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Preparing for the Needs of an Aging California: Building and Supporting California's Direct Care Workforce

Prepared for The SCAN Foundation by Monique Parrish, DrPH, MPH, LCSW, LifeCourse Strategies.

Ensuring the quality of life and quality of care for seniors and persons with disabilities is dependent on the availability of a competent direct care workforce. California's direct care workforce currently represents a staggering group of over half a million personal care attendants, nursing aides, and home health aides.[1] These direct care workers provide critical assistance to seniors and individuals with chronic illnesses and disabilities in a wide range of areas, e.g., eating, bathing, dressing, toileting, grooming, medication management and light housekeeping. Employed in a variety of settings (skilled nursing facilities, hospitals, clinics, assisted living facilities, residential care homes, and consumer private residence) under different work arrangements, direct care workers are the de-facto lifeline for many individuals managing illnesses or disabilities requiring long-term care.

Despite their essential role, the direct care workforce is all too often undervalued, underpaid, undertrained, and overworked. With seismic increases in California's older adult population and a parallel labor shortage forecasted for California over the next few decades, addressing this workforce issue is paramount. In 2009, The SCAN Foundation launched the Direct Care Workforce Initiative to identify opportunities to increase geriatric training for California's direct care workforce, specifically certified nurse assistants (CNAs) and Home Health Aides (HHAs). To frame the training needs of CNAs and HHAs, The SCAN Foundation commissioned a set of issue papers and convened a diverse group of stakeholders.[*] Subsequently, grants were awarded to five organizations to develop geriatric-focused in-service/continuing education curricula for training direct care workers. The SCAN Foundation held a second convening of stakeholders in November 2010 to further identify priority policy issues and strategic opportunities to advance the direct care workforce. This policy brief presents recommendations from the 2010 convening and individual stakeholder interviews (see Stakeholder Participant List) for building and supporting a direct care workforce to meet the needs of an aging California.

Direct Care Workforce: Demographics and Training Requirements

Direct care workers in California are predominantly women of color with a high school education and an average age of 44 years; approximately half are foreign born.[2] Most of California's direct care workforce is comprised of Personal Care Aides (PCAs) who typically work in private or group homes and assist clients with activities of daily living (bathing, dressing, toileting, etc.), as well as household chores, meal preparation, and medication management. The majority of PCAs work in the In-Home Supportive Services Program (IHSS), the largest publicly-funded home-and community-based services program in

[*] For more information, a summary of the 2009 stakeholder meeting and perspectives papers can be accessed at: http://www.thescanfoundation.org/commissioned-work/investing-californias-direct-care-workforce-increasing-geriatric-training-opportun

California, and the largest personal care program in the United States. Developed in the 1970's, the IHSS program provides Californians who meet low-income eligibility requirements and are blind, disabled, or over the age of 65 with personal assistance, primarily in the home setting. Services range from assistance with household chores to personal care, such as dressing and bathing, to paramedical services. The program is often seen as an alternative to assisted living or nursing facilities. In 2009, approximately 376,000 individuals were employed as IHSS workers.[3] IHSS workers have fingerprinting and criminal background check requirements, as required by law, but no certification or in-service/continuing education requirements.

Two other groups of direct care workers complement the overall workforce: Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs) – representing 21% and 11% of the direct care workforce respectively (note: the latter group also includes orderlies and attendants).[4] CNAs and HHAs have certification and in-service/continuing education requirements, as well as standards, detailed in Title XXII, California Welfare and Institutions Codes. Both groups are overseen by the California Department of Public Health (CDPH), Licensing and Certification Program.[5] CDPH is also responsible for approving all initial and in-service/continuing education providers and curricula offered by employers. Initial certification programs for CNAs and HHAs are provided primarily through community colleges, adult education regional occupational programs, and private schools. These same groups offer in-service/continuing education training courses along with a host of other providers that include hospitals, care facilities, home health agencies, and online sources.

CNAs are generally employed by nursing facilities, hospitals, and clinics. To become a CNA, an individual must complete 60 hours of classroom training and 100 hours of supervised clinical training in the fundamentals of basic patient care. The composite training covers a wide range of skills and topics appropriate to the CNA role: patient safety and emergency procedures, patient rights, infection control, body mechanics, elder abuse prevention, and communication and interpersonal skills. To maintain certification, CNAs must obtain 48 hours of in-service/continuing education units every two years. Nursing homes, the primary employer of CNAs, are responsible for providing at least 24 hours of varied in-service/continuing education units each year, during the CNAs regular work hours. CNAs are eligible to take up to 12 hours of their 24 required hours of in-service/continuing education through online courses per year

HHAs primarily work for home health agencies, health or welfare agencies or hospitals and have a minimum of 75 hours of basic training, which includes classroom and clinical training, to receive certification. Training focuses on the provision of personal care services: bathing, toileting, ambulation, monitoring of care recipient health condition (e.g., checking pulse, and changing bandages), meal planning, laundry, light housekeeping, etc. Once certified, HHAs are required to take 12 hours of in-service/continuing education annually. Home health agencies employing HHAs are responsible for providing a minimum of 12 hours of in-service/continuing education each year during the HHA's regular work hours. Both CNAs and HHAs are free to obtain in-service/continuing education units outside their respective facilities from other approved providers.

There are many reasons to promote substantive changes on behalf of California's direct care workers: low pay, training and support structures, inattention to the needs of a

significantly diverse workforce, challenging work and working conditions, and limited career advancement opportunities. Median hourly wages for each subgroup of direct care workers in 2009 were among the lowest in the state with a median annual earnings for all direct care workers of $16,000, with the lowest wages of $12,766 for PCAs.[6] Another chief reason to address the direct care workforce issue is the aging of an increasingly ethnically, racially, linguistically, and culturally diverse California population.[7] Over the next two decades, California is expected to experience a 100 percent increase in the number of adults age 65 and older, from 4.41 million in 2010 to 8.84 million in 2030. The number of Californians age 85 and older is also expected to increase by approximately 72 percent, from over 628,000 in 2010 to 1.08 million in 2030.[8] As California's population ages, it is anticipated that many older adults will have substantial and increasingly complex health care needs.[9]

To meet the tremendous care needs of the changing population and the associated demand for care anticipated throughout California in the next few decades, the state needs to develop a robust direct care workforce. Based on need, PCAs and HHAs are currently identified as the third and fourth fastest-growing occupations in the state, 45.7 and 43.6 percent respectively, with the state expecting to create over 200,000 PCA jobs between 2008 and 2018.[4] These projections are tempered however by estimates of population attrition for the direct care primary labor pool – women aged 25-54 over the next decade, and significant challenges recruiting and retaining a direct care workforce.[10] Now is the time for California to address direct care workforce policies.

Recruitment, Training and Retention

Findings from the 2010 convening and stakeholder interviews highlighted the need for policy changes in the areas of recruitment, training, and retention for California CNAs and HHAs. The following is a summary profile of stakeholder-identified challenges and opportunities in each of these three key areas.

RECRUITMENT: Level of pay, training options, and the availability of career development and advancement opportunities heavily influence occupational choices. Although these and other core factors currently challenge recruitment of individuals into the direct care workforce, California has the capacity to make significant improvements in this area.

Challenges

Primary challenges to the fluid recruitment of direct care workers include low-pay, limited fulltime work opportunities, lack of career pathways, and inadequate training. Stakeholders also cited several additional barriers: limited slots for certification programs offered by community colleges, expensive certification programs offered by private providers, difficult state credentialing processes for certification providers, an English-only certification exam, and lack of public awareness regarding the direct care worker field and the lives and care needs of older adults and persons with disabilities.

Opportunities

Successful strategies for recruitment must initially support improved training, increased pay, opportunities for fulltime work, and accessible well-designed career ladders. Launching a simultaneous recruitment and education campaign to better inform the public

about career opportunities associated with direct care work as well as the specific care needs of older adults and persons with disabilities is equally essential. We can learn from other countries, for example in South Korea, children and youth are encouraged to engage with older adults, "Schools offer community service credit, encouraging work with dementia patients, whom students call grandmas and grandpas."[11] Exploring the possibility of offering CNA and HHA certification programs in high schools may be a viable next step. Other strategies to improve recruitment include evaluating the state's CNA and HHA credentialing and certification processes. A critical review of current regulatory requirements may lead to legislative changes in areas that would directly enhance direct care worker recruitment. Finally, expanding opportunities for volunteers in direct care work represents another strategy for recruiting new workers to the field.

TRAINING: Findings from numerous surveys and focus groups of direct care workers consistently identify lack of adequate training as both a concern and a factor influencing workers decisions to stay in the field.[8, 9] Understanding the barriers and opportunities for providing quality training is necessary for constructing improvements in this critical area for California's CNAs and HHAs.

Challenges

Certification training challenges focus largely on cost, availability, and quality. Although community colleges provide low-cost, quality initial certification programs, the system overall experiences difficulty finding instructors who meet the Title XXII CNA instructor qualification of *one year experience in long-term care* (most applicants have acute care experience), resulting in fewer training programs and slots. By contrast, private training programs throughout the state have slots available, but the costs of these programs are prohibitive for many low-income individuals seeking entry into the direct care workforce.

Another significant challenge centers on the initial training curricula. Although certification program curricula are carefully outlined in the statute (Title XXII), stakeholders have signaled that the absence of core competencies in geriatrics, soft skills (e.g., listening, communication, empathy, decision-making, personal time management, etc.), cultural competency, and an understanding of complex chronic conditions, represent critical holes in the current training platform. Moreover, inadequate training is cited as a contributing factor in cases of inappropriate care and abuse of older and dependent adults in facilities.[12]

Similar challenges are associated with in-service/continuing education efforts for CNAs and HHAs. Although California law requires facilities to provide ongoing in-service/ continuing education training, facility-based training is frequently disrupted due to facility needs (e.g., workers are pulled out of training sessions because they are needed back on the floor). Additionally, not all facility staff providing the training – Directors of Staff Development and others – has been trained in adult-learning techniques, geriatric core competencies, and soft skills. A final challenge involves the state. Recent state budget cutbacks, resulting in staff furloughs, have impacted staffing at the California Department of Public Health, charged with overseeing the initial certification and ongoing training of CNAs and HHAs.

Opportunities

There is strong and growing interest in improving the quality, content, and structure of training for California 's CNAs and HHAs. Stakeholders have recommended a broader framework for effective and efficient training focusing on geriatric content, complex chronic care and medication management, soft skills, mental health, dementia, challenging behaviors, cultural diversity, care coordination, and goals of care development. The focus of these recommendations is addressed in the recent health care reform package. The federal Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148) addresses the need for improved direct care worker training through the Personal and Home Care Aide State Training (PHCAST) program administered by the Health Resources and Services Administration (HRSA), which supports the development, evaluation, and demonstration of a competency-based uniform curriculum to train qualified personal and home care aides.

Seven California partners (California Community Colleges Chancellors Office, Pasadena City College, Mt. San Antonio College, Mission College, North Orange County Community College District-School of Continuing Education, IHSS Consortium/Training Academy for Personal Caregivers and Assistants, and California Association for Health Services at Home) through Personal and Home Care Aide State Training (PHCAST) grants, entitled The California Partnership for Standards-Based Personal Care Training and Certification project, to develop core competencies, pilot training curricula, and certification programs for personal and home care aides.

The ACA provides further opportunities to support direct care workers through two advisory groups: the Personal Care Attendants Workforce Advisory Panel through the CLASS Act, addressing workforce supply, education and training, and retention; and, the National Health Care Workforce Commission, focusing on the larger health workforce issue, including the direct care workforce. The sum of these provisions under ACA is a direct acknowledgement of the importance of addressing the direct care workforce issue. In conjunction with current training efforts underway in California (e.g., The SCAN Foundation's in-service/continuing education development grants), these developments represent positive steps toward a better-trained California direct care workforce.

RETENTION: Retaining direct care workers is frequently distilled to three elements: improved pay, improved training, and improved working conditions. This triad of supporting factors is endorsed by the Institute of Medicine (IOM) in its 2008 Report, *Retooling for an Aging America*, which found direct care worker turnover and job dissatisfaction associated with low pay, poor working conditions, high rates of on-the-job injury, and few opportunities for advancement.[13] California stakeholders echoed these challenges and highlighted several opportunities to support increased retention.

Challenges

Low pay is recognizably the single most visible defining characteristic of the direct care occupation; it is also the primary reason reported for the high turnover rate among direct care workers.[14-16] Inadequate training and limited fulltime work and lack of career advancement opportunities are also significant challenges for direct care worker retention. Along with these challenges, many direct care workers report feeling discouraged in their roles due to a lack of respect on the job, difficult working conditions, and a feeling of disempowerment.[17]

Opportunities

Many of the same factors that would increase recruitment would also increase retention. Increasing pay, benefits, and work hours; providing comprehensive and supported training using dynamic and interactive mediums that respect the learner (e.g., role-play, mentors, teams); and, creating career ladder and lattice (career movement in several directions rather than just upward) opportunities would change the structure, economics, and appeal of direct care work. For example, establishing a smoother pathway for CNAs or HHAs to become Licensed Vocational Nurses, other related allied health professions, and Registered Nurses, promotes career development, foundational skill building, and lifelong learning.

Expanding the spectrum of CNA and HHA responsibilities and opportunities for enhanced interpersonal connection between the direct care worker and care recipient, through continuous assignment, is also likely to yield positive effects on retention. Lastly, providing adjunct in-depth training, with certificates of completion, focused on educating direct care workers about communication and problem solving in complex subject areas such as mental illness and behavior management, can further develop the role of direct care workers on the patient health care team. Increased competency in these areas, in turn, may positively influence worker decisions to remain in the field.

Key Stakeholder Recommendations for the Direct Care Workforce
• Expand opportunities for initial certification training. Improve in-service/continuing education curricula in the areas of geriatric core competencies, cultural competency, soft skills development, and culture change;
• Increase direct care worker wages and opportunities for fulltime work;
• Develop accessible well-designed career ladders and lattices with opportunities for professional development for CNAs and HHAs;
• Support enhanced skills training for in-service/continuing education providers;
• Promote and facilitate local and statewide collaboration and coordination regarding recruitment, training, and retention;
• Promote awareness of the diversity of direct care workers and care recipients;
• Assess California's current credentialing and certification processes – explore opportunities to create more flexible and responsive requirements; and
• Convene the Council, representatives from state level agencies, and statewide health workforce associations, coalitions, provider organizations, and educational institutions to address strategies focused on direct care workforce needs.

Next Steps

There is growing awareness among a widening group of stakeholders that California must prepare for the state's growing older population with a better-trained direct care workforce. Critical next steps include assessing and responding to stakeholder-identified challenges and opportunities to improve the training, recruitment, and retention of California CNAs and HHAs. In addition to the PHCAST grants, the California Workforce Investment Board (State Board) in partnership with the California Office of Statewide Health Planning and Development (OSHPD) received a Planning Grant, under the ACA, to establish the Health Workforce Development Council (Council). Comprised of a broad group of public and private health workforce and education stakeholders, the Council was formed in August 2010 to help ensure that California has the health workforce needed to provide all Californians with access to quality health care.[18] Specifically, the Council is tasked with understanding the current and future workforce needs of California and developing a comprehensive strategy to meet those needs.

To meet the Planning Grant goal of developing this comprehensive plan, the State Board, with the support of the Council, is gathering health workforce information from an extensive group of stakeholders, experts, and data resources. The process entails a thorough review of the literature; solicitation of stakeholder feedback on key health workforce issues and concerns at the local level – via a series of regional convenings, focus groups, and key informant interviews; and, analysis of health workforce data including state and federal labor market projections and models. Planning efforts also include identifying policy, regulatory, and administrative actions needed to collect health workforce and education data, as well as the identification of priority education and career pathways needed at the state and regional level. Finally, planning efforts will assess the need for policy changes to advance a comprehensive health workforce strategy.

California's success in developing a comprehensive strategy is dependent on a strong working partnership with diverse stakeholder groups (health care employers, labor, education, industry associations, community-based organizations, Legislature, State Departments, philanthropic organizations, etc.), dedicated to a strong, expanded, and prepared direct care workforce. It is also dependent on the state's effective collaboration with established statewide health workforce initiatives, e.g., the California Health Workforce Alliance, California Health Professions Consortium, etc. By leveraging the skills, expertise, and experience of these well-respected groups, California can develop a bold and innovative direct care workforce.

The SCAN Foundation supports the state's leadership role in developing a comprehensive strategy to meet California's direct care workforce needs. Given competing health workforce needs for the state however (e.g., need for primary care physicians, nurse practitioners, dentists, optometrists, allied health professionals, etc.), it is imperative that the direct care worker issue is not overlooked. To ensure that a well-trained direct care workforce, adequate in size to meet the needs of aging Californians, is a central part of the health workforce strategy, the state is encouraged to actively address this significant group of health care workers and consider the following summary stakeholder recommendations for improving the recruitment, training, and retention of California CNAs and HHAs.

*Stakeholder Participant List**

Kevin Barnett,
Director
California Health Workforce Alliance

Patricia Blaisdell
Vice President, Post-Acute Services
California Hospital Association

Debra Cherry*
Executive Vice President
Alzheimer's Association, Southland Chapter

Jack Christy
Director, Public Policy
Aging Services of California

Judy Citko*
Executive Director
Coalition for Compassionate Care

Bonnie Darwin
Health Consultant

Steve Decker*
Executive Director
Homecare Workers Training Center

Loriann DeMartini
Interim Assistant Deputy Director, Licensing and Certification, CA Department of Public Health

Pam Dickfoss
Interim Deputy Director, Licensing and Certification, CA Department of Public Health

Deborah Doctor
Legislative Advocate
Disability Rights California

Myriam Escamilla
Director, Convalescent Division
SEIU-UHW

Cheri Etheredge
Professor, Pediatric Nursing
Contra Costa College

Sandi Fitzpatrick
Executive Director
California Commission on Aging

Moreen Lane,
Senior Policy Analyst
California Workforce Investment Board

Jordan Lindsey*
Director of Policy & Public Affairs
California Association for Health Services at Home

Mary Jann
Director, Regulatory Affairs
California Association of Health

Cathy Martin*
Director, Allied Health Care Workforce Coalition
California Hospital Association

Patricia McGinnis
Executive Director
California Advocates for Nursing Home Reform

Jackie McGrath
State Public Policy Director
Alzheimer's Association

Jose Millan
Vice Chancellor,Economic Dev. & Workforce Prep. Division
California Community Colleges Chancellor's Office

Jocelyn Montgomery
Director of Clinical Affairs
California Association of Health Facilities

Andrea Mournighan*
Policy Director
SEIU-ULTCW

Jacquie Page*
Executive Council Member
AARP

Gary Passmore,
Executive Assistant to the State President
Congress of California Seniors

Evon Redding
Chief, Professional Certification Branch
Licensing and Certification, CA Department of Public Health

Alison Ruff*
Assembly Committee on Aging and Long-Term Care

Barbara Halsey
Executive Director
California Workforce Investment Board

Dionne Jimenez
SEIU Healthcare

Koontz, Jim
Director
Quality Care Health Foundation

Kai Eldridge*
Legislative Advocate
SEIU-ULTCW

Herb Schultz
Regional Director, Region IX
U.S. Department of Health and Human Services

Carol Sewell*
Program Analyst on Aging
California Commission on Aging

Leonila Vega
Executive Director
Direct Care Alliance

* Participated in The SCAN Foundation's 2010 *Training Direct Care Workers Convening*

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