

When No One Cares

Why We Need to Save Connecticut's Direct Care Workforce

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Senior Resources-Agency on Aging
Direct Care Workforce Shortage Team

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EXECUTIVE SUMMARY

"Do every day or two something for no other reason than you would rather not do it, so that when the hour of dire need draws nigh, it may find you not unnerved and untrained to stand the test."

- William James; *Philosopher, 1842-1910*

Purpose of this white paper

Connecticut faces a challenge: will we save our direct care workforce? For older adults and persons with disabilities – in short any person with the audacity to age or ail – the stakes are far too high. Without swift and appropriate intervention the demand will overwhelm supply. The grim reality: if we fail to solve the labor crisis, we risk a situation when no one will render care.

Alarmed by this state of affairs, in 2008 **Senior Resources-Agency on Aging** founded the Direct Care Workforce Shortage Team (DCWST). **When No One Cares** is more than a call to action: it is a test of our resolve to care for our neighbors.

What happens when no one cares?

Residents of every age can rely upon Connecticut's direct care workforce to provide assistance when recovering from accident or injury. This resource is especially important to older adults and persons with disabilities. It is projected that by the year 2030 the elder population in Connecticut will increase 69 percent. Simultaneously the already shrinking pool of traditional direct care workers will decrease by nearly 10 percent.

The consequence for persons in need of care –namely individuals who age, ail or suffer accident- is dire. Left unchecked the shortage of direct care workers would imperil Connecticut's ability to care for consumers and disproportionately harm older adults and persons with disabilities. The growing shortfall in the direct care workforce does not take into account the number of paraprofessionals needed to assist persons with physical, developmental and mental health disabilities. **When No One Cares** calls for immediate action.

What can be done?

The state of Connecticut must invest in smart strategies that will strengthen the direct care workforce – including budget neutral and other fiscally sensitive options. **When No One Cares** illuminates opportunities that can be maximized through policy, planning and practice:

- **Recruitment:** Attract new persons to the field and increase the number of qualified direct care workers.
- **Retention:** Professionalize the workforce through career ladders, training and education to stabilize the labor pool.
- **Reimbursement:** Develop incentives that lead to living wages and benefits.

Past practices have not resolved the labor problem and have resulted in a costly, complex and confusing system.

Connecticut can benefit from the investigation of existing models in other states and the utilization of evidence-based practices that can responsibly develop the direct care workforce. By acting now we can prevent a future **when no one cares**.

SITUATION

For several years both federal and state healthcare policy has focused on initiatives to "re-balance" the delivery of long term care away from institutions and back into the community. Specifics on key elements supporting these initiatives, along with an in-depth assessment on long term care needs in Connecticut, can be found in the **Long Term Care Needs Assessment** conducted by UCONN Health Center, Center on Aging¹, and the Long Term Care Advisory Council in February 2007². These initiatives have been applauded by both consumers and health care professionals.

It has been clearly understood by healthcare professionals and long overlooked by policy-makers that older adults and persons with disabilities prefer to remain in the community. Therefore the "re-balancing" of Medicaid expenditures certainly makes sense in terms of consumer satisfaction and cost savings. But while policy and programs have promoted the delivery of care back into the community setting, the question of "who will provide the care in the home?" has been left unanswered.

Undoubtedly the biggest obstacle to the delivery of long term care services in the community is the lack of direct care paraprofessionals to provide these services. Connecticut is experiencing what every other state is facing: an explosion of aging baby boomers. But what makes Connecticut different and adds to the urgency of our situation is this: U.S. Census estimates that by 2030 Connecticut's elder population will increase by 69 percent. In comparison, the state's overall population is expected to increase by only 5 percent. By that year the traditional care giving workforce (women aged 25-44) will decrease by almost 10 percent³. This will exacerbate an already wide "care gap" between those needing services and those workers available to provide services. **Put simply, our population is aging and wants to stay home; we are directing patients out of institutions back into the community and at the same time our workforce is dwindling.** Those persons available to work in this field are not attracted to direct care positions. The need to increase our workforce, though well-documented in reports like the **Long Term Care Needs Assessment**, has yet to be definitively addressed. We have studied the problem, surveyed the consumer and made policy recommendations but that is where it has ended. The time to act is now. The situation is dire and decisive action is required to resolve the caregiver workforce shortage.

At first glance the problem seems one dimensional. In 2008 Senior Resources-Agency on Aging, which serves the 56 towns in Eastern Connecticut, created the multi-disciplinary **Direct Care Workforce Shortage Team (DCWST)** to examine this issue. DCWST soon realized the problem is multifaceted and recognized that solutions to address the complexity of workforce shortages will need to look at a variety of critical issues. DCWST held two roundtables (in April 2008 and October 2008). Issues affecting the availability of direct care paraprofessionals were identified at both roundtables. The most pressing considerations include:

- Transportation
- Training/Supervision
- Unemployment Compensation
- Low Wages
- Liability Protection
- Health Insurance

Connecticut, though not alone in grappling with labor needs, is lagging in finding viable alternatives. Several states are diligently working on this issue and we should examine their best practices. For example, Iowa developed a **Direct Care Worker Task Force**. The Centers for Medicare Medicaid Services (CMS) has the **National Direct Service Workforce Resource Center**. This website is devoted to helping states recruit and retain a direct care workforce.

We cannot, with clear conscience, promote the option of remaining in the community without addressing the lack of an adequate workforce. We need to meet the demand - but not just in numbers. We must ensure that these workers are trained, have a livable wage and can access health coverage.

The problem of sustaining a viable direct care workforce has been articulated by policy-makers, healthcare professionals, community stakeholders and supported by demographic and academic studies. The problem can no longer be ignored. By remaining stagnant we jeopardize the most vulnerable residents in our state and bring risk to those who dare to age or ail. Our hope is **When No One Cares** will re-introduce this issue and reinvigorate the call to action.

CHALLENGE

The challenges to overcome the direct care workforce shortages are many. **When No One Cares** condenses the challenges into three major components: **recruitment**, **retention** and **reimbursement**.

Challenge: Recruitment

By definition recruitment means "to take on people as workers or members." What we find in Connecticut is not just a lack of interest in these careers but a lack of workers in general. The state's traditional care giving workforce of women aged 25-44 is decreasing every year. By the year 2030 that group will have diminished by almost 10 percent⁴. This phenomenon is worsened by the demographic trend of the younger segments of the population transferring out of the state in large numbers. The palpable drain on the labor pool, although felt throughout the state, is particularly evident in Southeastern Connecticut. In this region the competition to attract workers is notably fierce due to the overwhelming presence of the gaming industry. The region boasts two major casinos with jobs that can offer better wages and benefits than paraprofessional health care positions.

Non-institutional health care jobs lack an opportunity for professional advancement, additional training, supervisory feedback or the camaraderie of working within a group. The impetus, then, is to improve the perception of direct care jobs in order to better compete for the dwindling number of available workers. Recruitment efforts could be enhanced by professionalizing paraprofessional roles. **No one wants to work in a thankless job.** The direct care field should merit respect for its role in caring for our most vulnerable residents - the elderly and disabled.

Challenge: Retention

Retention poses a challenge in two areas. First is the ability of paraprofessionals to meet their own basic needs of life, which entails:

- wages that will create a livable income
- affordable housing within the locus of employment
- health care benefits

Continuity of employment is a key component to preserving the workforce. For example, some direct care workers will see an interruption in their earnings or outright loss of employment should their client require hospitalization or institutional care. There is little to no liability protection. There is a tangible need for a comprehensive public transportation system. Current regulations limit the number of compensable hours certain direct care workers (like a Personal Care Attendant) can spend with a client, so paraprofessionals are not guaranteed a minimum number of hours a week of employment.

The second challenge delves into the desire to professionalize the workforce. There is a lack of adequate standardized training and continuing education opportunities, as well as a lack of a career ladder/career paths. There is no active professional association for peer support. Paraprofessionals may have little to no supervision while they are with a client and potentially no contingency plans if staff fails to report for duty. This could mean the person just finishing a shift may have to cover a second shift with no relief. **There are no federal job descriptions, guidelines or criteria for direct care workers or their educators to help set standards and expectations.** These factors combine to create a sense of frustration and give the impression that this field is not a valued career.

Challenge: Reimbursement

A key factor in any profession is compensation and that point is no less salient when applied to the direct care workforce. Traditionally direct care workers experience low pay, limited health care benefits at best and often a less than desirable work environment – to the point where **55 percent of direct care workers did not wish to remain in the field for the next three years**⁵. The Carsey Institute at the University of New Hampshire issued a policy brief that documented how direct care workers are relied upon to provide the majority of paid hands-on care, yet earn low wages and experience high turnover rates. This can destabilize the field. The document noted that 50 percent of direct care workers have low income but adds that “as annual earnings rise, the odds of remaining in the direct care occupation increase by 21 percent⁶.”

In 2007 the national median annual earnings for direct care workers was only \$17,000 with personal and home care aides earning just \$14,000. The wages for nursing, psychiatric and home health aides was \$18,502⁷. In comparison, these wages are beneath the federal poverty threshold for a family of four, which is \$20,650⁸.

Clearly, appropriate reimbursement is a primary factor in strengthening the direct care workforce. Workers need living wages and employers want to control spiraling costs.

Another challenge in addressing reimbursement is the lack of full faceted partnerships, preferably across state agencies and with local and regional stakeholders. This may be best illustrated through a suggestion proffered by **Better Jobs Better Care (BJBC)**, a four-year \$15.5 million research and demonstration program funded by the **Robert Wood Johnson Foundation and The Atlantic Philanthropies**. In order to better leverage existing resources to invest in the direct care workforce, BJBC recommends using the **Workforce Investment Act (WIA)**. This federal initiative involves workers, employers and community stakeholders in workforce training and development and is tied to local economic opportunities. The need for direct care workers, one of the fastest growing occupations in the nation, dovetails with the intent of the WIA. WIA could help recruit, screen and test direct care workers; create partnerships to develop career paths; provide certification; incentivize the workforce and provide training. BJBC cites several successful practices that use WIA for these specific purposes. However, Connecticut has no such partnership to champion reimbursement for direct care workers.

Solutions

The means to address the challenges of recruitment, retention and reimbursement facing the direct care workforce can best be identified by exploring solutions as they relate to planning, policy and practice:

Planning: the restructure and reorganization of the current direct care workforce system.

Policy: the creation and refinement of laws and policies.

Practice: the implementation, implication and enforcement of policy.

Planning

The initial step in planning requires a comprehensive review of the extensive literature available on the direct care workforce shortage. For example, one best practice study by the **Cooperative Home Care Associates (CHCA)** in the South Bronx, NY recommends a "layered assessment and selection process [for direct care workers] to identify candidates most likely to succeed as caregivers" by looking for candidates with "some formal or informal caregiving experience who express compassion for other human beings and demonstrate an ability to set priorities and resolve problems."¹⁰ Another recommendation is based on an award-winning program started in Ohio: **Linking Employment, Abilities, and Potential (LEAP)**. It offers three employee skills training and placement programs for persons with disabilities: Home Health Aide Training, State Tested Nurse Assistant and Dining Assistant Training as a means of creating a direct care workforce to specifically service the needs of people with disabilities¹¹. A report by the **National Blue Ribbon Panel on Personal Assistance Services** found it would be beneficial to consumers to expand the pool of potential employees to include all family members that are currently excluded under certain state regulations¹².

Planning should include input from **multiple regional focus groups** composed of current and prospective direct care workers, service and caregiving agencies, personnel from educational and training facilities, family caregivers, care recipients and legislators. The information gathered from the literature review and best practices coupled with the recommendations of the focus groups will provide the framework necessary to develop a viable plan to resolve the workforce shortage. In the current distressed economic environment, this multifaceted plan would benefit Connecticut by using budget neutral tactics and other methods designed to save money.

Strategies that would save money should include measures of **prevention** which could be accomplished by any or all of the following:

- 1) **Provide training** to current and potential family caregivers in order to improve contact with and care for the disabled and elderly while they are still home and community based - before placement in a long term care facility with a significantly higher cost of care.
- 2) **Combine funds authorized for the numerous waiver programs** so that we eliminate overlapping administrative costs attached to each waiver and help simplify enrollment.
- 3) Create **intergenerational companions** through

mentor-based high school work study groups and elementary and middle school service learning projects. These endeavors would save money, reduce stigma and create an appropriate environment to introduce potential paraprofessionals to the field.

4) Coordinate **increased involvement by members of community groups** such as scouts, faith-based groups and civic groups to contribute to the continuum of care with activities such as transportation assistance, pet care, companionship, cooking, gardening, and lawn work. Technical schools and tradespersons, both active and retired, can be enlisted to volunteer for home and car repairs, meal preparation, and similar projects.

Budget neutral to real cost strategies could be realized through the refinement of current regulations to allow for the development of new job descriptions, guidelines and criteria for direct care workers and instructors **based upon the formation of a new and expanded care matrix**. This new care matrix could be accompanied by a freshened approach to training (educators, methodology and criteria) coupled with new competencies, certifications and continuing education programs. **Instruction can be web-based** with the added advantages of easy access (community sites like libraries would be used) and student flexibility. Hands-on competencies and testing could be offered through existing teaching sites or regional teaching centers; in turn such centers could be supported through the WIA In order to attract and retain students scholarships, loan repayment and tuition stipends can be tied to service obligations. Incentive programs evident at entry-level could thread workers into the field and result in the recruitment and retention of highly trained and licensed professionals¹³.

The new direct care work force would be taught to perform any task - hands-on or otherwise - that a family member could be taught, with appropriate teaching, competencies and supervision. Workers would have increased responsibilities and compensation commensurate with their expanded capacity with an emphasis on active learning techniques, team building dynamics, support services, written educational materials and peer mentoring. Cost savings along the entire long term care continuum could begin at the teaching level.

In order to expand the pool of available teachers, teaching qualifications could be based upon competency exams to determine ability and demonstrate a firm grasp of the material rather than relying solely on possession of a degree or nursing license. This step has multiple benefits. It would create a larger body of teachers, enable greater peer-to-peer instruction and develop a rung on the career ladder. Additional cost savings could be obtained via the new care matrix where

direct supervision is handled by a worker with advanced learning (at least one level higher on the care matrix than the worker being supervised) rather than immediate supervision by a licensed worker (however, licensed personnel would always be accessible). Knowing when to ask for help or re-evaluation of a client would be emphasized in all aspects of the teaching curriculum.

Policy

The **Re-tooling of the Health Care Workforce for an Aging America Act** aims to expand education and training opportunities in geriatrics and long-term care for licensed health professionals, direct care workers and family caregivers.¹⁴ In order to make the new direct care workforce structure feasible the policy phase of the process involves widespread adjustments in the current health care delivery model. We know that our health care delivery system is inadequate and that we desperately need to create jobs that cannot be outsourced overseas.

The current model allows states to use a variety of waivers. Connecticut could simplify and use one entity as done in other states. Ideally, the resultant program would be supported at the federal level and developed under state and local guidance.

Key elements to consider include the following:

- Create statewide teaching criteria and mandate uniform training standards
- Ensure that all direct care workers undergo training and continuing education and can demonstrate competency for their position
- Require that direct care providers establish a 24-hour emergency back up supervisory and staffing personnel pool.
- Assure that the level of care rendered must be sufficient for each care recipient to attain their highest practicable physical, mental and psychosocial well-being¹⁵.
- Develop Good Samaritan protections so that paraprofessionals operating within their scope of practice would be immunized from liability for any injury caused to a client under their care, unless due to willful/reckless misconduct.
- Give direct care agencies similar indemnification and

reasonable errors and omissions insurance coverage for their workers, commensurate to the scope of practice of each worker.

- Provide a variety of incentives to build the workforce, such as worker compensation, benefits and a statewide peer alliance.
- Create tax incentives to help family caregivers. For example, if IRA benefits are used to provide care, those expenses could be exempted from tax liability.
- Modify regulations that prohibit legally responsible family members from receiving compensation for personal care services¹⁶.
- Create educational and training opportunities for family caregivers akin to the standards for direct care workers.
- Establish a peer-to-peer paraprofessional organization to offer advocacy, support and continuing education to the direct care workforce.

Practice

To actualize these recommendations a comprehensive plan that incorporates around-the-clock-care must be developed. Current regulations limit the number of hours some direct care workers may be employed and thus create a barrier to continuity of care. Care management is essential to the coordination and oversight of services (including emergency and on-call staff).

An attractive living wage must be offered that is proportional to increased responsibility. The utilization of career ladders could provide exposure to related career paths and help grow the workforce. The proposed paraprofessional organization should provide a support and advocacy network that augments professionalism. Furthermore, the alliance could facilitate job sharing, continuing education and the exchange of resources such as housing, transportation and child care. It would also serve to eliminate the isolation often associated with this field.

Additionally, incentives in the form of guaranteed pay if the worker agrees to work alternating weekends or to be on call can help stabilize the work force. Wage differentials for shift work and weekend/holiday care could also make the field more desirable, encourage retention and allow for worker flexibility.

CONCLUSION

With advances in health care the numbers of persons who are aging, chronically ill and disabled are growing. It behooves us to develop a strong continuum of care that will address the mounting need for supportive services.

Although Connecticut has expanded programming for services to meet the needs of older adults, persons with disabilities and persons with chronic health needs, we are losing the necessary labor force to properly provide these services. We must invest in strategies that will stabilize and enhance the paraprofessional workforce. Failure to do so undermines the vitality of our state and belies the capacity of our stakeholders. Worse, it jeopardizes our most vulnerable residents and leads us to a grim prospect **when no one cares.**

Direct Care Workforce Shortage Team

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*Knowing is not enough; we must apply.
Willing is not enough; we must do.
Goethe*

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