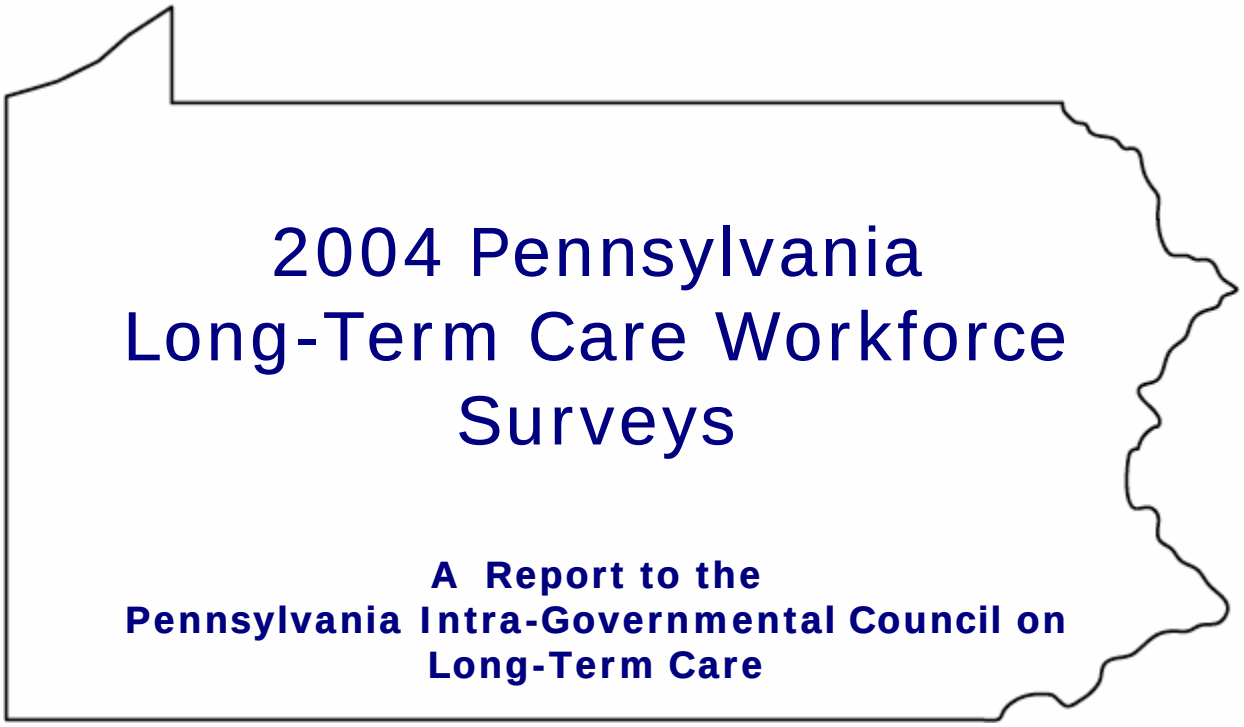

2004 Pennsylvania Long-Term Care Workforce Surveys

A Report to the Pennsylvania Intra-Governmental Council on Long-Term Care

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Executive Summary

Study Purpose and Auspices

The Pennsylvania Intra-Governmental Council on Long-Term Care (IGCLTC) has played a major role in monitoring and planning for challenges in the long-term care workforce. Changes in the Commonwealth's demographics and in policies that realign service delivery along the continuum from institution-based to community-based care have increased the need for information about the workforce required to implement reform efforts. The recruitment and retention of a qualified long-term care workforce of paraprofessionals to provide direct care remains a policy priority.

This report serves to update information provided in reports done by the Polisher Research Institute in late 2000. Based on a telephone survey of administrators and a series of focus groups with direct care workers (DCW), the reports (*Pennsylvania's Frontline Workers in Long Term Care: The Provider Organization Perspective* and *In Their Own Words: Pennsylvania's Frontline Workers*) served as important sources for planning within and beyond the Commonwealth. In reporting the findings of the 2004 surveys, we make reference to findings of the earlier surveys.

In consultation with the Workforce Issues Work Group of the IGCLTC, the research team at Penn State planned, conducted and analyzed three separate surveys. The 2004 provider survey was a mail survey, and as such yielded a 40 percent response rate, compared to the 70 percent response rate achieved in the 2000 telephone survey of providers. Also, there were some differences in the list of organizations used to create the sample. We were unable to recreate the three categories of home care used in the 2000 survey and instead use two categories. Thus, the survey of provider organizations represents the population of personal care facilities, adult day centers, skilled nursing facilities, licensed home health care agencies, and unlicensed home care/home health agencies.

From the sample of organizations participating in this survey, a purposive sample of providers was contacted to gain employers' cooperation in surveying direct care workers. Our goal was to survey direct care workers in those organizations that had been very active in using retention strategies, and also those in organizations that had not used any strategies to address retention.

Workforce issues in Centers for Independent Living are examined in a separate mail survey of consumers receiving care via the consumer-directed care model. Findings from the exploratory survey of consumers who manage their own direct care workers are presented to highlight the need for more in depth examinations of workforce issues in that area.

Methods

Provider Survey

A listing of Pennsylvania long-term care provider organizations was assembled by the investigators with assistance from members of the IGCLTC Workforce Issues Group. The list included 3,562 different long-term care providers, including nursing homes, personal care homes, adult day centers, home health agencies (state licensed and certified/non-certified), and unlicensed home care/home health agencies. The list was then provided to the Penn State Survey Research Center (SRC) and a sampling plan designed.

By way of comparison, the IGLTC 2000 survey was based on 3,411 provider organizations. The numbers of each provider type show a decrease in the number of nursing homes and equivalent totals for all other categories except the unlicensed home care/home health agencies. The 2000 report identified only 50 unlicensed home care providers but it is unclear if any of those provided home health services as well. Our initial list included 355 unlicensed home care/home health agencies.

The sample of organizations was drawn to ensure representation of long-term care providers, the regions of the Pennsylvania Workforce Investment Areas, and rural and urban zip codes. The final sample consisted of an approximately 50 percent random sample of each provider type with an equal probability of urban/rural and regional representation.

As of January 31, 2005, 762 surveys were completed, resulting in a response rate of 39.6 percent. Of these, three were returned with their tracking number cut from the survey form, making identification of organization type impossible. Of the remaining 759 surveys, 23 (less than 2.0 percent) were completed on-line. The highest response rate was for the adult day centers (58.1 percent) while the lowest rate was for the unlicensed home care/home health agencies (20 percent). The response rate by region ranged from 60 percent for the North Central region to 33 percent for the Southeast region. The response rate was considerably higher from rural organizations. This rural/urban difference is most pronounced among nursing homes and personal care homes.

Survey of Direct Care Workers

A total of 236 providers were chosen as potential sites for the DCW survey. These were selected to provide the greatest variation in provider organizations' reported efforts to improve retention.

Providers were contacted via telephone to obtain permission to administer this survey at their site. Of these providers, 16 were determined to be ineligible so the number of eligible providers was reduced to 220. Of the 220 remaining providers, 67 (30 percent) agreed to participate and sent lists of their direct care workers.

The original list of 236 providers was divided into two subgroups based on the extensiveness of their retention practices in the previous two years (as reported on the provider survey). Of the 67 providers who participated, 35 reported engaging in at least three (out of eight) retention strategies. The other 32 participating providers were among those who reported no retention strategies in the previous two years.

After a provider agreed to participate it was asked to send the Penn State SRC a listing of all of direct care workers. If a provider had more than 50 direct care workers, a random sample of 50 was selected from its list.

Each provider was sent a batch of survey packets (one packet for each DCW at the facility), including the surveys, cover letter, business reply envelopes, and a $2 incentive, along with a distribution letter explaining to the provider how to distribute the surveys. As of January 31, 2005, 640 surveys had been returned, resulting in an overall response rate of 53.2 percent.

Survey of Consumer-Directed Care Recipients

An exploratory mail survey of consumers participating in the consumer-directed care model was conducted in cooperation with the Department of Public Welfare's Office of Social Programs (OSP) and one Area Agency on Aging (AAA) that was known to have a long history of offering the consumer-directed care option. Another large AAA was originally asked to cooperate, but the mail survey timeframe overlapped with the AAA's own internally initiated telephone survey of consumer-directed care recipients.

HIPPA privacy rules prohibited the Penn State survey team from knowing the identity of consumers participating in the consumer-directed care programs. Therefore, designated employees at the OSP generated a randomly drawn list of 1,000 enrollees in the consumer-directed care waiver programs administered by the Department of Public Welfare, including the ACT 150 Attendant Care Program (ACP), Attendant Care Waiver Program (ACWP), COMMCARE, CSPPPD, Independence, and OBRA Waiver programs. The Penn State SRC mailed 1,000 surveys in bulk to the OSP. Because the Department of Aging does not have a centralized list of consumers opting to participate in the consumer-directed care waiver program(s) offered by AAAs, a bulk mailing of 150 surveys was sent by the SRC to the participating AAA where designated staff members identified a list of eligible consumers.

The inability to identify consumer-directed care recipients by name prevented the survey team from including incentive payments or generating follow-up reminders. Both limitations are reflected in the low overall response rate of 16.6 percent for the OSP sample and 13.3 percent for the AAA sample. A similarly low response rate (19 percent) was obtained in the PA Centers for Independent Living backup study which used the same blinded mailing methodology.

Provider Survey Results

Worker Shortages Persist

Vacancy rates are perhaps the most objective assessment of workforce shortages. The vacancy rate is calculated this way:

$$\frac{\text{(\# of additional positions that could be filled today if qualified applicants were identified)}}{\text{(\# of additional positions could fill today if qualified applicants were identified) + (\# of FTE positions currently filled)}}$$

High vacancy rates remain a serious issue for Pennsylvania's long-term care provider organizations. The 2000 study observed an average job vacancy rate for all provider types of 11 percent. The average vacancy rate for all providers in the 2004 provider survey was 9.1 percent, evidence that the demographic and economic forces underlying the frontline worker shortage remain in place even in a less robust economy.

While proportionately fewer nursing facilities and personal care facilities report moderate or high vacancy rates, the proportion of licensed home health agencies reporting moderate or high vacancy rates has increased over time. Thirty-two percent of licensed home health agencies reported having more than 20 percent vacancies.

A Majority of Providers Still Report Very Serious or Somewhat Serious Retention and/or Recruitment Problems

The proportion of providers self-identifying as having "very serious" recruitment problems is lower when compared to 2000, but the proportion of organizations reporting either "very serious or somewhat serious" problems remains high. The percentage of providers in our sample with "very serious" recruitment problems was 19 percent, whereas it was reported to be 35 percent four years ago. The combined proportion of providers reporting either very serious or somewhat serious recruitment or retention problems remained above 60 percent.

Providers reported that on average, 38.7 percent of their direct care workers had been employed in their setting less than one year, up from 29 percent in 2000. Yet the average proportion with ten years or more years in their current job increased from 18.4 percent to 28.4 percent. This positive retention indicator was evident in all provider types, with the largest gains in home care and home health care agencies. Unfortunately, it is impossible to parcel out the effects of strategic initiatives to confront the problem from broader changes that took place in the Commonwealth's economy between 2000 and 2004. Recruitment and training expenditures have remained stable over the past two years for most providers, though 49 percent of nursing homes reported an increase in these costs.

What Initiatives Appear Useful?

Effects of Wages

On average, starting wages increased by 12 percent since the previous data were collected four years ago. Higher starting hourly wages are associated with lower vacancy rates in all types of home care/home health agencies, but the relationship is less clear in nursing homes, personal care homes, and adult day centers.

Effects of Employee Benefits

Understanding the role of benefits in recruitment and retention continues to be complicated by variations among provider types. The personal care sector offers significantly fewer benefits to employees. Further, across provider types, employers that have no recruitment or retention problems are more similar to those who report very serious problems than they are to those with moderate recruitment or retention problems. The distribution is most clearly evident in personal care homes.

Effect of Strategies for Handling Recruitment and Retention Problems

The most frequently mentioned **retention** efforts were across the board wage increases, flexible scheduling, and worker recognition programs. Flexible scheduling and increasing worker involvement are associated with reports of no retention problems, though the overall pattern is not strongly supportive of any one intervention.

There is a trend for providers who have used more than three different **retention** strategies to report decreased retention problems in the past two years. Also, those who have seen improvements are less likely to report using no retention strategies. While it is not clear that any one approach is most effective, it seems that a multi-faceted strategic effort has had an impact. The apparent effect of these management changes suggests that efforts to improve the work of long-term care are valuable.

Providers that have a serious **recruitment** problem have made more efforts to solve the problem in the past two years than those who do not have a serious problem. The most frequently reported recruitment efforts were raising entry level wages, special promotional efforts, and using staff referrals. None of the recruitment strategies was associated with a provider being more likely to report minor or no current recruitment problems versus very or somewhat serious problems. Provider recruitment strategies do not appear to have been very effective.

Effect of Career Enhancement Programs

The impact of career enhancement programs in retaining direct care workers is mixed. Career ladder and peer programs are being used primarily by the nursing home sector and most frequently where retention is a problem. There is some evidence that both recruitment and retention are positively influenced by training focused on improving communication skills.

Direct Care Worker Survey Results

While the response rate for the direct care worker survey was quite good (53.2 percent), there are at least two limitations in the extent to which it is fully representative. First, those who responded had been

employed in their current positions on average 7.3 years and as direct care workers for 10.5 years. While this gives their "voice" a special validity, it should not be assumed that all direct care workers are as satisfied and self-confident as those whose views are expressed here. The second issue is that because provider management was required to send a list of staff names, some provider types were more willing to do this than others. Unlicensed home care/home health agency staff are underrepresented for this reason. Although we deliberately sampled from organizations that had been very proactive in retention efforts and those who reported no such efforts to maximize variability in workers' experiences, the response rate from the proactive organizations was considerably higher than from the other group, 56.9 percent vs. 43.1 percent. Unlike the provider organization survey, then, the survey of direct workers should not be viewed as representative of the population of direct care workers in Pennsylvania.

What is the Employment Status of DCWs?

Eighty-two percent of these staff view direct work as a long term career and about 12 percent work at a second formal caregiving job. About 13 percent of the respondents think about quitting all the time, but 41 percent indicate that they are somewhat or very likely to leave their job within the year.

How Do DCWs Perceive Their Organizations?

Just over half expressed that they are "somewhat satisfied" with their jobs and another 34.8 percent reported being extremely satisfied. Across provider types, 87 percent of DCW would definitely or probably recommend their organization to a friend or family member who needed care. Just under 80 percent would recommend that a friend or family member take a job as a DCW at their employer.

For these direct care workers, poor supervision does not seem to be a problem, though across the board, there is room for improvement indicated in the effectiveness of supervisors. The weakest aspects of supervision are in using discipline to insure fair workloads and in giving constructive criticism.

What Kinds of Training Programs are DCWs Participating in and How Useful are They?

Communicating with residents/clients was the training topic most frequently reported. Home care workers reported attending more training and reported their training to be somewhat more useful than that provided in other settings. Personal care workers appear to receive less training than those in other settings. On average, the effectiveness of all types of training programs was evaluated as about 3 on a scale of 1-4, indicating room for improvement.

Suggestions for Improving Jobs

Similar to the 2000 "In Their Own Words" report, DCWs most often mentioned improved compensation and management practices when asked this open-ended question. About one quarter of respondents identified each of these as the single most important thing that could be done. Increased staffing to alleviate "working short" was identified by nearly one-fifth of respondents, most often in adult day centers and nursing homes.

When asked to rate the extent to which specific factors are rewards in their work, helping others was identified as the best reward of the job. The work is generally viewed as offering reasonable challenge and recognition, with adult day center workers reporting the lowest scores. Home care workers are most positive about the support they receive from supervisors. Satisfaction with pay was the least rewarding aspect of the job across all provider types.

In terms of concerns with their jobs, overload is less of a problem in home care than in other settings. Perhaps despite pressures to complete more visits, serving one client at a time alleviates the sense of overload. Most direct care workers in this sample did not view their work as a dead-end job. Staff in adult day centers and

nursing homes most often perceived exposure to health and injury hazards as a problem, though reported injuries in the provider survey indicated that unlicensed home care agencies have the most reported injuries.

Consumer-Directed Survey Results

Nineteen percent of consumers managing their own caregivers report a very serious problem recruiting staff. This is exactly the same percent as reported by the provider organizations. Also, like the provider organizations, they report significantly less problem with retaining workers than with recruitment.

Almost half the consumers report that they have had more than one paid caregiver in the past week. Forty-four percent report having the same caregiver for more than one year.

Most of the consumers do not appear to be acting as explicit managers in the sense of providing written performance feedback on a regular basis. Most report no training to communicate effectively or manage people. Still, they rate their caregivers' competence on average as 8.3 out of 10, only slightly lower than the mean of the provider sample which was 8.7. The consumers are themselves very proactive in managing their health care as measured on the Patient Activation Measure.

Study Recommendations

1. ***Increase and maintain higher standards for training direct care workers.***

The training direct care workers receive is not of uniformly high quality and those staff who responded to the survey reported that much of it is not as useful as it could be. This is an area where centralized and regional action could most logically have an impact. A task group of key stakeholders should be convened to target changes in the way direct care worker training (including but not limited to certification training) is provided and monitored. Uniform core training that equips direct care workers to work effectively across settings is a key component of professional development. Under the current system in home care, there is considerable variability in the range of training workers report, with licensed providers generally offering more training than others. It is difficult for the public to know what care they can expect from a home care assistant under such a scenario. The PA Better Jobs Better Care project is currently developing "person-centered care" uniform core curriculum that may be considered for adoption if preliminary studies of its implementation show it to be effective and useful for different providers along the continuum. The HRSA-funded Geriatric Education Centers at Temple, Penn State and the University of Pittsburgh represent an established network of experts who provide training in geriatric-related topics to allied health personnel in PA. The Commonwealth could expand the scope of these centers to include training development and quality oversight for direct care workers.

2. ***Provide incentives to employers to improve the workplace.***

The provider survey results show that retention is improved in organizations where multiple management interventions are employed. As was observed in the 2000 surveys, however, there is no single solution to stabilizing the long-term care workforce. Consequently, we recommend the Commonwealth consider broad-based, comprehensive workplace improvement standards for its provider organizations, with financial incentives to promote their adoption. These may be accomplished either through "pay-for-performance" reimbursement models or through selective contracting for services.

3. ***Fund a demonstration project to evaluate the impact of a comprehensive workplace improvement incentive program.***

We recommend that the Commonwealth consider funding a statewide demonstration

project building on the special licensure designation model that is currently being tested in North Carolina across the continuum of long-term care provider organizations. The Commonwealth could implement a demonstration project that is administered centrally with geographic-based collaboratives as the operating units. A thorough and independent evaluation should be included.

4. *Create and support a cadre of peer mentors for organizations undertaking workplace redesign.*

The improvements in retention identified in the provider survey, most notably in the nursing home sector, indicate that there are some provider organizations who have mastered the management of change processes needed to improve the work and workplace of direct care workers. Individuals from these settings should be supported to consult as peer mentors to other managers and direct care workers, perhaps administered through the auspices of regional collaboratives (resembling the more advanced regional partners in the PA BJBC demonstration).

5. *Support evidence-based practices in improving pay, benefits and supervision through a series of well-organized, one-day, high-impact conferences.*

We recommend that the Commonwealth sponsor a conference that brings together experts in compensation policy, benefits policy and administration, policy-makers and key stakeholder groups to produce a position paper that addresses the following:

- What is the relationship between starting wages and recruitment in the human service sector?
- What wage structures support increased retention of the most qualified direct care workers?
- What is the relationship between munificence of benefits packages and recruitment in the human service sector?
- What benefits structures support increased retention of the most qualified direct care workers?

We recommend that the Commonwealth sponsor a conference that brings together experts in supervision of direct care workers, policy-makers and key stakeholder groups to produce a position paper that addresses the following:

- What are the alternative models of supervision that appear to be most successful in supporting recruitment and retention in community-based and institution-based care settings?
- What are the reasons why home care workers report greater satisfaction with supervision than do other direct care workers?
- What are the needs of consumers and direct care workers regarding communication, negotiation and supervisory relationships in consumer-based care?

6. *Support a social marketing campaign on behalf of direct care careers.*

The relevant Commonwealth agencies should solicit the development of direct care career promotional materials that could include television ads, billboards, and interactive software to distribute to high school counseling offices. There is much that is positive about the direct care workers' perceptions of their jobs and their employers as reported in the 2004 survey of direct care workers.

7. *Provide infrastructure for a database on the direct care work force in PA.*

The problem of providing adequate levels of care for Pennsylvania's aging and disabled populations is just beginning to present itself. Recruiting qualified individuals to fill the more than 10,000

vacancies that currently exist in home care, personal care, nursing homes and adult day centers is a major challenge. The vacancy estimate does not account for the number needed to fill the demand for consumer-directed in-home care, though the evidence shown here is that the recruitment problem is similar with this model. The magnitude of this service demand is not understood because the state has very little information about these caregivers and their consumers/employers. Indeed, it is not even clear how many people are receiving and providing care in this model given that several waiver programs are currently operating somewhat separately.

We recommend that the Commonwealth require all organizations providing long-term care or supportive services through state-funded or administered programs contribute data on a periodic basis on the hiring and termination of direct care workers. An Excel-based management information system that inputs such data from providers and provides quarterly benchmarking reports to them on their comparative turnover statistics is currently operating at the Penn State University Survey Research Center for those organizations participating in the five state demonstration projects funded under the Better Jobs Better Care Initiative (funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies). Expansion of this system to include all PA providers (including the consumer-based intermediaries) would be a cost-effective approach.

8. ***Successful consumers in the consumer-directed care model should be encouraged to share their insights about direct care worker management with others who are less experienced with the model.***

The selected sample of participants in the consumer-directed model who responded to the mail survey appear to be highly "activated" as consumers of health services, and yet few provide performance feedback on a regular basis and most report no explicit training in management skills related to effective communication. Successful, long-time consumers of consumer-directed care could be enlisted to share their insights about how to effectively manage direct care workers with others who are new to the consumer-directed care model.

The Centers for Independent Living are appropriate venues through which the Commonwealth could provide additional resources to encourage consumers to conduct more performance appraisals of their direct care workers.

9. ***Develop a strategic plan for the long-term care workforce to address the state's service needs for the coming decade.***

The problems and opportunities summarized in these recommendations require active collaboration among several state agencies and many constituent groups and will, in some cases, require legislative action. A plan that articulates short, mid-range and long-term goals is needed to serve as a blueprint against which to measure progress and provide direction.

Introduction

Study Purpose and Auspices

The Pennsylvania Intra-Governmental Council on Long-Term Care (IGCLTC) has played a major role in monitoring and planning for challenges in the long-term care workforce. Changes in the Commonwealth's demographics and in policies that realign service delivery along the continuum from institution-based to community-based care have increased the need for information about the workforce required to implement reform efforts. The recruitment and retention of a qualified long-term care workforce of paraprofessionals to provide direct care remains a policy priority.

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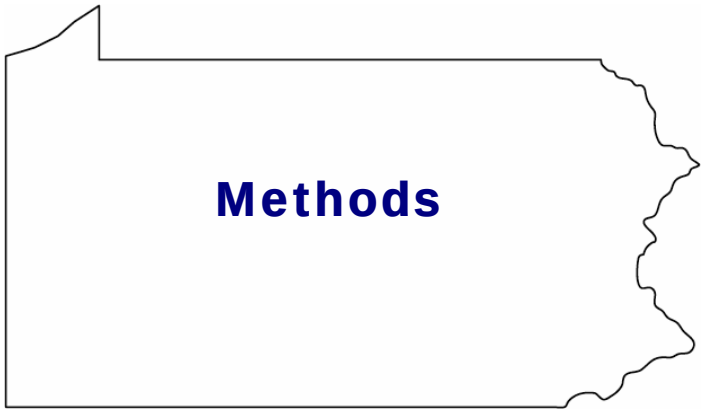
In consultation with the Workforce Issues Group of the IGCLTC, the research team at Penn State planned, conducted and analyzed three separate surveys. The 2004 provider survey was a mail survey, and as such yielded a 40 percent response rate, compared to the 70 percent response rate achieved in the 2000 telephone survey of providers. Also, there were some differences in the list of organizations used to create the sample. We were unable to recreate the three categories of home care used in the 2000 survey and instead use two categories. Also, workforce issues in Centers for Independent Living are examined in a separate mail survey of consumers receiving care via the consumer-directed care model. Thus, the survey of provider organizations represents the population of personal care facilities, adult day centers, skilled nursing facilities, licensed home health care agencies, and unlicensed home care/home health agencies.

From the sample of organizations participating in this survey, a purposive sample of providers was contacted to gain employers' cooperation in surveying direct care workers. Our goal was to survey direct care workers in those organizations that had been very active in using retention strategies and in those that had not used any strategies to address retention.

Lastly, an exploratory survey of consumers who manage their own direct care workers was conducted. Each of these surveys is presented separately and a summary of findings from all three is included.



Provider Survey

Sampling Frame

A listing of 3,562 Pennsylvania long-term care organizations was compiled by the investigators (see Table 1-1). By way of comparison, the IGLTC 2000 survey was based on 3,411 provider organizations. The numbers of each provider type show a decrease in the number of nursing homes and equivalent totals for all other categories except the unlicensed home care and home health agencies. The 2000 report identified only 50 unlicensed home care providers but it is unclear if any of those provided home health services as well. The list we obtained through a marketing firm contracted by the National Association for Home Care was the most extensive available since it included not only agencies that were paid members of the Association but others that were not. It included 355 home care and unlicensed home health agencies.

Table 1-1. Long-Term Care Providers by Type Included in the Sample

Provider Type	Number of Providers	Data Source
Nursing Homes	740	Pennsylvania Department of Health
Licensed Home Health Agencies (Certified and Non-certified)	422	Pennsylvania Department of Health
Unlicensed Home Care/Home Health Agencies	355	National Association for Home Care
Personal Care Homes	1,805	Pennsylvania Department of Welfare
Adult Day Centers	240	Pennsylvania Department of Aging
Total	3,562	

A sample of 1,993 facilities was drawn from the total universe of organizations. It was later determined that 69 of these facilities were ineligible for the survey, leaving the sample size at 1,924. Because the sample was such a large fraction of the population (54 percent), disproportionate stratification was not used. The sample size reflects the aim to obtain 800 completed surveys, assuming a 40 percent response rate.

The sample was drawn to ensure representation of: 1) all types of long-term care providers; 2) the regions of the Pennsylvania Workforce Investment Areas and rural and urban zip codes. The ten regions (with counties) of the Pennsylvania Workforce Investment Areas are:

1. Central (Centre, Clinton, Columbia, Lycoming, Mifflin, Montour, Northumberland, Snyder, Union)
2. Northwest (Clarion, Crawford, Erie, Forest, Lawrence, Mercer, Venango, Warren)
3. North Central (Cameron, Clearfield, Elk, Jefferson, McKean, Potter)
4. Northern Tier (Bradford, Sullivan, Susquehanna, Tioga, Wyoming)
5. Northeast (Carbon, Lackawanna, Luzerne, Monroe, Pike, Schuylkill, Wayne)
6. Southwest (Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Washington, Westmoreland)
7. Southern Alleghenies (Bedford, Blair, Cambria, Fulton, Huntingdon, Somerset)
8. South Central (Adams, Cumberland, Dauphin, Franklin, Juniata, Lebanon, Perry, York)
9. Southeast (Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, Philadelphia)
10. Lehigh Valley (Lehigh, Northampton)

Survey Administration

The first step in administering the survey was to contact by telephone each facility to determine who the provider survey should be directed to. Following the phone calls, the survey (along with a cover letter, business reply envelope, and a $5 cash incentive) was mailed to 1,924 facilities on June 30, 2004. If a name for the clinical manager was not obtained over the phone, the survey was mailed to the administrator. Respondents were also offered the opportunity to complete the survey on-line by using the URL listed in their cover letter. A week later a postcard reminder was sent to all providers. And finally, a third mailing was administered to all non-respondents in an effort to increase the response rate. This third mailing was sent as priority mail on July 20, 2004 and it consisted of a follow-up letter, survey and business reply envelope.

Response Rate

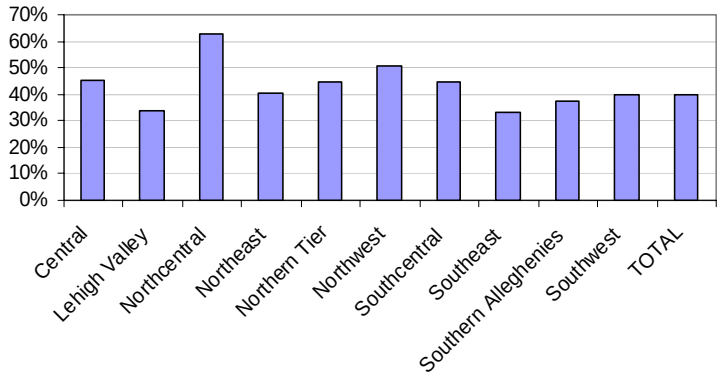
As of January 31, 2005, 762 surveys were completed, resulting in a response rate of 39.6 percent. Of these 762 surveys, only 23 (3 percent) were completed on-line. The breakdown of response by provider type and region is shown in Table 1.2 (the providers determined ineligible have been removed from these counts).

Table 1-2. Response Rates by Provider Type

Provider Type	Surveys Completed	Total Sent	Response Rate
Adult Day	68	117	58.1%
Home Care/Home Health Unlicensed	30	159	18.9%
Licensed Home Health	111	260	42.7%
Nursing Home	172	427	40.3%
Personal Care	378	961	39.3%
TOTAL	759*	1924	39.6%

*3 completed surveys were excluded from this total because their organizational type and region were unknown (their survey IDs were intentionally cut from the response form by respondents).

Figure 1-1. Response Rates by Region



Weighting for Accuracy of Estimations

The data in the survey have been weighted to correspond to the actual distribution of providers by type and region. (After weighting by type and region, the distribution of rural/urban status was accurately representative, so weighting by rural/urban status was not necessary.) These weights adjust for any differential non-response associated with provider type and region.

Additional information comparing nursing home responders to non-responders is included in Tables 1-3a and 1-3b on the following page. The nursing homes that chose to respond to the survey had fewer Medicare/Medicaid certified beds and had lower percentages of Medicaid residents. They were less likely to be for-profit or belong to a chain. Also, responding homes were more likely to be hospital-based.

Table 1-3a. Mail Survey Respondents and Non-Respondents: (Nursing Homes Only)

	Mail Survey Response	N	Mean	SD
Current health deficiencies	non-respondent	255	4.5	3.7
	Respondent	172	4.1	3.3
Medicare/Medicaid certified beds*	non-respondent	255	130.1	76.6
	Respondent	172	110.1	78.1
Percent Medicaid*	non-respondent	255	57.7	23.5
	Respondent	172	50.8	29.0
Percent Medicare	non-respondent	255	14.7	16.5
	Respondent	172	17.3	23.5
Residents/total adjusted RN FTE	non-respondent	255	13.5	7.4
	Respondent	172	12.4	7.8
Residents/total adjusted LPN FTE	non-respondent	255	8.3	6.3
	Respondent	172	8.3	5.6
Residents/total nurse aide FTE	non-respondent	255	2.7	3.4
	Respondent	172	2.4	1.2
Occupancy Rate	non-respondent	255	.90	.11
	Respondent	172	.87	.16

* T-test for difference in means significant p < .05

Table 1-3b. Mail Survey Respondents and Non-Respondents: (Nursing Homes Only)

	Mail Survey Response	N	%
For-profit*	non-respondent	255	50%
	respondent	163	38%
Chain Membership*	non-respondent	255	57%
	respondent	163	46%
Hospital-based*	non-respondent	255	6%
	respondent	163	14%

* Chi-square distribution test significant p < .05

Instrument Development

The questionnaire was developed by the research investigators as an adaptation of the instrument being used by the Pennsylvania State University to conduct the national study of the Better Jobs Better Care Demonstrations. The original instrument had been piloted with cognitive testing by the Penn State SRC, saving considerable time for the survey project. New items were included that corresponded to questions asked in the IGC-LTC 2000 survey and in response to review of the draft by members of the IGC's Workforce Issues Group. While direct, quantitative comparisons cannot be made between the two surveys, as the one in 2000 was a telephone survey and the current one a mail survey, the goal of benchmarking current workforce issues and strategies with the 2000 report was clear. In addition to this, the goals driving the instrument's development were to assess current workforce needs and the prevalence of initiatives to address these needs.

The final questionnaire, the protocol, and the consent letter were approved by the Pennsylvania State University's Office for Research Protection. The questionnaire consisted of 54 questions and required approximately 25 minutes to complete. The final format of the questionnaire was issued by the Penn State SRC (see Appendices).

Direct Care Worker Survey

Survey Administration

A total of 236 providers were selected as potential sites for the DCW survey. These providers were contacted via telephone to obtain permission to administer the survey at their site. Of these providers, 16 were determined to be ineligible so the number of eligible providers was reduced to 220. Of the 220 remaining providers, 67 (30 percent) agreed to participate and sent lists of their direct care workers. Table 1.4 shows the outcome for all providers.

Table 1-4. Outcome of Phone Calls Made to Potential Sites for DCW Survey.

Outcome	N	%
Agreed to participate and sent DCW lists	77	32.6%
Agreed to participate, but did not send DCW lists	29	12.3%
Not eligible (did not hire DCW's)	14	5.9%
Not eligible (part of BJBC project)	2	0.8%
Refused	60	25.4%
Invalid telephone number (could not contact)	4	1.7%
Never available (could not establish contact)	50	21.2%
TOTAL	236	100.0%

The original list of 236 providers was divided into two subgroups based on the extensiveness of their retention practices in the previous two years (as reported on the clinical manger survey). Of the 67 providers who participated, 35 reported engaging in at least three (out of eight) retention strategies. The other 32 participating providers were among those who reported no retention strategies in the previous two years.

After a provider agreed to participate, they were asked to send the Survey Research Center a listing of all of their direct care workers. If a provider had more than 50 DCWs, a random sample of 50 was selected from their list. The lists were returned at different times, so they were divided into three waves. The administration of these surveys involved sending each provider a batch of survey packets (one packet for each DCW at their facility), including the surveys, cover letter, business reply envelopes, and a $2 incentive, along with a distribution letter explaining to the provider how to distribute the surveys. The first wave, consisting of 50 providers (a total of 775 DCWs), was sent on August 18, 2004, with the follow-up sent a month later. The second wave, consisting of 25 providers (a total 363 DCWs), was sent on September 10, 2004, with the follow-up sent a month later. And a final wave, consisting of 2 providers (a total of 67 DCWs) was sent in October, with a follow-up sent in November (see Appendices for survey).

Response Rate

As of January 31, 2005, 640 surveys were completed, resulting in a 53.2 percent response rate.

Analytic Methods

Descriptive statistics were explored for each of the questions in the DCW Survey. In the case of continuous data, means were calculated and compared using t-tests and/or analysis of variance. For nominal data, frequencies were used and compared using chi-square analysis.

Several items on the survey were adapted from Marshall's "Job Role Quality" survey to determine how DCW's view certain job characteristics. These characteristics were divided into "Job Reward" factors and "Job Concern" factors. Using the results from a confirmatory factor analysis, each factor was then subdivided into scales as described in Appendix Tables 3-1a and 3-1b.

Consumer-Directed Survey

Survey Administration

An exploratory mail survey of consumers participating in the consumer-directed care model was conducted in cooperation with the Department of Public Welfare's Office of Social Programs (OSP) and one Area Agency on Aging (AAA) that was known to have a long history of offering the consumer-directed care option. Another large AAA was originally asked to cooperate, but the mail survey timeframe overlapped with the AAA's own internally initiated telephone survey of consumer-directed care recipients.

HIPPA privacy rules prohibited the Penn State survey team from knowing the identity of consumers participating in the consumer-directed care programs. Therefore, designated employees at the OSP generated a randomly drawn list of 1,000 enrollees in the consumer-directed care waiver programs administered by the DPW, including the ACT 150 Attendant Care Program (ACP), Attendant Care Waiver Program (ACWP), COMMCARE, CSPPPD, Independence, and OBRA Waiver programs. The Penn State University SRC mailed 1,000 surveys in bulk to the OSP. Because the PDA does not have a centralized list of consumers opting to participate in the consumer-directed care waiver program(s) offered by AAAs, a bulk mailing of 150 surveys was sent by the SRC to the participating AAA where designated staff members identified a list of eligible consumers. OSP and AAA staff generated mailing labels which were then affixed to sealed, pre-stamped envelopes containing a cover letter, survey and a pre-stamped return envelope addressed to the Penn State SRC. All surveys were mailed to consumers from either the OSP or the participating AAA.

Response Rates

The inability to identify consumer-directed care recipients by name prevented the survey team from including incentive payments or generating follow-up reminders. Both limitations are reflected in the low overall response rate of 16.6 percent for the OSP sample and 13.3 percent for the AAA sample. A similarly low response rate (19 percent) was obtained in the PA Centers for Independent Living backup study which used the same blinded mailing methodology.

The low response rates preclude the generalization of the report's findings. It is worth noting that even phone interviews of consumers of supportive services are challenging, as the Cash and Counseling Demonstration survey illustrated. The telephone survey response rate was only 23 percent in New York and 34 percent in Arkansas. Reasons for refusal in that study included feeling "too sick, too disabled or too old" and no interest in answering any survey. Respondents were younger on average than non-respondents in all four states.

Instrument Development

The final questionnaire, protocol and consent letter were approved by the Pennsylvania State University's Office for Research Protection. The brief questionnaire consisted of 19 questions and required approximately 10 minutes to complete. The final format of the questionnaire was approved and issued by the Survey Research Center. The questions were designed to solicit information about the following:

- Profile of services received from DCW
- Communication with and among paid DCW
- Knowledge of work/training history of DCW
- Training and experience of consumer-directed care respondents in managing DCWs
- Recruitment and retention of DCW
- Perceived overall competency of DCW
- Extent of consumer "activation" and its relationship to DCW management factors.

Provider Survey Results

DCW Vacancy Rates

The average vacancy rate among all providers was 9.2 percent (Table 2-1). The highest reported vacancies were in unlicensed home care/home health (10.3 percent) and licensed home health care (12.0 percent). Across all provider types, 39 percent reported having no DCW job vacancies in their organizations, similar to results in 2000. The percentage reporting modest vacancy rates (1-10%) was 22 percent. Twenty-two percent of providers reported vacancy levels between 10 and 20 percent. The proportion with high vacancy rates (greater than 20 percent) was 17 percent. The Northwest region had a comparatively high average DCW job vacancy rate (10.3%), along with the Southcentral (9.8%) and Southeast (9.9%) regions.

Unadjusted unemployment rates from August 2004 are shown in Table 2-1 for comparison across regions.

Table 2-1. The Distribution of the DCW Job Vacancy Levels by Provider Type and Region

	Region jobless rate 8/04	Average Vacancy Rate[a]	Proportion of Providers within each DCW Job Vacancy Level Category			
			None	Low (less than 10%)	Moderate (10% to 20%)	High (greater than 20%)
All providers		9.2%	39%	22%	21%	17%
Adult Day		6.8%	63%	13%	12%	11%
Unlicensed Home Care/Home Health		10.3%	12%	44%	32%	12%
Licensed Home Health Care		12.0%	45%	10%	13%	32%
Nursing Home		9.8%	10%	46%	35%	9%
Personal Care		8.5%	48%	17%	18%	17%
Region:						
Central	6.0	8.7%	40%	27%	19%	13%
Lehigh Valley	6.0	6.8%	43%	29%	19%	10%
Northcentral	6.2	6.9%	50%	17%	25%	8%
Northeast	6.4	8.7%	49%	16%	21%	14%
Northern Tier	5.6	8.9%	54%	15%	15%	15%
Northwest	6.5	10.3%	36%	28%	23%	13%
Southcentral	4.0	9.8%	31%	29%	20%	20%
Southeast	5.0	9.9%	35%	28%	17%	20%
Southern Alleghenies	6.2	9.2%	44%	18%	21%	18%
Southwest	6.3	9.2%	40%	17%	26%	17%

Due to rounding, percentages may not sum to 100

[a] Vacancy rate is calculated as: (number of additional positions could fill today/ (number of additional positions could fill today + number of FTEs positions currently filled))

Table 2-2 shows the distribution of the state's estimated 10,046 vacancies across provider types. The overall number of vacancies is about 1,000 less than that estimated in the year 2000. Nursing homes continue to account for the largest number of unfilled positions, though the number is lower than in 2000, due in part to the fact that 60 fewer nursing homes were identified in the population. In addition, because nursing homes responding to the mail survey had significantly fewer beds in comparison to non-respondents (Table 1-3a), the reported average number of unfilled DCW FTE in nursing homes is likely an underestimate of actual unfilled positions in that sector.

Table 2-2. Estimated Number of Unfilled FTE (Vacancies) by Provider Type

Provider Type	Total Number of Providers in State	Average Number of Unfilled DCW FTE/Provider in Sample	Estimated Total Unfilled DCW FTE
Adult Day	240	1.1	264
Unlicensed Home Care/Home Health	355	4.0	1,420
Licensed Home Health	422	3.6	1,519
Nursing Homes	740	5.1	3,774
Personal Care Homes	1,805	1.7	3,069
Total			10,046

DCW Positions Filled and Temporary Worker Use

The use of temporary employees to meet long-term care workforce needs is generally viewed as less than ideal given the complexity of the clientele. Respondents were asked to report the number of their direct care staff who were temporary workers on a typical day. Across all provider types, 4.3 percent of DCWs are temporary employees on a typical day, a figure somewhat lower than the 5.1 percent reported in 2000 (see Table 2-3).

Table 2-3. The Distribution of the Number of DCWs by Provider Type and Region

	Average Number of DCW Positions Currently Filled Per Organization	Average Percent Temps[a]
All providers	28.3	4.3%
Adult Day	21.4	4.6%
Unlicensed Home Care/Home Health	35.9	3.0%
Licensed Home Health	22.6	6.4%
Nursing Home	49.8	2.5%
Personal Care	17.8	4.6%
Region:		
Central	28.5	5.4%
Lehigh Valley	32.5	1.9%
Northcentral	19.4	1.5%
Northeast	25.9	5.4%
Northern Tier	13.4	7.2%
Northwest	24.9	4.8%
Southcentral	23.8	4.4%
Southeast	30.9	4.0%
Southern Alleghenies	17.1	4.1%
Southwest	24.5	4.5%

[a] Calculated as (number of DCWs likely to be temps / total number of DCWs on a typical day)

Job Tenure of the Direct Care Workforce

For the average provider, about 38.7 percent of their frontline workers had been employed by the organization less than a year (up from the 29 percent reported in 2000). However, the average proportion of DCW on the job for 10 or more years increased to 28.4 percent from around 18 percent in 2000. This presents a bimodal picture of frontline staff tenure, whereby providers have been able to retain a sizable proportion of their workforce while still contending with turnover among new hires.

Gains in retaining workers for more than ten years are shown in all provider types, with the largest increases in home health/home care. This is further evidence of the maturation of home care as part of the service continuum that has occurred over the past two decades. The Lehigh Valley shows the high percentage of DCWs employed less than a year and the lowest employed 10 years or more (see Table 2-4).

Table 2-4. Percent in Short and Long Tenure Groups by Provider Type and Region

	Percentage of the Total Number of DCWs Who Have Worked at the Provider…	
	Less than 1 year	10 or more years
All providers	38.7%	28.4%
Adult Day	31.9%	28.5%
Unlicensed Home Care/Home Health	40.7%	33.5%
Licensed Home Health	38.5%	33.8%
Nursing Home	32.9%	28.4%
Personal Care	41.5%	25.6%
Region:		
Central	34.6%	24.6%
Lehigh Valley	52.6%	19.2%
Northcentral	38.1%	37.9%
Northeast	36.1%	27.7%
Northern Tier	38.8%	33.7%
Northwest	36.4%	28.5%
Southcentral	40.1%	26.6%
Southeast	36.2%	25.2%
Southern Alleghenies	35.1%	37.3%
Southwest	40.3%	30.9%

Due to rounding, percentages may not sum to 100

Hourly Wages by Provider

The starting hourly wage for DCWs in this sample ($8.21) is over 12 percent higher than the average starting wage rate reported in 2000 ($7.29). It compares favorably with the Keystone Research Center interpretation of CPS data in which they report a 2003 median hourly wage (not starting wage) for women without a high school degree at $7.50. For women with a high school degree, however, the median salary was reported at $10.38.

DCWs in nursing homes and all types of home care/home health agencies are reported to have a higher starting wage than those in other types of providers.

DCWs with tenure of 10 years or more make, on average, only $2.14 (or just under 25 percent) more than the average for those with tenure of less than one year. By comparison, in 2000, the average starting wage for direct care workers was $7.29 and the mean for the top paid workers was $9.51, a difference of 30 percent. The smaller differential is relatively equivalent across provider types and may suggest the need for wage compression adjustments.

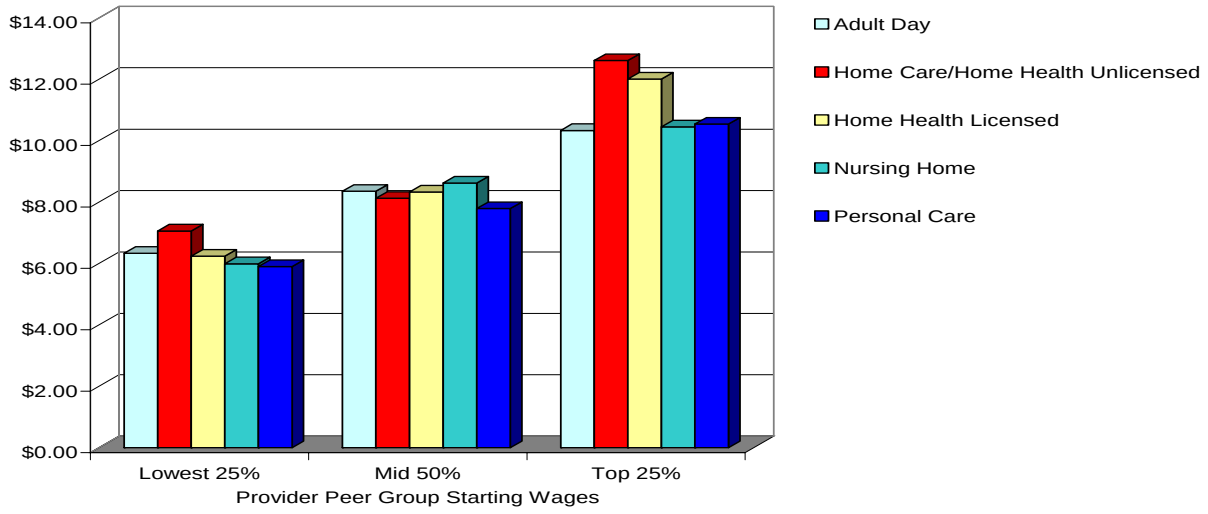
Starting hourly wages are somewhat higher than wages earned in 2000 in all regions. Similar to four years ago, average hourly wage for DCWs working at their organization for one year or less were lowest in the Northcentral, Northern Tier and Southern Alleghenies. Like four years ago, the mean top hourly wage was highest Southeast and Southcentral regions of the state. 2002 Bureau of Labor Statistics' median hourly wage across the nation ranged from $7.81 to $9.59 for direct care workers.[1]

Table 2-5. Average Hourly Wage Rates for Short & Long Tenure DCW by Provider Type & Region

	Starting Hourly Wage		Average Hourly Wage	
	Less than 1 year	10 or more years	Less than 1 year	10 or more years
All providers	$8.21	$10.09	$8.69	$10.83
Adult Day	$8.23	$9.70	$8.45	$10.85
Unlicensed Home Care/Home Health	$9.91	$11.43	$10.36	$11.37
Licensed Home Health	$9.55	$10.97	$9.99	$11.80
Nursing Home	$9.46	$10.98	$9.69	$11.63
Personal Care	$7.17	$8.90	$7.72	$9.80
Central	$7.81	$9.78	$8.17	$10.11
Lehigh Valley	$8.37	$10.04	$9.13	$11.25
Northcentral	$7.06	$8.88	$7.49	$9.64
Northeast	$8.14	$9.84	$8.48	$10.86
Northern Tier	$7.06	$8.65	$7.41	$9.63
Northwest	$7.68	$10.32	$8.16	$10.34
Southcentral	$8.63	$10.35	$9.16	$11.34
Southeast	$9.37	$11.23	$10.02	$12.42
Southern Alleghenies	$7.23	$9.42	$7.54	$10.33
Southwest	$7.55	$9.34	$7.74	$9.57

Figure 2-1 shows the average starting wage rates where providers are categorized into high, middle, and low levels depending on their level of starting wages compared to provider group peers. On average, the starting hourly wage rates among top paying home health/home care providers were over $12, compared to $10 for the highest paying nursing homes, adult day centers and personal care homes.

Figure 2-1. Entry-Level Wage Rates by Provider



Relationship Between Starting Hourly Wages and DCW Vacancy Rates

Higher starting hourly wages are associated with lower vacancy rates in some types of provider organizations. Nursing homes, personal care facilities and licensed home health care agencies show this trend. Adult day and unlicensed home care provider groups do not. Across the regions, the trend is evident except for the Southcentral and Southwest regions.

Figure 2-2. Average Starting Hourly Wage for DCW Hired in the Last Year, by **Provider Type** and Vacancy Rate

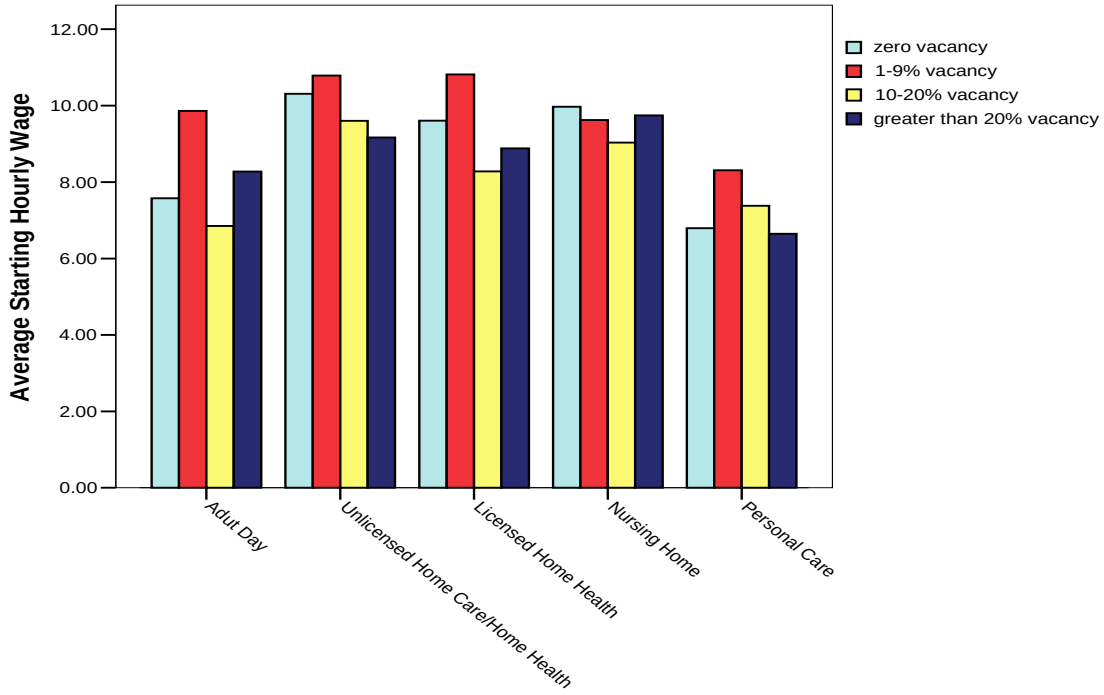
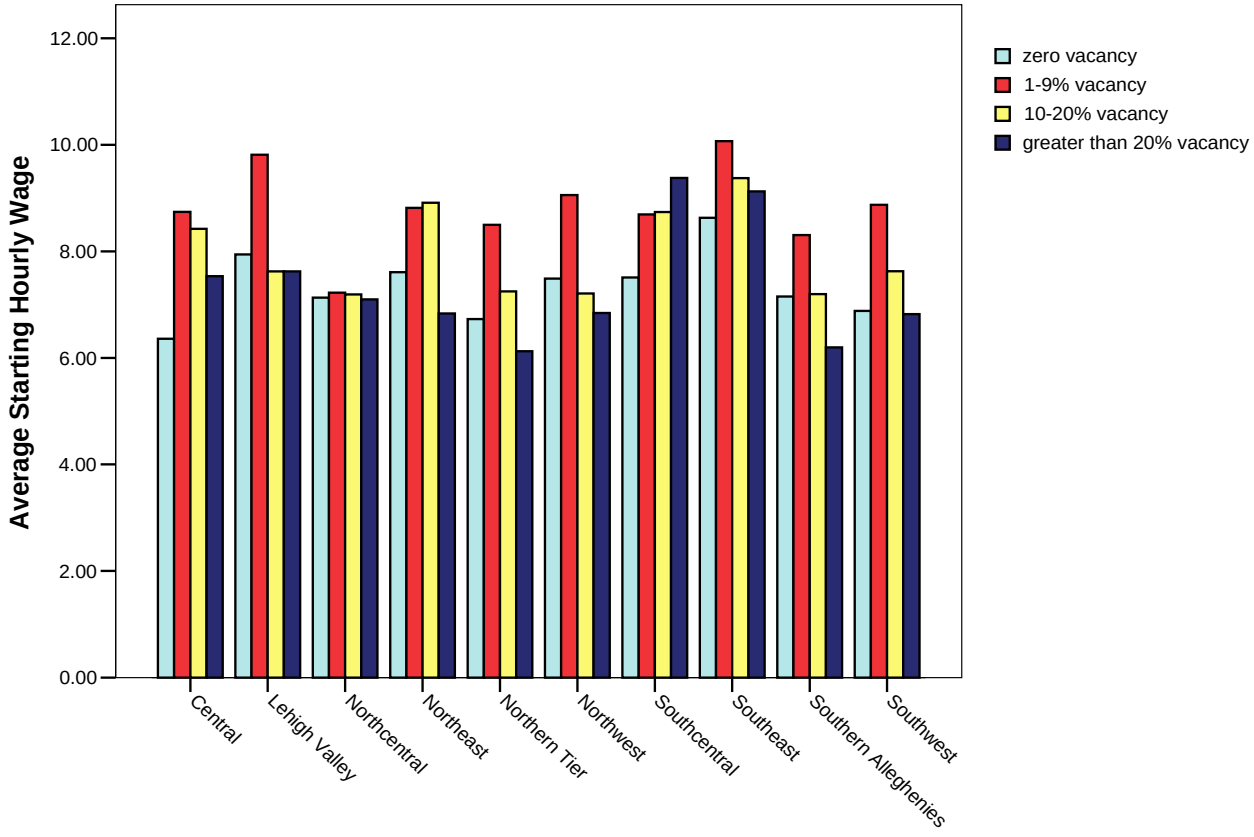


Figure 2-3. Average Starting Hourly Wage for DCW Hired in Last Year, by **Region** and Vacancy Rate



Benefits Offered by Provider Organizations

Three quarters of all providers in the sample offer health insurance benefits to DCWs, two-thirds provide sick leave and a large majority provide paid vacations. Transportation assistance is more likely in home care and home health care. Fewer personal care organizations offer health insurance and paid sick leave to DCWs. The majority of all provider types offer health insurance to at least some DCW employees. Fewer organizations in the Central and Southwest regions of the state offer health insurance to DCWs, though more than half of providers in all regions offer health insurance benefits to DCWs. These data do not indicate what proportion of the cost of health insurance is paid by the employer.

Table 2-6. Distribution of Provider Offering Selected Benefits to Any DCWs, by Provider Type and Region

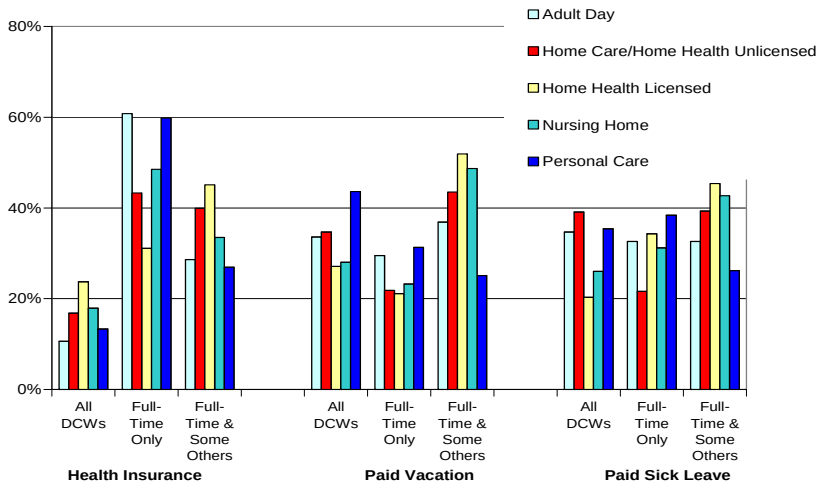
	Health Insurance	Paid Sick Leave	Paid Vacation	Transportation
All providers	75%	67%	86%	11%
Adult Day	91%	89%	95%	3%
Unlicensed Home Care/Home Health	78%	63%	82%	23%
Licensed Home Health	89%	75%	87%	15%
Nursing Home	100%	92%	99%	10%
Personal Care	56%	51%	79%	11%
Region:				
Central	71%	63%	81%	18%
Lehigh Valley	82%	82%	96%	13%
Northcentral	80%	52%	86%	14%
Northeast	69%	75%	86%	15%
Northern Tier	56%	71%	87%	.
Northwest	75%	57%	86%	7%
Southcentral	83%	64%	91%	9%
Southeast	89%	80%	94%	14%
Southern Alleghenies	70%	71%	82%	3%
Southwest	61%	58%	78%	8%

Benefits Variation by Provider and Region

For those providers that offer health insurance to DCWs, the majority offer it only to full-time workers (see Appendix Table 3-2). Another 32 percent offer it to some others but not all DCWs. About one quarter of the licensed home health care agencies offer health insurance to all DCWs. However, compared to other provider types, these agencies offer other types of benefits such as paid sick leave and paid vacation to a smaller percentage of workers (see Figure 2-4).

At least some employers in all provider types offer some form of transportation benefit, except those in the Northern Tier region of the state. Personal care facilities are less likely to offer benefits of all types. Family/social benefits are relatively modest across all provider types (see Appendix Table 3-3).

Figure 2-4. Benefits by Provider Type



Provider Organization Participation in Workforce Development Efforts

The Commonwealth of Pennsylvania has been a leader in addressing the direct care worker shortage. Programs include DCW Initiative bonuses administered through the Area Agencies on Aging, the Frontline Conference in Harrisburg, and "Key Solutions" training for DCW. Findings from the table below are taken from an open-ended question that asked the respondent to report what if any such programs they had participated in. It is likely that those who left the answer blank did not participate, but since we cannot know that definitively, we show the participants as a percent of those who responded to the question and as a percent of the total sample.

Assuming that no answer means that the organization did not participate, 10 percent of the total sample has been involved in these initiatives. One-quarter of those who responded to the question reported participating in some way, though rates vary significantly across region and provider type. The greatest level of participation has been on the part of the home care/unlicensed home health agencies and the adult day centers. The Southeast region has been most involved in these programs, and the Lehigh Valley and Southern Alleghenies regions have been less involved.

Table 2-7. Percentage of Providers Who Participated in the Recent State-Sponsored Initiatives.

	Percent among those responding to the question	Percent among total (with missing answer coded as "No Participation")
All providers	25%	10%
Adult Day	54%	30%
Unlicensed Home Care/Home Health	69%	29%
Licensed Home Health	35%	17%
Nursing Home	15%	6%
Personal Care	14%	5%
Region:		
Central	21%	10%
Lehigh Valley	11%	4%
Northcentral	27%	10%
Northeast	26%	10%
Northern Tier	25%	6%
Northwest	35%	14%
Southcentral	30%	11%
Southeast	40%	18%
Southern Alleghenies	6%	3%
Southwest	10%	4%

Recruitment and Training Expenditures

The majority of providers report that training and recruiting expenditures have been stable over the past two years, but nearly 40 percent have seen an increase. Providers in the Southcentral, Central, and Lehigh Valley regions gave the most frequent reports of increases in expenditures.

Table 2-8. Expenditures Associated with Recruiting and Training New DCWs, Compared with Two Years Ago, by Provider Type and Region.

	Compared with 2 Years Ago, Total Expenditures Associated with Recruiting and Training New Direct Care Workers Has...		
	Increased	Decreased	Remained about the Same
All providers	39%	6%	54%
Adult Day	32%	8%	61%
Unlicensed Home Care/Home Health	28%	8%	64%
Licensed Home Health	38%	6%	57%
Nursing Home	49%	9%	42%
Personal Care	39%	5%	56%
Region:			
Central	51%	7%	42%
Lehigh Valley	48%	5%	48%
Northcentral	27%	0%	73%
Northeast	35%	6%	59%
Northern Tier	31%	0%	69%
Northwest	30%	7%	63%
Southcentral	58%	6%	37%
Southeast	35%	9%	56%
Southern Alleghenies	32%	3%	65%
Southwest	43%	6%	51%

As Figure 2-5 illustrates, starting wage increases (47 percent) and staff referrals (45 percent) were the most often used recruitment strategies.

Figure 2-5. Most Frequent Staff Recruitment Strategies

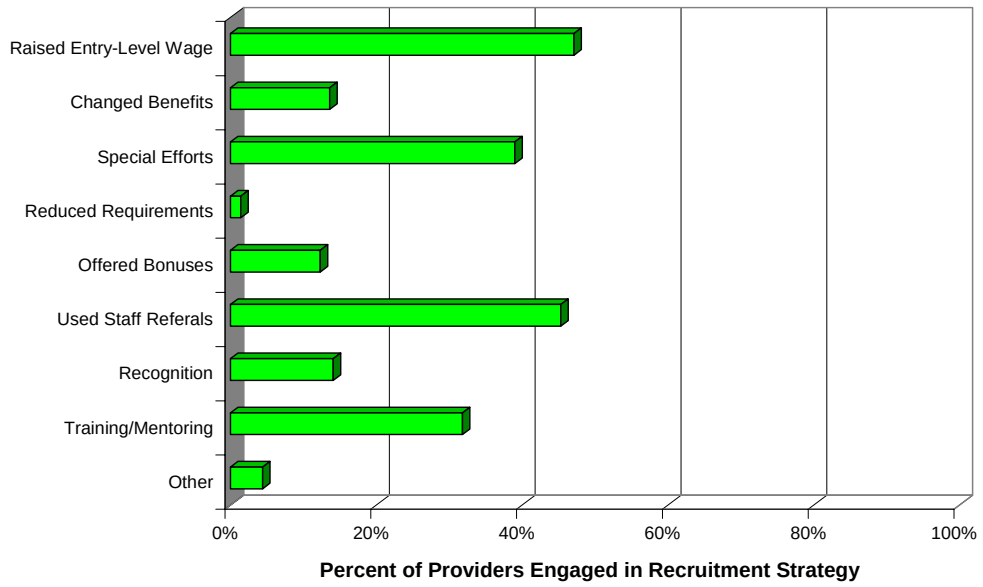
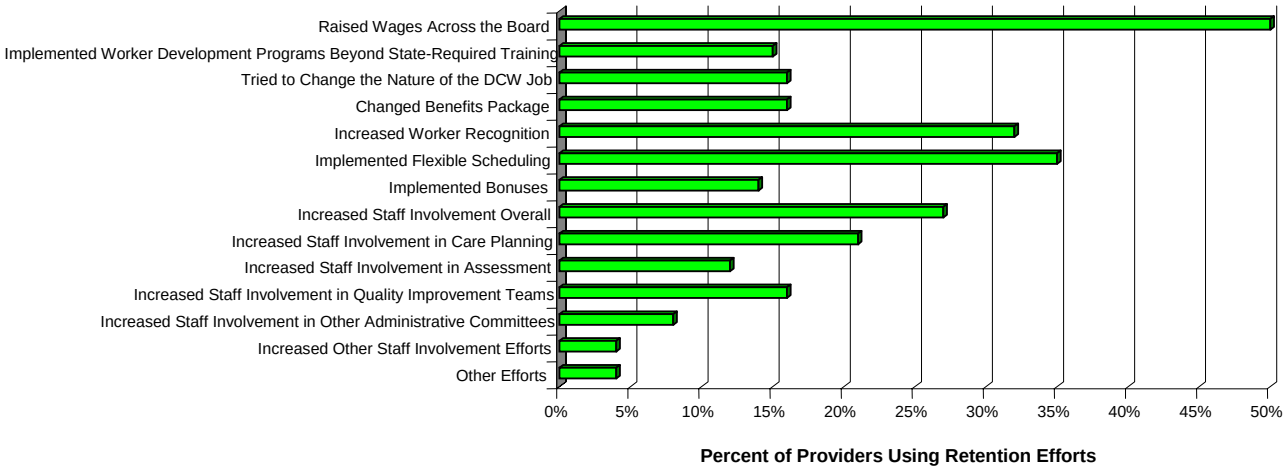


Figure 2-6. Most Frequent Staff Retention Strategies



Career Development Efforts

Formal in-service programs beyond those required for certification were offered by 85 percent of the providers in this sample. Training to enhance communication with residents was offered by 85 percent of providers. Over 44 percent of nursing homes offered career ladder programs and nearly 55 percent offered a designated peer mentoring program. Self-directed educational videos/computer based training and diversity training were offered in a majority of all provider types.

Table 2-9. Distribution of DCW Participation in Career Enhancement Activities Provider Type

Activity	Overall Sample	Adult day	Home Care and Home Health Care*	Nursing Home	Personal Care
Career ladder program for the DCW to advance to a higher level of DCW (for example, team leader or dementia care specialist)	28%	24%	15%	34%	30%
Career ladder program for the DCW to become an LPN	21%	12%	14%	44%	15%
Designated peer mentor	39%	32%	39%	55%	33%
Formal in-service programs beyond those required for certification	85%	94%	88%	95%	78%
Self-directed educational video or computer-based training program while at work	62%	65%	70%	70%	55%
Attended a conference or workshop away from work	71%	91%	65%	73%	68%
Received training in communicating effectively with other employees	75%	80%	81%	81%	69%
Received training in communicating effectively with residents/clients	85%	99%	85%	88%	80%
Received training in diversity or cultural issues	64%	64%	75%	70%	57%

* In some of the tables it was necessary combine the two types of home care in order to have sufficient numbers in each for comparison

Very Serious Recruitment or Retention Problems

Recruitment continues to be a more serious concern for more providers than does retention. Home health agencies continue to report the highest levels of **very serious** recruitment problems. The Lehigh Valley, Southcentral and Northwest regions have the highest proportion of providers with very serious problems followed by the Southcentral and Northwest regions.

Table 2-10. Very Serious Recruitment/Retention Problems by Provider Type and Region

	Percent of Providers Who Have a **Very Serious** Problem with:		
	Recruitment	Retention	Recruitment or Retention
All providers	15%	7%	19%
Adult Day	6%	3%	9%
Unlicensed Home Care/Home Health	11%	7%	15%
Licensed Home Health	23%	5%	25%
Nursing Home	13%	9%	18%
Personal Care	16%	8%	19%
Region:			
Central	10%	2%	12%
Lehigh Valley	26%	13%	26%
Northcentral	16%	13%	19%
Northeast	11%	6%	14%
Northern Tier	13%	6%	19%
Northwest	21%	4%	23%
Southcentral	23%	11%	27%
Southeast	12%	7%	15%
Southern Alleghenies	18%	8%	21%
Southwest	15%	8%	19%

Nursing homes in the sample with very serious recruitment or retention problems have had significantly more health deficiencies, but do not otherwise significantly differ from others on a variety of characteristics.

Table 2-11. Characteristics of Nursing Homes with Very Serious Recruitment/Retention Problems

Characteristic	Type of Nursing Home	N	Mean	Std. Deviation
Percent Medicaid	Other	138	49	29
	Very Serious Recruitment or Retention Problem	29	56	28
Occupancy Rate	Other	138	87	16
	Very Serious Recruitment or Retention Problem	29	89	12
Percent Medicare	Other	138	18	25
	Very Serious Recruitment or Retention Problem	29	16	22
Residents/total adjusted RN FTE	Other	137	12	8
	Very Serious Recruitment or Retention Problem	29	14	7
Residents/total adjusted LPN FTE	Other	137	8	5
	Very Serious Recruitment or Retention Problem	29	10	7
Residents/total nurse aide FTE	Other	138	2	1
	Very Serious Recruitment or Retention Problem	29	3	1
Medicare/Medicaid certified beds	Other	138	111	82
	Very Serious Recruitment or Retention Problem	29	102	52
Current health deficiencies*	Other	138	4	3
	Very Serious Recruitment or Retention Problem	29	5	4

* t-test for differences in means $p < .05$

More than Minor Recruitment/Retention Problems

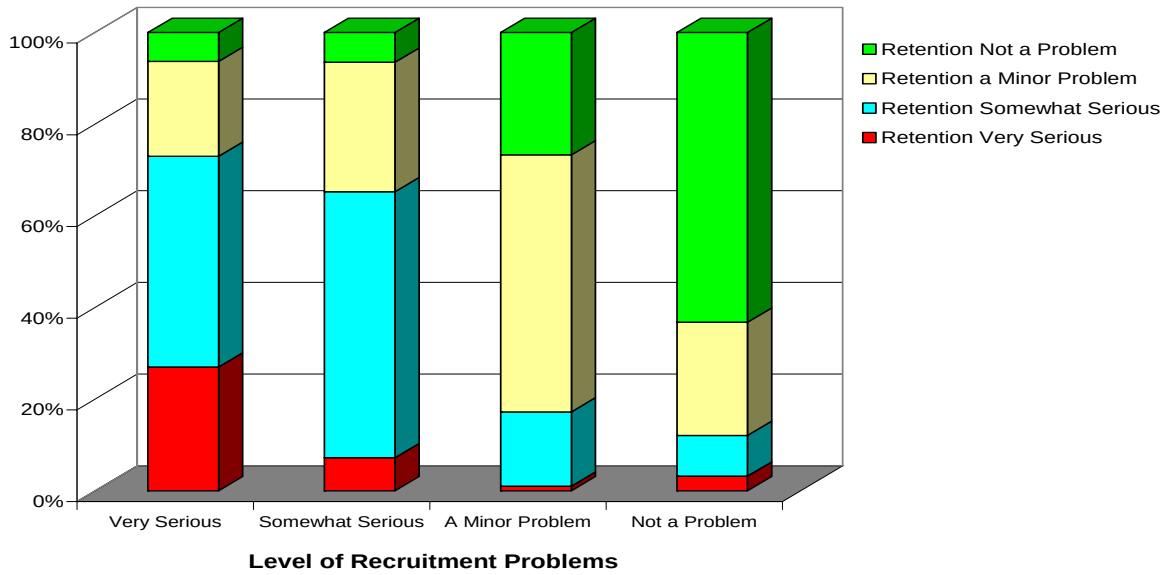
The percent of providers reporting a **very serious or somewhat serious** problem with recruitment or retention was 60 percent in 2004.

Table 2-12. Very or Somewhat Serious Recruitment/Retention Problems by Provider Type & Region

	Percent of Providers Who Have a **Very Serious or Somewhat Serious** Problem with:		
	Recruitment	Retention	Recruitment or Retention
All providers	53%	42%	60%
Adult Day	41%	24%	46%
Unlicensed Home Care/Home Health	57%	37%	57%
Licensed Home Health	54%	41%	61%
Nursing Home	55%	52%	67%
Personal Care	53%	42%	60%
Region:			
Central	63%	46%	63%
Lehigh Valley	57%	57%	70%
Northcentral	32%	32%	36%
Northeast	51%	31%	56%
Northern Tier	44%	38%	50%
Northwest	54%	41%	60%
Southcentral	70%	47%	75%
Southeast	48%	43%	58%
Southern Alleghenies	40%	34%	42%
Southwest	55%	44%	65%

As was the case in 2000, recruitment and retention problems do overlap in the same providers, but the two problems are not entirely reciprocal. Almost 35 percent of providers who said they had a very serious recruitment problem reported only a minor or no retention problems. In contrast, over 15 percent of providers with a minor recruitment problem had somewhat or very serious retention problems. Recruitment problems are generally considered to be more related to the available pool of workers in local employment markets, whereas retention is related to within-sector competition related to wage rates and working conditions among long-term care providers.

Figure 2-7. Overlap of Recruitment and Retention Problems



Comparing Seriousness of Recruitment and Retention Problems to 2 Years Ago

There is a clear relationship between the seriousness of the current **recruitment** problem and whether it has decreased, remained the same or gotten worse. Those who report a minor or no recruitment problem are more likely to have seen improvement or no change in the past 2 years.

While half or more of both nursing homes and the home care/home health agencies report very serious recruitment problems, the proportion that have experienced a reduction in the problem is considerably higher in the nursing home sector. The decrease in recruitment problems is concentrated in the nursing home sector.

As expected, the likelihood that the **retention** problem has decreased in the past two years is higher for those who currently report a minor or no problem with retention. The clearest relationships between the trajectory of the problem and the severity of the retention problem can be seen in home care/home health care and personal care. There is a trend for providers who have used more than three different **retention** strategies to report decreased retention problems in the past two years (see Appendix Tables 3-4a, 3-4b and 3-4c). Also, those who have seen improvements are less likely to report using no retention strategies.

Table 2-13. Change in Level of **Recruitment Problem** over the Past Two Years by Provider Type

Current Level of Recruitment Problem		Compared to 2 Years Ago, Recruitment Problem Has:		
		Increased	Decreased	Remained About the Same
All Providers	Very Serious	50%	5%	46%
	Somewhat	23%	25%	52%
	Minor	8%	29%	63%
	Not at all	4%	17%	80%
Adult Day	Very Serious	25%	0%	75%
	Somewhat	33%	8%	58%
	Minor	0%	24%	77%
	Not at all	0%	14%	86%
Home Care and Home Health*	Very Serious	52%	0%	48%
	Somewhat	24%	22%	53%
	Minor	16%	16%	69%
	Not at all	0%	22%	78%
Nursing Home	Very Serious	59%	18%	23%
	Somewhat	29%	36%	35%
	Minor	9%	41%	50%
	Not at all	0%	21%	79%
Personal Care	Very Serious	48%	2%	50%
	Somewhat	18%	23%	59%
	Minor	6%	30%	65%
	Not at all	7%	13%	79%

* In some of the tables it was necessary combine the two types of home care in order to have sufficient numbers in each for comparison. Due to rounding, percentages may not sum to 100

Table 2-14. Change in Level of **Retention Problem** over the Past Two Years by Provider Type

Current Level of Retention Problem		Compared to 2 years Ago, Retention Problem Has:		
		Increased	Decreased	Remained About the Same
Overall Sample	Very Serious	56%	2%	43%
	Somewhat	18%	22%	60%
	Minor	7%	28%	65%
	Not at all	1%	20%	79%
Adult day	Very Serious	50%	0%	50%
	Somewhat	7%	29%	64%
	Minor	8%	38%	54%
	Not at all	4%	11%	85%
Home Care and Home Health*	Very Serious	71%	0%	29%
	Somewhat	20%	16%	64%
	Minor	0%	20%	80%
	Not at all	0%	17%	83%
Nursing Home	Very Serious	36%	7%	57%
	Somewhat	17%	33%	50%
	Minor	19%	24%	58%
	Not at all	0%	30%	70%
Personal Care	Very Serious	61%	0%	39%
	Somewhat	20%	17%	63%
	Minor	4%	30%	66%
	Not at all	1%	21%	78%

* In some of the tables it was necessary combine the two types of home care in order to have sufficient numbers in each for comparison. Due to rounding, percentages may not sum to 100.

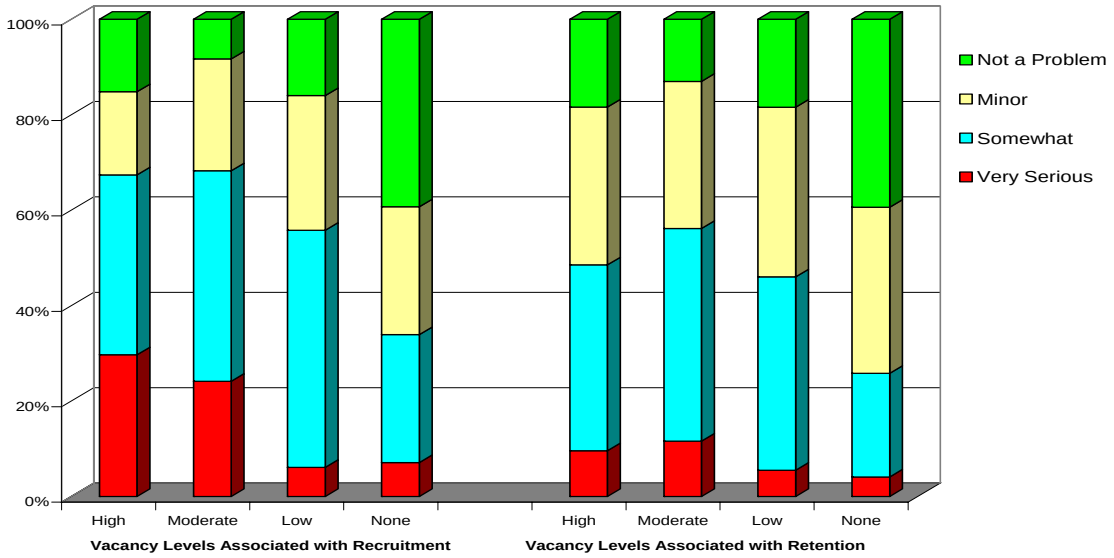
Vacancy Rates and Recruitment/Retention Problems

Among providers with vacancy rates greater than 20 percent, 29 percent reported very serious recruitment problems; only 10 percent of these high vacancy providers reported very serious retention problems (see Figure 2-8).

Those proportions are substantially lower than those reported in 2000, where 59 percent of high vacancy providers reported very serious recruitment problems and 30 percent reported very serious retention problems. These disparate findings may be a function of the different data collection methods employed in 2000 and 2004, whereby those who responded via the written mail survey to the recruitment/retention "seriousness" items may have interpreted the question differently than those who participated in the telephone interview format in 2000, where the interviewer related the "seriousness" scale in sequential order, with the "very serious" response as the final choice provided.

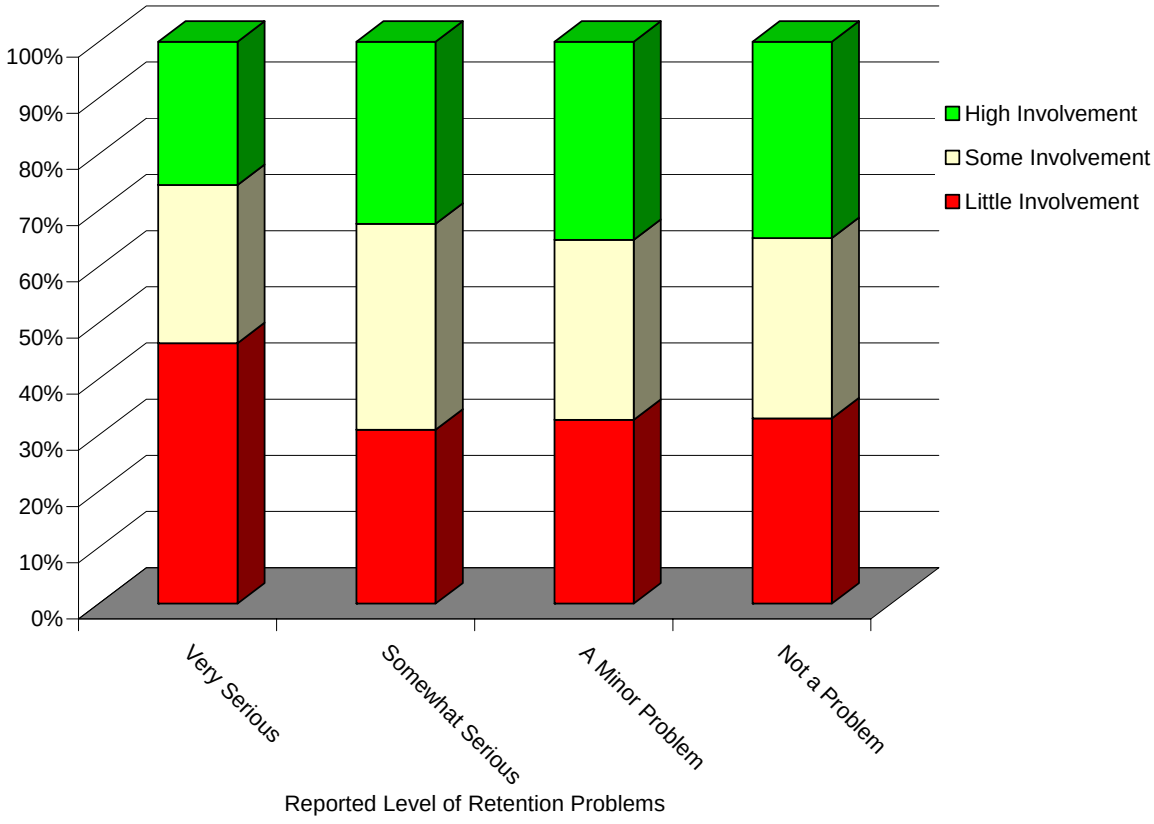
However, it may also be related to the factors that influence providers' general impressions about "seriousness." High vacancy rates may be judged more problematic in markets where workers are scarce in absolute terms due to competing demands from other segments of the service sector. The lower unemployment levels in 2000 certainly contributed to a tight labor market for long-term care providers. During times such as now when unemployment is higher, high vacancy rates may be perceived as less serious in situations where a greater overall supply of workers exists. Thus, the issue of a worker's "qualifications and fit" is given greater weight in the hiring decision. The question posed to the providers was, "If you had enough qualified applicants, how many positions could you fill today?" In such a context, workforce development initiatives become that much more important in terms of creating a ready pool of direct care workers who can be hired as a good "fit" with the provider's organizational culture.

Figure 2-8. Job Vacancy Levels by Degree of Recruitment and Retention Problems



Among providers with very serious retention problems, 40 percent reported little DCW involvement in care planning compared with less than 30 percent among those providers where retention was judged to be less of a problem.

Figure 2-9. Involvement in Care Planning and Retention Problems



Direct Care Worker Survey Results

Who is in the Sample of Direct Care Workers?

Personal care home DCWs (n=291) made up 45.5 percent of our sample of 640 DCWs. DCWs from 40 personal care homes, 10 nursing homes, 11 home care or home health care agencies and 5 adult day centers are represented in the data. Respondents were more likely (56.9 percent) to belong to organizations that reported more retention efforts in the survey of clinical managers. Respondents had an average tenure as a DCW of 10.5 years and an average tenure at their current organization of 7.3 years.

Table 2-15. DCW Sample Characteristics

Provider Type	Number of DCWs	Percent of Sample	Number of Organizations	Mean Number of Respondents
Adult Day	47	7%	5	9
Home Care or Home Health Care	116	18%	11	11
Nursing Home	186	29%	10	19
Personal Care	291	46%	40	7
Total	640	100%	67	10

Over 19 percent of the respondents in the sample were over age 55. The DCW respondents in the sample were 11.7 percent African-American and 1.9 percent Hispanic/Latino.

Table 2-16. DCW Sample Demographics

	Percent
Age	
Less than 25 years	12.3%
25-34 years	18.6%
35-44 years	24.4%
45-54 years	25.6%
55-64 years	15.5%
65 years or older	3.6%
Gender	
Male	5.2%
Female	94.8%
Education	
High School or GED	54.6%
Some college/trade school	38.6 %
College graduate or post college	6.8%
Race/Ethnicity	
Caucasian	80.9%
Hispanic/Latino	1.9%
African American	11.7%
Other	5.5%

What are the Wages and Benefits of Direct Care Workers in the Sample?

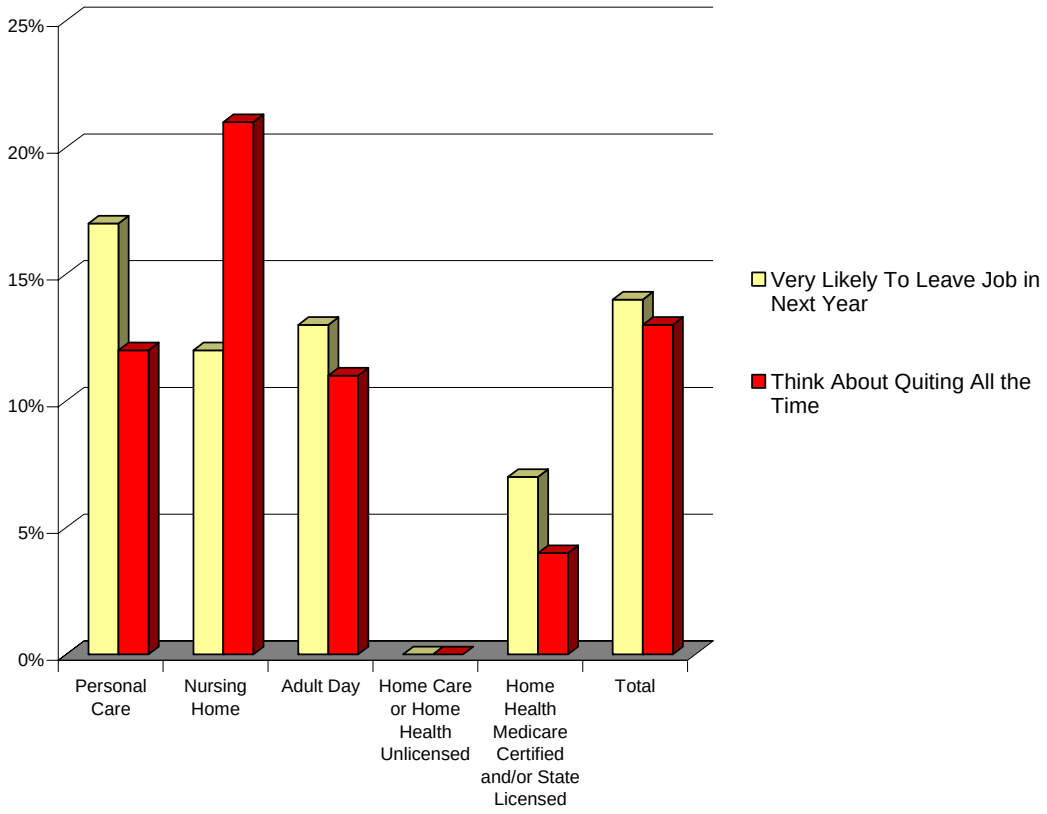
The average hourly wage across all DCW types in the sample is $9.61. It is $10.25 for nursing home DCW, $10.36 for home care/home health, $12.06 for adult day and $8.55 for personal care. These higher than average wage rates reflect the long job tenure of the respondents in the sample compared to the total population of DCWs. Over 46 percent of the DCW respondents receive health insurance via their employer. Another 25 percent do not participate in health insurance programs offered by their employer. Nearly 12 percent of respondents work for pay at another job as a DCW and 82 percent view their job as a long-term career.

Table 2-17. DCW Sample Wages

Provider Type	Mean Hourly Wage
All Providers	$9.62
Adult Day	$12.06
Home Care or Home Health Care	$10.36
Nursing Home	$10.25
Personal Care	$8.55
Criteria	
Highest number of retention efforts	$9.35
Lowest number of retention efforts	$9.98

DCWs from the sample who work in nursing homes and personal care homes are the most likely to express an intention to leave their job in the next year. DCWs from the sample working in home care are the least likely to think about quitting.

Figure 2-18. Intent to Leave in the Next year/Thinking About Quitting Among DCW in the Sample



How Do DCWs in the Sample Perceive Their Organizations?

Overall, DCWs in this sample are satisfied with their jobs. Over 86 percent of DCWs in the sample reported being either extremely or somewhat satisfied. There were no significant differences in job satisfaction across provider types. DCW across the continuum are highly likely to recommend their organization to friend or family member in need of care, though home care DCW are the most likely (98 percent). DCWs in home care are also the most likely to recommend a job in their organization to a friend or family member (92 percent).

How Do DCWs in the Sample Evaluate Their Supervisors?

Home care DCWs are more likely to strongly agree that their supervisor provides clear instructions when assigning work, is open to new ideas, listens to concerns of DCWs, supports teamwork and appropriately disciplines DCWs. DCWs in home care are also more likely to strongly agree that their supervisor gives praise for good work and offers constructive criticism. DCWs in home care are more likely to strongly agree that their supervisor is interested in DCW job development. DCWs in providers with few retention efforts are more likely to strongly disagree with the statement that their supervisor is interested in DCW job development. DCWs in nursing homes and those in organizations with few retention efforts are more likely to report that they are not encouraged by supervisors to discuss the care of residents/clients with the families of residents/clients. DCWs in home care were more likely to agree that both their supervisor and residents respect them as part of the health care team (see Appendix Table 3-5).

DCW Suggestions for Improving Their Jobs

DCWs were asked to respond to the open ended question, “What is the single most important thing your employer could do to improve your job?” Responses were categorized into one of four categories: compensation, staffing, management practices or no recommendation (some in this category expressed a positive opinion, as in “Things are fine, I wouldn’t recommend a thing”).

Results are comparable to those in the report, “In Their Own Words”, where compensation and management practices such as more respect were highlighted as most important. It also appears that “working short” (not having enough staff) was mentioned more in this survey than in the focus groups conducted in 2000. However, results are not entirely comparable in that the survey allowed only one recommendation per DCW. Improved compensation was the recommendation cited by a majority of DCWs across all provider types. DCWs in adult day centers were more likely to recommend increased staffing. A high proportion of (39 percent) of home care DCWs expressed no recommendation.

Table 2-19. Recommendations to Improve DCW Job

What is the single most important thing your employer could do to improve your job?	All Providers	Adult Day	Home care and/or home health care	Nursing Home	Personal Care
Improve compensation	27.5	20.0	30.4	29.4	26.2
Increase staffing	19.3	42.2	2.6	31.6	14.8
Improve management practices (training, respect, supplies, etc.)	26.4	22.2	27.8	19.8	30.7
No recommendation/no response	26.8	15.6	39.1	19.2	28.3

What Kinds of Training Programs Did Direct Care Worker Respondents Participate in and How Did They Evaluate Them?

The highest rates of DCW training participation were in home care. Among those who did attend, home care DCWs rated their training as most useful. Nearly all DCWs feel as though they have the skills necessary to do their job well (98 percent) and have confidence in their ability to do it (98 percent). Eighty-one percent of respondents somewhat or strongly agreed that they have the opportunity to work in a team.

Table 2-20. Participation in and Evaluation of Direct Care Workforce Training Programs

	Adult Day		Home care and/or home health care		Nursing home		Personal Care	
	N=44		N=108		N=168		N=276	
Training Programs	% of DCW who attended program	**How useful was it? (1-4)**	% of DCW who attended program	**How useful was it? (1-4)**	% of DCW who attended program	**How useful was it? (1-4)**	% of DCW who attended program	**How useful was it? (1-4)**
Resident or client care skills	74	**2.9**	87	**3.2**	80	**2.8**	63	**3.1**
Specialized clinical training	56	**2.9**	83	**3.3**	74	**3.0**	52	**3.1**
Communicating with residents or clients	91	**3.0**	89	**3.3**	83	**3.0**	71	**3.1**
Communicating with coworkers	72	**2.9**	76	**3.1**	56	**2.7**	57	**2.9**
Working with family members of residents or clients	69	**2.7**	81	**3.2**	60	**2.8**	49	**3.0**
Working with supervisors	49	**2.8**	64	**3.1**	38	**2.6**	38	**2.9**
Recording residents or clients information	87	**3.0**	86	**3.2**	75	**2.8**	63	**3.1**
Organizing your work tasks	54	**3.0**	72	**3.3**	51	**2.7**	47	**3.1**
How to mentor or coach other direct care workers	24	**3.0**	48	**3.2**	43	**2.7**	37	**2.9**
How to work in teams	41	**2.8**	60	**3.2**	50	**2.7**	48	**2.9**
Dealing with problems at work	53	**2.8**	79	**3.1**	65	**2.6**	57	**2.9**
Dealing with personal problems outside of work	11	**2.2**	35	**3.0**	18	**2.3**	21	**2.8**
Other	40	**2.8**	54	**3.1**	48	**2.9**	45	**3.2**

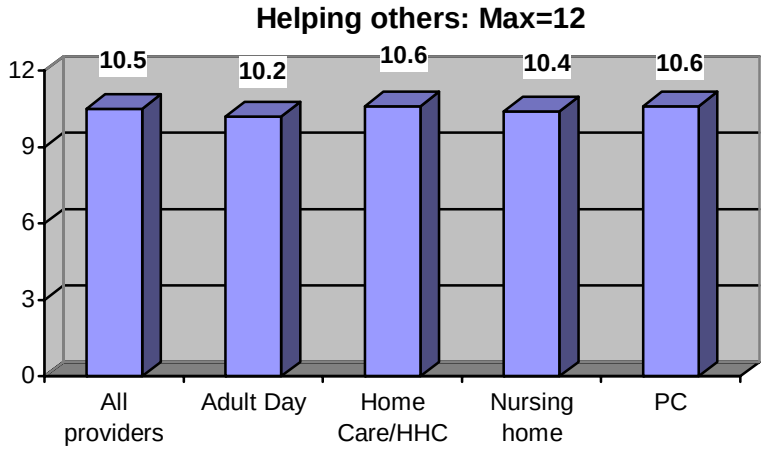
DCWs on "Out of the Ordinary" Efforts to Improve the Job

Table 2-21. Is your employer currently doing anything out of the ordinary to improve your job or to encourage DCWs to keep working there? (Number of non-responses=515)

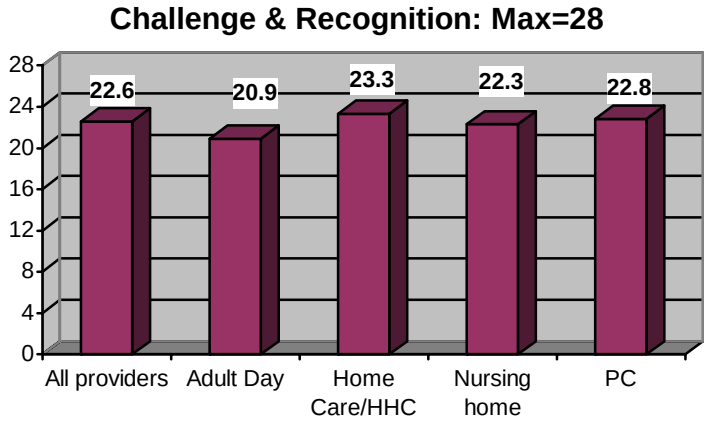
Praise and annual raises	$1.00 an hr differential on weekends
Given pay increase, trying to fix Health Care Insurance	Aides come a dime a dozen they say.
Changing other workers hours to benefit other family members that work here.	Give incentives, bonus, gift cards, girls night out.
Trying to keep the staff happy by giving/working with our needs	She lets me work hours to suit me
Helps with individual needs/problems as needed and requested, very small home.	Working with all of us!
Increasing office space. Aids are going to be using cell phones. We just got a raise	We receive a bonus in every check (x-days pay) for being on time and not calling off.
Enrolls employees in DSP Training with Comm. College	Rewards, shows appreciation, great team work.
Talk with us- get yearly evaluations!	We have staff meetings & it keeps us informed on what to do.
Recruiting help	They are always looking for ways to improve
Making us feel valuable.	To keep full staff and trying to act better rates on health insurance.
Improving communication skills.	They give you a pat on back, job well done.
$ incentive (pay raise) for not calling off work in a 2 week pay period.	Meetings on how we are doing as a team.
More bonus pay for good attendance.	Working with co workers
Putting girls through school.	Only trying to help the new ONC's so they will stay.
Lots of incentives for field employees.	She thinks she's improving things but the more she tries to change it, the more the employee's get disgusted.
Bonus incentives.	Flexible about time off.
All home health aides are offered the opportunity to go to college to become nurse aides. My company paid all expenses and I became a nurse aide.	Encourage us and tries to hire help for us and tries to get us to work together as a team
Employee gifts	doing activities with residents
They sent me to school for CNA	She makes it fun. I look forward to come to work now. We do a lot of different activities with the residents.
A lot of incentives.	CPR training and first aid
Sent me to school for CNA	$1.00 an hr differential on weekends
training – insurance	Aides come a dime a dozen they say.
They just hired a Human Resource Person	Give incentives, bonus, gift cards, girls night out.
Encourages me to continue.	She lets me work hours to suit me
Such as appreciation dinners, at Christmas a gift, wage increases, recognition for year of employment, sending thank you notes for special acts of loyalty.	Working with all of us!

Job Rewards

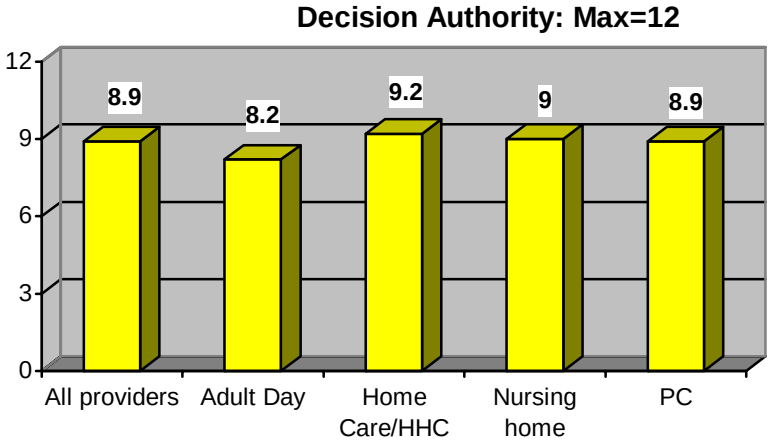
Helping others appears to be a rewarding part of DCWs' jobs across all provider types.



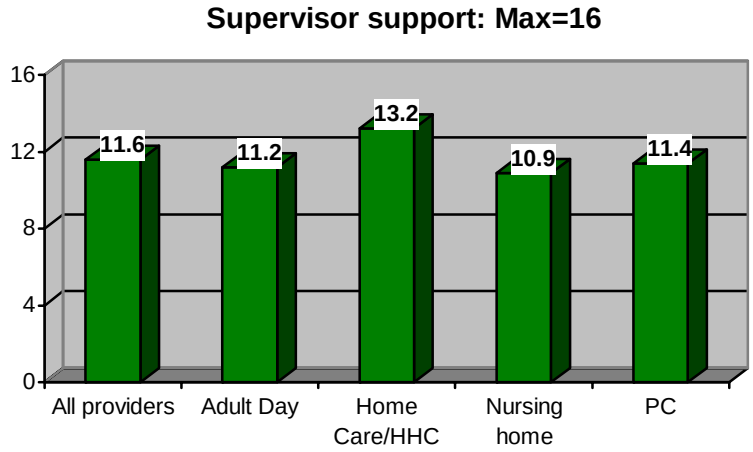
DCWs at adult day centers view Challenge and Recognition as significantly less rewarding than other provider types.



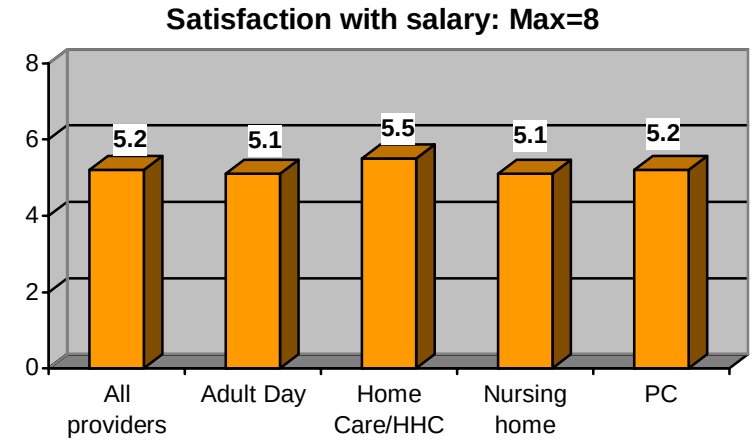
Overall, DCWs report having autonomy in decision making as somewhat rewarding and there were no differences across provider types.



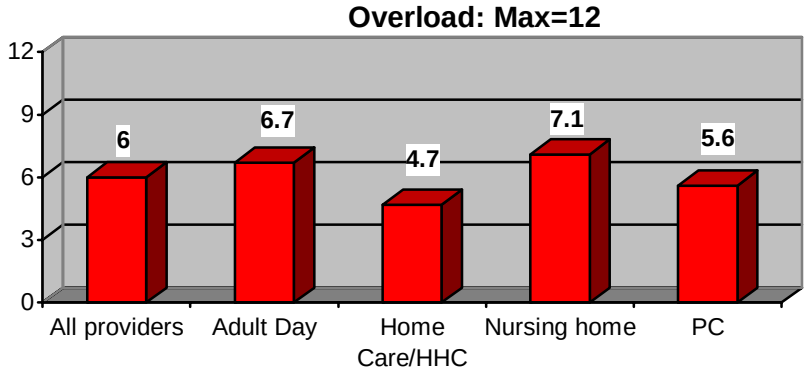
Home care and home health care workers report more "support from supervisors" when compared to other provider types.



Home care and home health care workers report that their income is more rewarding than other provider types.

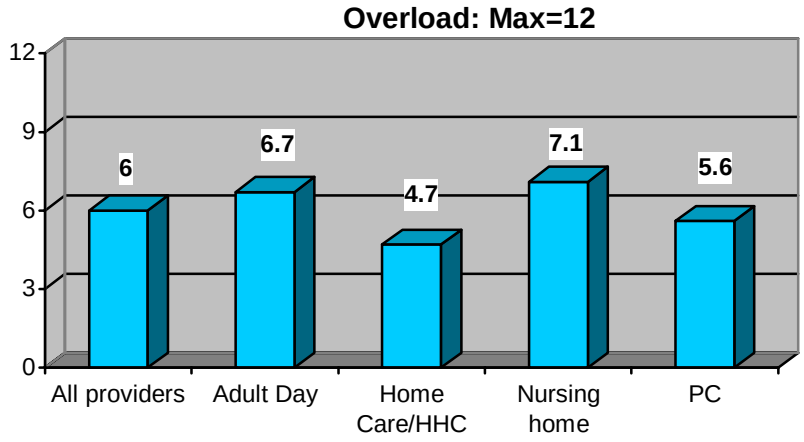


DCWs in all types of providers report satisfaction with salary as a somewhat rewarding part of their jobs.

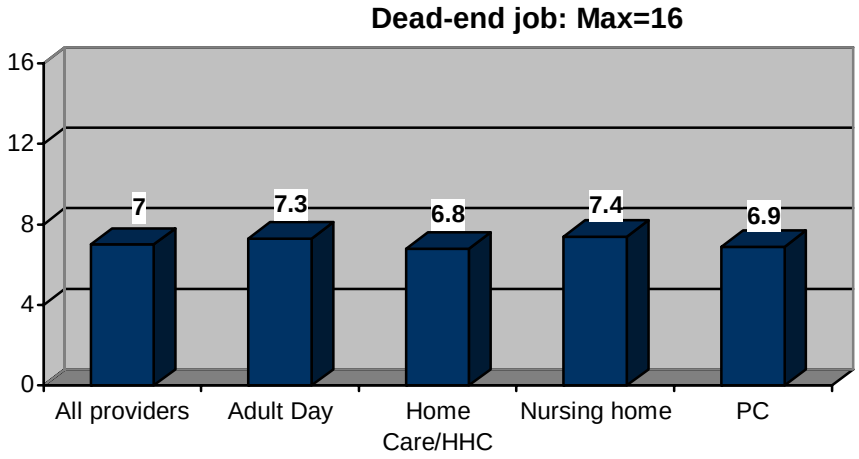


Job Concerns

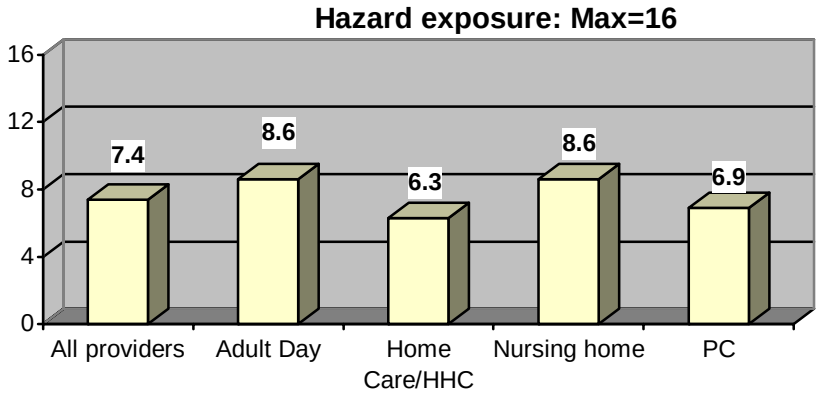
Home care and home health care workers report work overload as significantly less of a problem than other provider types.



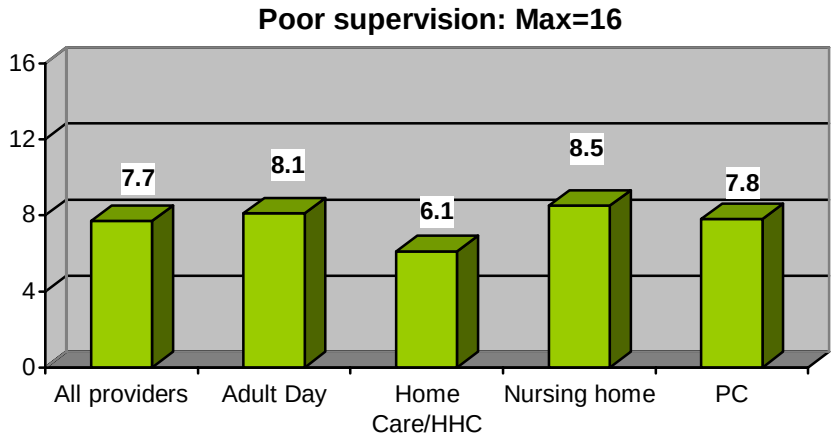
DCWs across provider types report that lack of opportunity in their jobs is not much of a problem.



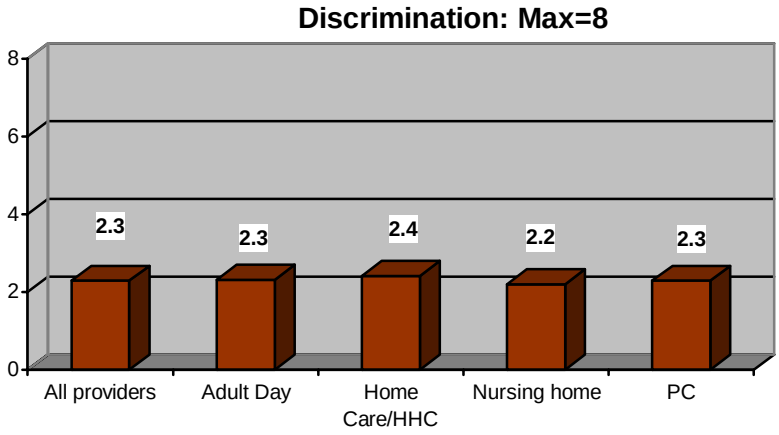
Home care and home health care workers view hazard exposure as significantly less of a problem than other provider types.



Home care and home health care workers view poor supervision as significantly less of a problem than other provider types.

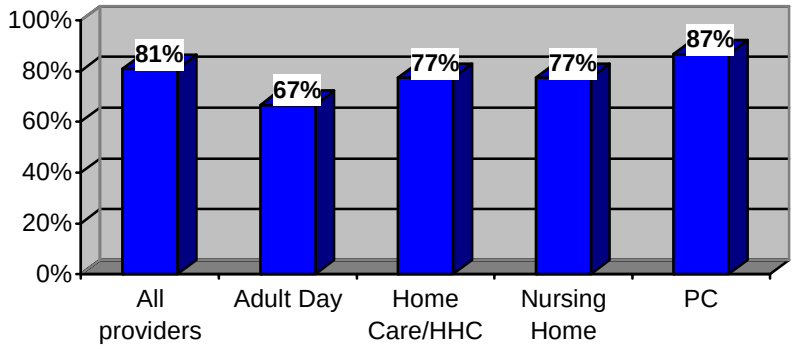


Discrimination based on race, ethnicity and gender were viewed as not much of a problem by DCWs across provider types.



Perceived Opportunities for Other Work

In response to the statement, *"I could get a job that paid more than this job,"* the majority of respondents across all provider groups responded with "agree" or "strongly agree."



Consumer-Directed Care Survey

Background

Individuals of all ages would like to be more involved in directing their chronic care services.[2,3] Consumer-directed models for people with supportive service needs are expanding as evidence suggests the advantages of such programs generally outweigh the disadvantages for most consumers.[4,5]

However, important questions remain about variations by age in preferences for and experience with consumer-directed care.[6,7] Younger individuals are more likely than older ones to prefer self-direction, though multiple studies have shown that at least a third of the elderly population is willing to assume more responsibility for organizing their supportive services.[8,9] Evaluations of the In-Home Supportive Services (IHSS) program in California have shown that while age is not a uniform predictor of service experience under consumer-direction, older adults tend to be less enthusiastic about the experience than younger persons.[10] Yet the California IHSS program operates such that "little if any program training or assistance is provided to consumers, who are responsible for making all service arrangements while a fiscal agent pays the worker."[10]

The training of consumers in the management skills necessary to self-direct their care is a critical area of interest among stakeholders interested in expanding consumer-directed care. A study published in June 2004 examined the preferences of 2,140 traditional agency model Medicaid home care recipients in four states (Arkansas, Florida, New Jersey and New York).[9] The telephone survey was done in advance of the Cash and Counseling Demonstration Evaluation (CCDE) in those states. The authors examined what demographic and background characteristics affect interest in consumer-directed care. They also studied what types of supports are needed among those with an expressed preference for consumer-directed care. They found that preference for consumer-directed care was positively associated with experience in the hiring, firing, supervising or training of workers.

The study also found that while consumers over age seventy were less likely to show interest in the consumer-directed option when compared to other age groups, more than 60 percent of respondents in their sixties, seventies and eighties reported a willingness to perform tasks associated with the consumer-directed option (showing a worker what to do, scheduling, supervising, paying a worker and firing a worker). Importantly, a majority of those consumers expressed a desire for training in how to perform those tasks.

The importance of training consumers of personal assistance services (PAS) in Pennsylvania was observed in the Backup PAS and Employment survey conducted by the Pennsylvania Council on Independent Living (PCIL) in late 2003.[11] The study showed that reliable backup is influenced by a complex array of factors, including labor supply and the willingness of the payer to pay family members for backup services. However, an "activated" consumer with the management skills necessary to navigate the task of arranging for backup is also a critical factor in the equation. Consider some of the responses of PAS consumers to the question "What Works?" in the PCIL backup study:

- Write out a back-up plan
- Personal advertising
- Give backup PA part-time hours
- Hire multiple personal assistants
- Have regular PA train backup
- Differential pay

Each of those strategies involves the consumer self-directing their supportive services. And each may be necessary to varying degrees depending on the consumer's relationship with and management of her or his primary paid DCW.

Self-directed management of the primary paid DCW was the focus of a brief survey sent to participants in the consumer-directed PAS model in Pennsylvania. The intent was to modify the clinical manager survey and view consumers as managers of the DCWs providing services to them. Because of the workforce focus of this report, the survey was aimed at assessing the workforce characteristics of DCWs providing consumer-directed care. The survey also included a consumer "activation" scale recently developed by researchers at the University of Oregon aimed at quantifying the extent to which individuals demonstrate behaviors consistent with self-directed care.[12] Exploratory analyses were performed to investigate whether consumer activation was related to training and/or recruitment and retention problems.

Who were the Consumer-Directed Care Respondents?

Sixty percent of the respondents were aged 45-64, only 12 percent aged 65 or over. Sixty-eight percent described their health as either poor or fair, and the average number of chronic care diseases was 2.5.

Table 2-19. Demographics of Consumer-Directed Care Respondents (n=186)

Age under 35	9%
35-44	19%
45-54	30%
55-64	30%
65-74	4%
75-84	5%
85 or older	3%
Education	
High school graduate or less	43%
Some college or trade school	40%
College graduate or more	17%
Sex	
Female	61%
Male	39%
Self-Rated Health	
Poor	26%
Fair	42%
Good	23%
Very Good	7%
Excellent	1%
Race	
Black	12%
White	82%
Other	6%
Chronic Disease	
Angina/heart problem	24%
Arthritis	43%
Chronic Pain	45%
Depression	41%
Diabetes	28%
Hypertension	32%
Lung Disease	13%
Cancer	7%
High Cholesterol	18%
Average Number of Chronic Diseases (SD)	2.5 (2.3)

Profile of Services Received from DCW

Forty-eight percent had more than one paid caregiver in the past week, while 44 percent had retained their current paid caregiver for over a year. Eighty-three percent received more than 12 hours of care in the previous week.

Table 2-20. Care Received from Paid Caregivers (n=186)*

	Response	%
How many different paid caregivers have you had in the past week?	0	11%
	1	39%
	2	25%
	3	23%
How long has your current primary caregiver been paid for the assistance he/she has provided to you?	Less than 6 months	27%
	6 to 12 months	25%
	1 to 3 years	32%
	More than 3 years	12%
How may hours per week of care do you receive on average (total from all caregivers)?	1 to 6 hours/week	11%
	7 to 11 hours/week	3%
	12 or more hours/week	83%
Have you ever had a live-in paid caregiver?	Yes	12%
	No	85%

* percentages that do not sum to 100 are due to missing responses

Communication with and Among DCW

According to the respondents, written and verbal communication among their paid caregivers is relatively rare. Over a third report providing no more than occasional verbal feedback and 80 percent report providing no more than occasional written feedback. A quarter of the respondents conduct a formal performance appraisal of their primary paid caregiver at least once a month.

Table 2-21. Communication with and among DCW (n=186)*

	Never	Seldom or Occasionally	Frequently or Always	Don't Know	Does Not Apply
How often does your primary paid caregiver communicate about your care in writing to other caregivers that you have?	48%	13%	15%	5%	17%
How often does your primary paid caregiver communicate about your care verbally to other caregivers that you have?	36%	20%	27%	3%	14%
How often does your primary paid caregiver communicate about your care in writing to the case manager?	49%	17%	6%	15%	11%
How often do you provide verbal feedback to your primary paid caregiver about the quality of his/her work?	8%	28%	59%	2%	2%
How often do you provide written feedback to your primary paid caregiver about the quality of his/her work?	60%	20%	6%	1%	11%

* percentages that do not sum to 100 are due to missing responses

Table 2-22. Performance Review of DCW (n=186)*

	Never	Annually	2 to 5 times a year	Monthly or bi-monthly	More than once a month
How often does your primary paid caregiver receive a formal performance appraisal by you?	51%	11%	8%	10%	15%

* percentages that do not sum to 100 are due to missing responses

Knowledge of Work/Training History of DCW

Many respondents did not know about their paid caregiver's work history and ongoing training.

Table 2-23. DCW Work History and Training (n=186)*

	Yes	No	Don't Know
Has your primary paid caregiver ever been employed as a direct care worker in a hospital, nursing home, or home care agency?	50%	35%	15%
Does your primary paid caregiver plan to pursue a career in nursing (certified CNA, LPN, or RN)?	18%	37%	42%
To the best of your knowledge, has your caregiver ever completed a self-directed educational video or computer-based training program?	22%	31%	46%
To the best of your knowledge, has your primary paid caregiver ever attended a conference or workshop away from your home?	25%	34%	38%

* percentages that do not sum to 100 are due to missing responses

Training in DCW Management

Over three-quarters of the respondents reported receiving no formal training on how to communicate effectively with their primary paid caregiver and a majority had never received more general training in skills to manage people.

Tables 2-24. Training in DCW Management (n=186)*

	Yes	No
Have you ever received any formal training in communicating effectively with your primary paid caregiver?	21%	78%
Have you received any formal training in skills for managing people?	37%	62%

* percentages that do not sum to 100 are due to missing responses

Recruitment and Retention of DCW by Consumer-Directed Care Respondents

Similar to the survey of providers, 19 percent of consumers report a very serious problem recruiting DCWs. Nine percent report a very serious problem retaining DCWs.

Table 2-25. Recruitment and Retention of DCW (n=186)*

	A very serious problem	Somewhat of a problem	A minor problem	Not a problem at all
How serious a problem is the recruitment of caregivers for you currently?	19%	21%	15%	42%
How serious a problem is the retention of caregivers for you currently?	9%	16%	17%	56%

* percentages that do not sum to 100 are due to missing response

Perceived Competency of DCW

Respondents rated the overall competency level of their primary DCW high, on average rating them 8.3 (SD=2.8) on a scale of 0-10. (The rating is similar to that observed in the provider survey.)

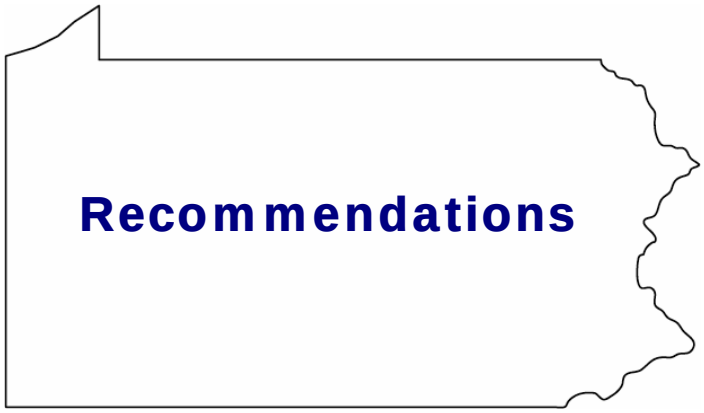
Consumer "Activation"

When examined by chronic condition, the consumer-directed care respondents had activation scores that were similar or slightly better in comparison to a large sample of healthier community-dwelling individuals over age 45 (assessed by the Oregon developers of the PAM; data are not shown as they are not yet published).

However, there were no observed relationships between consumer activation scores and DCW management characteristics related to communication and feedback.

Table 2-26. Consumer Activation and Socio-Demographic Characteristics

	Study Sample (N=186)	
	% in sample	"Patient Activation Measure"
Chronic Condition		
NONE	0%	--
Angina/heart problem	24%	56.7
Arthritis	43%	57.4
Chronic pain	45%	56.5
Depression	41%	56.1
Diabetes	28%	59.1
Hypertension	32%	57.9
Lung disease	13%	58.3
Cancer	7%	62.2
High cholesterol	18%	58.4
Self-Rated Health		
Poor	26%	54.2
Fair	42%	56.7
Good	23%	67.3
Very Good	7%	76.3
Excellent	1%	82.1
Age		
Under 35	9%	71.5
35-44	19%	63.4
45-54	30%	59.3
55-64	30%	58.5
65-74	4%	56.8
75-84	5%	51.0
85 and over	3%	45.6



Study Recommendations

1. ***Increase and maintain higher standards for training direct care workers.***

The training direct care workers receive is not of uniformly high quality and those staff who responded to the survey reported that much of it is not as useful as it could be. This is an area where centralized and regional action could most logically have an impact. A task group of key stakeholders should be convened to target changes in the way direct care worker training (including but not limited to certification training) is provided and monitored. Uniform core training that equips direct care workers to work effectively across settings is a key component of professional development. Under the current system in home care, there is considerable variability in the range of training workers report, with licensed/certified providers generally offering more training than others. It is difficult for the public to know what care they can expect from a home care assistant under such a scenario. The PA Better Jobs Better Care project is currently developing a "person-centered care" uniform core curriculum that may be considered for adoption if preliminary studies of its implementation show it to be effective and useful for different providers along the continuum. The HRSA-funded Geriatric Education Centers at Temple, Penn State and the University of Pittsburgh represent an established network of experts who provide training in geriatric-related topics to allied health personnel in PA. The Commonwealth could expand the scope of these centers to include training development and quality oversight for direct care workers.

2. ***Provide incentives to employers to improve the workplace.***

The provider survey results show that retention is improved in organizations where multiple management interventions are employed. As was observed in the 2000 surveys, however, there is no single solution to stabilizing the long-term care workforce. Consequently, we recommend the Commonwealth consider broad-based, comprehensive workplace improvement standards for its provider organizations, with financial incentives to promote their adoption. These may be accomplished either through "pay-for-performance" reimbursement models or through selective contracting for services.

3. ***Fund a demonstration project to evaluate the impact of a comprehensive workplace improvement incentive program.***

We recommend that the Commonwealth consider funding a statewide demonstration project building on the special licensure designation model that is currently being tested in North Carolina across the continuum of long-term care provider organizations. The Commonwealth could implement a demonstration project that is administered centrally with geographic-based collaboratives as the operating units. A thorough and independent evaluation should be included.

4. ***Create and support a cadre of peer mentors for organizations undertaking workplace redesign.***

The improvements in retention identified in the provider survey, most notably in the nursing home sector, indicate that there are some provider organizations who have mastered the management of change processes needed to improve the work and workplace of direct care workers. Individuals from these settings should be supported to consult as peer mentors to other managers and direct care workers, perhaps administered through the auspices of regional collaboratives (resembling the more advanced regional partners in the PA BJBC demonstration).

5. ***Support evidence-based practices in improving pay, benefits and supervision through a series of well-organized, one-day, high-impact conferences.***

We recommend that the Commonwealth sponsor a conference that brings together experts in compensation policy, benefits policy and administration, policy-makers and key stakeholder groups to produce a position paper that addresses the following:

- What is the relationship between starting wages and recruitment in the human service sector?
- What wage structures support increased retention of the most qualified direct care workers?
- What is the relationship between munificence of benefits packages and recruitment in the human service sector?
- What benefits structures support increased retention of the most qualified direct care workers?

We recommend that the Commonwealth sponsor a conference that brings together experts in supervision of direct care workers, policy-makers and key stakeholder groups to produce a position paper that addresses the following:

- What are the alternative models of supervision that appear to be most successful in supporting recruitment and retention in community-based and institution-based care settings?
- What are the reasons why home care workers report greater satisfaction with supervision than do other direct care workers?
- What are the needs of consumers and direct care workers regarding communication, negotiation and supervisory relationships in consumer-based care?

6. ***Support a social marketing campaign on behalf of direct care careers.***

The relevant Commonwealth agencies should solicit the development of direct care career promotional materials that could include television ads, billboards, and interactive software to distribute to high school counseling offices. There is much that is positive about the direct care workers' perceptions of their jobs and their employers as reported in the 2004 survey of direct care workers.

7. ***Provide infrastructure for a database on the direct care work force in PA.***

The problem of providing adequate levels of care for Pennsylvania's aging and disabled populations is just beginning to present itself. Recruiting qualified individuals to fill the more than 10,000 vacancies that currently exist in home care, personal care, nursing homes and adult day centers is a major challenge. The vacancy estimate does not account for the number needed to fill the demand for consumer-directed in-home care, though the evidence shown here is that the recruitment problem is similar with this model. The magnitude of this service demand is not understood because the state has very little information about

these caregivers and their consumers/employers. Indeed, it is not even clear how many people are receiving and providing care in this model given that several waiver programs are currently operating somewhat separately.

We recommend that the Commonwealth require all organizations providing long-term care or supportive services through state-funded or administered programs contribute data on a periodic basis on the hiring and termination of direct care workers. An Excel-based management information system that inputs such data from providers and provides quarterly benchmarking reports to them on their comparative turnover statistics is currently operating at the Penn State University Survey Research Center for those organizations participating in the five state demonstration projects funded under the Better Jobs Better Care Initiative (funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies). Expansion of this system to include all PA providers (including the consumer-based intermediaries) would be a cost-effective approach.

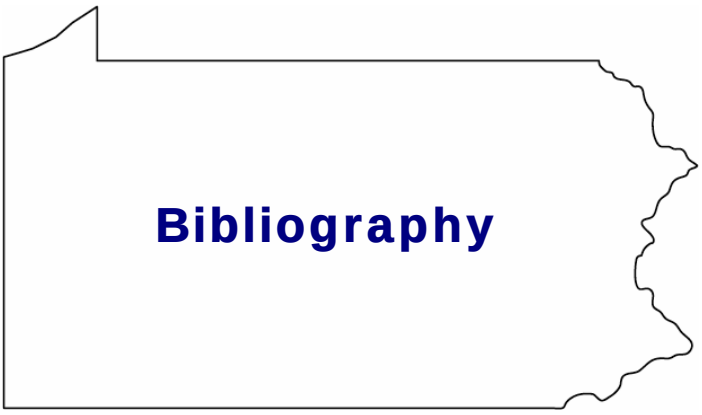
8. ***Successful consumers in the consumer-directed care model should be encouraged to share their insights about direct care worker management with others who are less experienced with the model.***

The selected sample of participants in the consumer-directed model who responded to the mail survey appear to be highly "activated" as consumers of health services, and yet few provide performance feedback on a regular basis and most report no explicit training in management skills related to effective communication. Successful, long-time consumers of consumer-directed care could be enlisted to share their insights about how to effectively manage direct care workers with others who are new to the consumer-directed care model.

The Centers for Independent Living are appropriate venues through which the Commonwealth could provide additional resources to encourage consumers to conduct more performance appraisals of their direct care workers.

9. ***Develop a strategic plan for the long-term care workforce to address the state's service needs for the coming decade.***

The problems and opportunities summarized in these recommendations require active collaboration among several state agencies and many constituent groups and will, in some cases, require legislative action. A plan that articulates short, mid-range and long-term goals is needed to serve as a blueprint against which to measure progress and provide direction.



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