers; and,
3. Tying reimbursement rate increases or enhancements to health benefits.

Two other approaches, expanding eligibility for publicly funded plans and assisting workers with some of their health expenses, are underway in some states. For example, Massachusetts and Vermont have passed major expansions for their state programs, and New Mexico offered participating direct-service workers an arrangement that combines a limited health insurance product, a prescription discount card, and contributions to a tax-free health reimbursement account.[9]

Subsidizing ESI Premiums

Several states have programs designed to subsidize the employer and/or the employee share of the insurance premium. For example, Massachusetts, Vermont, and Wisconsin all offer programs that support employer-sponsored health insurance by helping to subsidize premium payments for small employers. In Maine, small businesses with 2-50 full-time employees, self-employed individuals, sole proprietors, and uninsured individuals are eligible to participate in the state-subsidized Dirigo Health plan.[10] Employers pay 60 percent of the premium cost; workers receive a sliding scale subsidy to cover their share. As a CMS grantee funded to conduct outreach to home care agencies to promote Dirigo, Maine found that employers lack reliable information about coverage options, and when presented with options, believe premium costs are unaffordable for their businesses. In fact for many of these providers who are heavily dependent on public funds to provide services, the state reimbursement rates are so low that providing health insurance is not possible.

Another CMS grantee, North Carolina, used their funds to subsidize direct service workers employed by four agencies that were already offering insurance prior to the demonstration. Subsidies of up to $108 per month were provided to employees for benefits that varied across agencies from comprehensive coverage to mini-medical plans.[11] Results of the demonstration found that the vast majority (89%) agreed that the availability of health insurance was valuable to them, and 68% indicated that the availability of insurance had increased their overall job satisfaction. Furthermore, three-fourths of respondents agreed that they were more likely to remain a DCW because of the availability of health insurance.[12]

---

[8] PHI, 2006, April.

[9] Ibid. The lack of evaluation data on the NM model of health benefit (also a federal DSW demonstration program) precluded treating this as a distinct category, and the VT and MA plans are just now underway.

[10] PHI, 2006, February. Eligibility is capped for uninsured individuals.

[11] PHI, 2007, January.

[12] Direct Service Workforce Final Summary Grant Report, Caregivers are Professionals, Too (CAPT), North Carolina, August 2007 See

Employer Purchasing Pools

Sharing the risk is essential for lowering insurance premiums. That is why it is easier for large health systems with multiple facilities that share a single health plan to make insurance affordable. Small employers, particularly in home care as well as organized groups of independent providers, are experimenting with employer pools as a way to share risk and increase their bargaining power with insurers.

In New York City, a labor/management jointly-administered Home Care Industry Benefit Fund provides health coverage to over 39,000 workers and their families (a total of 77,000 enrollees). These workers are employed by 66 New York City home attendant agencies that contribute a "cents/hour worked" rate for each eligible employee into the fund for health benefits. Home attendants pay no premium or deductible, but they do pay limited co-pays.

Oregon and California formed "public authorities," employers of record for self-employed home care workers. As a result, workers were able to unionize, and in partnership with consumers they successfully advocated for affordable group health insurance benefits.[13]

Increasing Medicaid Reimbursement

Many long-term care employers rely heavily on Medicaid reimbursement. While long-term care is financed through a combination of public and private sources, the Medicaid program is by far the single largest payer of long-term care services, financing 49% of long-term care services in 2005.[14] It covers the cost of both institutional care and home and community-based services.

Limited Medicaid reimbursement rates are an obstacle for employers who want to provide health care coverage for their employees. These reimbursement rate structures, which vary by state and sector, do not always entirely cover the cost of health insurance or other benefits for workers. A recent study found that most states set reimbursement rates for Medicaid-funded personal care services in a relatively ad hoc manner and without knowledge of whether the provider agencies they contract with provide health care coverage.[15] In addition, while Medicaid reimbursement rates for nursing facilities are typically updated annually based on an inflation factor, this is extremely rare for Medicaid reimbursement for home and community-based services. Too often, rates fail to keep up with provider costs and inflation.

However, some states have used the Medicaid reimbursement to pay for health benefits and to capture federal matching funds to help offset total costs. Several examples include:

---

http://www.directcareclearinghouse.org/download/Caregivers%20Are%20Professionals,%20Too!%20(CAPT)%20Final%20Summary%20Report%202007.pdf

[13] PHI, 2008, January.
[14] Komisar, H. L. & Thompson, L. S., 2007.
[15] Seavey, D. & Salter, V., 2006.

- New York State pays up to $2,500 annually (per employee) for health insurance coverage for service providers under contract with the state's Office of Mental Retardation and Developmental Disabilities,[16]
- Montana passed a bill in 2007 that raises the Medicaid rate to provide health insurance for an estimated 1000 in-home caregivers.[17]
- California has included part of the cost of health insurance in the Medicaid rates for its In-Home Supportive Services program since 2000.[18]

Lessons Learned

The unique characteristics of this workforce (i.e., low wage, part-time, high risk) and their employers (i.e., small, independent with limited resources) make accessing affordable employer-sponsored coverage difficult. Moreover, it hasn't been until recently that researchers have begun to explore the impact that health coverage may have on stabilizing the direct care workforce. New data sources are also emerging, including data from a 2004 national survey of nursing aides conducted by the National Center for Health Statistics, and a similar survey on home health care workers that is currently underway.[19] These survey data include information on health insurance coverage.

Two analyses of coverage models are worth noting:

- In 2004, an evaluation of the Home Care Workers Health Insurance Demonstration Project, enacted in 1999 to address workforce recruitment and retention of NY City home attendants, found that workers enjoyed longer tenure and greater job satisfaction largely as a result of the new health benefits (but also as a result of substantially increased wages).[20]

- A preliminary analysis of the six CMS grantees engaged in health insurance interventions was conducted in late 2006, and it found variations in its success among the states.[21] Overall, the grantees struggled to design interventions that would be both affordable and offer comprehensive benefits, and they also wanted the programs to be simple to understand and sustainable over time. The grantees found, for example, that the health premium subsidy was popular with both participating employers and employees, and that it has been associated with positive outcomes in the areas of recruitment and retention. However, while the subsidy reduces, and in some cases eliminates, the employee share of

[16] Proposed regulation available at http://www.omr.state.ny.us/hp_healthcare_summary.jsp.
[17] For a more detailed description of this program see, "Healthcare for Montanans Who Provide Healthcare: A Case Study on Expanding Health Coverage for Direct Care Workers." Forthcoming in March 2008: www.coverageiscritical.org.
[18] New York, Office of Mental Retardation And Developmental Disabilities. See CA AB2876, Chapter 108, Statutes of 2000.
[19] National Center for Health Statistics, CDC, 2005. See: http://www.cdc.gov/nchs/nnhs.htm. The National Home and Hospice Care Survey went into the field in Fall 2007.
[20] Berliner, 2004, June 28.
[21] The demonstrations ended in 2007 and the Rand Corporation is completing a full evaluation and the reports will be available in the fall of 2008.

monthly premiums, direct service workers continue to face high out-of-pocket medical costs. Without additional cost controls to reign in premium levels, employers anticipate a further shift away from plans that offer comprehensive benefits towards low-cost "mini medical plans" with limited benefits.

These demonstration projects and experiences from other state and employer efforts underscore the need for government support for these workers and their employers. Coverage must be affordable for workers who earn very low wages, and reimbursements or other enhancements must be adequate to assist employers who want to provide coverage. Finally, there is a need for alternative coverage mechanisms developed for the growing number of workers in home and community-based services that, due to their work status, will not be covered by their employers.

Conclusion

The provision of health insurance is clearly an important element of a quality job, and it has been shown to improve retention critical to ensuring quality of care. With the demand for jobs in the home and community-based setting outpacing the supply of workers, policymakers and employers must work together to ensure a quality workforce. Health insurance will remain an essential part of any solution.

Appendix: Coverage Models "At A Glance"

Strategy	State Example	Description	Advantages	Disadvantages
1. Expand public insurance coverage	Massachusetts: Health Reform Law	A state mandate requires all adults age 18 and older to have health insurance. Three public programs (MassHealth, the state's Medicaid program, Commonwealth Care and Commonwealth Choice) provide comprehensive insurance options for individuals and families and offer subsidized options to those at or below 300 percent of FPL.	✓ Comprehensive ✓ Affordable ✓ Accessible	✓ Options are complex and difficult for some to understand ✓ Mandate does not work for those who can- not find affordable option.
	Vermont: Catamount Health Program	New public health care program for individuals below 300 percent of the FPL. Funded through a combination of state funds (tobacco taxes and employer assessments) and a Medicaid waiver to provide coverage to adults with incomes between 150 and 200 percent of FPL.	✓ Comprehensive ✓ Includes program to subsidize employer sponsored health insurance	✓ High out of pocket costs for workers
	Rhode Island: RIte Care Child Care Program	A Medicaid Managed Care program, expanded to allow eligibility for certain child care providers, 300 currently enrolled.	✓ Comprehensive ✓ Affordable	✓ Does not address direct-care workforce
2. Make employer based insurance more affordable	Michigan: Access Health Plan	One of several county-based health care plans that divide insurance premiums between the employer, employee, and county.	✓ Comprehensive ✓ Affordable for employers and employees ✓ Community-based wellness program	✓ Relies on Medicaid DSH funds ✓ Funding stream may not be secure
	North Carolina: Premium Subsidies Demonstration	Used CMS funding to subsidize employee share of insurance premiums for home care workers employed by four home care agencies, 200 workers participated.	✓ Popular ✓ Associated with improved recruitment and retention	✓ No cost controls ✓ High costs for employers ✓ High out-of-pocket costs for employees
	Maine: DirigoChoice	A state-supported health insurance plan aimed at small businesses. Provides subsidies for employee premiums.	✓ Established public program	✓ Premium costs unaffordable for small home care employers

Strategy	State Example	Description	Advantages	Disadvantages
3. Establish coverage through collective bargaining	New York: 1199SEIU Benefit and Pension Funds	Two Taft-Hartley multi-employer benefit funds governed by a labor-management partnership. Participants include 80,000 home attendants and their families and 10,000 home health aides.	✓ Comprehensive ✓ Affordable ✓ Union advocacy ensures ongoing funding	✓ Uncertainty regarding new financing mechanism.
	Washington: SEIU 775 Multi-Employer Health Benefits Trust	A Taft-Hartley multi-employer benefit fund governed by a labor-management partnership. Participants include 6,399 Individual Provider home care workers and 3,003 agency home care workers.	✓ Comprehensive ✓ Affordable for workers ✓ Union advocacy means stable funding	✓ Hours eligibility requirement (86 hours per month) ✓ Outreach is challenging
	Oregon: Home Care Union Benefits Board	Union-run third party administrator of health benefits for 3,500 independent home care workers.	✓ Comprehensive ✓ Affordable ✓ Union advocacy means stable funding	✓ Hours eligibility requirement (80 hours per month) ✓ Outreach is challenging
4. Build insurance costs into Medicaid reimbursement	Montana: Health Care for Health Care Workers	Beginning in January 2009, it will enhanced rate to Medicaid-funded home care agencies to provide affordable health insurance coverage for an estimated 1,000 uninsured home care workers.	✓ Simple and easy to understand ✓ Utilizes federal matching funds ✓ Potential to provide comprehensive, affordable coverage	✓ Specifics on benefit design and affordability protections not yet defined. ✓ Voluntary participation could leave some out ✓ Ongoing advocacy needed
	California: HealthyWorkers	Joint effort between union, public authority and government officials to offer county-run Medicaid HMO to independent home care workers, 10,000 currently enrolled.	✓ Comprehensive ✓ Affordable ✓ Stable funding ✓ Broad support from multiple stakeholder groups	✓ Delivery through county health system means some waits and limited choice
5. Assist workers with health care expenses	New Mexico: Health Care Reimbursement Arrangement	A package of three components, including a basic health care insurance, a prescription discount card and monthly cash benefit account, 200 workers employed by 7 developmental disability providers participated.	✓ Low-cost for employers ✓ Flexible for employees	✓ Complex ✓ Limited assistance only ✓ Not comprehensive

Resources

Berliner, H. (2004, June). *Home Care Workers Health Insurance Demonstration Project: Final Evaluation*. New York City: New School University.

Bureau of Labor Statistics, U.S. Department of Labor. (2006). Survey *of occupational injuries and illnesses.* Retrieved on January 15, 2008, from http://www.bls.gov/iif/oshwc/osh/case/osch0034.pdf.

Duffy, N. (2004). *Job tenure of frontline healthcare workers, Working Paper 102.* New York City: JFK Jr. Institute for Worker Education, City University of New York.

Howes, C. (2005). Living wages and retention of homecare workers in San Francisco. *Industrial Relations*, 44(1): 139-163.

Komisar, H. L., & Thompson, L. S. (2007). *National spending for long-term care.* Washington DC: Georgetown University Long Term Care Financing Project.

Lipson, D. & Regan, C. (2004, March). Health insurance coverage for direct care workers: Riding out the storm. *Better Jobs, Better Care Issue Brief 1(3).*

National Center for Health Statistics, Centers for Disease Control and Prevention. (2005). *National Nurses Aides Survey, 2004.* Retrieved on January 15, 2008, from http://www.cdc.gov/nchs/nnhs.htm.

New York State, Office Of Mental Retardation And Developmental Disabilities. (2007, October 10). *Summary - Health Care Enhancement III Proposed Regulations.* (CA AB2876, Chapter 108, Statutes of 2000). Retrieved on April 3, 2008, from http://www.omr.state.ny.us/hp_healthcare_summary.jsp.

PHI. (2006, February). *Health insurance coverage for the home care sector: Experience from early DirigoChoice enrollment in Maine*. Bronx, NY: PHI.

PHI. (2006, April). *CMS Direct Service Workforce Demonstration Grants: Overview and discussion of health coverage interventions*. Bronx, NY: PHI.

PHI. (2007, January). *Emerging strategies for providing health coverage to the frontline workforce in long term care: Lessons from the CMS Direct Service Community Workforce Demonstration Grants*. Bronx, NY: PHI.

PHI. (2008, January). *Coverage models from the states: Strategies for expanding health coverage to the direct care workforce*. Bronx, NY: PHI

PHI. (2008, March). *Healthcare for Montanans who provide healthcare: A case study on expanding health coverage for direct care workers.* Bronx, NY: PHI. Forthcoming at www.coverageiscritical.org.

PHI. (2008). *The invisible care gap: Caregivers without health coverage*. Bronx, NY: PHI.

Rodin, H.A. (2006). *Increasing the supply of certified nursing assistants, PhD dissertation.* Minneapolis, MN: School of Public Health, University of Minnesota.

RTZ Associates, Inc. (2005). *Expanding health benefit eligibility: Impacts on the IHSS workforce*. Los Angeles, CA: Personal Assistance Services Council of Los Angeles County (PASC).

Seavey, D., & Salter, V. (2006). Paying for quality care: State and local strategies for improving wages and benefits for personal care assistants. Washington, DC: AARP Public Policy Institute.