

Michigan's Care Gap:

Our Emerging Direct-Care Workforce Crisis



By Hollis Turnham and Steven L. Dawson

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The nonprofit *Paraprofessional Healthcare Institute (PHI)* 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. Our work is guided by the belief that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

A recognized leader in long-term care workforce policy, PHI runs the **National Clearinghouse on the Direct Care Workforce** (www.PHInational.org/clearinghouse), a national information center on the staffing crisis in long-term care. In addition, PHI staffs the national **Direct Care Alliance**, an advocacy voice representing consumers, workers, and concerned providers who together are creating both quality jobs and quality care within the long-term care sector. Finally, PHI has state-based policy experts working with providers, consumers, and worker/labor organizations in New York, Pennsylvania, Massachusetts, Maine, Michigan, and California.

PHI's workplace practice and caregiving innovations have been developed in cooperation with a federation of direct-care staffing agencies and training programs that include the highly successful **Cooperative Home Care Associates** of the South Bronx and **Independence Care System**, a nonprofit managed long-term care program for people living with physical disabilities. Through its consulting practice, PHI assists health care providers across the long-term care spectrum to adapt these practices to their specific environments.

PHI's expertise in both industry *practice* and *public policy* has made the organization a valued partner to state and federal agencies and industry stakeholders. In affiliation with the Institute for the Future of Aging Services, PHI draws on this dual expertise in its role as designated national technical assistant for the **Better Care: Better Jobs Demonstration Project**, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies.

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The purpose of this publication is to build on the work of many individuals and organizations in Michigan that are concerned about the state's long-term care system and the critical role that direct-care workers play in delivering quality services every day. We hope this paper 1) provides an overview of the current situation relating to the Michigan long-term care workforce, 2) builds support for a statewide, multi-stakeholder coalitional approach to address the issues, and 3) encourages discussion of a specific set of both short- and long-range solutions that reflect the common ground needed to create a valued, qualified, motivated direct-care workforce.

Thanks go out to these organizations, their leadership and their members for sharing experiences, information, time, and thoughts in the development of this paper: AARP, The Arc Michigan, Area Agencies on Aging Association of Michigan, BEAM (Bringing the Eden Alternative™ to Michigan), Campaign for Quality Care, Citizens for Better Care, Center for Civil Justice, Community Services Network, Developmental Disabilities Institute at Wayne State University, Elder Law of Michigan, Family Independence Agency, Health Care Association of Michigan, Michigan AFL-CIO, Michigan Alliance of Direct Support Professionals, Michigan Association of Centers for Independent Living, Michigan Association of Homes and Services for the Aging, Michigan Assisted Living Association, Michigan Department of Career Development, Michigan Department of Community Health, Michigan Department of Consumer and Industry Services, Michigan Disability Rights Center, Michigan Home Health Association, Michigan Future, Inc., Michigan League for Human Services, Department of Psychiatry at Michigan State University, Region 7B Michigan Works, RGE Consulting, Service Employees International Union, South Central Michigan Works!, and Visiting Nurse Association, Inc.

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EXECUTIVE SUMMARY

A Workforce Crisis

Michigan’s network of long-term health care supports and services is experiencing an unprecedented labor crisis. High turnover and vacancy rates among home health aides, certified nursing assistants, direct-support professionals, and personal care assistants—our state’s direct-care workforce—are dangerous to both consumers and workers. This mismatch of the supply of unlicensed direct-care workers and the demand for services and supports is creating an instability that threatens the quality and sheer availability of health care services for thousands of Michigan’s citizens who live with chronic illnesses or disabilities.

Without fundamental changes in both public policy and employer practices, Michigan will be unable to find enough hands to help all the people who need services—and there will be even fewer hands to help an ever-growing number of people in need of assistance over the next 30 years. Soon, the politically powerful “Baby Boomer” generation will be experiencing our state’s direct-care workforce crisis as they search for care and services to supplement their own support for “mom and dad.” These same “Baby Boomers” will face even greater problems when they need services or supports for themselves. More immediately, our fellow citizens in Michigan who are living with disabilities have already begun to face the brunt of the workforce crisis.

Currently, most direct-care jobs are not competitive with other entry-level jobs, in terms of wages, benefits, and working conditions. Long-term care jobs are so physically and emotionally challenging, and yet so poorly compensated, that long-term care employers across the state and the continuum have documented unprecedented rates of vacancies and turnover among direct-care staff.

Moreover, the workers who want to perform these vital personal services are often not valued by their employers, consumers, or frankly, our society. The state’s average wage for all direct-care workers, \$9.27 an hour, qualifies a full-time worker with two children to receive food stamps. Furthermore, many direct-care workers are not offered or cannot afford offered health care coverage; ironically, these workers provide health care services that they and their children cannot expect to receive. To attract and retain quality direct-care workers within

“I cannot afford to keep doing this job that I love.”

— A Michigan direct-care worker (Eggleston 1999)

an increasingly competitive workforce, all segments of Michigan’s long-term health care system must begin to offer higher-quality jobs.

Impact on Stakeholders

High staff vacancy and turnover rates harm all three key stakeholders within the long-term care system: *consumers* (and their families), *providers*, and *workers*.

Consumers: Health care researchers have long noted that long-term care consumers define quality services as those delivered by staff they know and who know them. High turnover rates—resulting in an ever-changing parade of strangers—produce the antithesis to consumer-defined quality. The status quo results in inadequate, unsafe care that is delivered by fewer direct-care workers serving more individuals in a rushed and risky manner. Moreover, increasingly, care is simply denied as new clients are turned away by providers or absolutely essential services are forgotten or ignored in the rush to drive to the next client’s home or to answer the next call light.

Providers: Long-term care services are, by nature, labor intensive, and thus high turnover and vacancy rates result in higher recruitment and training costs, separation costs, and temporary, or “pool,” worker replacement costs. Income is also lost as facilities and agencies close admissions or suffer lower volume due to poor outcomes or experiences that tarnish reputations.

Workers: The harm to workers is visible and pernicious. Prepared with inadequate training and supported by overwhelmed supervisors, many of Michigan’s direct-care workers live on poverty-level wages without benefits, contend with dangerous workloads and injuries, and are often forced to accept second jobs. The result all too often is a downward spiral of instability that feeds on itself as more workers leave the work and abandon their calling as caregivers.

The emerging crisis is both urgent and long-term and, thus, requires both immediate actions to stop the downward spiral, and a multi-faceted, far-reaching response to address its complex structural causes.

Recommendations and Strategies for Change

Despite all the challenges, direct-care work can be shaped into a decent, quality job and, at the same time, can be used as a vehicle to reduce poverty. Direct-care work appeals to women and men who are strong caregivers—those who are fulfilled by easing another’s pain or supporting personal independence in the face

of overwhelming obstacles. If treated with dignity, provided adequate support and training, paid a self-sufficient salary and benefits, and recognized for their essential role in Michigan’s health care system, direct-care workers can find their work both challenging and rewarding. Even now, tens of thousands of Michigan women and men come to work each day *“because I make a difference.”*

If designed pragmatically, a “high-road” employment strategy can rebuild the direct-care labor market, providing:

- Consumers with consistent, quality services and care in a variety of settings of their choice, with dependable, qualified, motivated caregivers;
- Workers with a family-sufficient wage, family health benefits, adequate and effective training, and respect while working in a career with opportunities for growth; and
- Employers with a stable, qualified workforce, resulting both in more satisfied consumers and employees.

In order for direct-care employers to compete successfully for workers, **the quality of jobs must be substantially improved.** To improve jobs, the state must work with providers to increase wages and benefits and to change existing workplace cultures that foster turnover into cultures that retain workers. The following list of recommendations require that both policymakers and employers embrace a new vision that values the critical importance of direct-care workers in the delivery of long-term care services.

Improving wages and benefits

As the primary financier of long-term care services, Michigan, through its public policies, not only determines governmental reimbursement rates but also influences the overall distribution of resources and the compensation of direct-care workers. To improve wages and benefits, we recommend the following:

- 1) **Allocate sufficient public resources** to providers to pay direct-care workers family-sufficient wages by 2008.
- 2) **Review state reimbursement methodologies** to ensure that all long-term care services—residential and home- and community-based—are funded in a manner that reflects both current labor market realities and maximizes consumer preferences.
- 3) **Help workers increase their cash income**, by developing a joint state and stakeholder effort to promote the availability of the federal earned income tax credit (EITC) and other federal and state tax credits.

- 4) **Provide access to affordable health care coverage** for long-term care workers and their dependents as well as vacation pay, sick pay, paid holidays, retirement benefits, and other benefits that improve the value of work.
 - Conduct a state-funded, independent study of the health insurance status and needs of direct-care workers and their families, possibly as a part of a larger examination of the state’s uninsured workers and their families.
 - Promote health insurance programs such as MI Child and other employer/employee/government initiatives, until the state’s study of health insurance needs is completed and solutions developed.
 - Review how providers’ resources are currently allocated to determine if wages or benefits could be increased.

Creating cultures of retention

The quality of direct-care work is not simply a matter of better wages or benefits. Frontline workers seek a job designed to recognize their skills as well as their special knowledge of clients. All stakeholders need to be open to genuine change that can transform existing “cultures of turnover and vacancies” to “cultures of retention.” Thus, the following recommendations focus on creating a culture in long-term care that offers quality jobs that attract and sustain a quality workforce:

- 1) **Explore ways to re-design the care delivery system and the structure of direct-care work.**
 - Abandon outdated “command and control” managerial practices and embrace participatory management structures that empower direct-care workers to meet consumer needs and preferences safely and effectively.
 - Use supervisory approaches such as job coaching that emphasize problem solving over traditional disciplinary actions.
 - Recognize, encourage, and replicate provider practices that change the workplace culture.
- 2) **Ensure consistent, enhanced training** for all direct-care jobs, so that workers are prepared to do a quality job.
 - Establish uniform, versatile, and useful training requirements across all long-term care settings. Training should be relevant, practical, and consistent (not necessarily more hours).

- Develop a basic common curriculum that ensures adequate preparation, particularly for home care and assisted living sectors that currently require little or no job preparation.
 - Assess and cultivate problem-solving, interpersonal, and communication skills as a part of initial training programs.
 - Incorporate into training specific skill development related to supporting consumers with significant cognitive and mental impairments.
 - Ground training in a consumer-centered ethic that instills strong clinical knowledge and skills, along with an abiding mandate to deliver services according to consumer needs, preferences, and instructions.
 - Train trainers to use effective adult learner-centered teaching methods to improve the quality of all educational programs.
 - Maximize federal, state, and local resources to support training programs for a quality direct-care workforce, assuring quality supports and services.
- 3) **Provide workers with genuine opportunities for career growth** within individual provider organizations and across the full continuum of long-term care services.
- Promote the status and value of direct-care work as both a career and as the first step to other health care careers.
 - Make community resources—scholarships, child care assistance, employer tuition reimbursement systems—readily available to caregivers who seek more education in order to become health care professionals (e.g., LPNs or RNs).
- 4) **Guarantee safe, healthy workloads** that protect workers and consumers.
- Establish realistic guidelines across the sector for staffing and workload levels that are safe and effective for workers and consumers.
 - Restructure direct-care jobs to offer a minimum 35-hour workweek to those seeking full-time employment.
- 5) While wages and benefits remain low, **provide adequate supports for workers and their families** to stabilize their lives.
- Help workers identify resources for affordable housing, child care assistance, transportation benefits, and other supports.
 - Create capacities within human resources, partnerships with community-based organizations, or regional caregiver resource centers to help local employers and family caregivers find needed supports.

The Vehicle: A Statewide Stakeholder Approach

These recommendations are a rallying point for the three key stakeholders. In order to develop and implement a thorough strategy for public policy and workplace reform, worker, consumer, and provider stakeholders must begin to transform their general understanding of the crisis and their desired solutions into concrete proposals for change.

For some, the state's economic and budget crisis suggests that now is not the time for such bold monetary recommendations. However, the evidence of voter support for long-term care services, particularly in-home services, suggests otherwise. Several counties have enacted and re-authorized "senior mileages" that

raise revenues for senior services, largely in-home care, but also to support county medical care facilities. Also, an April 2002 survey of residents 50 and older found that 75 percent support increased funding for long-term services, even if it means delaying a reduction in state taxes (AARP April 2002, 3).

Michigan stands poised to respond to its current long-term care workforce crisis. Many providers, consumer advocates, and worker organizations, working individually and collectively, have identified the importance of the direct-care workforce for the provision of quality services. Over 20 consumer, worker, and provider organizations have signed AARP's Call to Action, which recognizes the "critical shortage of long-term care workers" and calls for stakeholders to overcome the barriers to a qualified workforce: "complacency or maintaining the status quo will not be an effective response" (AARP Michigan State Office October 2002).

A network or coalition of individual worker, consumer, and provider organizations that is capable of combining their expertise and political clout could wield influence in the state with a unified voice. The coalition could set the stage for concerted, multi-stakeholder advocacy or provide a base for the emergence of smaller working partnerships. The most important feature of such a group, however, will be its commitment to establishing common ground. Coalitions all too often fracture at stressful moments because members have been unwilling to set aside individual agendas to pursue the goals embraced by the group.

"Complacency or maintaining the status quo will not be an effective response."

— AARP Michigan
Call to Action (2002)

The severity of the emerging care gap and the state's revenue crisis must not immobilize but rather galvanize this state and its citizens into immediate, thoughtful actions. One MI Choice aide had a specific message for state policymakers:

*"I would just like the people in Lansing to know that there is a portion of the population that is elderly or baby boomers. **Somebody must do something.** It is not just us [aides] saying we need a raise. This is not something for the future. They must do something now. There are so many people who need care, but some of us will be saying, **'I cannot afford to keep doing this job that I love'**" (Eggleston 1999, 20).*

PART I: INTRODUCTION

Overview

Michigan’s network of long-term health care supports and services is experiencing an unprecedented labor crisis. High turnover and vacancy rates among home health aides, certified nursing assistants, direct-support professionals, and personal care assistants—our state’s “frontline” direct-care workforce¹—are dangerous to both consumers and workers. This mismatch of the supply of unlicensed direct-care workers and the demand for services and supports is creating an instability that threatens the quality and sheer availability of health care services for the thousands of Michigan’s citizens living with chronic illnesses or disabilities.

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Without fundamental changes in both public policy and employer practices, Michigan will be unable to find enough hands to help all the people who need services—and there will be even fewer hands to help an ever growing number of people in need of assistance over the next 30 years. Soon, the politically powerful “Baby Boomer” generation will be experiencing our state’s direct-care workforce crisis as they search for care and services to supplement their own support for “mom and dad.” These same “Baby Boomers” will face even greater problems when they need services or supports for themselves. More immediately, our fellow citizens in Michigan who are living with disabilities have already begun to face the brunt of the workforce crisis.

Currently, most direct-care jobs are not competitive with other entry-level jobs, in terms of wages, benefits, and working conditions. Moreover, the workers who want to perform these vital personal services are often not valued by their employers, consumers, or frankly, our society. To attract and retain quality direct-care workers within an increasingly competitive workforce, all segments of Michigan’s long-term health care system must begin to offer higher quality jobs. The emerging crisis is both

¹ Direct-care workers include certified nursing assistants (CNAs), home health aides, personal care assistants, and direct-support professionals providing supportive services in individual and congregate residential settings. The term is meant to be inclusive of an almost unending array of job titles and to be descriptive of a range of personal, supportive, and health-related services delivered in many different settings to aid people of all ages living with chronic illnesses or disabilities. While licensed nurses and other licensed health care workers play critical roles in long-term care, that workforce contingent is not the focus of this paper.

urgent and long-term and, thus, requires both immediate actions to stop the downward spiral, and a multi-faceted, far-reaching response to address its complex structural causes.

This paper offers a close look at Michigan’s formal or paid long-term health care workforce, the emerging crisis, and possible solutions. We describe:

- The direct-care workers themselves, the nature of their jobs, their employers, and the thousands of consumers who seek support and independence through their work;
- The harm that results from poor-quality jobs to consumers and their family caregivers, to the workers and their families, and to their employers;
- Obstacles that Michigan faces in creating quality jobs;
- Current public policy initiatives and employer practices across the long-term care sector; and
- Steps that both state and federal policymakers and long-term care providers might take to start rebuilding Michigan’s direct-care workforce.

However, before we begin our analysis of the direct-care workforce itself, we provide a brief overview of Michigan’s long-term care network of services and supports.

Michigan’s Long-Term Care Network of Services and Supports

Annually, Michigan’s long-term health care sector provides vital services to an estimated 150,000 individuals of all ages and their families. A 35-year-old man with cerebral palsy needs help in getting ready for work. A 58-year-old woman whose MS has forced her to leave employment needs regular help to remain independent. A 79-year-old woman recovering from a stroke or hip replacement surgery needs both physical therapy and assistance with daily chores.

Direct-care workers—certified nursing assistants, personal care assistants, home health aides, and direct-support professionals—provide eight out of every ten hours of paid hands-on care (McDonald 1994).² In Michigan, over 100,000

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² This statistic relates to formal or paid caregiving and does not include the hours of informal, volunteer, or family caregiving.

direct-care workers³ labor within more than 5,000 licensed and unlicensed residential long-term care facilities, and increasingly, within tens of thousands of individual homes.

- **Nursing homes:** More than 50,000 people used Michigan’s 450 licensed nursing homes in 2000 (Tilly and Kasten 2001, 1-2). Certified nursing assistants (CNAs) and other direct-care workers in nursing homes provide over 16.6 million days of care per year, working every night, weekend, and holiday of the year (MDCH 1996-2000). The typical nursing home resident is an 84-year-old woman with three to four chronic illnesses. She has more than likely outlived a husband and some of her children. Her nursing home stay may be very short for rehabilitative services or last for months or years.
- **Assisted living facilities:** In Michigan, both state licensed facilities and those that have not sought state licenses deliver “assisted living” services, long-term care services that do not require the presence of licensed nurses or continuing nursing services. Most assisted living services focus on the activities of daily living—eating, toileting, dressing, and so on.

An estimated 50,000 people live for some part of the year in the state’s 4,673 licensed assisted living facilities: adult foster care homes and homes for the aged.⁴ This segment of the state’s inventory of residential long-term care services is extremely diverse: Michigan’s licensed assisted living homes serve three distinct populations—the elderly, individuals with developmental disabilities, and people with chronic mental illnesses. Assisted living homes vary widely in size and design, from a single bedroom in a home to a purpose-built 300-bed facility.

Describing a “typical” assisted living resident is even more difficult than describing a “typical” nursing home resident. Some assisted living residents are elders who no longer want to maintain a home or apartment; the few studies on this segment of the elderly population in Michigan (Mickus 2002) indicate demographic data strikingly similar to that of nursing homes...overwhelmingly female, 80+, and facing multiple chronic illnesses. A substantial

³ While the Bureau of Labor Statistics estimates some 80,000 direct-care workers in Michigan, the federal data shows that the 35,000+ Home Help workers have not been accurately counted. See pages 16-17 for a more thorough discussion.

⁴ For this paper, licensed assisted living refers to the state’s adult foster care homes and homes for the aged, which together total about 47,000 beds. These homes are licensed by the Bureau of Regulatory Services within the Department of Consumer and Industry Services. An unknown number of unlicensed residential facilities market their services to a largely elderly population under the title “assisted living”; frontline care workers serving the residents of all these facilities are included in our definition of the state’s direct-care workforce (Tilly and Kasten 2001, 2).

portion of the licensed assisted living facilities serve people with physical or mental impairments who have never been capable of employment and who depend on several governmental programs for their care and services. The segment of assisted living homes discussed here, often called “group homes,” traditionally have contractual relationships with local community mental health authorities to serve the mentally ill and developmentally disabled.

- **Home Help program:** In-home services and supports are available for those consumers who do not need, or want, facility-based services. Created over 25 years ago, Michigan’s largest in-home services program—the Medicaid-funded Home Help program—serves low-income adults living with disabilities (Tilly, Ullman, and Chesky 2002). Annually, 46,000 low-income individuals living with disabilities hire one or more direct-care workers to provide some 25 million hours of personal care services (Mickus, Luz, and Hogan 2002).⁵

The typical Home Help consumer is a woman, 58 years old, who will use the service for 5.8 years (VeCasey 2001). Like Medicaid programs in some 34 other states, the Michigan Home Help program allows consumers to hire and pay some family members for providing assistance with shopping, cooking, bathing, medications, and other needed services. Approximately, 40 percent of the state’s Home Help clients directly hire a family member. The remaining 60 percent look to the wider labor market; a quarter of these consumers rely on some kind of agency to provide and coordinate direct-care worker services.⁶

- **MI Choice:** The state’s Medicaid-funded home- and community-based waiver program, MI Choice, is designed to serve frail older adults and people living with disabilities who are at risk of nursing home placement. Waiver clients remain in their own homes and are provided a wider array of services and supports than other home care recipients, funded through traditional Medicare and Medicaid sources; waiver clients also receive special “Medicaid waiver” services and funding. Three out of every four waiver clients are over 65 years old, and the typical waiver client uses program services for about nine months. The program began in 1992 as a geographically limited program and then expanded statewide in 1998. Using a variety of services and

⁵ Personal care services, an optional Medicaid service, include activities of daily living (ADL) and instrumental activities of daily living (IADL) such as assistance with eating, meal preparation, bathing, grooming, dressing, toileting, moving from one position or location to another, taking medications, and housekeeping (FIA Adult Services Manual, item 361).

⁶ Conversations with Robert Cecil, former Family Independence Agency Director of Adult Services Division, and Bill Prince, Department of Community Health Long-Term Care Policy Staff. See also the FIA Adult Services Manual, item 361.

supports coordinated by a care management team employed by a waiver agent, almost 15,000 individuals were served throughout the state in 2001. The MI Choice Medicaid home- and community-based waiver program's funding for FY 2002 decreased and only a handful of new clients have been enrolled in the last 18 months. As a result, an estimated 11,000 people were served in FY 2002 and less than 8,000 people will likely be served in FY 2003 (AAAA of Michigan 2001; Mickus 2002).⁷

- **Medicare- and Medicaid-Funded Home Health Care:** There are more than 250 Medicaid- or Medicare-certified home health agencies in the state that provide “skilled” in-home care services to people with disabilities (Tilly and Kasten 2001, 2). In calendar year 2000, almost 112,000 Michigan Medicare beneficiaries received over 3.5 million home health visits resulting in payments of over \$325 million to Medicare-certified home health agencies.⁸ In the first six months of 2001, the GAO reports that Michigan's Medicare home health processed claims data show that 45 beneficiaries out of every 1,000 beneficiaries used the service as compared to 38 beneficiaries out of every 1,000 nationally (GAO 2002).⁹ These figures do not, however, paint a complete home care picture; Medicare and Medicaid home health expenditures have not grown within the state or nation over the last five years. Through the combined actions of state and federal policies, spending on Medicare and Medicaid home health services is falling. In fact, from 1997 to 1998, the combined Medicare and Medicaid home health expenditures for the state fell by 16 percent, compared to a national fall-off of 4 percent (Mickus 2002).
- **Other home care services.** Measuring the real size of the home care portion of the long-term care business sector and its workforce is virtually impossible in this state. First, many in-home services (basic cooking, cleaning, personal assistance) do not qualify for any governmental assistance or the consumer does not qualify for available governmental assistance. These services, totally dependent on consumer dollars, are hard to quantify. Second, increasing public funds, outside the Home Help program, are being used by consumers to directly hire their own direct-care workers. And the federal government is bringing more support to this type of long-term care (CMS 2003). Third,

⁷ Conversations with waiver agents.

⁸ Medicare Home Health Data for calendar year 2000 from HCIS through the National Association for Home Care. Only five other states in the country (CA, FL, NY, PA, and TX) received more Medicare home health care payments than MI.

⁹ The same report explains that beneficiaries nationally average 25 visits per person while Michigan beneficiaries average 23 visits per person.

Michigan is one of the few states in the nation that does not license or register any in-home care service or support agencies. Most certified home health agencies have a separate non-certified agency or arm conducting its non-Medicare and non-Medicaid business.¹⁰ That business is again difficult to quantify.

Some home care agencies, certified and non-certified, also act as staffing agencies for long-term care facilities, providing either “temporary,” or “pool,” employees to cover for an absent employee through a “staff leasing” arrangement.

Although these various home- and residential-care settings and organizations vary widely, the type of basic core services and supports provided by unlicensed direct-care workers is quite similar across the spectrum of long-term care. Furthermore, despite the distinct funding silos that separate these services, the worsening direct-care worker crisis is weakening portions of Michigan’s entire health care delivery system. Consequently, the state must address the challenge of stabilizing the direct-care workforce systemwide and in each community.

¹⁰ Sometimes, these non-certified agencies are called “private duty agencies.”

PART II: OVERVIEW OF THE MICHIGAN DIRECT-CARE WORKFORCE

“The staffing crisis is our biggest issue and challenge.”

— Michigan provider association executive

“The consumer was eligible for five hours a day of personal care services. Despite the efforts of the agency, she never got more than one or two hours a day. It is just not working.”

— Advocate for people living with a disability

“I love this work but I cannot make it. I have to think of my son’s needs.”

— Home health aide

Section A: Dimensions of the Michigan Direct-Care Workforce

Direct-care workers labor independently, as well as in thousands of small and large organizations in every community in the state. Direct-care workers, overwhelmingly women and disproportionately women of color, constitute the hands, feet, and backbone of Michigan’s long-term health care industry. CNAs, home health aides, personal care assistants, and others provide intimate personal care, housekeeping, and home management tasks across a variety of settings—private homes, group homes, homes for the aged, and nursing homes.

The formal employment relationship between the consumer and the worker varies. In some cases, the worker is hired directly by the consumer and functions explicitly at his or her direction. In others, the worker is employed by an agency or facility, which in turn directs and is responsible for that worker.

Nationally and within each state, the federal government tracks both the numbers and wages of direct-care workers in three major subcategories of occupations—personal/home care aides, home health aides, and nursing aides. In the last two years, these federal estimates pegged Michigan’s direct-care workforce at some 78,500 workers. These federal calculations, however, likely underestimate the overall size of the state’s direct-care workforce. The Family Independence Agency (FIA) reports that over 38,000 people are employed in the state’s Home Help program,¹¹ yet only 15,000 “personal care” workers are

¹¹ Conversations with FIA and DCH staff.

counted by the federal Bureau of Labor Statistics. This discrepancy suggests that the current size of the home care and personal care attendant workforce is likely seriously underrepresented in the occupational data currently available to policymakers. Also, the counting methodologies used by the BLS likely miss many of the independent direct-care workers—those hired directly without public assistance by consumers. Hence, our estimate is that at least 100,000 direct-care jobs exist in Michigan.

Michigan has seen and will likely continue to see remarkable growth in the number of direct-care positions available to workers as demand for services grows. Using 1999 and 2000 data, Table 1 illustrates the exponential growth of direct-care jobs within an economically healthy, growing Michigan. In sheer numbers, 8,240, or 10 percent of the 88,340 new jobs created in the state from 1999 to 2000, were direct-care jobs.

Table 1: Federal Estimates of Michigan Direct-Care Workers and all Workers in 1999-2001¹²

Occupation Category	Workers in 1999	Workers in 2000	Workers in 2001	Growth or Reduction in Jobs	Percentage Increase or Decrease
Personal/Home Care Aides ¹³	10,570	14,900	15,510	4,940	46% increase
Home Health Aides ¹⁴	21,280	24,370	22,120	840	4% increase
Nursing aides, orderlies, and attendants ¹⁵	39,440	40,260	40,410	970	2% increase
Direct-Care Worker Total	71,290	79,530	78,040	6,750	9% increase
All Occupations	4,498,570	4,586,910	4,442,500	-56,070	1% decrease

The table also illustrates the influence of public policies on services and direct-care jobs. Home health jobs were reduced by 10 percent between 2000 and 2001 as Medicare implemented a new reimbursement system for certified home health agencies. Commentators have noted that the changes have resulted in fewer visits and fewer home health aide jobs in certified agencies. However,

¹² Source: U.S. Bureau of Labor Statistics – 1999 and 2000 State Occupations Employment and Wage Estimates, Michigan.

¹³ Personal and home care aides assist with activities of daily living, including housekeeping tasks, meal preparation, and supervision, according to the federal Department of Labor (DoL) occupational definition.

¹⁴ Home health aides provide routine personal health care in the home of patients or in a residential facility according to the DoL definition of this occupation.

¹⁵ Nursing aides, orderlies, and attendants provide basic “patient” care under direction of nursing staff in both nursing homes and hospitals according to the DoL definition of this occupation. Approximately, 25 percent of the staff in this occupation category work in hospitals. The relatively slow growth in this portion of the direct-care workforce may be due to the closing of 13 nursing homes with over 1,500 beds in 1999 and 2000. Conversations with MDCIS Manager Mike Dankert in September 2002.

DIRECT-CARE WORKFORCE STATISTICS

- Over 100,000 direct-care workers are employed across Michigan's continuum of long-term care.
- One in five Michigan health care workers is a direct-care worker.
- Of the over 88,000 new jobs created between 1999 and 2000, 10 percent were direct-care jobs.
- In the next decade, across the country, direct-care jobs are expected to grow by 39 percent.

notwithstanding these changes, direct-care jobs grew by 9 percent in the three years, far outperforming the rest of the state's economy that saw a 1 percent decrease in the number jobs in Michigan.

Direct-care workers are also a substantial segment of the state's health care economy. The federal government reports that Michigan had a total of about 362,000 health care workers in 2000 and 2001.¹⁶ According to the U.S. Department of Labor, about 80,000 of these workers held positions as CNAs, home health aides, personal care assistants, or other direct-care workers. Thus, one in five health care workers in Michigan is a direct-care worker (BLS, www.bls.org).¹⁷

Long-term care will continue to create jobs at an exponential rate within the country and state. From 2000 to 2010, the overall number of direct-care jobs in the U.S. is projected to grow an additional 39 percent, twice the rate of all jobs nationally. Across the U.S., more than 780,000 new direct-care worker positions will be created according to the latest projections (BLS 2001b).

Despite this presentation of workforce data, the state of Michigan lacks most basic data—education levels, age, sex, marital status, work history, family size—to help researchers and others understand and describe the individuals who currently make up the state's direct-care workforce.

Section B: Dynamics of the Health Care Labor Market

Michigan's Emerging Care Gap

During the 1990s, Michigan experienced relatively restrained growth compared to the rest of the nation and the Midwest region, both in its general population and its labor force. Michigan is one of the few states in the country to lose a Congressional district as a result of the 2000 census and re-districting. However, in the late 1990s, the state's economy grew at historic rates and workers enjoyed unemployment rates below the national level for the first time in decades. In turn, long-term care consumers and providers began to experience firsthand the impact of a full-employment economy—the revolving door that had in the past

¹⁶ Health care employment included the following occupations from the Bureau of Labor Statistics' Standard Occupational Classification System: Medical and Health Services Managers (11-9111), Healthcare Practitioners and Technical Occupations (29-0000), Healthcare Support Occupations (31-0000), and Personal and Home Care Aides (39-9021).

¹⁷ Using our estimate of 100,000 Michigan direct-care workers, we would estimate that one in four health care workers in the state is a direct-care worker.

brought replacement workers suddenly stopped. Workforce vacancies and turnover quickly became “our biggest struggle.”

Currently, the direct-care workforce crisis in Michigan is verified and documented by providers, workers, consumers, and researchers:

Every [Michigan] long-term care provider representative interviewed reported difficulty recruiting and retaining workers, and said worker turnover is very high. Competition from other, less stressful service jobs reportedly aggravates these problems. Observers cited cases where clients did not actually receive services because agencies already had as many beneficiaries as they could manage (Tilly, Ullman, and Chesky 2002, 11).

Despite the growing overall unemployment rate in Michigan during the past 18 months, direct-care worker turnover remains much higher than the overall labor force’s turnover rate of 13 to 18 percent and the turnover rate of 20 percent in the nation’s entire service sector (GAO 2001, 12). Job vacancies and debilitating turnover rates plague the long-term care sector:

- In a survey of Michigan nursing homes, the American Health Care Association (AHCA) estimated 1,548 vacant CNA positions in Michigan nursing homes in June 2002, and an annual CNA turnover rate of 65.6 percent in 2002. With some 40,000 CNA positions in the state, the turnover rate means some 26,000 certified nursing aides are leaving a position every year (AHCA 2003).¹⁸
- Of the state’s Home Help clients who no longer receive authorized services (bathing, shopping, cooking, help with medications, etc.), 21 percent report that the loss of services was caused by a direct-care worker who quit or was terminated or by the inability to find any appropriate staff at all (FIA 2000, 13).
- In Kalamazoo County, 38 aging service provider agencies from across the entire long-term care sector reported the need for more than 750 additional direct-care workers (Healthy Futures 2001).
- Of the state’s mental health assisted living facilities, 97 percent answering a survey report at least one direct-care staff vacancy in any given month. While the majority of surveyed providers reported an average of nine or fewer vacancies, 30 percent had 10 to 39 vacancies and one provider had 80 vacancies in an average month (MALA 2001).

The annual turnover rate for Michigan CNAs in 2002 was estimated at 65.6 percent.

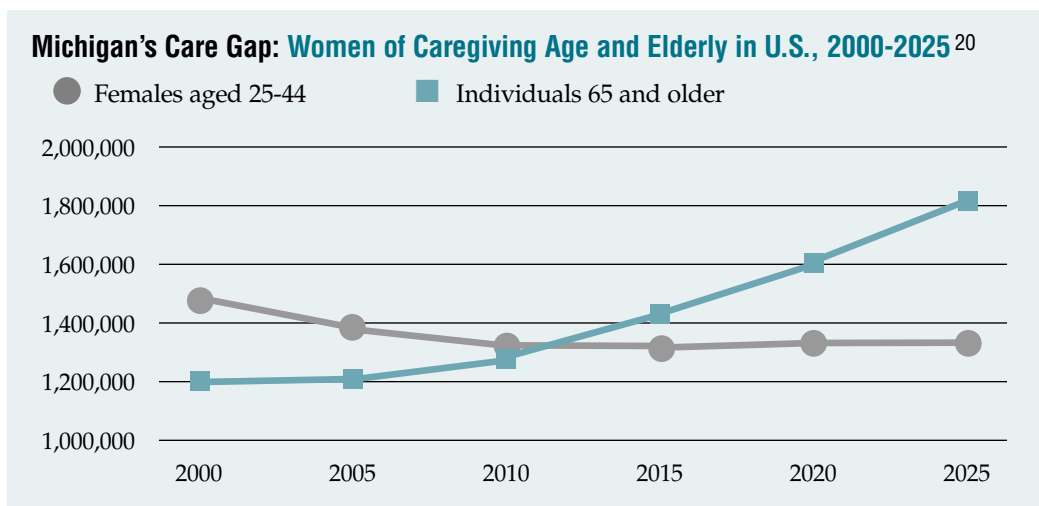
¹⁸ The CNA turnover rate was 71.1 percent nationally and 75.2 percent in the Midwest states during the same time period.

- The same set of mental health assisted living facilities report a turnover rate averaging 65 percent; individual employers report an average turnover rate of 9 percent to 229 percent (MALA 2001).
- For years, staffing shortages have been reported as among the top four complaints reported by nursing home residents and investigated by the Michigan Long-Term Care Ombudsman program (MLTCO 1994-2000).
- According to The Arc Michigan (January 2002), “High turnover in support assistants discourages the development of relationships that promote stability, friendships, companionship, and champions for life dreams and consumer needs.”

To fill these positions, newspaper ads across Michigan offered signing bonuses from \$350 to \$1,200 for direct-care workers¹⁹—yet most employers report that bonuses fail to produce strong applicants.

Unfortunately, the present foreshadows an even larger and deeper crisis as baby boomers begin to need long-term care—first for their parents and, then, for themselves (GAO 2001, 8-10). An unprecedented shift in the state’s aging and worker demographics is going to make it increasingly difficult for providers not only to replace those workers who come and go but also to find and retain additional workers to meet new demands.

As depicted in the following chart, Michigan’s elderly population is projected to expand during the next 25 years by more than 52 percent—**while the traditional source of new caregivers (women aged 25 to 44) is projected to shrink by more than 10 percent.**



¹⁹ Examples include: *Lansing State Journal*, June 16, 2002 and December 8, 2002; *Detroit Free Press*, July 8, 2001 and July 14, 2002; *Flint Journal*, July 3, 2001; *Kalamazoo Gazette*, July 9, 2001; *Grand Rapids Press*, July 14, 2002.

²⁰ Source: U.S. Census Bureau, Population Estimates Program, online at www.census.gov/population/estimates/state

The state's overall population patterns reinforce these trends. The state's population is growing substantially slower than the nation's. As of 2000, the 16-24 and 25-44 age cohorts, the core of the workforce for the next several decades, had fewer individuals than in 1990. The state's fastest-growing age cohort is the 45-64 cohort, people who are leaving the workforce over the next several decades (Glaser and Grimes 2002, 4). At the time the state needs more direct-care paraprofessional workers, the traditional pool of potential new workers is beginning to shrink.

Supply and Demand for Direct-Care Labor

Long-term care employers operate within a variety of competitive markets. They must compete against each other to attract both clients and employees and against other organizations and industries for public and private funding. If long-term care employers do not offer a competitively attractive service, they will lose clients; if they do not offer a compelling funding proposal or a competitive return on investment, they will not receive sufficient capital.

A paraprofessional health care labor market exists as well. Yet for much of the past 30 years—with a seemingly endless supply of low-income individuals (usually women, and disproportionately women of color) willing to work in direct-care jobs—our long-term care system has been able to ignore the reality of that labor market. That old fundamental market reality has now begun to change.

Several factors drive the increasing demand for paraprofessional health care workers. Clearly, the growing number of older adults expands the number of people with chronic, debilitating illnesses. Health care technology and innovations have not only helped to expand the elderly population, but have also allowed many more people, of all ages, to manage their illnesses and disabilities outside of hospital-based settings. And, the Supreme Court's *Olmstead* decision, requiring more noninstitutional long-term care service delivery systems in the states, will likely increase the number of home care workers and personal care assistants. All these factors increase the demand for hands-on caregiving staff to help consumers live with chronic illnesses and disabilities.

While these factors drive the overall need for more labor, other properties of the health care labor market arguably curb, or at least distort, the demand for labor. Since long-term health care is funded largely by both public (Medicaid,

At the time the state needs more direct-care paraprofessional workers, the traditional pool of potential new workers is beginning to shrink.

Medicare, Veterans, county mileages) and private third-party payers who have strong financial incentives to limit their costs, these public/private payers will likely always see less need for labor than is directly perceived by consumers or their health care service providers.

Federal and state public payers are also influenced by the broader political process of allotting tax dollars to a wide array of public services—health care being only one among many. In that broader political process, many would argue that images of incurable physical and mental disabilities make long-term care a less favored health care program. Within the public policy discussion of Medicaid, many believe that this largest of public payers ought to be a program reserved for poor families and children, not adults (particularly not older adults) who live with disabilities and use long-term care services.

Public policies have created stratified payment systems with some provider classes receiving more public resources or tax dollars. For example, in Michigan’s Medicaid system, more than \$1 billion is spent on nursing home services and less than \$300 million on all forms of non-nursing home services, including Home Help and MI Choice. Home Help, which provides Medicaid-funded personal care services, is an optional service; the state is not required to offer this service and thus it tends to receive fewer funds than federally-mandated nursing home and home health services. To provide nursing home level services in some setting other than a nursing home through its MI Choice program, the state must get a waiver from the federal government. But the federal Medicaid law requires that the state spend no more in the aggregate on MI Choice home- and community-based waiver services than on nursing home care and that the average amount spent on an individual in the MI Choice program not exceed the average amount spent on an individual in a Medicaid nursing home. As a result, fewer dollars are allocated to home- and community-based care settings, leading to lower wages, on average, for direct-care workers in that sector.

Even within a provider class, the payment stratifications continue. For example, Michigan counties pay varied rates to Home Help providers, with wages to direct-care workers ranging from \$5.15 to \$10.00 per hour from one county to another.²¹

²¹ Each local FIA county office establishes and annually updates its Home Help program wage rate schedule based on the “going rate in the community for Home Help services.” Exceptions to the established wage rate are allowed based on the needs of the client and other factors. The program also sets maximum payment levels that are applied to the amount or cost of services received by a client. Individual FIA adult services workers can authorize Home Help services of \$333 a month or less. Home Help services of \$334 to \$999 a month require prior local office approval. Home Help services of over \$1,000 a month requires state approval (FIA Adult Services Manual, Home Help Program Procedures, item 363, 14-16). The rates do not appear to be related to county labor market forces—Ingham and Washtenaw counties that generally have very low unemployment rates pay \$5.15 and \$5.25 an hour respectively. And Genesee, Delta, Gogebic and other counties with high unemployment rates all pay over \$7.00 or more per hour.

Although governmental and other third-party payers largely determine provider revenues across the entire sector, providers nonetheless retain some degree of discretion over how total payments are allocated among all of their costs, including the cost of direct-care labor. As evidence, look at Table 2, which shows the average wage and the range of wage rates from one Michigan employer to another employer within the same segment (Home Help rates for individuals and agencies) and across different segments (Home Help and nursing homes).

Within the same job category—a starting CNA in a Michigan nursing home—the salary range is \$5.77 to \$11.06. Within one county, the range of CNA salaries is substantial, \$7.25 to \$10.00. Clearly, even employers who rely heavily on public revenues have discretion in designing salary structures within their organizations. Nonetheless, overall, long-term care providers have more limited flexibility—designed largely by public reimbursement policies—than many employers, making it difficult to raise wages to levels that are sufficient to attract or retain workers.

Table 2: Michigan Direct-Care Worker Wage Rates Across Provider Segments

LTC Segment	Average Wage	Lowest Wage	Highest Wage
Home Help payment to individual worker ²²	\$6.41	\$5.15	\$10.00
Home Help payment to agency ²³	\$9.87	\$5.15	\$17.00
CNA in a nursing home, starting wage ²⁴	\$9.27	\$5.77	\$11.06
Kalamazoo county study; CNA/PCA ²⁵	N/A	\$7.25	\$10.00
Kalamazoo county study; non-certified aide ²⁶	N/A	\$6.80	\$ 8.00
Direct-care staff in mental health assisted living ²⁷	\$8.50	\$6.75	\$10.55

Although wages and benefits are an essential part of employment—and heavily influence workers’ decisions—working conditions are equally important to direct-care workers. Working conditions include a broad array of factors, from the tangible (part-time employment or unsafe workloads) to the intangible (feeling respected) and much in between (good training or opportunities to advance). As one Michigan long-term care provider executive explained:

²² MDCH 2000.

²³ MDCH 2000. This amount is an hourly rate paid to the agency that employs the Home Help worker. The hourly rate pays not only the worker’s wages but also the agency’s expenses.

²⁴ HCAM 2001.

²⁵ Healthy Futures 2001.

²⁶ Healthy Futures 2001.

²⁷ MALA 2001.

The long-term health care labor market can best be understood as driven by massive demographic forces that are increasing the demand for services, while simultaneously, public and private payers attempt to reduce or slow the increase in that demand.

“The key to retaining quality employees is changing the culture of most of our workplaces. Some ‘get it’ and have already figured out how to be successful at changing; others are openly fighting the change. But the overwhelming majority is struggling with the idea of the changes and do not have the energy to do anything but attend to day-to-day operation.”

Direct-care workers are very clear about the tangible and intangible working conditions they want to see changed. For example, a focus group of Michigan direct-support professionals serving people with developmental and mental disabilities recommended to employers that they:

- Create a career ladder with increased wages for positions with more responsibility
- Consider starting a co-op day care for employees
- Pay wages when people are enrolled in mandatory initial training
- Create a dignified work environment
- Listen to direct-support professionals and use their ideas
- Treat all employees with respect and dignity
- Create teams that support individual workers (Wolf-Branigin and Wolf-Branigin 2000)

Home Help and MI Choice direct-care workers asked to identify factors that influenced their decisions to remain in a direct-care position indicated the following priorities:

- Job stability: 54 percent responding
 - Respect: 52 percent responding
 - Training opportunities: 43 percent responding
 - Workload: 29 percent responding
 - Tuition reimbursement: 17 percent responding
- (PASS 2002, 9-10)

These findings are remarkably consistent with the results of other direct-care worker focus groups across the country (Kopiec 2000; Pennsylvania Intra-Governmental Council on Long-Term Care February 2001). Direct-care workers want a job design and work environment that recognizes their skills as well as their special knowledge of the consumer. These frontline caregivers want to be

seen, heard, and made a member of a team—which is one essential element of changing the culture of the long-term care work environment from one of turnover to one of retention. Without these changes in the workplace, we are likely to see continued high rates of turnover and vacancies as direct-care workers search for better employment opportunities.

Systemwide, the long-term health care labor market can best be understood as driven by massive demographic forces that are increasing the demand for services, while simultaneously, public and private payers attempt to reduce or slow the increase in that demand through regulatory constraints and cost containment measures. At the same time, every long-term care provider facility or agency is challenged to create a workplace that values and respects direct-care workers—the same workers who see with every paycheck how little economic value is associated with their caregiving work.

Direct-care workers want a job design and work environment that recognizes their skills as well as their special knowledge of the consumer.

PART III: BARRIERS TO ESTABLISHING A QUALITY HEALTH CARE WORKFORCE

Section A: The Current State of Caregiving Employment

Within the twenty-first century's competitive labor markets, Michigan's direct-care jobs are relatively unattractive:

- Wages are low
- Access to health benefits is very limited
- Training and supervision is inadequate
- The work itself is dangerous

Wages Are Unattractive

In 2001, the average wage of a Michigan direct-care worker was just \$9.26 per hour—substantially less than the average wage of \$17.31 per hour in Michigan. Michigan car mechanics earn \$17.55 an hour, aerobic instructors average \$12.57 an hour in the state, and dog trainers are paid \$10.34 an hour in Michigan (BLS 2001a).

Table 3: Average Hourly Wage Comparisons With Other Jobs

Job Category	Average Wage/Hour
Direct Care Worker	\$ 9.26
Car Mechanic	\$17.55
Aerobics Instructor	\$12.57
Dog Trainer	\$10.34
Statewide average wage of all workers	\$17.31

Direct-care workers earn less than 55 percent of the average workers' wage across the state.

The average wages of Michigan's direct-care workers, laid out in Table 2 (page 23) keep many workers and their families in poverty and dependent on welfare programs. For a family of three, a full-time wage of \$6.77 an hour or less—the average wage of a Home Help personal care attendant—lands that family in poverty (MLHS January 2001). The same family of three is eligible for food stamps in Michigan with a full-time wage of \$9.90 an hour or less—the average

wage of all direct-care workers in the state.²⁸ Put another way, even after working a 40-hour week, the average direct-care worker in Michigan with two children is income-eligible for food stamps.

The Michigan League for Human Services (MLHS) estimates that a single-parent with two children requires, without benefit of public assistance, a full-time job with an hourly wage of \$15.72 to be “economically self-sufficient”—that is, able to pay for minimally adequate housing, food, clothing, child care, health care, transportation, and taxes (MLHS October 2001).

Michigan’s long-term care consumers report that low wages are the largest factor interfering with their ability to control, or even receive, needed services and supports. Of the users of Michigan’s Medicaid funded personal care services, 54 percent rate “low wages” and the general lack of direct-care workers as the two major issues faced (PASS 2002, 5-6). Other consumer groups have also reported the barriers created by poor wages (The Arc Michigan 2002; AARP Call to Action October 2002).

Even after working a 40-hour week, the average direct-care worker in Michigan with two children is income-eligible for food stamps.

Little or No Health Care Coverage for Health Care Workers

Most of Michigan’s direct-care workers do not have health care coverage for themselves or their families—ironically, our largely publicly-funded long-term health care system fails to ensure its own workers’ health care coverage. Many long-term care providers, particularly in home care, offer no health insurance at all or offer coverage only to full-time employees. While many other long-term care providers offer some health care insurance coverage to their employees, few employees and even fewer of their children actually have coverage.

Too often the offered health care insurance requires employees to make significant contributions to premiums,²⁹ is only offered to full-time staff, or has limited dependent coverage. For example, although most mental health-related assisted living facilities do offer health care coverage, most also require premiums of up to 50 percent of the cost of coverage, far beyond the financial grasp of

²⁸ The maximum monthly allotment a family of three would receive in food stamps is \$356. The specific allotment is determined by multiplying the net monthly household income by .3, and the result is subtracted from the maximum food stamp allotment for the family’s size (FIA website).

²⁹ While no Michigan data is available, the Massachusetts Extended Care Federation has quantified the costs of health care coverage in that state’s nursing homes. In that state, only 29 percent of eligible CNAs actually received employer-based individual health insurance and only 15 percent of CNAs received employer-sponsored family health insurance. CNAs who received employer-based health insurance contributed a median of \$830 a year for individual coverage and \$3,640 a year for family coverage. Homes paid a median of \$2,832 annually for the most popular individual insurance plan and \$6,571 a year for their most popular family health plan (Blanks 2002).

Ironically, our largely publicly-funded long-term health care system fails to ensure its own workers' health care coverage.

employees. As result, 70 percent the workers eligible to have health care coverage have **no** employer-based health care coverage (MALA 2001, 1-12).

Michigan's disabilities organizations label the lack of benefits as a "contributing [factor] to a direct-care worker shortage [that is] nearing crisis proportions" (MSILC 2003, 10).

Training Is Not Adequate and Career Advancement Opportunities Are Rare

The highest initial training requirement in the entire sector is found in federal Medicare and Medicaid policy, mandating 75 hours for nursing home workers in certified homes. There is broad-based agreement among state regulators, nurse supervisors, CNAs, and consumers that the federal training requirements have not kept pace with the needs of nursing home residents (OIG November 2002).³⁰ The Office of Inspector General of the Department of Health and Human Services notes the training methods for certified nursing home aides are likely ineffectual and the clinical, hands-on training is too short and not relevant. As a result, 26 states now require more than 75 hours initial training for nursing home workers, and 13 states require more than 100 hours (OIG August 2002).

Federal law requires home health aides to be "competency evaluated" in 12 skills and knowledge levels to work in Medicare- or Medicaid-certified agencies. Federal law also leaves it to each state to decide whether home health aide candidates must be trained prior to testing. Michigan is one of at least nine states in the country that allows home health agencies to hire aides who can pass the home health aide test without training. It is not clear how many home health aides are trained before testing or what kind of training they receive. As a result, some certified agencies only test or hire applicants who have completed the 75-hour CNA training course.

Many other direct-care workers can, and do, legally begin work in other parts of Michigan's long-term care industry—for example, as personal care assistants (PCA), direct-care staff in homes for the aged and unlicensed assisted living homes, or Home Help workers—with no training or testing whatsoever. As one former PCA described her first job, "*I had no training; it was scary*

³⁰ The OIG report documents a number of problems with current CNA training programs across the country and makes several recommendations for improvements.

particularly in dealing with aggressive or paranoid behaviors.” The state’s Home Help program’s initial and ongoing training requirements and opportunities are frankly nonexistent. The single requirement is that the Home Help worker or “provider” be “willing to participate in available training programs, if necessary” (FIA Adult Services Manual Item 363, 13).

Direct-care workers in the state’s 4,500-plus licensed adult foster care homes are trained by the owner/administrator in first aid and CPR, reporting requirements, residents rights, safety and fire prevention, universal precautions, reporting, and the services to be delivered—“personal care, supervision, and protection.” While the Bureau of Regulatory Services approves some training programs, there is no requirement that these programs be used.³¹ Researchers have noted, with concern, that “untrained [assisted living] personnel are commonly assisting residents with medications, including dispensing” (Mickus 2002, 18). There are no training requirements for the direct-care staff serving citizens living in homes for the aged.

Moreover, the investments in ongoing training to improve skill levels, learn new approaches, or address performance weaknesses are few³² and far between, particularly for home care workers. The state Office of Services to the Aging requires some workers to “be trained by a qualified person and...tested for each task” and others are required to “complete a home health aide or nurse aide training curriculum approved by the area agency.” In-service training is quite limited—twice a year—for homemaker, personal care, home delivered meals, home care assistance, respite care, home care aide, and adult day services (MOSA 2001-2003). Indications are that these standards result in “quite a variety” of initial training programs and little evidence of in-service education (Eggleston 1999, 3, 13).

Consumers recognize and support the need for well-trained workers (The Arc Michigan January 2002; AARP Call to Action October 2002; MACIL, 2003, 4). According to the Michigan State Independent Living Council, the lack of sufficient training “threatens the health of long-term care recipients” (MSILC 2003, 10). For example, services are often delivered by “unqualified attendants” in both the MI Choice waiver and the Home Help program (MACIL 2003, 29).

Many direct-care workers can, and do, legally begin work in parts of Michigan’s long-term care industry with no training or testing whatsoever.

³¹ Listings of approved trainers and programs for AFC homes can be found on the website for the Michigan Department of Consumer and Industry Services within the Bureau of Regulatory Services under “Family and Health Services.”

³² Certified nursing assistants and home health aides must have 12 hours annually of ongoing training.

Michigan’s Home
Help and MI Choice
workers are as
dissatisfied with
their lack of
“promotion
opportunities”
as they are with
their wages.

Training is important to the interests of all stakeholders and yet it should not be an insurmountable hurdle for the work. For many job seekers, there’s an astonishing final hurdle to becoming a competent direct-care worker. Many employers who offer or require initial training for a job do not pay workers while they are in training. So, workers can face two or more weeks without any income. As one former nursing home administrator noted:

“This is the only industry in America that does not connect its recruitment and retention crisis to the terrible practice of not paying prospective CNAs during their initial 75 hours of training. What dedication it takes for these caregivers to take a job that does not pay them for two weeks of initial training.”

Many Michigan long-term care provider organizations follow the same practice: workers are not hired and paid until after completion of initial training.

Once on-the-job, most workers are in “dead-end” jobs—few opportunities are available to acquire additional training and skills that lead to greater responsibility and meaningful salary rewards. Rarely is there a “lead” or “senior” aide, support professional or CNA within a long-term care workplace. Employers are not taking advantage of the abilities of exemplary direct-care workers to support, mentor, or teach new employees. Such promotions could end the “dead-end” job title and expand the abilities of an organization to model quality work habits and caregiving techniques. Michigan’s Home Help and MI Choice workers are as dissatisfied with their lack of “promotion opportunities” as they are with their wages (PASS 2002, 11).

Workloads Are Dangerous

Long-term care is delivered every weekend and holiday, 24 hours a day, 365 days each year. Thousands of workers are needed on the job every hour of every day. Unfortunately, many of those jobs are not filled. Direct-care staff must often “work short” in nursing homes³³ or decrease the number or length of visits to home care clients. In other cases, providers increase their use of agency (or “pool”) staff or simply limit the number of persons served.

³³ Almost all nursing homes exceed the state staffing requirements. Generally, “working short” means that a scheduled CNA position is vacant or a scheduled worker has not come into work for that shift and no temporary coverage can be arranged.

Another course of action is to ask or demand that workers “stay over” through an extra shift. Some Michigan assisted living facilities report that the “average direct-care staff person works 19 hours of overtime per month; it ranges from as low as 2 overtime hours to as much as 57 overtime hours per month” (MALA 2001). In 1998, 10 percent of all hours worked by CNAs in Michigan nursing homes were overtime. In 2000, that figure had jumped to 16 percent (HCAM 2001).

Vacancies, overtime, fatigue, “working short or fast,” and inadequate training standards combine to produce dangerous results for workers, consumers, and ultimately providers: Michigan’s nursing home workers experience the fourth highest injury rate of all industries in the state. Only foundries, special machine shops, and the air transport industries have greater injury rates (BLS 2000).

Michigan’s nursing home workers experience the fourth highest injury rate of all industries in the state.

“Workers Don’t Leave Their Jobs; They Leave Their Supervisors.”³⁴

Most people called upon to lead, manage, and supervise direct-care workers have little or no training, support, or experience to take up that task and it shows. Generally, schools of nursing do little to prepare RNs or LPNs to motivate, teach, or inspire direct-care workers who provide most of the hands-on care in facilities or individual homes. Supervisors have intensive scheduling and administrative responsibilities that leave little time for quality interactions with paraprofessional workers.

Surveys document that employers and supervisors see the need for training in how “to motivate workers” and basic supervisory skills. Most importantly, supervisors need to learn to “coach” frontline workers, helping them to develop the communication and problem-solving skills that will make them effective caregivers. Reports by paraprofessionals that supervisors and clients treat them disrespectfully suggest that there is much work to be done in this area (SCMW 2002, 24; HCAM 2001, 13; PASS 2002, 11).³⁵

³⁴ Quotation from a Massachusetts nurse working in a nursing home.

³⁵ For other states, see Iowa CareGivers Association 1999, Wisconsin Department of Health and Family Services 1999, and Leon et al. 2001.

Section B: Public Policy’s Contribution to Creating Poor Quality Jobs

All the factors reviewed—insufficient wages, lack of health insurance, insufficient training and career advancement opportunities, dangerous workloads, poor quality management and supervision—contribute to the poor quality of direct-care jobs. Combined, they make direct-care employment increasingly unattractive to current and potential workers. Though many of these problems are a direct result of industry practices, public policies create much of the framework that continues to support these practices.

Long-term care providers, as employers, do not enjoy the flexibility necessary to meet wage, benefit, or training demands to attract and retain workers in an ever-changing labor market.

Poor Wages Spawn Poor Wages

Public payers, Medicaid and Medicare in particular, contribute the majority of funding for long-term care in this state and the country.³⁶ Of those long-term care costs, 50 to 70 percent encompass direct labor costs. Government nursing home rate determinations are typically based on historical costs. Thus, historic wage and benefit costs become a fundamental determinant for future nursing home reimbursement rates and, in turn, limit wage rate increases. In particular, this system of rate setting fails to cover the full labor costs of nursing homes that pay more than average wages and, thus, “punishes” any nursing home attempting to offer something closer to a self-sufficient wage.³⁷

In recognition of the limitations of using historical costs to determine funding for future operations, some governmental programs (e.g., Medicare home health) use adjusters to set or update labor costs. Yet, this still makes the payment system structurally resistant to labor market pressures when those pressures exceed general inflation costs. As a consequence, long-term care providers, as employers, do not enjoy the flexibility necessary to meet wage, benefit, or training demands to attract and retain workers in an ever-changing labor market. While this system of rate-setting clearly helps to constrain costs, it is also a non-market mechanism that fails to adjust to labor market realities when demand for labor is high.

³⁶ Of the nearly \$127 billion spent on non-hospital-based long-term care in 1999, approximately 60 percent was funded through public tax dollars (Burwell 2000).

³⁷ As discussed above, a single parent with two children needs an hourly wage of \$15.72 in Michigan to be economically self-sufficient.

Medicaid payments to other long-term care providers (home- and community-based waiver services, Home Help, adult foster care homes, and homes for the aged) have never been influenced by the wages or benefits paid to workers or any other expenses. MI Choice rates have not been changed since 1997. All these non-nursing home rates have been based on a “flat” fee schedule largely governed by the amount appropriated by the legislature and, in the case of Home Help, determined by local FIA boards. These flat rates are unresponsive to the labor market forces driving wage, benefit, training, and other expenses.

Workforce Development and Welfare Policy

Almost all Michigan direct-care workers are “low-wage workers” and, therefore, are affected by public policies relevant to low-income families. Many rely on public assistance programs—welfare cash assistance now called Temporary Assistance to Needy Families (TANF), food stamps, public housing, Medicaid, child care subsidies—to compensate for the inadequate wages and benefits they receive.³⁸ Some workers came to direct-care work through publicly funded training programs—Work First, the Workforce Investment Act, School to Work, and others.

Inadequate public supports—training, housing, child care assistance, transportation—drive workers out of caregiving. In fact, nursing home managers report “child care issues” as the number one reason for voluntary terminations of direct-care workers (HCAM 2001, SCMW 2002). Child care costs are extremely expensive. In 1997, low-wage families who paid for child care spent almost one out of every five dollars earned on child care (Snyder and Adams 2001, 2, 13).³⁹ Access to affordable housing is also problematic. In some parts of the state, direct-care workers have reduced work hours in order to maintain eligibility for decent subsidized housing.⁴⁰

Transportation is particularly problematic for home health care workers, consumers, and providers. The public transportation infrastructure in most areas of

Many direct-care workers rely on public assistance programs—welfare cash, food stamps, public housing, Medicaid, child care subsidies—to compensate for the inadequate wages and benefits they receive.

³⁸ Nationally, more than 13 percent of nursing home aides and nearly 15 percent of home health care aides rely on food stamps to help feed themselves and their families, compared to less than 6 percent of all workers in the U.S. (GAO 2001).

³⁹ A low-wage family is at or below 200 percent of poverty or \$25,258 for a two parent-one child family.

⁴⁰ Conversations with Michigan Works! and Work First staffs.

There appears to be no overarching statewide strategic plan from the Department of Career Development to address one of the state's largest job-creating business sectors.

the state is fragile or nonexistent, making a driver's license and reliable car prerequisites for home care aide employment.

In addition to weak supports for low-wage workers, the state's welfare policies still maintain a "work first" mandate rather than a "workforce development or human development" model. National pressure is increasing to force welfare recipients to work now—and 40 hours a week—rather than allow recipients to train for "better" jobs. Yet this model has not proved effective for expanding the direct-care workforce. In fact, Michigan's welfare-to-work requirements—combined with the provider practice of unpaid initial certification training—may undermine recipients who risk losing public assistance in order to follow their "call" to caregiving.

The state can and should do more to help those welfare recipients who want to be caregivers fulfill that employment goal by aligning welfare and workforce policies with the needs of long-term care workers, consumers, and providers. For example, the state could count the initial 75 hours of training to become a CNA or other direct-care worker as "work," allowing trainees to continue to receive cash assistance and other welfare-to-work assistance while learning to deliver quality services. This support to welfare recipients interested in caregiving work could greatly expand the pool of potential candidates for direct-care jobs.

States, providers, and workers can and do turn to publicly funded workforce resources for supports. Several regional Michigan Works! boards and service centers have begun to address the paraprofessional workforce as a distinct employer and development assignment. For example:

- The Jackson Service Center has pieced together an array of services and supports for potential and eligible direct-care workers for the Jackson County Medical Care facility.
- In the same region, the Michigan Works! board conducted a survey of health care sector providers and workers focused on recruitment and retention efforts.
- The Region 7B Michigan Works! organization serving six northeast counties facilitates a regional task force and has conducted training for area providers, workers and advocates on its services.

- At least three Michigan Works! boards have funded initial direct-care worker trainings for eligible workers.⁴¹

Despite these regional efforts, there appears to be no overarching statewide strategic plan from the Department of Career Development to address one of the state’s largest job-creating business sectors.

Michigan has been generous in some programs that provide employment supports. A large amount of the state’s TANF surplus has been invested in child care assistance. Eligible recipients can access \$800 per family in TANF funds toward the purchase of a car. The value of vehicles is excluded in determining food stamp eligibility as well as a semi-annual reporting of household earnings. These publicly financed supports will need to be maintained or enhanced so long as long-term care public reimbursement systems do not recognize the costs of family-sufficient wages or adjust to competitive labor market demands.

Section C: **Consequences: Poor Quality Jobs and Poor Quality Care**

In sum, comparatively low wages have been combined with few benefits, unbalanced workloads, poor training, and inadequate supports to create structural barriers to increasing the number of competent direct-care workers in Michigan. Fortunately, the joint legislative and executive work group on long-term care officially acknowledges the direct-care workforce crisis:

All sectors of the long-term care delivery system... have significant problems both with recruiting and retaining direct-care workers.... The causes of the problems are multiple. They include: low pay and poor benefits, lack of appreciation for the value of the work, high turnover (which causes short staffing), demanding working conditions, and the element of risk involved, lack of control over work product, poor supervision, lack of a career path, an increasing acuity rate of those needing care and a tight labor market (MLTCWG 2000, 24).

The poor and deteriorating quality of direct-care positions harm all three stakeholders—workers, consumers, and employers.

Comparatively low wages have been combined with few benefits, unbalanced workloads, poor training, and inadequate supports to create structural barriers to increasing the number of competent direct-care workers in Michigan.

⁴¹ Kalamazoo, Battle Creek, and Traverse City.

For workers, the harm is visible and pernicious:

- Relegated to the bottom rung of respect within the health care workforce hierarchy, living on poverty-level wages without any benefits, contending with dangerous workloads, and often forced to accept part-time hours, workers struggle to survive;
- High rates of injury lead to lost wages, disability, and limited future employment opportunities;
- High levels of stress and frustration as staff “work short” cause many dedicated workers to leave the field altogether because they cannot deliver the care their clients require or desire;
- Inadequate training and support from over-stretched supervisors and relatively inexperienced fellow paraprofessionals undermines the desire of workers to deliver the highest quality of care; and
- Inadequate child care and transportation options, particularly for afternoon, night and weekend shifts, coupled with a two-week unpaid initial certification training course, create insurmountable barriers even for those who are called to caregiving.

The result is spiraling instability: a growing exodus of experienced direct-care staff who leave behind a workplace that is increasingly less attractive to potential new staff. Evidence is found in the state’s CNA registry maintained by the Department of Consumer and Industry Services (MDCIS). Since the registry’s beginnings in the early 1990s, MDCIS reports that over 100,000 individuals have completed the training and certification requirements to become certified CNAs in Michigan. However, over 65,000 people who became CNAs have left the work and are now considered “inactive” by the department.⁴²

For consumers, the harm is debilitating and often dangerous:

Researchers have long noted that long-term care consumers define quality services as those delivered by a staff they know and who knows them (NCCNHR 1985; Grau, Chandler, and Saunders 1995; Deutschman 2001). Relationships with caregivers that are both respectful and nurturing are essential to the care of and support for the frail elderly, chronically ill, and those living with disabilities. Yet high turnover rates are the antithesis to these consumer-

⁴² Communications with Rae Ramsdell, MDCIS.

defined quality measurements. High rates of direct-care staff vacancies and turnover deeply affect consumers in four disruptive ways:

- Inadequate, unsafe care is delivered by fewer direct-care workers serving more individuals in a rushed and risky manner;
- Disconnected, impersonal care delivered by replacement/new staff (i.e., strangers), who are unfamiliar with the client's needs or preferences, increases the opportunities for mistakes and indignities;
- Increasingly, care is simply denied as clients are turned away by providers, or absolutely essential services—such as bathing, toileting, feeding, and hydration—are forgotten or ignored in the rush to answer the next call button or drive to the next home and client; and finally
- “No-shows”—or no caregiver at all—leave consumers in emergency situations all too frequently (MACIL 2003, 29).

For providers the harm is costly, both to mission and the bottom line:

Even among those employers who are experienced in the economic whims of high and low unemployment, the crisis of today is truly distinctive. While attempting to manage this unprecedented workforce crisis, long-term care employers are also dealing with an ever-changing delivery system (HMO, PPO, PPS, fee-for-service), a Congress intent on making dramatic changes in reimbursement formulas, historic state and federal budget deficits, and Medicaid's increased use of managed care.

In Michigan, the impact of the direct-care staffing problems cause providers to incur:

- High **recruitment** and learning/training costs, with more advertising, signing bonuses, orientation activities, and intensified managerial resources devoted to recruitment and training processes (GAO 2001, 14);⁴³
- High **retention** costs, from being forced to select candidates with greater barriers to employment—low education, poor work histories, inadequate child care, or lack of transportation—and to devote more managerial resources to oversight and disciplinary actions;

A growing exodus of experienced direct-care staff is leaving behind a workplace that is increasingly less attractive to potential new staff.

⁴³ One multi-state nursing home corporation operating in Michigan calculates that the direct and indirect costs of each employee who leaves is \$4,000 to \$6,000 and that annually, turnover costs the company \$48 million a year.

- High **separation** costs, as more exit interviews, worker’s compensation, and unemployment claims are processed by managerial staff completing a higher number of termination procedures;
- Higher **temporary worker replacement** costs, as employers, particularly nursing homes, turn to pool agencies for temporary workers, with hourly costs totaling two and three times the hourly rates of regular employees; and
- **Lost income**, as many residential facilities and home care agencies close admissions due to staff vacancies, or suffer lower volume due to poor outcomes that tarnish word-of-mouth reputations.

Providers, organized labor, and consumers recognize that inadequate wages, largely determined by government funding, are undermining the stability of the workforce (AARP Call to Action October 2002). One group of home care consumer ranks “better wages” and “more hours” for workers as the most important way to improve the state-funded program (FIA 2000, 13). In response to the workforce crisis, for more than six years, nursing home trade associations and organized labor have worked together each year to advocate for dedicated Medicaid funding of annual wage and benefit increases for nursing home workers.

This common understanding among long-term care stakeholders is rare, for historically, key actors within the long-term health care sector have competed against each other, particularly over how public health resources should be allocated across the settings. The three key stakeholders in long-term care—labor unions, employers, and consumers—have often argued over quality care issues.

Now, however, the health care industry’s common self-interest has become readily apparent: “Quality improvement,” “good outcomes,” “customer satisfaction,” and the avoidance of “medical errors” are growing health care criteria for payment and contract renewals. But to meet these criteria, providers need a stable, competent workforce. Since low-quality jobs have failed to attract a stable workforce,⁴⁴ the quality of these jobs must be improved.

This industry self-interest offers a rare opportunity for workforce and quality advocates to join forces and take advantage of both political and business trends that are beginning to support a true restructuring of low-wage health care jobs—with improved training and supervisory support, higher wages, and articulated career ladders. And for consumers, this moment is the chance to reward the needed hands, voice, and backbone of thousands of caregivers.

⁴⁴ As one association representative described it, “Continuing to do the same thing and expecting a different result is insane.”

Although these three groups—workers, employers, and consumers—can and do disagree on many aspects of public policy and industry practice, all have publicly stated their concerns about the long-term health care workforce. Those separate statements, actions, and resources now can and should be aggregated into a single movement that produces truly valuable results for all long-term care workers, employers and consumers... *Quality Jobs = Quality Care.*

One group of home care consumers ranks “better wages” and “more hours” for workers as the most important way to improve the state-funded program.

PART IV: **RECOMMENDATIONS AND STRATEGIES FOR CHANGE**

Section A: **Promising Initiatives**

Despite all the challenges, direct-care work can be shaped into a decent, quality job and, at the same time, can be used as a vehicle to reduce poverty. Direct-care work appeals to women and men who are strong caregivers—those who are fulfilled by easing another’s pain or supporting personal independence in the face of overwhelming obstacles. If treated with dignity, provided adequate support and training, paid a self-sufficient salary and benefits, and recognized for their essential role in Michigan’s health care system, direct-care workers can find their work both challenging and rewarding. Even now, tens of thousands of Michigan women and men come to work each day *“because I make a difference.”*

If designed pragmatically, a “high-road” employment strategy can rebuild the direct-care labor market, providing:

- Workers with a family-sufficient wage, family health benefits, adequate and effective training, and respect while working in a career with opportunities for growth;
- Consumers with consistent, quality services and care in a variety of settings of their choice, with dependable, qualified, motivated caregivers; and
- Employers with a stable, qualified workforce, resulting both in more satisfied consumers and employees.

Michigan stands poised to respond to its current long-term care workforce crisis. Many providers, consumer advocates, and worker organizations, individually and collectively, have identified the importance of the direct-care workforce for the provision of quality services. Over 20 consumer, worker, and provider organizations have signed AARP’s Call to Action that recognizes the “critical shortage of long-term care workers” and calls for stakeholders to overcome the barriers to a qualified workforce—“complacency or maintaining the status quo will not be an effective response” (AARP Michigan State Office October 2002).

Some Michigan providers, consumers and their advocates, and state agencies have long believed in the capacity of innovative workplace practices—a change in the culture—to reduce turnover and otherwise improve the quality of a workforce and, in turn, the quality of care. Several Michigan providers, mainly nursing

homes, have undertaken efforts to address the intangible working conditions that play a critical role in reducing turnover and staff vacancies within their organizations. Beginning in 1994, pioneering efforts to change both the workplace and residential culture of nursing homes came to the state. Today, Michigan has the largest number of registered Eden Alternative™ nursing homes in the country.⁴⁵

Using the Eden Alternative™ model, one registered south central Michigan home reports a reduction in its CNA turnover rate from 58 percent to 22 percent over the course of its management “culture transformation.” A western home reports a better than 50 percent drop in staff turnover and a reduction in payment to pool agencies from \$60,000 in 2000 to less than \$250 in 2002.⁴⁶ Another pioneering facility, Leelanau Memorial Health Center, using a wide variety of innovations over five years, reports a drop of employee turnover from 72 percent in 1997 to 17 percent in 2001. That northern facility’s goal is to reduce turnover to 9.6 percent (Bull 2002). In addition to these efforts, the state has provided funds for a variety of other “quality” and “innovations” projects in long-term care staffing.⁴⁷

Furthermore, across the state, providers, consumers, and worker organizations are joining with local Michigan Works! staff, community college instructors, FIA staff, researchers, and other community organizations to discuss and implement solutions to the workforce crisis in long-term care. These efforts have brought together health care providers, workforce development agencies, and community-based organizations to respond to specific regional issues surrounding recruitment and retention.⁴⁸

In addition, on a statewide basis, the Michigan Direct Care Workforce Initiative (MDCWI), a developing coalition of long-term care providers, provider associations, consumers, worker organizations, workforce and education agencies, researchers, and interested members of the public, is looking for ways to

⁴⁵ BEAM—Bringing the Eden Alternative™ to Michigan, a nonprofit organization, leads the culture change efforts within the state’s nursing homes. The Eden Alternative™ seeks to create a human habitat in long-term care residential facilities by empowering the staff working closest to the residents. It envisions a much flatter management structure and teams of workers serving residents in neighborhoods. There are 27 registered homes and about 800 certified Eden Associates are associated with another 75 nursing homes in the state.

⁴⁶ Lenawee County Medical Care Facility (Adrian, MI) and Oak Crest Manor (Holland, MI), as reported in *The Beacon* (January 2002, 4).

⁴⁷ The Department of Consumer and Industry Services awarded annual “Quality Grants” to hundreds of nursing homes; the grants provided approximately \$271 per bed for three years. A handful of the homes focused their quality projects on staff retention and training issues. Efforts to continue these “quality grants” in 2002 and 2003 have been vetoed by the governor. Also, the Department of Community Health made a one-time investment of \$2 million of Tobacco Funding for three-year long-term care staff development and training grants.

⁴⁸ Regional groups working on direct-care workforce issues are based in Jackson, Gladwin, Traverse City, Kalamazoo, Grand Rapids, and Battle Creek. A large coalition of organizations have worked together to submit a “Better Jobs, Better Care” proposal in response to a call from the Robert Wood Johnson Foundation and The Atlantic Philanthropies. See www.bjbc.org for more information on the call for state-based worker/consumer/provider coalitions to address provider practices and public policies related to recruitment and retention of the direct-care workforce.

An effective resolution of the direct-care staffing crisis in Michigan requires that the three major stakeholder groups work collaboratively to restructure direct-care workplace cultures and public policies.

improve the recruitment and retention of direct-care workers in Michigan. With initial funding from Michigan’s Office of Services to the Aging,⁴⁹ the coalition plans to survey current and former CNAs and home health aides to gather basic demographic data and to better understand why workers have chosen to stay in the work and why others have left. Through the research and discussion of innovative workplace practices, the MDCWI is charged to create “an ideal recruitment and retention model” for replication and enhanced public policy discussions. The coalition’s ambitious charge is to complete its work by the fall of 2003.

These kinds of efforts are the key: an effective resolution of the direct-care staffing crisis in Michigan requires that the three major stakeholder groups work collaboratively to restructure direct-care workplace cultures and public policies.

To achieve this vision, it is essential that out of these distinct and important initiatives a cohesive statewide stakeholder advocacy effort emerge. Michigan’s diverse geography and political perspectives demand comprehensive, balanced solutions that can synthesize the needs of its urban and suburban centers with those of the small towns and rural centers. The new governor wants a changed political culture in Michigan—“One Michigan” that defines its public policies through an open and engaged process that makes room at the table for all stakeholders.

Fundamental change in long-term care industry practices, as well as both legislative and departmental workforce-related policies, are far more likely to occur if all the communities affected by the workforce crisis understand their common stake and are willing to craft practical, yet creative, solutions. Policymakers wary of having to balance competing interests are more likely to respond to a unified voice, a coalition calling for a new commitment to Michigan’s frontline caregivers and the people they serve.

While diverse stakeholder participation is essential, it is equally important that the separate state departmental policymaking worlds that converge within long-term care are redesigned to address the crisis in a coordinated fashion. Key state agencies (Community Health, Office of Services to the Aging, Family Independence Agency, MDCIS, MDCCD) must engage in a shared effort

⁴⁹ This funding was awarded to coalition member BEAM.

to restructure long-term care public policy around the quality job/quality care connection.

State financing and regulatory policy should build on a core ethic of care that recognizes a stable, competent, and respected caregiving workforce as essential to preserve the dignity and autonomy of Michigan’s families living with disabilities. Effective state policies can sustain provider practices that recognize the dignity of caregiving work, provide fair compensation, and facilitate strong relationships between caregivers and consumers.

Section B: Recommendations

The following recommendations for state public policy and industry practice call for better compensation, restructuring of workplace practices, and improving the status of frontline caregiving. These recommendations present a comprehensive “high-road” strategy to address the long-term care staffing crisis. No single action alone will be a panacea, nor can staffing problems be resolved lastingly without coordination by the diverse stakeholders across all long-term care delivery systems. Working together within this suggested framework, however, key actors in Michigan’s long-term care system can marshal and leverage the various initiatives already under way, creating a stable, quality workforce to provide better care for both current and future consumers.

Improving Wages and Benefits

Providers and the taxpayers must be willing to compensate direct-care workers in a way that reflects the social and market value of their work. The state is the primary financier of long-term care services, and through its public policies, it not only determines governmental reimbursement rates but also influences the overall distribution of resources and the compensation of direct-care workers. Public financing systems must allocate sufficient resources to providers so that they can pay family-sufficient wages and offer health and other benefits to direct-care workers. To improve wages and benefits, we recommend the following:

- 1) Allocate sufficient public resources to providers to pay direct-care workers family-sufficient wages by 2008.** The state’s long-range goal for direct-care wages should be a wage that provides for “family-self sufficiency,” achieved incrementally and adjusted for inflation. Wages should rise for all workers so

It is time for Michigan to make the necessary financial commitments to assure quality long-term care services for all its citizens.

that they can reasonably afford housing, food, clothing, and transportation—the basics of life—when working an average 40-hour workweek. Higher wages would concurrently reduce reliance upon public subsidies. It is time for Michigan to make the necessary financial commitments to assure quality long-term care services for all its citizens.

- 2) **Review state reimbursement methodologies to ensure that all long-term care services—residential and home- and community-based—are funded in a manner that reflects both current labor market realities and maximizes consumer preferences.** Funding levels should support choice across the continuum and eliminate any bias related to setting. Financing sources should encourage parity of compensation across the long-term care continuum to actualize consumer options and stabilize the workforce.
- 3) **Help workers increase their cash income, by developing a joint state and stakeholder effort to promote the availability of the federal earned income tax credit (EITC) and other**

federal and state tax credits. While these tax credits cannot produce self-sufficient wages for all workers, refunds can be substantial—the equivalent of a \$2.00 an hour raise for some low-wage taxpayers.⁵⁰

- 4) **Provide access to affordable health care coverage for long-term care workers and their dependents as well as vacation pay, sick pay, paid holidays, retirement benefits, and other benefits that improve the value of work.**

Disturbingly, direct-care workers, who provide essential services within our health care system, often cannot afford to meet their own health care needs.

- **Conduct a state-funded, independent study of the health insurance status and needs of direct-care workers and their families, possibly as part of a larger examination of the state’s uninsured workers and their families.** This study should include an evaluation of the particular barriers faced by long-term care providers, large and small, in securing group health care coverage for their direct-care workforce. The results of this study should guide efforts to secure health care coverage for this segment of the state’s uninsured population.

⁵⁰ The Center for Budget and Policy Priorities (www.cbpp.org) is a national resource on maximizing the federal EITC. The Michigan League for Human Services annually coordinates a “Money Back in Michigan” campaign that can assist the state in formulating its efforts to promote access to existing state and federal tax credits available to low-wage workers.

- **Promote health insurance programs such as MI Child and other employer/employee/government initiatives, until the state’s study of health insurance needs is completed and solutions developed.** The MI Child’s outreach efforts should develop a special focus on the long-term care workforce to ensure that all eligible children are enrolled.⁵¹ The HealthChoice program serving Wayne County-based employers and employees as well as the Ingham Health Plan could be offered to direct-care workers and their employers and expanded to other counties (Tilly, Ullman, and Chesky 2002, 6-7). Information about available health programs could be included in the state notification sent to newly-registered CNAs and included regularly in the payroll check for Home Help workers.
- **Review how providers’ resources are currently allocated to determine if wages or benefits could be increased.** Although third-party payers largely determine their revenues, providers themselves retain some degree of discretion over how total payments are allocated among all their costs, including the cost of direct-care labor.

Creating Cultures of Retention

The quality of direct-care work is not simply a matter of better wages or benefits. Frontline workers seek a job designed to recognize their skills as well as their special knowledge of clients. Thus, developing evidence suggests that changes in provider workplace practices, bolstered by supportive public policies, result in improved worker retention and quality care (Hollinger-Smith et al. 2002; Leon, Marainen, and Marcotte 2001; Richardson and Graf, 2002; Stone et al. 2002). Some of those successful practices⁵² include:

- Inclusive, supportive management and supervisory practices, especially an emphasis on “coaching” rather than “directive” supervision of frontline workers.
- Individualized, consumer-directed services in both residential and home- and community-based settings.

⁵¹ Michigan receives over \$3 million in federal funds annually for MI Child outreach through Title 21 of the Federal Social Security Act and annual state appropriations.

⁵² The Centers for Medicare and Medicaid Services in conjunction with PHI has developed a database, which catalogues innovative recruitment and retention practices among long-term care providers. www.directcareclearinghouse.org/practices

- Inclusion of direct-care workers in care planning and decision-making, in recognition of their skills and intimate knowledge of consumers and the primacy of the caregiving relationship.

In addition to these changes in workplace and caregiving practices, transforming the culture of long-term care requires improvements in training and career opportunities for direct-care workers, safe and healthy workloads, and a range of workplace supports that help workers maintain steady employment. Thus, the following recommendations focus on creating a culture in long-term care that offers quality jobs that attract and sustain a quality workforce:

- 1) **Explore ways to redesign the care delivery system and the structure of direct-care work.** Every segment of the long-term care sector must explore ways to redesign the care delivery system and the structure of direct-care work. All stakeholders need to be open to genuine change that can transform existing “cultures of turnover and vacancies” to “cultures of retention.”
 - **Abandon outdated “command and control” managerial practices and embrace participatory management structures that empower direct-care workers to meet consumer needs and preferences safely and effectively.**
 - **Use supervisory approaches such as job coaching that emphasize problem solving over traditional disciplinary actions.**
 - **Recognize, encourage, and replicate provider practices that change the workplace culture.**
- 2) **Ensure consistent, enhanced training for all direct-care jobs, so that workers are prepared to do a quality job.** All direct-care workers need to be prepared and skilled to do a quality job. Workers want better training that is relevant, practical, and consistent. Though more is not necessarily better, as consumers become sicker and more frail, there may be need for extending the standard nursing assistant training beyond the federally required 75 hours. The current curriculum does not cultivate or assess problem solving, interpersonal and communication skills. Nor does it include specific competencies related to supporting consumers with significant cognitive and mental impairments. A thorough review of the curricula used to train nursing assistants and home health aides should quantify and address these deficits.⁵³

⁵³ See Abt Associates' *Appropriateness of Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, Chapter 7, for a full discussion of paraprofessional training issues.

- **Establish uniform, versatile, and useful training requirements across all long-term care settings.** A thorough review of entry-level as well as on-going training requirements is needed to determine appropriate standards for the full range of long-term care settings and direct-care workers.
- **Develop a common curriculum that ensures adequate preparation, particularly for home care and assisted living sectors that currently require little or no job preparation.** Training credentials should be “portable” for the worker that moves from a Medicaid-certified nursing home and a Medicare-certified home health agency and, particularly, for those workers who may move from a Home Help consumer to a private duty home health agency or to an agency funded by the local area agency on aging.
- **Assess and cultivate problem-solving, interpersonal, and communication skills as part of entry-level training programs.** These skills are critical to establishing the positive relationships that are the foundation of quality care.
- **Incorporate into training specific skill development related to supporting consumers with significant cognitive and mental impairments.** Direct-care workers currently do not receive the training necessary to provide quality care to a growing number of consumers with cognitive impairments.
- **Ground training in consumer-centered ethic that instills strong clinical knowledge and skills, along with an abiding mandate to deliver services according to consumer needs, preferences, and instructions.** Revised training protocols should recognize the right of self-directed consumers to educate their own personal assistants as they see fit.
- **Train trainers to use effective adult learner-centered teaching methods to improve the quality of all educational programs.** Many people who are called to caregiving have not experienced success in traditional educational environments, in which teachers lecture and students listen. Participatory classrooms, in which a variety of activities are used to build critical-thinking and communication skills, help nontraditional students absorb and retain new concepts and skills.

Transforming the culture of long-term care requires improvements in training and career opportunities for direct-care workers, safe and healthy workloads, and a range of workplace supports that help workers maintain steady employment.

- **Maximize federal, state, and local resources to support training programs for a quality direct-care workforce, assuring quality supports and services.** As major employers in many rural parts of the state, local Michigan Works! boards should seek out long-term care stakeholders' advice and assistance in developing regional priorities and programming. Categorical restrictions on who can be trained with what monies should be eased to allow for retention activities such as training for supervisors as well as entry-level training.
- 3) **Provide workers with genuine opportunities for career growth within individual provider organizations and across the full continuum of long-term care services.** Workers must have genuine opportunities for career growth and development. All providers should examine their ability to create internal career ladders or pathways that monetarily connect increased training and skills to higher responsibilities and status. These ladders can be built around mentoring new employees, leading a team, specific additional clinical duties, or other responsibilities.
- **Promote the status and value of direct-care work as both a career in itself and as the first step to other health care careers.** Internal career ladders should not require a worker to become a licensed professional to advance within the organization.
 - **Make community resources—scholarships, child care assistance, employer tuition reimbursement systems—readily available to caregivers who seek more education in order to become health care professionals (e.g., LPNs or RNs).** To rebuild the ranks of nursing professionals, the state should support paraprofessional staff who are motivated to pursue professional health care careers.
- 4) **Guarantee safe, healthy workloads that protect workers and consumers.** To ensure a safe, healthy working environment, staffing guidelines must be combined with adequate funding, quality training, and the restructuring of workplace practices.
- **Establish realistic guidelines across the sector for staffing and workload levels that are safe and effective for workers and consumers.**
 - **Restructure direct-care jobs to offer a minimum 35-hour workweek to those seeking full-time employment.** When direct-care workers are forced to take on extra shifts and second jobs to make ends meet, they often put themselves and those they care for at risk.

- 5) **While wages and benefits remain low, provide adequate supports for workers and their families to stabilize their lives.** Many direct-care jobs are filled by individuals who have relatively few financial assets to call upon—particularly when something goes wrong either at work or at home. Many of these workers—“living on skinny branches” as one home health care agency president described them—are relying on public benefits to fill gaps in housing, transportation, child care, and other necessities. The state needs to maintain funding for these vital state-based programs that support low-income workers and to encourage employers in their efforts to stabilize the lives of their staff.
- **Help workers identify resources for affordable housing, child care assistance, transportation benefits, and emergencies.** For low-wage workers, barriers to maintaining employment abound. A sick child, a late rent payment, or an erratic public transport system can upend the strongest desire to be a responsible employee. When employers help workers access public supports, they demonstrate their respect for their workers and their commitment to a quality workplace.
 - **Create capacities within human resources, partnerships with community-based organizations, or regional caregiver resource centers to help local employers and family caregivers find needed supports.**⁵⁴

Section C: The Vehicle: A Statewide Stakeholder Approach

These recommendations are a rallying point for the three key stakeholders. In order to develop and implement a thorough strategy for public policy and workplace reform, worker, consumer, and provider stakeholders must begin to transform their general understanding of the crisis and their desired solutions into concrete proposals for change.

For some, the state’s economic and budget crisis would argue that now is not the time for such bold monetary recommendations. However, the evidence of voter support for long-term care services, particularly in-home services, suggests otherwise. Several counties have enacted and reauthorized “senior mileages” that raise revenues for senior services, largely in-home care but also to support county medical care facilities. Also, an April 2002 survey of residents 50 and

⁵⁴ For an in-depth description of a range of creative employer support activities, see *Finding and Keeping Direct Care Staff: Employer of Choice Strategy Guide for Catholic-Sponsored Long-Term Care and Home Care Providers* (Catholic Health Association 2002).

The frightening severity of the emerging care gap and the state's revenue crisis must not immobilize, but rather galvanize this state and its citizens into immediate, thoughtful actions.

older found that 75 percent support increased funding for long-term services, even if it means delaying a reduction in state taxes (AARP April 2002, 3).

Drawing from the discrete efforts already in place or announced, Michigan's consumer advocates, providers, labor unions, and worker advocates can define and cultivate specific efforts to improve compensation, training, caregiving and workplace practices, and career opportunities for the state's direct-care workers. For one example, AARP's Call to Action (AARP Michigan State Office October 2002) identifies workforce as one area of long-term care reform ripe for common ground and collective action. Its staffing/workforce subcommittee has begun meeting. In another development, many organizations have banded together to respond to the "Better Jobs, Better Care" proposal issued by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. The call for proposals requires workers, consumers, and providers to work collaboratively on workplace practices and public policy issues over a three-year period.

A network or coalition of individual worker, consumer, and provider organizations that is capable of combining their expertise and political clout could wield influence in the state with a unified voice. The coalition could set the stage for concerted, multi-stakeholder advocacy or provide a base for the emergence of smaller working partnerships. The most important feature of such a group, however, will be its commitment to establishing common ground. Coalitions all too often fracture at stressful moments because members have been unwilling to set aside individual agendas to pursue the goals embraced by the group.

PART V: **CONCLUSION**

Addressing Michigan’s direct-care staffing crisis is not only a matter of public policy, it is also a matter of the practical implementation of cultural change. Each of the three key stakeholders—providers, consumers, and workers—must consider new models of service delivery and work cooperatively to restructure direct-care employment.

The frightening severity of the emerging care gap and the state’s revenue crisis must not immobilize, but rather galvanize this state and its citizens into immediate, thoughtful actions. One MI Choice aide had a specific message for state policymakers that is probably applicable to all stakeholders:

*“I would just like the people in Lansing to know that there is a portion of the population that is elderly or baby boomers. **Somebody must do something.** It is not just us (aides) saying we need a raise. This is not something for the future. They must do something now. There are so many people who need care, but some of us will be saying, ‘**I cannot afford to keep doing this job that I love**’”*
(Eggleston 1999, 20).

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Additional Publications Available from the Paraprofessional Healthcare Institute

Effective Practice Descriptions

Training Quality Home Health Aides. Spring 2003.

A description of the learner-centered training practices employed by the Cooperative Healthcare Network.

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This guide provides employers with immediate, concrete suggestions on how to find and keep direct-care staff.

“The Right People for the Job: Recruiting Direct-Care Workers for Home- and Community-Based Care,” by the Paraprofessional Healthcare Institute and MED-STAT. *Workforce Tools, Vol. 1, No. 1.* Centers for Medicare and Medicaid Services. Fall 2002. (8 pgs.)

This publication provides agencies and individual consumers with straightforward information on how to recruit, assess, and select personal assistance workers and home health aides.

Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision. 2001. (22 pgs.)

An introduction to coaching supervision: how coaching differs from traditional supervisory practice, the skills needed to become an effective coach, and the organizational structures that make coaching effective.

Recruiting Quality Health Care Paraprofessionals. August 2000. (26 pgs.)

A description of the successful recruiting strategies used by the Cooperative Healthcare Network.

Case Studies

We Are the Roots, by Ruth Glasser and Jeremy Brecher. University of California Center for Cooperatives, 2002. (130 pgs.) \$10 plus shipping and handling.

We Are the Roots tells the compelling story of Cooperative Home Care Associates (CHCA), a highly-successful worker-owned agency in the South Bronx. Through the voices of managers and workers, we learn of CHCA’s culture of cooperation, caring, and learning, which has sustained a vibrant community through tremendous growth and change over 17 years.

The Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach, by Anne Inserra, Maureen Conway, and John Rodat.

The Aspen Institute, February 2002. (86 pgs.)

The Aspen Institute uses Cooperative Home Care Associates and its affiliation with PHI to demonstrate the success of industry-based workforce development strategies.

Quality Care Partners: A Case Study, by Karen Kahn. August 2000. (24 pgs.)

This case study traces the early development of a home care cooperative, initiated as a sectoral development project, in Manchester, New Hampshire. The study draws attention to key “lessons learned” in the areas of financing, leadership, market analysis, and customer development.

Policy Papers

Long-Term Care Financing and the Long-Term Care Crisis: Causes and Solutions, by Steven L. Dawson and the Paraprofessional Healthcare Institute. 2002. (36 pgs.)

This paper examines the “care gap” in long-term care and the negative impact of staff shortages on the three primary stakeholders: consumers, providers, and workers. It recommends a national strategy—integrating both federal and state policy into a comprehensive system of long-term support and services—to address the direct-care crisis.

Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on Implementing California’s Public Authorities, by Janet Heinritz-Canterbury. 2002. (46 pgs.)

This paper analyzes the four-stakeholder coalition that successfully passed legislation and implemented the county public authority structure to improve the quality of jobs and services offered by California’s In-Home Supportive Services.

Cheating Dignity: The Direct Care Wage Crisis in America, by the Paraprofessional Healthcare Institute. AFSCME, August 2001. (38 pgs.)

This report provides a detailed analysis of how our nation fails to pay our direct-care staff “self-sufficient” wages and benefits, by comparing wages across several service sector occupations.

“Direct Care Health Workers: You Get What You Pay For,” by Steven L. Dawson and Rick Surpin. *Generations*. Vol. XXV, No. 1. Spring 2001. (6 pgs.)

This paper examines labor supply and demand and suggests that improving the price of labor, through changes in policy and practice, is the only way to attract workers to long-term care.

Direct Care Health Workers: The Unnecessary Crisis in Long-Term Care, by Steven L. Dawson and Rick Surpin. The Aspen Institute, January 2001. (33 pgs.)

Dawson and Surpin examine the structure of long-term care, its financing, and the current labor crisis, arguing for sectorwide restructuring supported by labor, welfare, and health care policies that work together to support high-quality care for consumers, decent jobs for workers, and a more rational environment for providers.

“The Home Health Aide: Scarce Resource in a Competitive Marketplace,” by Steven L. Dawson and Rick Surpin. *Care Management Journals*, Vol. 2, No. 4, Winter 2000. (6 pgs.)

Noting that labor has become a scarce resource, this paper suggests that employers must create higher quality jobs for home care workers to compete successfully for workers in today’s economy.

“Toward a Stable and Experienced Caregiving Workforce,” by Mary Ann Wilner. *Generations*, Vol. XXIV, No. 3, Fall 2000. (6 pgs.)

Wilner reviews some of the mechanisms available for establishing a stable workforce for consumer-directed care.

Health Care Workforce Issues in Massachusetts, by Barbara Frank and Steven L. Dawson. Presented at the Massachusetts Health Policy Forum, June 22, 2000. (32 pgs.)

Arguing that the price of labor must rise to attract direct-care workers, Frank and Dawson make a number of key recommendations for changes in state policy and provider practice.

“Who Will Care for Mother Tomorrow?” By Andy Van Kleunen and Mary Ann Wilner. *Journal of Aging & Social Policy*. Vol. 11, No. 2/3, 2000. (11 pgs.)

This essay confronts the caregiving crisis by offering a closer look at paraprofessional caregivers and the nature of their jobs, summarizing some of the public policies that currently shape the quality of those jobs, and proposing some possible steps that policymakers could take to start rebuilding our nation’s direct-care workforce.

Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long-Term Care, by Mary Ann Wilner and Ann Wyatt. A conference background paper prepared for the AARP Long-Term Care Initiative. AARP, 1998. (75 pgs.)

This paper explores the role of the paraprofessional in long-term care and highlights the relationship between the paid caregiver and the consumer.

Jobs and the Urban Poor: Privately Initiated Sectoral Strategies, by Peggy L. Clark and Steven L. Dawson, et al. The Aspen Institute. November 1995. (41 pgs.)

Analyzing four sectoral initiatives, this report proposes a definition for “sectoral employment development,” explores thematic issues, and makes recommendations for pursuing sectoral development as an approach to improving employment prospects in urban areas.

Video

HeartWork: A video celebrating the lives and work of direct-care workers. 2001. (43 min.) \$100 plus shipping and handling for video and discussion guide.

HeartWork chronicles the development of an original theater piece created and performed by women who work as home health aides and certified nursing assistants (CNAs). Through music, dance, storytelling, and interviews, the video provides a real, honest, moving and often humorous account of what it means to be a direct caregiver.

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