

Improving Quality and Availability of Direct-Care Workers

a report prepared by Maine's Work Group for Community-Based Living

Maine, like nearly every other state in the country, faces a serious and growing shortage of direct care staff to meet the needs of persons with disabilities in both community-based and institutional settings. To reduce the shortage of direct care staff for community-based services, we recommend that the State should:

- collect data across departments to quantify the extent and impact of these shortages;
- create an effort across Departments to build new respect for the direct care profession;
- improve recruitment and training practices;
- create career opportunities for growth and advancement;
- improve wages and benefits;
- expand access to consumer-directed care options; and
- solicit outside funding and grant support to develop more permanent solutions.

Direct care workers are employed under many job titles: nurses aides, home health aides, home care aides, personal care aides, in-home service support workers, homemakers, behavioral specialists, mental health rehabilitation technicians, independent living skills specialists, crisis program workers, qualified mental health professionals, and educational technicians, among others. These staff provide basic and essential services and supports across the full range of disabilities including mental illness, developmental disabilities, physical disabilities, dementia, and the need for assistance with basic activities of daily living. These are the paid caregivers, who, along with unpaid relatives and friends, make it possible for many persons with disabilities to live at home or in other community settings, instead of in an institution.

Many direct care staff find their work personally rewarding. However, direct care work can often be physically strenuous, including turning, lifting, or physically supporting consumers. The work can also be emotionally challenging, and some of the tasks can be unpleasant.

Direct care staff are a fundamental key to the basic quality of life for the consumers they serve. The shortage or availability of direct care staff is a key variable in the quality of care.

The Need — Not Just Numbers, But Turnover and Quality

Direct care work is a fast-growing field. Agencies and programs need to keep creating more direct care jobs to keep up with the growing need for services. A recent survey of Medicaid agencies and State Units on Aging found that 42 of the 50 states already consider hiring and keeping direct care aides to be a "major issue"¹ (Harmuth 1999). While the hiring and retention of direct care staff is considered a serious problem in Maine, the state agencies that are

¹ Harmuth, S. (1999) *Comparing state efforts to address the recruitment and retention of nurse aide and other paraprofessional aide workers*. North Carolina Division of Facility Services: Raleigh, NC. Available: <http://facility-services.state.nc.us/recruit.pdf>

responsible for services for persons with disabilities, for the most part, do not collect data on the number of direct care staff, the number of vacancies, staff turnover rates, or the average number of days it takes to hire replacements for workers who leave the job.

In part, because our population is aging, demand for additional direct care staff is growing quickly. The U.S. Department of Labor has found that "personal care and home health aides" is the seventh-fastest growing occupation in the nation². They predict the number of new direct care jobs will increase by an average of 5% every year between now and 2008.

However, the need to fill new jobs is not even half the problem. Most newly hired direct care aides leave their jobs within the first year. Although there is no commonly accepted standard for measuring turnover, the annual turnover rates for all direct care aides across the country are reported to vary from 21% to over 100%. A recent survey of 23 Maine mental health services agencies found the annual turnover rate for 2,000 FTE (full-time equivalency) direct care staff positions averaged 29%.³ That means that for every newly created direct care job that programs need to fill, these same programs need to hire 4 to 20 or more persons to replace the workers who left. That means higher job advertising and hiring costs, higher training costs for agencies, and more stress and extra work for the direct care workers who stay on the job. It also means lower quality of care for consumers who are cared for by a string of inexperienced strangers who don't stay long enough to learn the consumer's preferences and needs. New aides who are unfamiliar with a consumer's disability, personality, and normal day-to-day condition may fail to recognize changes that would otherwise signal a need for serious attention. There is no single cause to the high turnover problem, and no single answer.

Several states across the country, including Pennsylvania, Ohio, Maryland, California and North Carolina have conducted one-time or on-going bi-annual surveys to measure healthcare and/or direct care workforce supply and demand. The surveys collect data on the number of persons in various direct care jobs, age of employees, number of students in training, numbers of vacant positions, vacancy rates across type of job and region, and average number of days to fill vacant positions. As an early step, we recommend that Maine conduct a similar survey of direct care staff and employers across the full range of types of disability. The Legislature is considering a resolve, L.D. 1498, "to Require the Collection of Health Care Practitioner Workforce Data," by surveying licensed or registered health care staff as a condition of licensure or renewal. While the bill is primarily aimed at medical providers, it could be broadened to cover a wider array of direct care staff. The survey would collect information on each provider's age, specialty, work setting, education, and activity status. It would also be useful to ask about the likelihood of remaining in the profession and reasons for staying or leaving.

The Legislature is also considering resolve L.D. 1346, "to Establish a Commission to Study the Health Care Workforce Shortage." While this bill is also focussed on nursing and other primarily medical professions, it too could be broadened to encompass direct care staff for persons with

² Braddock, D. (1999) *Occupational employment projections to 2008*. Monthly Labor Review (November), 51-77 and Bureau of Labor Statistics, U.S. Department of Labor. (1999) *1998 State Occupational Employment and Wage Estimates: Maine*. Washington, DC. Available: http://stats.bls.gov/oes/1998/oes_me.htm

³ Maine Association of Mental Health Services survey. (2001) Available: <http://me.nami.org/fgrep2001.htm>

disabilities. If created, this Commission could be charged with responsibility to conduct the kinds of surveys of health care staff and employers described above.

Members of the Work Group know from their own and from other's personal experience that many of the people who currently do get hired to perform direct care services lack the appropriate training, skills, trustworthiness, career dedication, and attitude to do the job properly, and that the situation won't change until the job itself is fundamentally redefined to become a more respected occupation.

Build Respect for the Profession

The problems of chronic high turnover and the challenge of filling new positions won't be solved until the job itself is defined and respected as a professional occupation commensurate with teaching, social work, or nursing. Enhancing the status of the direct care profession will be a process, which could involve some of the following approaches:

- Exploring an adaptation of the European "Social Pedagogy" or "Social Educators" model for professionalizing and improving the training of direct care staff who work with persons with developmental disabilities — an approach promoted by the Yarmouth, Maine-based International Learning Exchange in Social Education.
- Identifying constituencies among whom to build respect. These should include potential employees, providers who employ those staff, consumers, legislators, and the general public.
- Consider renaming the profession to overcome historical stigma and to more accurately reflect the important role and responsibilities of the staff.
- Develop and execute a public relations plan. This begins with articulating the message of how the importance and responsibilities of direct care workers have changed, and then bringing that message to the target audiences identified above through conferences, workshops, presentations, school visits, and high impact media. This plan could be modeled after the successful North Carolina Center for Nursing public relations campaign that operates at very low cost.

Improve Recruitment and Training

A 1997 survey of Maine nursing homes and boarding homes found that 79% of new Certified Nursing Assistants (CNAs) left within the first year.⁴ Many newly hired aides leave before their training and orientation are completed. Some people leave agencies shortly after being hired because the work is not what they expected, or because the job interview process was not structured to screen out persons whose work habits, abilities or attitudes were unsuited for the job. Agencies that address these problems by putting more thought and effort into the hiring and training process can achieve reduced turnover rates, reduced overall training costs, and better

⁴ Maine Labor Task Force. (1999) *The shortage of CNAs and PCAs in Maine: Short and Long Term Solutions*. Maine Labor Task Force: Augusta, ME.

quality of care and support. Improving recruitment and training requires a plan, which could include:

- Defining the competencies professional direct care staff should master;
- Creating and *effectively* training to convey those competencies;
- Consider increasing the direct care educational and training prerequisites for certain services;
- Provide direct, hands-on experience with consumers during training;
- Provide more supervision, transition, and mentoring support, especially during the first year of employment;
- Expand the number of direct-care work fields that require state certification so that direct care aides who change employers do not have to repeat the basic training they have already completed;
- Define and develop professional growth opportunities along a career track of increasing responsibility, reward, and compensation; and
- Create multiple levels of state certification within each direct care field to support the creation of career tracks.

Improve Wages and Benefits

Direct care jobs typically pay low wages and offer few, if any, benefits. As Robyn Stone, a leading long term care researcher, wrote last year, "Paraprofessionals are among the worst paid workers in the service sector."⁵ Nationwide, most community-based direct care staff work part-time⁶ due to a variety of factors, including unreimbursed travel time, difficulty with childcare due to awkward work schedules, and lack of motivation due to uncompetitive pay relative to the demands of the job. In 1998, home health aides in Maine were paid a median hourly wage of \$7.88, while personal and home care aides were paid \$7.34.⁷ Even assuming a 40-hour workweek, both groups still earned less than the 1998 Federal Poverty Level for a family of four,⁸ and less than two-thirds of the average annual salary for all Maine workers.

According to a study of the federal Current Population Surveys for 1987-89, fewer than half (43%) of all home care aides across the U.S. received health insurance benefits at work.⁹ More recent research suggests the proportion of home care staff earning health benefits may be below

⁵ Stone, R. (2000) *Long term care for the elderly with disabilities: Current policy, emerging trends, and implications for the twenty-first century*. Millbank Memorial Fund. Available: <http://www.milbank.org/0008stone/#workforce>

⁶ Crown, W.H. (1994) *A national profile of homecare, nursing home, and hospital aides*. Generations (18)3, 29-33.

⁷ Bureau of Labor Statistics, U.S. Department of Labor. (1999) *1998 State Occupational Employment and Wage Estimates: Maine*. Washington, DC. Available: http://stats.bls.gov/oes/1998/oes_me.htm

⁸ U.S. Census Bureau. (1999) *Poverty 1998*. Washington, DC. Available: <http://www.census.gov/hhes/poverty/threshld/thresh98.html>

⁹ Crown, W.H. (1994).

one-third.¹⁰ Nationwide, in the late 1980's, only a quarter of all home care staff in America earned retirement benefits.¹¹ Direct care staff usually have to provide their own transportation to-and-from consumer's homes or community-based care sites, and the costs of that transportation are often unreimbursed. In short, most direct care workers can often find other less challenging entry-level jobs at better wages and benefits, especially in the current climate of very low unemployment.¹² Employers of direct care staff should be encouraged to improve wages and benefits as one method to reduce turnover and attract new employees to the field. We should also explore whether the creation of a statewide or regional direct care staff association could lead to lower group rates for health insurance and other benefits. Since 1997, Rhode Island has allowed certified child care workers who serve children in state-funded programs to buy-in to the state's Medicaid managed care health insurance coverage at state-subsidized rates. The State could explore that option for extending health care benefits to direct care staff in Maine.

Consumer-Directed Care Options

Consumer-directed care programs provide vouchers or cash grants to consumers who then use the money to recruit, hire, train, and direct their own staff, or to purchase other supports. Consumer-directed options expand the size of the available work force because consumers often hire relatives, neighbors and friends who would normally not enter the direct care field. Therefore, some of the direct care staff shortage could be reduced by making consumer-directed care options available to consumers across all types of disability.

There are many existing examples of consumer-directed care programs across the country and in Maine, especially for persons with physical disabilities, long term care needs, and developmental disabilities. Consumers with serious cognitive impairments can often participate by way of a family member or friend with power-of-attorney to make necessary decisions on their behalf. Consumers who participate in these programs appreciate a greater degree of control over their own lives and the opportunity to be served by people they know and trust instead of having an agency send strangers into their homes. Among a sample of 139 of Maine long term care consumers surveyed by phone in 2000, 93% of those who had chosen a state-funded consumer directed care option were "very satisfied" with their services, while only 56% of the consumers served by traditional agency-based services within the Medicaid waiver programs for the elderly and adults with disabilities could say the same.¹³

There are important differences between consumer-directed care programs. Programs vary in their initial education and training requirements for consumer-participants. Some programs require the consumer to become the employer of record and to handle all the paperwork for

¹⁰ Grantmakers in Health. (2000) *Long term care quality: Facing the challenges of an aging population*. Washington, DC, Issue Brief 6, 11.

¹¹ Crown, W.H. (1994).

¹² Stone, R. (2000).

¹³ Bratesman, S. and Richards, M. (2000) *Preliminary findings from a survey of Maine's home-based care voucher program participants*. Edmund S. Muskie School of Public Service: Portland, ME.

payroll, withholding taxes and benefits. Some programs provide some or all of those services on every consumer's behalf, while others make those services optional at the consumer's choice. While consumer-directed care programs are thought to save states money, when compared to traditional agency-based services the full results of the first rigorous evaluation of consumer-directed care, the three-state Cash and Counseling program, will not be available until 2003. However, most states usually set the size of the month cash or voucher grants to a fixed percentage of the sum that would have been available for a consumer's care through a traditional agency. While consumer satisfaction with these programs is very high, there is a concern that the direct care staff often earn a lower wage and are far less likely to receive benefits than the direct care employees of traditional agencies.

Next Steps

Although beyond the scope of Maine's responsibilities under the *Olmstead* decision, consideration should be given to developing support of the profession from private corporate and charitable sources. Such support would not only contribute toward continued growth and stability of the profession, but also potentially reduce the demand upon state and federal funding, while still meeting essential human needs.

Summary

The current provision of home and community-based services for persons with disabilities is already hampered by a shortage of direct care staff, and these shortages are likely to get worse in the absence of direct efforts to reverse current trends. We recommend that the State should:

- Collect data across Departments and programs to quantify the supply and demand for direct care staff who provide services and supports for persons with disabilities;
- Create an effort across Departments to build new respect for the direct care profession;
- Improve recruitment and training practices;
- Create career opportunities for growth and advancement;
- Improve wages and benefits;
- Expand the availability of consumer-directed care options; and
- Transform the nature of direct care work from semi-skilled, low-wage to a professional occupation commensurate with teaching, social work, or nursing.