

# The Direct Care Worker: A Key Dimension of Home Care Policy

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*Home health aides, home care workers, and personal care attendants form the core of the formal home care system by providing assistance with activities of daily living and the personal interaction that is essential to quality of life and quality of care for their clients. High turnover and long vacancy periods are costly for providers, consumers, their families, and workers themselves. In 2002, 37 states identified worker recruitment and retention as major priority issues. Demographic and economic trends do not augur well for the future availability of quality home care workers. Policy makers in the areas of health, long-term care, labor, welfare, and immigration must partner with providers, worker organizations, and researchers to identify and implement the most successful interventions for developing and sustaining this workforce at both policy and practice levels. The future of home care will depend, in large part, on this third rail of long-term care policy.*

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**T**he home is the setting of choice for most Americans who need long-term care. National polls indicate that older adults and younger people with disabilities want to remain in their own homes in their own communities for as long as possible. Many hospitalized individuals with postacute care needs also rely on home health care to make that transition back into the community, provide rehabilitation, and address restorative concerns.

Since the early 1980s, policy makers, providers, and consumers have focused primarily on how to finance home care and, in particular, how to level the playing

field between Medicaid-funded, nursing home care and community-based, long-term care. Federal policy makers have focused most of their attention on how to control expenditures associated with the Medicare home health benefit. Until recently, very little attention has been paid to the availability and quality of the workforce that provides the services and supports. During the economic prosperity of the 1990s, however, providers and consumers began to experience a serious shortage of direct care workers across nursing homes, assisted living, adult day care, and home care. Even individuals able to purchase services in the private market expressed frustration at their inability to find qualified workers. Unlike the late 1980s when an economic downturn solved the worker shortage, the recent economic slowdown and rising rates of unemployment have not stemmed the tide of unprecedented vacancies and turnover among direct care workers. In a 2002 national survey, 37 states reported that nurse and home care aide recruitment and retention are priority concerns (Paraprofessional Health Institute [PHI] & North Carolina Department of Health & Human Services [NCDHHS], 2002).

Many factors contribute to high vacancy and turnover rates among direct care workers. Wages tend to be quite low. In 2001, the median hourly wage was \$8.46 for home health aides and \$9.27 for nursing aides, orderlies, and attendants (U.S. Bureau of Labor Statistics [BLS], 2001). Benefits are typically inadequate. Of particular concern to many workers is the lack of access to health insurance. Where coverage is provided, the premiums and co-pays are frequently not affordable for

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most of these low-wage workers living at or near the poverty level.

The negative public image of the home care worker (e.g., a poorly trained woman with few skills, receiving low pay for unpleasant work, and with little hope for advancement) discourages individuals from seeking or remaining in this occupation. Research supports anecdotal evidence that workers themselves do not feel valued by their employers and, particularly, their immediate supervisors (Stone & Weiner, 2001). Findings from a number of studies underscore the prominent role supervisors play in determining the frontline workers' level of job satisfaction and decisions to remain on the job (Feldman, 1994). The work is physically and emotionally challenging and these pressures are exacerbated by staff vacancies and the lack of a back-up workforce. At the same time, the clients to be cared for are increasingly sick and more disabled. Job preparation and continuing education and training frequently fail to prepare workers for these challenges.

### CHARACTERISTICS OF THE HOME CARE WORKFORCE

Direct care workers form the core of the formal post-acute and long-term care system. After informal caregivers, these frontline workers provide the majority of hands-on care, supervision, and emotional support to millions of people with chronic illnesses and disabilities living in their own homes or other community-based settings. The care they provide is intimate and personal. It is also increasingly complex and frequently both physically and emotionally challenging. Because of their ongoing, daily contact with the care recipient and the relationships that develop between the worker and client, these frontline workers are the "eyes and ears" of the care system. In addition to helping with activities of daily living such as bathing, dressing, toileting, eating, and managing medications, these workers provide the personal interaction that is essential to the quality of life and quality of care for chronically disabled individuals.

The term *direct care worker* subsumes several categories of individuals providing home and community-based services. Home health aides tend to be employed by certified home health agencies and work under the supervision of a registered nurse (RN). Those providing home health services reimbursed by Medicare or Medicaid are subject to federally or state-mandated training requirements. Home care or personal care

workers hired by state, local, or nonprofit agencies to provide assistance with activities of daily living and other supports may or may not work under RN supervision and may or may be subject to any training requirements. Independent providers are hired directly by individual consumers rather than through an agency. A growing number of public programs have adopted this consumer-directed model where beneficiaries have the option of hiring and firing their own workers including family members.

According to BLS (2000) estimates, home health and personal care aides held about 746,000 jobs in 1998. This figure, however, underestimates the total number of home care workers, because many aides are hired privately and may not be included in official federal statistics. One California study of independent home care workers, for example, reported that the state employs more than 200,000 independent personal care workers through its In-Home Supportive Services (IHSS) Program—72,000 in Los Angeles County alone (Cousineau, 2000). In their national study of home care workers providing assistance to the Medicare population, Leon and Franco (1998) found that 29% of the workers were self-employed.

A comprehensive profile of nurses' aides (NAs) and home care workers using national data from the Current Population Survey from 1987 through 1989 compared demographic characteristics and work conditions for hospital aides, NAs, and home care aides (Crown, Ahlburg, & MacAdam, 1995). Yamada (2002) updated the data on home care workers using the same data sources and methodology to assess trends in this workforce between the late 1980s and late 1990s. Not surprisingly, the vast majority of these workers in both periods were female. Compared to the late 1980s, home care aides in the late 1990s were younger, more educated, and more likely to have children. Although home care aides tended to be older than nursing home and hospital aides in both periods, the mean age of home care aides declined over the 10-year period. Home care aides still have less education than other aide categories, but almost 30% of these workers in the late 1990s had at least some college education.

With regard to working conditions, the proportion of home care aides working full-time increased over the 10-year period from 29% to 46%. These workers were still less likely to work full-time and full-year than were NAs or hospital aides. Yamada (2002) found that 18% of those working part-time preferred to be employed full-time but had not been able to find such a position.

Home care workers were somewhat more likely than NAs to have earnings from other work (23% compared with 20%) thus suggesting that many home care aides hold more than one job and work full-time but without access to the benefits of full-time status.

Yamada's (2002) analysis indicates that these jobs continue to be characterized by low wages and poor benefits. Median hourly wages of home care aides increased slightly over the 10 years from \$5.81 to \$6.00 (adjusted to 1998 dollars based on the Consumer Price Index), and both mean and median family income increased as well. Hospital aides still had the highest wages of the three groups. In the late 1990s, 16% of NAs and 22% of home care aides were likely to be living at or below the poverty line.

Yamada (2002) found little change over the 10-year period in employer-provided health insurance coverage for NAs and hospital aides (42% and 62%, respectively), but the proportion of home care aides with some type of employer-sponsored coverage increased from 14% in the late 1980s to 26% in the late 1990s. Yamada also found a substantial increase in the percentage with Medicaid coverage, nearly tripling in all three groups—11% of NAs, 16% of home care aides, and 5% of hospital aides. These estimates, however, belie the fact that there have been significant increases in coinsurance rates for employees over the past 10 years. The employee portion of the insurance premium can be as high as 50% for long-term care employees (Michigan Assisted Living Association, 2001). For home care aides, this makes health coverage unaffordable. For example, a survey of nearly 200 direct care workers in Massachusetts found that one in four were uninsured in 2002 (Hams, Herold, Lee, & Worters, 2002). Cousineau (2000) found that 45% of the 72,000 independent home care workers hired through the IHSS program in Los Angeles were uninsured.

## DEFINING THE PROBLEM

The severe shortage of NAs, home health aides, and home care aides that began in the late 1990s has been the primary trend influencing the current wave of concern about the long-term care workforce. High turnover rates, particularly in the 3 months post-hire, and high vacancy rates have negative effects on providers, consumers, and workers. The cost of replacing workers is high. Zahrt (1992) documented the costs of replacing home care workers including the costs of recruiting, orienting, and training the new employee and the

costs related to terminating the worker being replaced (e.g., exit interview, administrative functions, separation pay, unemployment taxes). The total cost associated with each turnover was \$3,362.

In addition to the financial costs of the initial hire and termination, there are costs associated with lost productivity during the time it takes for each new hire to complete the learning curve (Atchley, 1996). Furthermore, this estimate does not include the costs of attrition that occurs between initial hires, training, and retention. White (1994) found that, out of 351 potential home care worker recruits who completed a scheduled interview, 216 were accepted into the training program, 133 actually started classes, 106 graduated, and only 46 were still with the agency 6 months after they were placed.

Leon, Marainen, and Marcotte (2001) found that, across all Pennsylvania long-term care providers, the estimated annual (recurring) cost of training due to turnover was at least \$35 million. Nursing home training costs accounted for \$23.9 million, and home health/home care agencies' costs accounted for \$4.8 million. The regions encompassing large metropolitan areas accounted for 75% of the costs. In addition to the recurring turnover costs, one-time state training costs for filling currently open jobs were estimated at \$13.5 million in 2000.

High turnover and vacancy rates also have negative consequences for consumers. Although there is little empirical evidence to establish causal links, anecdotes and qualitative studies suggest that problems with attracting and retaining direct care workers may translate into poorer quality and/or unsafe care, major disruptions in the continuity of care, and reduced access to care (Wunderlich, Sloan, & Davis, 1996). The reduced availability and frequent churning of home care workers may affect clients' physical and mental functioning. A reduced pool of workers also places more pressure on family caregivers who are already providing the bulk of care to disabled individuals living in the community.

Direct care workers also suffer from the effects of labor shortages and high turnover. Short staffing places undue burdens on individuals who remain on the job. In home care, short staffing may limit aides' personal interaction with their clients. Short staffing may also result in increased rates of injury and accidents, although there have been no empirical studies documenting a direct relationship. These workers are already employed in one of the most hazardous jobs in the service

industry (Service Employees International Union [SEIU], 1997; Wise, 1996). Some researchers have speculated that overworked and frustrated workers may also be more likely to physically or emotionally abuse home care clients or to become the victims of abuse from underserved clients (PHI, 2001).

The future availability of direct care workers does not look promising. There will be an unprecedented increase in the size of the elderly population as the baby boom generation ages. This will likely translate into increased demand for home and community-based services, particularly in light of the fact that most people prefer to remain in their own homes. The BLS estimates that personal and home care assistance will be the fourth fastest growing occupation by 2006 with a dramatic 84.7% growth rate expected. The number of home health aide jobs is expected to increase by 74.6% and that of NAs by 25.4%, although these estimates may be tempered by the rate of economic growth and the extent to which purchasers are willing or able to pay. At the same time, as baby boomers approach old age, the pool of middle-aged women with relatively low levels of education that have traditionally provided care will also be substantially smaller. Finally, with very low population and labor force growth, even a normal business cycle recession would likely yield only a modest increase in the number of unemployed who could become part of a direct care worker pool.

The problem, however, goes beyond the supply of direct care workers. Simply filling positions with warm bodies is not an adequate solution. Although there is little empirical research documenting the causal link between the quality of home care workers and the quality of care/life for consumers, anecdotal evidence suggests that the quality of the worker has a significant effect on clinical, functional, and lifestyle outcomes. To develop and sustain a quality home care workforce, policy makers, providers, and consumers must have a better understanding of the mix of appropriate screening, training, and ongoing supports necessary to achieve these objectives.

## **FACTORS INFLUENCING SUPPLY AND TURNOVER**

Most of the studies that have examined the factors affecting the supply of and turnover in the direct care workforce have been conducted in the nursing home setting. The most comprehensive study of home care

worker satisfaction and turnover was conducted over a decade ago (Feldman, Sapienza, & Kane, 1990). The research team designed a case-control study with a sample of 1,289 workers in five cities. They assessed the impact of salary increases, improved benefits, guaranteed number of service hours, and increased training and support on worker retention. In the aggregate, the interventions reduced turnover rates by 11% to 44%. The study found that financial rewards were important to worker satisfaction, motivation, and retention, but several job qualities proved to be even more important. Workers were more satisfied and more likely to remain in the job if they felt personally responsible for their work and received ongoing feedback from their supervisors. The researchers concluded that good personal relationships between management and workers and between the worker and the client are essential for successful retention.

A study of independent home care workers in California (Benjamin, Matthias, & Franke, 2000) found that those workers indicating more discretion about how they do their work reported less stress and greater job satisfaction. Another qualitative study of independently employed home care workers (Luz, 2001) found that the relationship with the client was a primary influence on whether someone remained in the job.

A recent study of wage increases for independent home care workers in San Francisco County, California (Howes, 2002), found that a near doubling of the wage rate (not adjusted for inflation) between November 1997 and February 2002 was associated with a 54% increase in the number of workers and a 17% decline in the proportion of the workforce leaving the job within the first year of employment. These results should be interpreted with caution as other external factors, including a welfare-to-work requirement that may have moved some welfare recipients into these jobs and the introduction of a low-cost health plan to home care workers, could have affected supply and turnover outcomes.

## **THE ROLE OF PUBLIC POLICY**

### **Health and Long-Term Care Policies**

Health and long-term care policies at the federal and state levels significantly affect the recruitment and retention of the direct care workforce through reimbursement, regulation, and program design. Medicare and

Medicaid account for most long-term care expenditures (Stone, 2000). Their reimbursement policies play a substantial role in determining workers' wages, benefits, and training opportunities. Although providers have some flexibility in setting wages and benefits, the flexibility is limited by this third-party-payer constraint (Atchley, 1996). If payment rates fail to keep up with the true cost of providing services, organizations have less flexibility to offer competitive wages and benefits.

For years, states have tried to control Medicaid home care expenditures by placing limits on reimbursement (HCIA-Sachs & Arthur Andersen, 2000). Many home health providers relied on Medicare to make up for Medicaid shortfalls. The Balanced Budget Act of 1997, however, reduced payments to home health agencies and now reimburses through a prospective payment system. At the same time, states are currently experiencing serious budget deficits that threaten to reduce Medicaid rates even further.

Regulatory policy in the long-term care area has focused primarily on protecting the consumer and pays little attention to the needs or concerns of direct care workers. Although the regulations do address the need for training, they do not fully address the range of educational and ongoing support activities that home health aides, home care workers, and personal care attendants may need to assume increasingly complex and complicated responsibilities. Federal law requires home health aides providing Medicare services to pass a competency test covering 12 areas and also requires 75 hours of classroom and practical training supervised by an RN. Home care and personal care workers employed by agencies that are reimbursed by Medicaid or other state programs may also be subject to certain training requirements, but this practice varies by state and local community.

One major issue for the development of the home care workforce and those providing services in residential settings such as assisted living and adult care homes is the degree to which states are willing to modify their nurse practice acts to allow aides to perform certain tasks (e.g., administering medications, changing catheters). A number of states including Oregon, Kansas, Texas, Minnesota, New Jersey, and New York have enacted nurse delegation provisions, but the latitude and interpretation of the provisions vary tremendously. The issue is important because nurse delegation provides more autonomy for the worker and also offers an opportunity to create career specialties (e.g., medica-

tion aide) that may empower workers and perhaps lead to higher wages.

### **Workforce Development and Educational Policies**

Federal and state labor policies also have an important role to play in the expansion of the labor pool and training of direct care workers. The federal Work Investment Act (WIA), administered by the U.S. Department of Labor (DoL), integrates employment, adult education, and vocational services at the state and local level. Local workforce investment boards (WIBs) oversee WIA service delivery and decide how funds will be used. One-stop centers, governed primarily by business leaders representing local industries with employment opportunities, are the hubs of WIA service access and delivery.

The DoL's Employment and Training Administration has begun to explore partnerships with employers to create apprenticeship programs for high school students and others interested in becoming nursing assistants and home care workers. The Carl D. Perkins Vocational and Technical Education Act, administered by the U.S. Department of Education, awards grants through the states to state and local secondary and postsecondary educational institutions to prepare individuals for further education and careers in current or emerging fields. The Perkins Act explicitly encourages partnerships between educational entities and employers by presenting opportunities to home care agencies that want to improve direct care worker recruitment and retention.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created the Temporary Assistance for Needy Families (TANF) block grant program and replaced Aid to Families with Dependent Children, the country's basic cash assistance program. TANF, administered by the U.S. Department of Health and Human Services (DHHS), espouses a *work first* philosophy and provides funds through a federal/state matching program for supportive services (e.g., transportation, child care), employment counseling and job placement, employability training, and occupational training. Although long-term care providers have been ambivalent about using TANF to expand their labor pool, there are multiple examples of organizations that have had success with training, placing, and retaining former welfare recipients as home care workers and personal care attendants (e.g., the Home Care Coopera-

tive in New York and the IHSS program in San Francisco and Los Angeles).

The Nurse Reinvestment Act of 2002 was passed in response to growing concerns about the nursing shortage in the United States. Although the legislation focuses primarily on activities designed to increase the supply of nurses in hospitals and outpatient acute and primary care settings, the provisions extend to the long-term care sector. The Health Resources and Services Administration, the DHHS agency responsible for implementing the law, has developed a series of grant programs designed to evaluate various career ladder models and to disseminate findings across the health and long-term care fields.

### Immigration Policy

Given the current labor shortage and gloomy projections about the future pool of workers, many providers and consumers have turned to immigrants as a source of labor. Immigration accounts for 40% of the labor force growth in the United States (SEIU, 1997). Almost two thirds of immigrants come to this country for family unification and are not seeking high-skilled employment opportunities. Therefore, they represent a current and future labor pool for the direct care workforce (Stone, 2000). Consequently, policies that limit the entry of low-skilled immigrants, particularly by limiting family-based immigration, may diminish the future pool of home care and personal care workers (Camarota, 1998).

Concerns about immigration have been exacerbated by the war on terrorism and the post-9/11 attitude toward immigrants. It is important, however, to recognize that immigrants reduce the employment opportunities of low-skilled workers in areas where the domestic economy is weak (Fix & Passel, 1994). This negative effect, furthermore, tends to fall disproportionately on people of color, many of whom are employed as direct care workers (Wilner & Wyatt, 1998). Thus, the role of immigration policy in mitigating recruitment problems in home care remains complex and uncertain.

## STATE AND LOCAL INITIATIVES

Recruitment and retention of the direct care workforce has become a priority for many states. Several studies have documented the range of legislative and administrative initiatives that have been explored over

the past 4 years (General Accounting Office, 2000; North Carolina Division of Facility Services [NCDFS], 1999, 2000). In the 2002 national survey, 37 states reported that nursing assistant and home care aide recruitment and retention were major policy issues (PHI & NCDFS, 2002). Even after the recent economic downturn and rising rates of unemployment, the vast majority of states continue to report significant difficulty in recruiting and retaining qualified direct care workers.

### Wage Increases

The most prevalent state initiative designed to ameliorate the workforce dilemma is the wage pass-through (WPT). Through this type of initiative, a state designates that some portion of a reimbursement increase (typically for Medicaid, but this may include other state funding sources) be used specifically to increase wages and/or benefits for direct care workers. WPTs have been implemented either by specifying some dollar amount per hour or per client day to be used for wages/benefits or by requiring that a certain percentage of a reimbursement increase be used for these purposes. In 2000, 18 states approved or had implemented some form of WPT: 9 targeted to home care workers, 6 targeted to nursing home aides only, and 3 targeted to both groups of workers (NCDFS, 2001).

There have been no evaluations of either the short- or long-term effects of the WPT strategy and differences in outcomes based on variations in the methodology. Consequently, there is no evidence concerning the extent to which this type of initiative has improved recruitment/retention or the quality of the direct care workforce. Most of the WPTs have been one-shot strategies and are subject to the vagaries of the state budgets. In addition, most increases have been relatively modest thereby limiting their effect on the financial status of home care workers. Given the current state budget crises, state policy makers are unlikely to implement WPTs in the near future.

### Health Insurance Coverage

The lack of access to benefits, particularly health insurance, has also been identified as a barrier to effective recruitment and retention. Over the past few years, several states have attempted to increase access for this workforce. Most of the activities have included home care workers as part of the larger low-income workforce that was covered through expansions of State

Children's Health Insurance Program (SCHIP) funds. Given the current state budget crises, however, many states are cutting back on these expansions.

New York's Health Care Reform Act of 2000 authorized the establishment of a state-funded health insurance program to cover uninsured home care workers. The legislation, however, only applied to workers in the New York City metropolitan area—a decision attributed to the strong unionization of the direct care workforce in that part of the state. To date, the program has not been implemented, and, given the poor budget situation in New York, its future looks dim.

In 1992, through the active intervention of consumers and organized labor, California began to establish county-based public authorities to assist independent home care workers and consumers participating in the state's IHSS program. These quasi-governmental public authorities created registries to help IHSS consumers identify and hire workers and to help potential workers find jobs. Most significantly, they became the employers of record for workers by providing them with a mechanism to bargain for improved wages and benefits.

In 1999, San Francisco County's Public Authority created Healthy Workers, a health insurance plan for its home care workers. Health care services are provided through the county's network of providers. Benefits include doctor visits, hospitalizations, pharmacy services, and vision care with few co-pays. Workers are qualified to participate if they have worked at least 2 months in the IHSS program with a minimum of 25 hours in one of those months. The worker contribution to the monthly premium is \$3.00 with IHSS covering the rest (approximately \$350 per month per enrollee).

### Career Ladders

Several states have explored the development of career ladders for direct care workers by establishing job levels in their public programs, training requirements, or reimbursement categories (NCDIFS, 1999). Activities have tended to focus on the design of traditional ladders that provide opportunities for career advancement from aide to LPN to RN.

Many direct care workers, however, are comfortable with their occupation and have no desire to move up the ladder of professional licensure. They may, however, be interested in developing additional skills and moving into a job specialty with more authority and higher wages. These advancement opportunities are often referred to as a *career lattice* rather than a *ladder* and

include such diverse positions as peer mentor, dementia specialist, and medication aide.

In the early 1990s, the New York City Human Resources Administration supported a study that tested the effectiveness of a new home care position: the field support liaison (FSL). Home care workers were hired and trained specifically to visit care attendants in the field to identify problems and provide peer support for workers in the community. A case-control study found that agencies employing FSLs reduced their turnover by 10% over a 2-year period compared with those not using FSLs (Feldman, 1993). Unfortunately, this demonstration never became an operational program because of a lack of city and state funding to support these positions.

The Extended Care Career Ladder Initiative (ECCLI) was created and funded by the Massachusetts legislature in 2000 to develop workforce skills training programs and opportunities for advancement for the direct care workforce (Stone & Weiner, 2001). To achieve its goals, ECCLI encourages partnerships between long-term care providers, educational organizations, and local workforce development agencies. Since its inception, about \$14 million has been allocated to support programs for skill development and advancement through career ladders. Providers have used these resources to create peer-mentoring programs and clinical specialty areas such as rehabilitation and dementia care. The initiative was originally targeted to certified NAs in nursing homes but has been expanded to home care.

In 1999, California launched the Caregiver Training Initiative that used \$25 million of federal Workforce Investment Act and Welfare-to-Work funds to develop innovative ways to recruit, train, and retain home care workers in the IHSS program as well as certified NAs in nursing homes (Harahan, Kiefer, & Edelstein, 2003). The Private Industry Council of San Francisco, for example, received a \$1.3 million grant to work with county welfare agencies, WIBs, the public authority, organized labor, the community colleges, and the school districts to increase enrollment in the IHSS training programs, provide training in basic skills and English as a second language, and improve career opportunities for IHSS home care workers through the development of career ladders. The Northern Rural Training and Employment Consortium, made up of five local WIBs, received more than \$2.6 million to provide career ladder training to an estimated 350 welfare-to-work recipients, other low-income individ-

uals, dislocated homemakers, and youth who had aged out of the state's foster care program.

In 2001, North Carolina received a \$1.6 million "Real Choice" grant from DHHS's Center for Medicare and Medicaid Services to improve recruitment and retention of home care aides and personal care attendants. (The Real Choice program is a federal initiative to help states expand their home and community-based service programs for people with disabilities). Grant activities included developing a career ladder for direct care workers and helping to establish a statewide association of workers to enhance their education, professional development, and public image.

### Expanding the Labor Pool

Given the current shortage and, more important, projections that the pool of potential workers will continue to shrink over time relative to the increasing demand, states are searching for alternative sources of workers. Some states have been experimenting with options for recruiting high school students through the School to Work Opportunities Act of 1994. Wisconsin, for example, received funds to create a Youth Apprenticeship Program for direct care workers in nursing homes and assisted living.

New Jersey, New Mexico, New York, Florida, and Arkansas have been somewhat aggressive in using TANF dollars to help prepare former welfare recipients for direct care jobs. The Riverside County, California, WIB used WIA and Welfare-to-Work funds to develop the Migrant Farm Worker and Limited English Proficiency Training Program. This initiative matches local, long-term care provider needs for direct care workers with the migrant farm workers' need to increase and stabilize their income.

In 1999, the Wisconsin Bureau of Aging and Long-Term Care Resources awarded grants to 28 counties through its Community Options Program to help expand the home and community-based workforce. One recipient, the Kenosha County Division on Aging and the Long-Term Care Staffing Task Force used its grant to develop an image campaign to enhance recruitment. The campaign resulted in an increased enrollment in the local technical college's nursing assistant classes, perhaps leading to an expansion of the pool. More recently, the Lancaster County WIB in Pennsylvania created a working group of stakeholders and launched a 10-county media campaign through a partnership with a local TV station to recruit health care workers at all levels. The WIB contributed \$100,000 to create the

messages, and 34 providers, including 15 long-term care providers, contributed \$560,000 to buy airtime for the project by purchasing "employer recognition tags" for each televised message. Although there has been no formal evaluation, preliminary evidence suggests that waiting lists have developed at all the region's allied health training programs following the airing of approximately 30 messages on a weekly basis.

North Carolina used part of its \$1.6 million Real Choice grant to develop a public education and awareness campaign titled "Challenging Careers, Compassionate Hearts." The multimedia activity was designed to improve the image of the direct care worker and to assist with recruitment of workers into home and community-based service jobs.

### PROVIDER-BASED INITIATIVES

Providers across the range of long-term care settings have experimented with various interventions to enhance their ability to recruit and retain workers and to develop a quality workforce (Stone & Weiner, 2001; Straker & Atchley, 1999). A review of the literature and discussions with key stakeholders found that most of the activity has been occurring in nursing homes. The vast majority of these initiatives, furthermore, have not been formally evaluated.

In 2002, DHHS funded the Institute for the Future of Aging Services (an applied research group within the American Association of Homes and Services for the Aging in Washington, D.C.) and the Paraprofessional Healthcare Institute (a worker-based research and policy group in the Bronx, New York) to create a database of promising provider practices in recruiting, retaining, and sustaining a quality direct care workforce. Drawing on the literature, discussions with key informants and snowball interviews, the project team identified 40 practices that met the following criteria: (a) The activity was ongoing and not just a research or demonstration project, (b) there was evidence of success based on external evaluations or documented internal assessments, and (c) the organization was willing to be contacted by interested parties. The following provides some examples of promising practices currently underway in home care. (For further information, readers can access the provider practice database at [www.futureofaging.org](http://www.futureofaging.org) or [www.directcareclearinghouse.org](http://www.directcareclearinghouse.org).)

Cooperative Home Care Associates (CHCA), a worker-owned and operated home care agency in the South Bronx, New York, employs approximately 650

direct care workers serving home care clients in the Bronx and upper Manhattan. Since its inception in 1985, CHCA has developed a five-pronged approach to recruiting, training, and retaining direct care workers. The elements include targeted recruitment (significant up-front assessment and screening), enhanced training (adult learner-centered training, communication, problem solving, and on-the-job training), supportive services (full-time employment counselors and coaching supervision), opportunities for personal and professional growth (worker participation in all decisions, career advancement, and leadership development), and wage and benefit enhancements. Of the aides CHCA trained between July 2001 and June 2002, 87% were employed with the agency after 90 days, and 72% were still working there after 1 year. Despite a doubling of its size since 1998, more than 25% of its workforce has been with CHCA for at least 5 years.

Since 1994, the George G. Glenner School of Dementia Care in San Diego, California, has partnered with local Alzheimer's day care centers and home care agencies. The organization, supported primarily by WIA and Welfare-to-Work funds, recruits unemployed individuals, welfare recipients, and other low-income people with the potential to become certified home health aides; provides vocational training to assist enrollees in getting certification; provides specialty training in dementia care; assists graduates with internships and job placement; and provides follow-up supports for 6 months following graduation. Internal evaluations indicate that 80% of the graduates are employed as direct care workers 6 months after completing the program.

Home Care Associates of Philadelphia, a home care agency that employs approximately 125 home health aides and personal care attendants, developed a 4-week, entry-level training program that includes the four *Ps*. This curriculum breaks down the problem-solving process into four steps. *Paraphrase* teaches trainees to listen actively and ask questions to gain a full understanding. *Pull back* encourages trainees to gain emotional control in stressful situations. *Present options* teaches trainees to identify critical facts, brainstorm solutions, consider the consequences, and present options to the client or supervisor. *Pass it on* encourages trainees to pass on important information to a supervisor or others involved in a situation. Current home health aides provide the real-life situations for the role-plays and act as models and mentors for the trainees. The four *Ps* are also integrated into the every-

day interactions between agency staff and between the aide and client.

Cooperative Care Inc. is a worker-owned home care agency based in Wautoma, Wisconsin, and serves three rural counties. This worker cooperative was founded in 2002 to offer to certified home health aides in rural communities opportunities for high-quality employment, leadership, and profit-sharing. Co-op members are entitled to differential pay for unscheduled work, paid travel time, nine paid holidays per year and overtime pay, subsidized health insurance for those who work at least 30 hours per week (company pays 75% of the premium), a flexible benefit plan, and subsidized training. The organization's start-up was supported by a state grant and a \$125,000 bank loan. The co-op is currently self-supporting through client payments (including a contract with the three county-based home care programs) and a \$50 initial membership fee.

## CONCLUSION

The future of home care will depend, in large part, on the development and support of a quality workforce. Individuals with chronic illness and disabilities may prefer to age in place in their own homes and community-based settings, but this will not be possible without qualified, committed home care aides, personal care workers, and other direct care workers to provide the services and support informal caregivers. Policy makers, providers, and consumers must recognize this third rail of home care policy and work in partnerships to create policies and practices that address both recruitment and retention goals. It is not enough, furthermore, to find and retain warm bodies. The quality of that workforce must also be addressed and resources must be invested in the training, ongoing education, and supports needed to produce and sustain quality caregivers.

Much of the current knowledge about promising policies and practices comes from the nursing home sector. We need to examine the applicability of various strategies that have been developed in nursing homes for home care and other community-based settings. We know, for example, that the relationship between the nurse supervisor and the nursing assistant significantly affects worker job satisfaction and retention and that some of the culture change activities in nursing homes (e.g., the Pioneer Homes, Wellspring) have improved these outcomes by flattening the organizational hierarchy and empowering the frontline workers (Stone &

Weiner, 2001). We do not, however, know what strategies would work best in home care and other community-based settings. Policy makers and providers, therefore, must partner with researchers to conduct demonstrations and evaluations of initiatives designed specifically to enhance the recruitment and retention of home health and home care aides, personal care workers, and attendants. Assuming we identify the optimal set of interventions, we will also need to figure out how to sustain the success over time.

We also need to explore creative ways of developing new pools of workers who can meet the demand for home care services in the future. Large influxes of immigrants or cadres of former welfare recipients will not solve the problem. It is imperative that we develop and test new strategies for expanding the potential pool, including exposing young students and elderly retirees to the possibility of obtaining quality jobs that improve the lives of people in their care.

The Robert Wood Johnson Foundation and Atlantic Philanthropies recently developed a \$15 million grant program to support five state-based policy and practice demonstrations and 8 applied research projects designed to advance our knowledge about long-term care workforce development. The Institute for the Future of Aging Services is serving as the national program office, and the Paraprofessional Healthcare Institute in the Bronx, New York, is the primary technical assistance contractor. We hope this initiative will provide important information about policy and practice strategies that work and do not work in recruiting and retaining a quality direct care workforce. This national program will also provide an opportunity for shared learning across states, providers, and worker organizations and allow wide dissemination of information across long-term care settings.

Ultimately, the public will have to make some decisions about the value of this workforce including whether these direct care workers deserve a livable wage and adequate benefits. Home health aides, home care and personal care workers, and attendants, together with families and friends, provide the majority of care in this country. Changing the image and rewards of the job is essential for the development of this workforce in the future.

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