



EXPLORING PATHWAYS TO LONG TERM CARE STAFFING SOLUTIONS

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The United States is facing an immediate critical shortage of long term care workers – a crisis that will worsen as our population ages and the number of people with long term care needs increases. This is a crisis of particular concern to the Alzheimer's Association, because persons with dementia make up at least half of the elderly who need long term care, and because those persons require a high level of individual attention from direct care workers.

The Association has joined forces with consumers, workers, and providers to address this staffing crisis. This paper, which is based on interviews with Alzheimer advocates and public officials across the country, provides a framework for public policy advocacy. It focuses on the direct care worker – the certified nursing assistant, the home care and personal care aide – because that is who provides most of the direct care in long term care settings. The author notes, however, that the current long term care worker crisis extends to registered and licensed nurses and to managers and administrators as well.

Setting the Context – Why We Have to Act, and Act Now

The Crisis Today

Five million people in the United States need long term care today. Families provide a great deal of that care. But they are also entrusting their loved ones to 1.5 million direct care workers for help with the most intimate daily living needs, to support remaining functional abilities, and to protect them from harm.

At least 90% of these workers are women. Most of them not only care for our loved ones but support their own families as well. We are asking them to do work that is not only extremely important but very difficult, physically and emotionally. Yet we pay them very little, offer few if any benefits, give them impossible workloads, and offer them little if any respect or control over the work they do.

Certified nursing assistants (CNAs) working in nursing homes earned an average hourly wage of \$7.50 in 1998. One in 10 earned less than \$5.87. Workers who went into the home earned even less -- \$7.20 on average for home health aides and \$6 to \$7 for personal care aides. According to the United States Government Accounting Office, the median annual income or

nursing home direct care staff was \$13,287 in 2000; the median for home care workers was \$12,265 – well below the federal poverty threshold for a family of three of \$14,150 in 2000.)

One-fourth of CNAs and one-third of home care aides have no health insurance -- this for a workforce that ranks third (behind truck drivers and laborers) in the largest number of work-related injuries and illnesses. Few have paid vacation, sick leave, or childcare benefits, which are common in other sectors of the economy.

Surveys of direct care workers reveal that, while low wages and poor benefits are problematic, it is the workload caused by understaffing that creates the most dissatisfaction. They simply don't have the time they know they need to provide quality care. The inadequacy of staffing levels and the effect on care was documented in a recent study released by the Health Care Financing Administration (now the Center on Medicare and Medicaid Services.) That study found that, to prevent direct harm to residents, a nursing home must provide at least 2 hours of direct care staff per resident per day – a minimum standard that more than half of nursing facilities do not meet. The same study defined a more “optimal” level of staffing as 2.9 hours per resident per day – a standard that 90% of facilities could not meet. At least half of the nursing facilities in the United States would have to double the number of aides to meet that standard of care. Most advocates would argue that even that level of staffing is insufficient for quality dementia care.

It is not surprising, therefore, that studies find annual rates of turnover among long term care staff that range from 45% to more than 100%, and job vacancy rates of 11% to 20%. The cost is enormous for providers, residents, and workers. Providers spend from \$1400 to \$4300 for each worker they have to replace – an amount that can exceed 4 times the monthly salary they pay that worker. The cost of temporary workers is estimated at 200% of that for a regular employee. The quality of care for residents suffer, as they lose the continuity of care from familiar workers who know them and understand their needs (a loss that is particularly acute for persons with dementia.) And the workers who remain face frustration, added stress, injury and accidents.

“Where have all the nurse aides gone?” The state of North Carolina conducted a study to try to answer that question. Over 180,000 workers in North Carolina had been trained as CNAs over the previous 10 years, yet less than half were currently certified as CNAs. The study found that those who remained “active CNAs” were working harder and for less money than those who left health care altogether.

- “Active CNAs” worked more than one job. Nearly three out of four earned extra income outside of health care, income that accounted for 38% of their total earnings. Even with all of that effort, their median income from all employers was only \$11,358. Only 20% earned more than \$18,360
- Those who had left health care on the other hand tended to work only one job and earned a median wage of \$14,425. The top 20% earned \$25,505 or more.

One might well ask, not why so many workers leave long term care but rather, why so many stay. Studies show they stay because they love the work, and the people for whom they care. But we are making it increasingly difficult for workers to make the decision to stay.

There is no question that part of the staffing crisis was exacerbated by a booming economy that offered workers employment elsewhere at better wages and benefits, with fewer physical and emotional demands and less frustration and stress. But the current economic downturn does not eliminate the crisis. Recycling low wage workers through a long term care workplace that does not value or reward the work they do serves neither the worker nor our loved ones who need their care. And it ignores the looming disaster that demographics alone will precipitate.

The Disaster Ahead

The United States is seeing only the tip of the iceberg of long term care needs. The 5 million people who need care today will explode to 15-22 million by 2020. But there will be far fewer workers to respond to that need. In the year 2000, there were 16.1 women age 20-54 (the pool from which most long term care workers come) for each person over age 85 (those most likely to need long term care.) That ratio will shrink to 5.7 by 2040. Looking beyond the traditional worker pool does not suggest a better picture. Today, there are 39.5 people of working age for every person over age 85. That ratio will be cut in half to 14.8 by 2040.

Looking just at the next decade, the Bureau of Labor Statistics estimates that we will need 1,048,000 new long term care workers by 2010. But the traditional sources from which we draw these workers will increase by only 400,000 in that same time period.

It is not just that there will be more elderly. They, and their caregivers, will look different and are likely to make more demands on the long term care system. While the health of people age 65 and over is improving steadily, it is the age group over 85 that is growing fastest and they are most likely to need care. One in five will be childless and without family caregivers. For those who do have family, their caregivers will likely approach their roles differently. They will be more dispersed geographically and may be less able to provide regular hands-on care. Some observers suggest that this next generation of caregivers, who have shared family responsibilities with paid caregivers from the time their children were born, will be more likely to arrange and manage care for their loved ones than to provide that care directly. Higher incomes among the elderly and an increase in the numbers holding long term care insurance policies will also increase the demand for paid caregivers

The long term care system will look different as well and there will be more competition for workers within that system (as well as from outside the system.) The demand for workers will come not just from the more traditional nursing home and home care industries, but from assisted living, adult day care, and new forms of home based and residential care that are only now beginning to emerge. The move toward consumer-directed care and the so-called “cash and counseling” systems that allow people to hire their workers directly will not reduce the demand for competent workers. It will only add more employers competing for available workers.

Developing a Policy Response

No single factor created the long term care staffing crisis and there will be no single solution. Research suggests that the management style and culture of the long term care setting is the most important predictor of job satisfaction and turnover. Providers can and must take responsibility for culture change. There are model long term care providers – nursing homes, assisted living facilities, day care centers, home care agencies – that have created work environments that attract, reward, and retain a quality workforce. It can be done.

But there is no way to get around the central role of public policy in devising solutions to the staffing crisis. Government is “the hundred pound gorilla” in long term care and the decisions of policy makers affect both the money available to pay for the workforce we need and the environment of the long term care workplace.

- State and federal governments, through Medicare and Medicaid primarily, pay 60% of the long term care bill in the United States.
- Local, state and federal governments share responsibility for licensing and regulating long term care providers and assuring quality of care.
- Employment policy and programs influence work requirements and training opportunities especially for low-wage workers. Immigration policy can affect the availability of long term care workers.

Federal Policy Solutions

The federal government has a key role to play – in direct funding through Medicare and Medicaid and in maintaining and enforcing consumer protection and quality assurance requirements that federal law imposes on providers that receive those funds. Over the past several years, primarily through the aggressive leadership of the Senate Aging Committee, Congress and federal investigating agencies have focused concern on quality and staffing, particularly in the nation’s nursing homes but also, more recently, in assisted living. Citing evidence from the Congressionally mandated study that documented the extent of understaffing and the impact on quality (noted above,) advocates are calling on the federal government to impose minimum staffing requirements for nursing homes receiving federal funds.

Legislation has been introduced in Congress to impose federal staffing standards. Other proposals, while not imposing federal mandates, would provide grants to states or funds to providers on the condition that they meet specified staffing requirements. While these proposals provide vehicles for continuing discussions in Congress, the price tag associated with imposing even minimal federal standards (estimated by providers at as much as \$3.3 billion annually) means at best that this is an uphill legislative battle. Imposing standards without funding to pay for increased staffing would be opposed, not just by providers but by governors and state legislators as an “unfunded federal mandate” at a time when states are already struggling to meet exploding health care costs with declining revenues and projected budget deficits.

One controversial proposal, offered by some as an interim solution, is to ease current federal requirements for certification and training of CNAs in nursing homes to allow the use of single task workers. A broad legislative proposal was defeated in the last Congress but the Centers for Medicare and Medicaid Services have proposed a rule that would allow use of “feeding assistants” and a number of states have enacted or are considering legislation along those lines.

Other federal proposals to address the workforce crisis include expansion of health insurance benefits to long term care workers (as well as child care workers), and various approaches to ease immigration requirements to expand the long term care workforce. Given the preoccupation of federal policy makers with the economic downturn, terrorism, and a possible war in Iraq, it is unlikely that Congress will act on any of these proposals in the near term.

State Policy Solutions

Thus, advocates are focusing their efforts at the state level, and states are responding with a variety of legislative and administrative actions that address a wide range of issues including:

- **Staffing levels.** According to the National Conference of State legislatures, 37 states now have staffing requirements for nursing homes, usually defined as staff hours per resident per day. In 2000, 6 states enacted legislation to establish or increase staffing requirements. In 2001, 50 bills were introduced in 19 states; bills were enacted in at least 3 states – California, Arkansas, and Florida.

In 2002, the debate over staffing levels in the states took a disturbing turn, as some states actually cut back on existing staffing standards or delayed their implementation. Others moved to provide more flexibility to facilities in determining staffing patterns, including authority for the use of single task workers.

- **Wage pass-throughs.** This is an approach that increases funding to providers with a requirement that funds be spent on wages – either wage increases for existing staff or wages for additional staff. At least 18 states have enacted such pass-throughs recently. The challenge of this approach is two-fold. First, the legislature has to spend a lot of money to get any significant amount to the individual worker. In Massachusetts, for example, it took a \$40 million appropriation to generate an average hourly wage increase of \$1. Second, it is not easy to account for the money in the system to assure that it is going for the purposes that legislature intends. Again, as states face budget shortfalls, such wage pass-throughs are in jeopardy.
- **Health insurance coverage.** Because their wages are so low, many long term care workers are eligible for health insurance under state Medicaid and child health insurance (CHIP) programs. States are beginning to explore ways to provide health insurance benefits to long term care workers and to their families who are not otherwise eligible, through expansion of CHIP programs and Medicaid waivers.

- Training. Federal law requires 75 hours of training for direct care workers in nursing homes – a minimum requirement that does not provide the level of training required to meet the complex needs of many residents, including particularly those who have dementia. One-third of the states go beyond these federal minimums. Some extend training requirements to other long term care providers including assisted living, adult day care and home care. Alzheimer advocates have pushed aggressively and with success in a number of places for dementia-specific training. Like staffing standards, training requirements may be resisted by providers unless there is funding attached to pay for such training.
- Career ladders. States are beginning to explore ways to encourage workers to stay in long term care by providing opportunities to advance within the system with rewards in higher wages and increased responsibilities. One of the most interesting is a demonstration in Massachusetts that is providing \$10 million in competitive grants to nursing homes. Thirty-one projects, involving 57 facilities, are participating in two types of demonstrations. Individual facilities are establishing career ladder programs and implementing skills training for direct care workers. In addition, regional partnerships of facilities, vocational and higher education institutions, and the workforce development system are developing models for systemic change to upgrade skills and retain workers.
- Nurse delegation provisions. At least 6 states now allow direct care workers to perform, with appropriate training and supervision, certain resident care duties (like passing medications) that nurse practice laws would otherwise require be done by a registered nurse or licensed practical nurse. These policies can be an important part of a career ladder strategy for direct care workers – expanding their roles and responsibilities within the facilities. They are often met with resistance, however, from professional organizations that express concerns over quality. For example, California conducted a successful demonstration that trained certified nursing assistants as “medical technicians” and allowed them to distribute medications. In spite of an evaluation that showed high worker and resident satisfaction and no medication errors, the state rejected a proposal to establish the program statewide because of opposition from professional societies.
- Restrictions on agency workers. Long term care providers turn to agencies that provide temporary or “pool” workers to meet their shortages in permanent staff – an approach that raises both cost and quality concerns. At least two states, Massachusetts and Minnesota, have enacted legislation to deal with those concerns. (While these statutes have faced court challenges, they have eventually been upheld.)
- Studies. Several states have undertaken comprehensive studies of the workforce crisis which have brought high visibility to the crisis in their own states and nationwide, and have provided a framework for action. In North Carolina, for example, the Division of Facility Services received a three-year foundation grant to address recruitment and retention issues which have resulted in a number of widely publicized reports (including “Where have all the nurse aides gone?” noted above.)

In Vermont, the Department of Aging and Disability brought together all of the stakeholders in the state to conduct a Paraprofessional Staffing Study which had at its core a survey of certified nursing assistants in nursing homes, personal care assistants in home and community based services, and long term care administrators. The results were used to develop a comprehensive plan to address the crisis.

Lessons for Advocacy

The following lessons for advocates were gleaned through interviews with Alzheimer advocates and state officials in a sample of states that are widely seen as leaders in tackling the long term care workforce crisis. While experience, strategies and tactics vary among these states, common themes emerge.

1. Advocates must be informed, smart, and sophisticated. The problem is complex and the issues are complicated. Being “right” is not enough to win. Everyone supports the concept of quality care and reacts strongly to horror stories of poor care. But advocates cannot depend on rhetoric and righteousness to carry the day. They need to learn the tough issues to sit at the table, they must be open to other points of view, and they must be willing to challenge their own assumptions. Above all, they need information, data, and hard evidence about the nature of the problem and the potential for success of the policy objectives they are advocating.
2. This requires a long term commitment. It takes time to develop strategies, build alliances, and gain momentum. Even when legislation is achieved, the struggle is not over. There are issues of implementation, accountability, and evaluation that require continued advocacy. And in today’s climate, when both federal and state budgets are under huge pressures from declining revenues, increased health care costs, and competing demands for dollars, advocates will have to fight to hang on to what they have already won and to avoid cutbacks in spending on long term care.
3. The approach must be comprehensive, multi-faceted, and strategic. Long term solutions to the staffing crisis require a holistic approach that takes into consideration all settings of care, as well as the direction of overall long term care policy in the state. Piecemeal approaches can lead to policy that is contradictory if not conflicting. Once an overall strategy is in place, than advocacy can proceed incrementally toward those larger goals.
4. Advocates must be flexible and opportunistic. Once a strategy is in place, creative advocates must seize opportunities to advance their objectives. They must be able to adjust their tactics to respond to political and economic developments.
5. Coalitions are essential. Advocacy works best when all the stakeholders are at the table. That includes consumers, workers, and providers. This is easier said than done. In many places, a great deal of distrust has been built over the years, with plenty of examples of bad faith and exaggerated rhetoric on all “sides.” But long term care staffing has now reached crisis proportions. It is time to leave the

disagreements outside the door and bring everyone to the table to find points of agreement on which workable solutions can be built.

6. Workers must be out front and visible. Successful advocacy puts the direct care worker out front, in the development and implementation of strategies, in meetings with legislators and state officials, and in legislative hearings and other public forums.
7. Successful advocacy requires official champions. Advocates need effective leaders in the state legislature, the governor's office, and key state agencies who can carry their proposals through the legislative, administrative, and budgetary processes. Those champions can be key to getting all of the stakeholders to the table.

Conclusion

Direct care workers are the key to quality dementia care. Advocates for persons with Alzheimer's disease, and for all long term care consumers, have no choice but to continue to fight for better wages, working conditions, and training for these essential workers. That requires advocacy with state legislators and regulators, with Congress and federal agencies, and with providers.

Appendix: Vignettes from the States

[Note: These vignettes are based on interviews with advocates and state officials in late 2001. They do not reflect continuing activity in these states in 2002.]

Minnesota – Building a Strategy, Developing a Coalition, and Rolling with the Punches

Seniors and workers in Minnesota have been working together for years in a long term care coalition. Brought together initially to fight for a fairer system of financing long term care and to expand options for care in residential, home and community based settings, the coalition responded to the emerging long term care staffing crisis, redirected its efforts, and developed a four part strategy for advocacy. The four planks in their staffing platform are staffing levels, continuity of care, training, and accountability.

The coalition reached out to the provider organizations and trade associations to join forces around staffing issues. While they made little progress at first, everyone worked to keep the lines of communication open until they found an issue of common concern on which they could work together – the impact of the growing reliance on agency or “pool” workers. Providers were concerned because agencies were drawing away workers they had trained. Facilities were facing skyrocketing costs for these agency workers. The issue was equally important to consumer and workers who were experiencing increased burden and disruption of care with serious consequences for the quality of care and life for workers and residents alike. Together, the groups developed – and won – legislation to “level the playing field” by requiring agencies to register with the state, subjected them to the same background checks as facilities, and capped wages for agency workers at 150% of the Medicaid rate.

That legislation addressed the second plank in the coalition’s platform – continuity of care. But it was part of a comprehensive package that included bigger wins on the rest of the platform:

- On staffing, they won \$46 million, a 3% increase in reimbursement to nursing facilities, 75% of which was earmarked for wages and benefits.
- On training, the legislature approved \$2.3 million, which goes to facilities for training and to further the careers of direct care workers, as well as a summer internship program in nursing facilities and home care to encourage students to pursue a career in long term care.
- On accountability, to lay the groundwork for future advocacy, they persuaded the legislature to allocate \$1 million for a time motion study to evaluate the adequacy of the state’s current case mix reimbursement system.

Now, a few bumps in the road have developed. The pool agencies went to the courts to try to stop implementation of the new legislation affecting them. Emerging budgetary problems in the state made further spending increases unlikely. The coalition has developed its legislative strategy for the coming year, based on those realities.

- On staffing, they will seek health benefits for the children of direct care workers through a Medicaid waiver.
- On continuity of care, they will go back to the legislature to address the court's concerns about the legislation just enacted.
- On training, they will push for an external evaluation of current training efforts and their impact on staff turnover.
- On accountability, they will require facilities to submit plans and provide evidence of how they spent their share of the \$46 million appropriated this past year.

Lessons from the Minnesota experience. Advocates have developed a comprehensive approach to the problem that is well informed and strategic. Within that strategic plan, they are flexible and opportunistic, adapting to changing circumstances brought on by the courts and by new budgetary pressures. They are investing in gathering information and evaluation, to provide the basis for future advocacy. They have worked hard to find ways to bring providers into their coalition. And throughout their advocacy, they have put workers at the forefront in public hearings, before legislators, and in the press.

Florida: Seizing Opportunities, Shaping the Agenda

In Florida, advocates for consumers and workers seized an opportunity presented by concerns over large settlements in wrongful death litigation brought against nursing homes in the state. When efforts to limit such settlements through tort reform legislation were blocked, the Governor set up a task force to examine the issue. Advocates mobilized to make sure that effort was about more than tort reform.

When the task force scheduled hearings around the state, members were shocked to find that every place they went, people showed up to talk about quality care. Direct care workers were visible and vocal at every public hearing, presenting compelling testimony about the realities of the impossible jobs they were being asked to do. Other advocates appeared as well. They came without any prior agreement about a common message or agenda. Each group had its own particular ideas about how to address the quality issue. For example, the Alzheimer's Association focused on the need for specialized training in dementia care.

The net effect was to persuade the task force and ultimately the state legislature that the quality issues were real and had to be addressed. In the end, legislation was enacted to limit punitive damages in nursing home cases, though the original proposal was watered down substantially. More important, the legislature voted funds to address the quality issue directly.

This included a \$xx increase in reimbursement to nursing facilities, tied directly to staffing. Facilities must increase their staffing from the current level of 2.3 hours of direct care per resident per day to 2.9 hours within the next 3 years. (Advocates had learned from experience. When the legislature last approved a reimbursement increase for facilities with "no strings" attached, there was little improvement in staffing and no real way to hold facilities accountable for the funds they received.)

In addition, the legislature increased in service training and added specific requirements for training in dementia – with funds appropriated to pay for that training. For the Alzheimer’s Association, this was the first victory in a campaign for funded dementia training requirements for all long term care settings in the state.

While consumer and worker advocates came together in this legislative effort, their efforts to engage provider associations met with limited success. It took a state legislator who was championing the training bill to get industry representatives to sit down at the table with consumer advocates. There is still a high level of suspicion and distrust between the groups.

Lessons from Florida

Advocates were opportunistic – taking advantage of a push for tort reform to reshape the debate to one about quality care. They gained visibility for their issue by putting workers out front. And they insisted on accountability. The experience showed advocates who had heretofore been working on their own the value of coming together in pursuit of a shared agenda. There is still a lot of work to be done to build the kind of coalition that can achieve long term gains.

Massachusetts: Coalitions Work

There is a long history in Massachusetts of successful collaboration between providers, workers, and consumer advocates – the result of a lot of hard work by leaders of all three groups. They achieved early successes in fighting cuts in Medicaid funding for long term care and in expanding home and community based options for care. They were ready to take on the staffing crisis.

In the 1970s, Massachusetts was the first state to establish staffing levels for nursing homes. But those levels had not changed in the intervening years. Many experts and advocates had believed that the current approach – which defined staffing levels as hours per resident per day – is difficult to interpret, to monitor, or to understand. Consumers and worker advocates wanted to change the system to a more transparent one that would define staffing as a staff to resident ratio. But everyone in the coalition agreed that they had to start by getting more money for staffing into the system.

The state developed a two-year sequenced response. In fiscal year 2000, the first stage of a wage pass to nursing facilities was implemented administratively. Then, in fiscal year 2001, the legislature approved an additional \$40 million for wage-pass throughs, with strong accountability measures that increase the ability to track the money through the system.

The wage pass-through was a cornerstone of a multi-part effort to improve staffing that also included funding for scholarships for certified nursing assistants for training, as well as \$3.75 million for competitive grants for career ladder programs described earlier in this paper.

With budget problems mounting in the state, the coalition has adapted its strategy for the coming year. They know they will have to fight to hold on to the gains they have already won and to avoid any cutbacks in long term care spending. But they will pursue other objectives that will require less spending. These include uniform training and certification requirements across settings – important not just for quality in all settings but to increase career opportunities for workers by making their skills transferable. The coalition will also work with the state to expand health insurance coverage to direct care workers in all long term care settings. The state has already received a federal grant to study ways to meet this last objective.

Lessons from Massachusetts

Coalitions work. Success happens when everyone leaves their disagreements at the door and tries working together toward a common agenda.

California – Winning Isn’t Everything

Observers and advocates often point to California as the state that has taken workforce issues seriously. There have been significant gains in the state as a result of a lot of hard work by advocates and legislators, including persistence efforts to work through governor’s vetoes to reach their objectives. Perhaps the most important lessons from California for advocates, however, is not how these victories were achieved, but how even significant victories have their limits and how advocates must constantly redefine strategies to achieve their ultimate objectives. There are three examples of this in California advocacy: on staffing levels, wage-pass throughs, and training.

Staffing levels. California is often noted for its relatively high staffing levels for nursing facilities – 3.2 hours per resident per day. But those levels are not being met. According to a study by the National Senior Citizens Law Center, 42% of facilities fall short of the state requirement. Some attribute this to high turnover, vacancies, and difficulties in finding qualified replacement workers – and those are certainly all problems. But advocates also point to a lack of accountability as a key factor.

Another factor that suggests the picture is not quite as good as it looks has to do with the “doubling” allowance, which permitted a facility to count a nurse as the equivalent of two certified nursing assistants in calculating its staffing levels. In a system where quality depends on direct hands-on care, that doubling made no sense to advocates for residents or for workers.

Advocates in California developed a multi-year strategy to deal with staffing. First, they won legislation to get rid of the doubling allowance. One direct care worker is one direct care worker – whether she is a registered nurse, a licensed practical nurse, or a certified nursing assistant. This year, they won legislation that will define staffing levels as staff to resident ratios rather than hours per person per day – creating staffing levels that will be more visible, easier for everyone to understand and to monitor. This change will be phased in over a long period of time (through 2006) and is conditional on annual funding sufficient to pay for the required ratios.

Wage pass-throughs. California has enacted pass-throughs for staffing in nursing homes for three years in a row now. That is a very significant achievement. But each of these pass-throughs has been conditioned on facilities meeting certain requirements, and each year those requirements have varied. (This year, for example, the increases are limited to facilities that have a collective bargaining agreement with their workers.) While there may be good argument for the particular conditions imposed, the changing requirements make it almost impossible to track the use of the funds and to assure accountability. And some of the conditions raise basic issues of equity for workers and residents.

Training. The Alzheimer's Association has fought for several years to increase training requirements for workers caring for persons with dementia. They have been successful. Last year, they established requirements for workers in residential care facilities and this year, for direct care workers in nursing facilities. The problem is that, as a result of changes during the legislative process, the requirements are different. Workers in residential care must have more hours of dementia training than those in nursing facilities. This means that trainers must develop two sets of curricula, even though they are teaching the same set of skills for workers in both settings. For the worker, it means that their training may not be transferable from one setting to another. (Advocates in Massachusetts are attempting to address this problem through uniform training and certification requirements across settings.)

Lessons from California

Piece-meal victories leave unresolved issues that can be avoided through a holistic approach that addresses issues across settings. Even substantial victories require follow up, evaluation, and adaptation. Accountability is essential to assure that legislative victories result in positive change.

Rhode Island – Working from a Blueprint

Since 1987, long term care policy in Rhode Island has been shaped by a Long Term Care Coordinating Council that is chaired by the Lieutenant Governor and includes all of the stakeholders – legislators, consumers, providers, workers, agency directors, and advocates. In 2000, the Council turned its attention to the workforce crisis and established a study group to define the scope of the problem and fashion recommendations. Prompted initially by severe staff shortages in nursing facilities, the study group quickly expanded the scope of its work to include all settings of care. The study group held a series of public meetings across the state, receiving testimony and evidence from all stakeholders, and reviewed extensive data from national and state sources.

In March 2001, the study group presented its report, “Crisis in Care,” with a comprehensive strategy to recruit and retain direct care workers. The Council has adopted a ten-step set of recommendations that begin with wage increases and include expanding and coordinating training opportunities, encouraging demonstrations and dissemination of best practices, and addressing a variety of barriers including language and cultural issues as well as child care.

The legislature has already acted on the first recommendation, providing \$13 million for wage increases for certified nursing assistants (CNAs.)

The long-range plan defines a comprehensive career ladder strategy that includes training in English as a second language, increased pay for CNAs who receive extra training, and tuition assistance for CNAs who want to become nurses. Using funds from a federal demonstration grant, the state will begin by providing 20 hours of added training in dementia care for home care workers which will lead to separate certification and higher pay. Home care agencies will receive extra funds to pay their CNAs for this training.

Lessons from Rhode Island

This is the work of a well-established coalition that has learned to work together. The state has developed a comprehensive multi-year plan with incremental steps that include demonstrations and evaluation to figure out what will make a difference. The plan is built on solid information and evidence. It includes strong accountability measures.

Vermont: Learning from the Experts – the Direct Care Workers

The Commissioner of the Department of Aging and Disabilities convened a steering committee, made up of all of the stakeholders, to develop an action plan for creating “a stable, valued, and adequately reimbursed long term care workforce in Vermont. The committee was to address the paraprofessional work force across settings – nursing facilities, home health, and personal care in home and community based settings including consumer-directed care.

While the steering committee examined extensive data from published national and state sources, the core of the study was the data gathered directly from workers. This included five focus groups of personal care attendants, licensed nursing assistants, supervisory staff, consumers who hire their own personal assistants, and high school students interested in health care careers. The focus groups were followed by surveys distributed to personal care attendants, licensed nursing assistants, persons participating in the consumer-directed care program, and administrators responsible for hiring and supervision.

It was the surveys of direct care workers that yielded the richest and most powerful data for the action plan. They were designed to learn what motivates workers and to find out from them successful best practices. Over 1000 workers returned the surveys. In addition to responding to the specific questions on the forms, they submitted over 100 pages of personal, mostly handwritten comments. Their insights permeate the final report.

The Paraprofessional Staffing Study released in March 2001 includes a comprehensive set of 26 recommendations. The top issues, as defined by the workers and reinforced by the rest of the data gathered by the committee, are wages, benefits, and staffing levels.

The legislature has already responded with an increase in reimbursement that must be tied to increases in staffing. Next year, the first priority will be action on health benefits and paid time off for home care workers.

Recognizing the importance of the worker's voice in defining problems and shaping policy, the state has applied for a grant that will provide seed money to establish an organization of paraprofessional workers, to empower workers and to establish an insurance pool.

Lessons from Vermont

The state has developed a comprehensive plan that addresses worker issues across settings. While all stakeholders were involved in developing the plan, the worker's voice has been the strongest and that is where the state has directed its response.