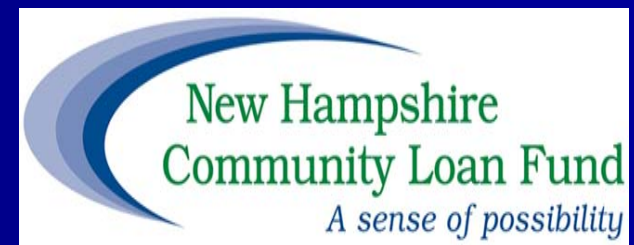


Strengthening New Hampshire's Direct-Care Workforce

Dorie Seavey, Ph.D.

Paraprofessional Healthcare Institute



Background Question for this Evening:

What can New Hampshire do to foster a stable and well-trained direct-care workforce adequate to meet the current and future needs of all long-term care (LTC) consumers?

Talk Overview

- What is New Hampshire's need for direct-care workers?
- Forging state approaches and strategies: What have we learned?
- Finding common ground: LTC workforce imperatives

NH's Need for Direct-Care Workers

Given projected disability rates & demographic change in NH, what are the implications of "rebalancing," "systems change," "Money Follows the Person

for:

- Formal direct-care workforce?
- Family caregiving?

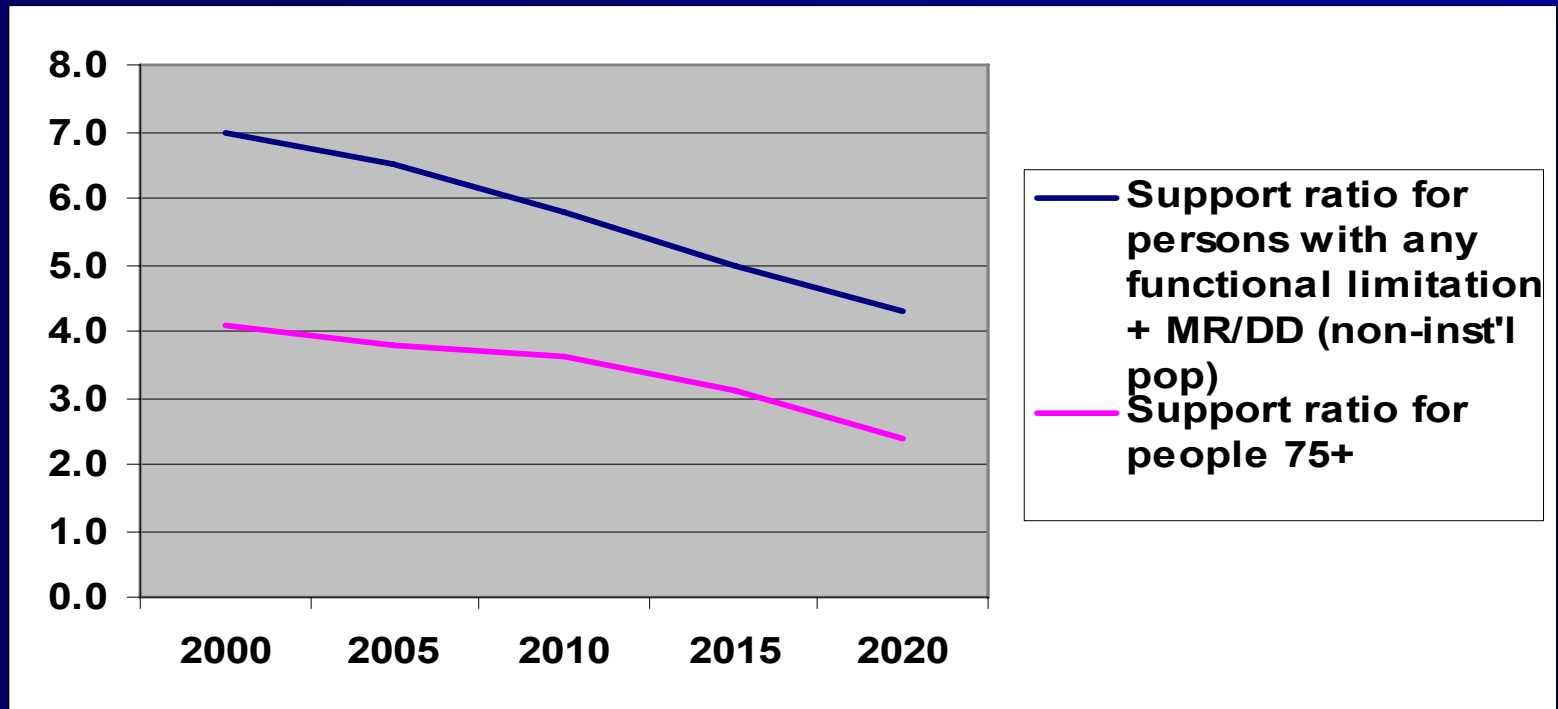
What Do We Know?

- ✓ Overall demographics of supply & demand
- ✓ Occupational projections
- ✓ Changing occupational composition of direct-care workforce → Changing roles and responsibilities for workers
- ✓ Impact of job quality on quality of care

Overall Demographics

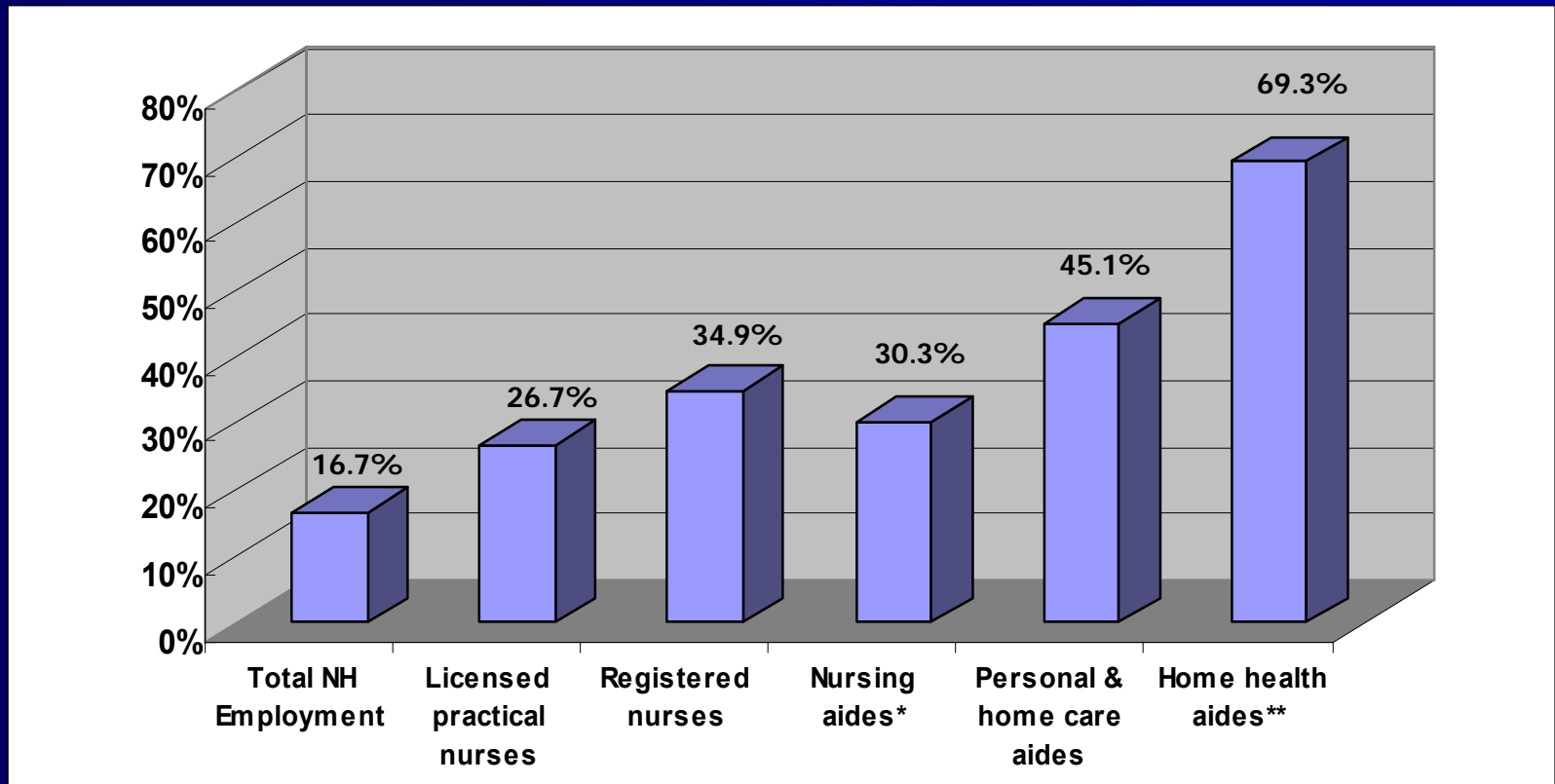
NH's LTC Support Ratio 2000-20

Number of traditional caregivers (women aged 25-54) for every LTC-eligible person (measured two ways)



Source: Speaker's calculations using population projections from NH Office of Energy & Planning (Nov. 2006) and Lewin HCBS Population tool.

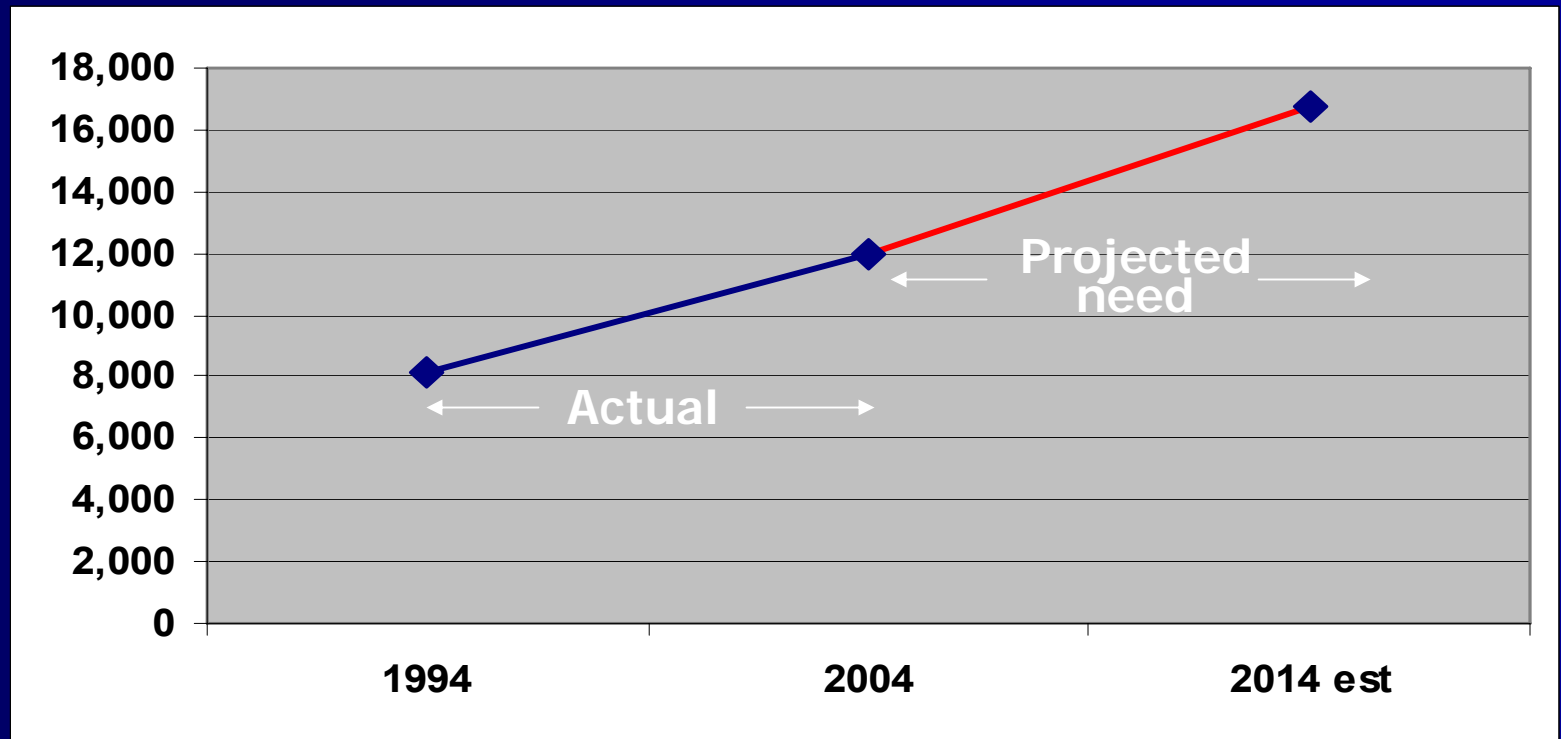
Projected NH Occupational Growth Rates, 2004-2014



* LNAs in non-home care settings; ** LNAs in home-care

Source: NH Employment Security (July 2006), *NH Employment Projections by Industry and Occupation 2004-2014*.

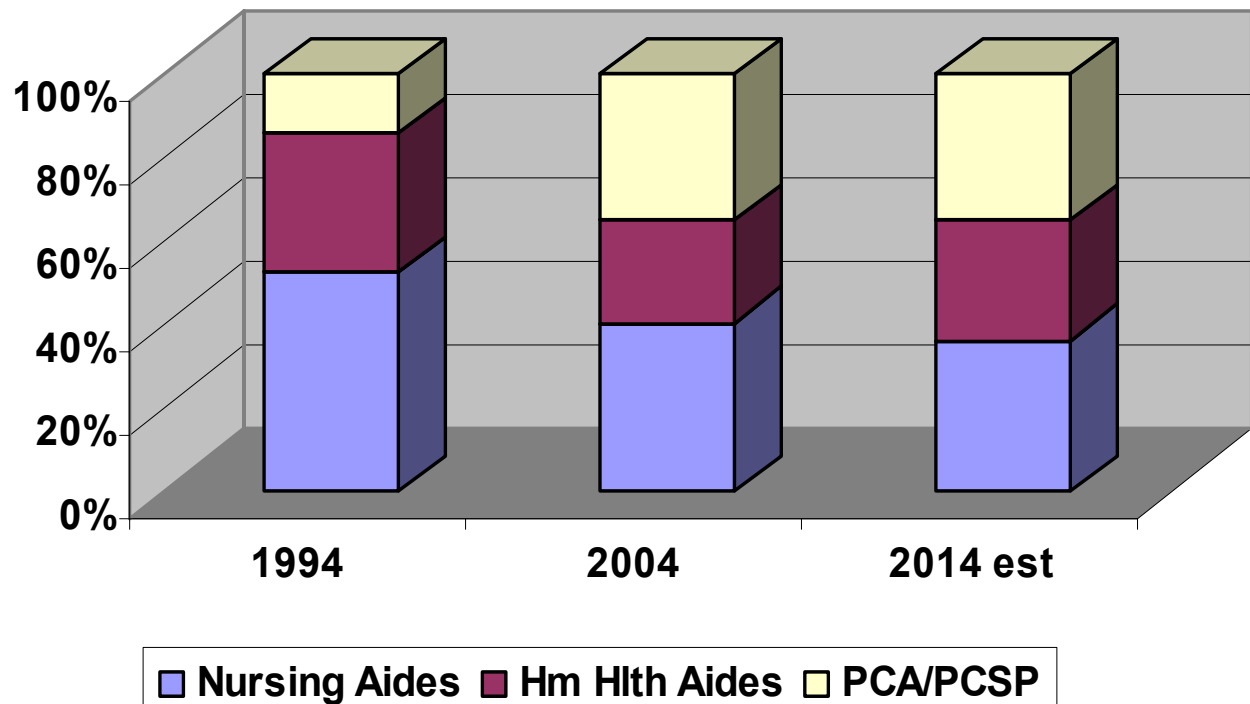
Increases in NH's Direct-Care Workforce (actual & projected need*)



*** Projected need refers to NHES employment demand projections.**

Source: Speaker's calculations using NH Employment Security (July 2006). Occupations included: nursing aides, home health aides, personal and home care aides.

Composition of NH's LTC Workforce Is Changing



Source: Speaker's calculations using NH Employment Security (July 2006); and US Bureau of Labor Statistics, Occupational Employment Statistics. Nursing aides in non-LTC settings excluded.

Changing Composition → Changing Roles & Responsibilities

- Increasing use of in-home services & supported living requires greater skill, judgment and personal accountability
- Skills are practiced with less direct supervision

Bottom line: Decentralization of LTC service delivery produces roles with greater autonomy and responsibility

Quality Jobs → Quality Care

- Size, stability and training of direct-care workforce profoundly impact quality of care received by consumers
- Wages and benefits play a critical role in determining adequacy and stability of direct-care workforce
- However, our policy practices are not aligned with this knowledge base

What Don't We Know?

SOME IMPORTANT SPECIFICS:

- Vital signs of direct-care workforce
- Vital signs of service delivery gaps & access
- Current & projected nos of persons with disabilities needing LTC by service setting
- Estimated demand for workers by setting & occupation
- Availability of family caregivers (paid/unpaid)

What Don't We Know?

Specifics (cont'd)

- Projections of public caseloads for nursing facility care and home- and community-based care by program
- Who are the employers? How are they changing?



"Are you just pissing and moaning, or can you verify what you're saying with data?"

Forging State Strategies for Workforce Improvement: What Have We Learned?

General:

- No one dominant state strategy
- Workforce is as siloed as service delivery systems, programs, and funding streams
- Opportunism often provides foothold but work on several different fronts required
- Rebalancing ultimately has implications for state Medicaid payment policies

What Have We Learned? (cont'd)

State government:

- Doesn't automatically "get it" that major service delivery change usually requires commensurate workforce policy
- Powerful incentives to focus on professional nursing jobs, not paraprofessional direct care
- Doesn't necessarily see economic development implications of LTC and direct-care workforce
- "Thinning-the-soup": $VOLUME \times QUALITY = COST$

What Have We Learned? (cont'd)

Consumers:

- Focus on creating greater consumer choice can obscure workforce implications and fact that concentration of volume in smaller number of providers may yield higher quality of care

Workers and their reps:

- May not understand how deeply some consumers want participant-directed care and will reject workers steeped in medical model

What Have We Learned? (cont'd)

Providers:

- Cooperation and collaboration problematic because of competition concerns
- Business case for investing in workforce requires paradigm shift
 - ***Old view:*** Workforce disposable and turnover costs an unavoidable cost of doing business
 - ***New view:*** Investing in retention and lower turnover can yield financial and other returns for providers

Building Blocks Across The States

- ❑ **Studies, surveys, research** – especially potent with multi-stakeholder support; help frame problem, generate accurate data & create accountability
- ❑ **Broad coalitions of provider + consumer + worker groups** – conduct advocacy, sponsor information gathering & legislation, educate public & policymakers
- ❑ **Involvement of workforce development system** – providers take lead to change industry practice

Building Blocks (cont'd)

- ❑ **Landmark state rebalancing initiative** – provides organizing principle
- ❑ **Novel or high-visibility demonstration program** – creates public and policy awareness
- ❑ **Embed cross-agency or overarching approach to LTC within state government** – e.g. Governor's Cabinet on Long-Term Care
- ❑ **Leadership** – powerful legislative champions

State Efforts To Improve Recruitment & Retention

Inadequate Funding

- Reimbursement analysis (VT, PA)
- Labor market analysis (WY, LA, VA, RI, VT)
- Wage floor study (ME)
- State/local efforts to improve wages/benefits

Underdeveloped Quality Assurance

- Contracting standards (PA)
- Incentive awards (NC, VT, RI, TX)

Variable Training Standards

- Core competencies (DC, OR, PA, VT)
- Universal core curricula (PA)
- Apprenticeship (IN, MI, PA, WA)

Limited Infrastructure

- Registries (~dozen states)
- Public authorities (CA, OR, WA, MI, MA, IA)
- Worker associations (ME, NC, VT)

Provider Efforts To Improve Recruitment & Retention

Cultures of Turnover

- Participatory management
- Coaching supervision training

Inadequate Training and Orientation

- Peer mentoring
- Core competencies
- Multi-employer collaboratives

Limited Advancement Opportunities

- Advanced aide categories
- Peer mentors/trainers

Low Wages and Few Benefits

- Business case: ↑ Wage ↓ Turnover
- Links to programs and services

Erratic Work Schedules

- Guaranteed hours
- Sharing across settings

Finding Common Ground: LTC Workforce Imperatives

Workforce improvement is a:

- Care availability issue
- Quality issue
- Economic development issue
- Provider business issue
- Moral issue

Turning To What Each of You Know

What can New Hampshire do to foster a stable and well-trained direct-care workforce adequate to meet the current and future needs of all long-term care consumers?

Specifically:

- ❑ What are the workforce implications of rebalancing & systems change in NH?
- ❑ Are there critical information gaps?
- ❑ Building blocks in NH: What's been tried and what looks most promising?

For more information contact:



www.paraprofessional.org

www.directcareclearinghouse.org

Dorie Seavey, Ph.D.

National Policy Specialist

dseavey@paraprofessional.org

617-630-1694

Carol Rodat

New York Policy Director

crodat@paraprofessional.org

718-402-7226