Paraprofessional Staffing Study

Presented by:

The Staffing Study Steering Committee

Presented to:

The Vermont Department of Aging and Disabilities

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Introduction

In Vermont, as elsewhere in the nation, the need for paraprofessionals to provide personal assistance services is increasing as the number of elders and persons with disabilities grows. The Vermont Department of Aging and Disabilities established a Steering Committee to develop an action plan for creating "a stable, valued, and adequately reimbursed workforce to provide quality care for individuals and families."

The Steering Committee began by gathering data, and then developed recommendations based on that data. Data gathering was focused on personal assistance services provided by Personal Care Attendants (PCAs) and Licensed Nursing Assistants (LNAs) working in home health and nursing home settings. Data was gathered to address the following questions:

1. Demand for services: What is the need for personal assistance services at present, and projected in the next 5 and 10 years?

2. Labor force: What are the demographics of Vermont's workforce and current LNA and PCA workforce? What are competing employment sectors?

3. Recruitment and retention:
    a. What motivates a person to choose employment providing personal assistance?
    b. What keeps PCAs and LNAs motivated to come to work each day?
    c. What are the barriers to retention?
    d. What solutions might address these issues?

4. Best Practices: What can we learn from around Vermont and the nation?

The following report outlines results for each of these questions, and concludes with the Steering Committees recommendations.

Demand for Services

Vermont, as the rest of the nation, will see a significant growth in the number of persons age 65 and older over the next 25 years. U.S. Census Bureau estimates suggest that the present Vermont elder population of 73,000 will grow to 101,000 in 2015, and to 138,000 in 2025[1]. Meanwhile, these same estimates indicate that the number of persons age 18 to 64 will remain stable, with little or no increase in numbers.

1 U.S. Census Bureau, *Population Estimates*, March 9, 2000.

A variety of sources were used to determine the demand for services among this projected population of elders and persons of all ages with disabilities. A full report outlining this effort is presented in Appendix A. Taken together, we estimate that at present there are between 3,000 and 5,000 Vermonters receiving paid personal assistance services. These figures increase by about 500 persons in five years, and another 1,000 to 1,500 in the following five years. That is, by the year 2015, the number of persons needing paid personal assistance services may be from 4,500 to 7,000. Thus, in the next 15 years, the demand for services is likely to grow by 40% to 50%.

Labor Force

While the demand for services may grow up to 50%, national estimates suggest that the labor force will increase by only 12% over all age groups (see Appendix A for more details). The cohort of workers age 55 years and older will grow by 48%, while the cohort of workers 25 to 54 years of age will only grow by 12%.

Survey data gathered from Vermont LNAs and PCAs (see Appendix B), indicates that the majority of this current workforce are women over age 35 (35% age 36 to 50; 25% age 51 to 65). On average, LNAs were 40 years of age, while PCAs were 47 years of age. Most of these workers had high school diplomas or GEDs. While nearly 25% had attended some college, there were few workers with college degrees.

The majority of the PCAs surveyed (83%) worked in client's homes, while the majority of LNAs surveyed (68%) worked in nursing homes. Only about a quarter of the PCAs (28%) worked full time as PCAs, while most of the LNAs (74%) were full time LNAs. Overall, LNAs tended to have been in their current positions an average of 6 years, while PCAs had been in their present positions an average of 4 years.

Taken together, these data suggest that the LNA workforce is more likely to be younger, full time workers employed by nursing homes, while the PCA workforce is more likely to be slightly older, part time workers, employed by home health agencies or directly by clients. Workers in both groups are likely to have a high school education.

Many employment sectors compete for female workers with high school education, particularly those in the service industries. In 1999, home health aides' median wages were $8.08 per hour ($16,810 annual median) and personal care aides earned a median of $6.68 an hour ($13,900 annual median)2 (LNA wages were not listed separately). The Vermont Assembly of Home Health Agencies report the following wages as of October 2000: weighted actual average wages

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2 Vermont Statewide Occupational Wages, published December 2000, Vermont Department of Employment and Training.

for LNAs was $9.21 per hour and for PCAs was $7.57 per hour.

A recent North Carolina study found that active nurse aides earned an annual income of $11,358 compared to an annual median of $14,425 for inactive aides, that is aides who had found other types of employment. Moreover, active aides worked for an average of 1.89 employers a year, while inactive aides worked for 1.05 employers3.

According to Vermont Department of Employment and Training 1999 data, employment categories with comparable wages include:

OCCUPATIONAL TITLE	EMPLOYMENT	MEAN	MEDIAN	ANN MEDIAN
Bus drivers, transit and intercity	310	$ 9.69	$ 9.64	$ 20,050
Child care workers	1860	$ 7.53	$ 7.12	$ 14,810
Cleaners of vehicles and equipment	560	$ 8.12	$ 7.82	$ 16,260
Cooks, fast food	1960	$ 7.52	$ 6.75	$ 14,040
Cooks, short order	390	$ 7.77	$ 7.53	$ 15,670
Counter attendants, cafeteria, food concession, and coffee shop	840	$ 6.92	$ 6.59	$ 13,710
Couriers and messengers	170	$ 7.65	$ 6.09	$ 12,670
Dishwashers	1370	$ 7.26	$ 7.10	$ 14,760
Food preparation workers	2960	$ 7.35	$ 6.95	$ 14,460
Home health aides	1400	$ 8.24	$ 8.08	$ 16,810
Janitors and cleaners, except maids and housekeeping cleaners	4870	$ 8.94	$ 8.31	$ 17,290
Laundry and dry-cleaning workers	320	$ 8.04	$ 7.82	$ 16,260
Maids and housekeeping cleaners	2600	$ 7.42	$ 7.20	$ 14,970
Nonfarm animal caretakers	420	$ 8.19	$ 7.71	$ 16,040
Nursing aides, orderlies, and attendants	2430	$ 8.46	$ 8.21	$ 17,080
Personal and home care aides	290	$ 7.22	$ 6.68	$ 13,900
Personal care and service workers, all other	110	$ 8.67	$ 8.68	$ 18,050
Physical therapist assistants	120	$12.55	$12.44	$ 25,860
Protective service workers, all other	90	$ 9.13	$ 7.43	$ 15,450
Recreation workers	1020	$ 8.82	$ 7.94	$ 16,520
Service station attendants	330	$ 7.45	$ 7.28	$ 15,140
Social and human service assistants	1070	$11.90	$11.98	$ 24,920
Taxi drivers and chauffeurs	430	$ 7.13	$ 6.67	$ 13,880
Veterinary assistants and laboratory animal caretakers	160	$ 8.54	$ 7.80	$ 16,220

Recruitment and Retention

Staffing shortages and high turnover have the potential of impacting both the quality of care as well as the availability of care for home health clients and nursing home residents. For example, in a study of nursing homes, Dresser, Lange, and Sirkus (1999)4 found that low turnover and

3 Thomas R. Konrad (2000). *Where have all the nurse aides gone*? North Carolina Institute on Aging.
4 L. Dress, D. Lange, & A. Sirkus (1999) *Improving Retention of Frontline Caregivers in Dane County*.

high retention rates were associated with higher quality of care (as measured by Federal regulation deficiencies, pressure sores, and number of complaints).

To better understand factors contributing to recruitment and retention, we began with a series of focus groups. PCAs, LNAs, consumers, and administrators responsible for hiring and supervision from around the state were asked a series of questions regarding recruitment and retention issues (see Appendix C for a complete report). Based on results from the focus groups, we developed surveys for these same four groups (see Appendix B). Results from the surveys and focus groups were then used to address the following issues regarding recruitment and retention.

What motivates a person to choose employment providing personal assistance?

The primary reason people choose to serve as PCAs or LNAs is their desire to help and care for others. While nearly half of the LNAs (42%) were also motivated by a desire to use the position as a step toward another health care career, few PCAs (12%) had a similar motivation. Although administrators (68%) and consumers (59%) often felt a primary motivation was the need for a job, far fewer PCAs (34%) and LNAs (28%) identified this as an important motivational factor. A majority of PCAs (61%) and nearly half of the LNAs (42%) identified a convenient location or flexible work hours as key motivators.

What keeps PCAs and LNAs motivated to come to work each day?

Focus group and survey results showed that the main motivational factors were the rewards for caring for others; knowledge that the work is important; and, respect and caring from clients. While half of the administrators (53%) and nearly half of the consumers (44%) thought that need for the job was one of the most important reasons PCA's and LNA's went to work each day, only 21% of PCAs and 16% of LNAs felt this was one of their most important reasons. One third of PCAs (32%) cited flexible work hours as a key factor, however only 12% of LNAs cited this factor. While focus group respondents often spoke about the need for support and recognition, very few LNA or PCA survey respondents identified supervisor's support and recognition as a motivational factor.

What are barriers to retention?

1. Compensation: Low wages were cited by all focus groups and survey participants as a key area of concern. While PCAs and LNAs were relatively satisfied with most aspects of their work, both groups expressed dissatisfaction with current wages. PCAs felt an increase to $9.60 per hour would represent a fair wage, while LNAs felt an average of $11.00 an hour was a fair wage. PCAs often reported not receiving any benefits, and said they most need paid vacation, paid sick leave, and health insurance benefits (in that order). LNAs were generally satisfied with the benefits they receive, but also felt paid

leave and affordable health insurance were very important. Finally, PCAs providing home health care reported that help with transportation was important.

2. Working Conditions: Understaffing was often cited as a problem by focus group participants. While this issue was not directly addressed in the survey, LNAs reported less satisfaction with the time they had to spend with clients than did PCAs. Indeed, this was one of the few areas of dissatisfaction for LNAs. Survey respondents were relatively satisfied with the hours they were expected to work, but felt extra pay for longer hours and off times (i.e., evenings or weekends) was important. Focus group participants emphasized the importance of consistent, predictable hours (and therefore, income). The consumer focus group also emphasized the importance of consistency and the need for a limited number of caregivers for any one client.
3. Staff support and development: Focus group participants cited management communication and support of workers as a key issue for their job satisfaction. Among survey respondents, these issues were more likely to be cited by LNAs than PCAs. LNAs were less satisfied with treatment by supervisors than PCAs; however, many PCAs said they had no supervision. (PCAs often work for family members.) Focus group participants spoke of the value of good orientation and training experiences, particularly training that was grounded in actual work conditions and expectations. About 20% of survey respondents cited training opportunities as important. LNAs working in nursing homes, and PCAs employed by home health agencies, expressed the most interest in training and development.

4. Worker's issues: Focus group participants identified key barriers to retention as arising from competing demands on their time from family needs, transportation issues, and the need to work multiple jobs given their low wages. Among survey respondents, more PCAs than LNAs felt assistance with transportation was important. Few respondents in either group felt child care assistance was important. Respondents who did identify child care assistance as important were much younger than those who did not. Employee loan programs and support with emotional issues also garnered little interest among survey respondents.

What solutions address these issues?

Improved compensation clearly stands out as an important solution. Improved compensation includes increase wages and benefits, as well as extra pay for shift work, assistance with transportation costs, and consistent work hours. Improved recruitment and retention will also address issues raised by staff shortages, including adequate time with residents and clients. As outlined below, best practices throughout the nation offer a number of specific strategies.

Best Practices

As part of the Steering Committee's information gathering, a survey of best practices throughout

the nation was conducted. A review of information gathered through this survey is included in Appendix D. A summary of findings is outlined below.

1. Recruitment and marketing strategies: To improve recruitment and marketing, it is important to improve the quality and compensation of jobs, including opportunities for advancement within PCA and LNA positions. Improved screening, orientation, and training all contribute to better retention. Finally, many efforts have been directed toward expanding the pool of possible workers (e.g., teamwork with workforce development efforts).

2. Compensation: Many states have sought to increase wages through pass-through strategies. Some states have targeted wage increases for shift differentials, career ladders, and performance. Home health agencies have worked to provide guaranteed hours for predictable income and reimbursement for travel and travel time. Many agencies provide paid time off and affordable health care benefits.
3. Working Conditions: Improved working conditions focus on staffing ratios, consistent and flexible scheduling, and permanent assignments. In addition, many agencies and institutions have focused on developing a team work approach, including workers in care planning, and even scheduling. Best practices include opportunities for growth, recognition, and respect within each position. Other strategies have included attention to improved job safety, reduction of reporting burdens, and development of family friendly policies. Support for workers has been provided through management practices as well as development of caregiver associations.

4. Orientation and training: Real-life experiences are being incorporated into training programs, sometimes through apprenticeships or job shadowing. Other training programs have been expanded to include problem solving and communication skills, as well as specific areas of high stress (e.g., death and dying). Well-defined and consistent orientation programs are cited as important to retention. Some agencies are experimenting with training across care settings to enable workers to serve in both home health and nursing homes. Finally, many agencies have developed mentorship programs providing opportunities for development among experienced workers and support for new workers.

5. Career Ladders: Several efforts have been initiated to develop new job levels within positions such as LNA and PCA. These new levels recognize and require advanced skills and training, and provide increased compensation for each advancement.

6. Supervision and Management: Management staff have been provided with specific training in leadership and supervision skills. Agencies have promoted more inclusive management styles, staff meetings that include all staff, and case conferencing that includes paraprofessionals. Some agencies have developed formal strategies to recognize effective work and demonstrate respect and value for workers. The focus is on coaching and developing strong, respectful relationships between management and workers.

Recommendations

Based on its review of data from Vermont and across the nation, the Steering Committee makes the following recommendations to address PCA and LNA staffing shortages in home health care and nursing homes.

Expand pool of possible workers:

Multiple strategies will be needed to expand the pool of possible workers. It is important that any effort to identify new workers attend to skills needed by PCAs and LNAs. These strategies may include:

1. Explore work force development initiatives. In each region of Vermont, communities are working to develop economic opportunities through federally funded work force development projects. There may be useful partnerships to be found with these existing efforts.

2. Establish partnerships with a range of social service providers and educational institutions. Partnerships could develop with a range of social service providers (e.g., Community Action Agencies, Area Agencies on Aging, shelters) working with persons changing careers, entering or re-entering the work force. In addition, it would be helpful to establish links with high school and college educators to tap into potential student interest in employment. Efforts to recruit older workers would also be important. It would be important for referral sources to understand the criteria for PCA and LNA candidates well enough to provide good referrals.

3. Develop marketing materials to describe the positive features of paraprofessional care. These materials would focus on PCA and LNA positions as important and valued, and the rewards gained by caring for others. Collaborate with other comprehensive statewide marketing campaign plans and activities focused on marketing all health care careers to ensure coordination between a campaign promoting PCAs and LNAs and a campaign promoting other health professions.

Improve Wages

The Department of Aging and Disabilities (DA&D) should seek ways to ensure that all persons working as PCAs and LNAs earn a liveable wage. Over the coming year, specific strategies will be developed to meet this goal. Some possible approaches include:

1. Increasing public awareness about value of personal assistance services. Education should focus on the crucial roles PCAs and LNAs serve, and the importance of personal assistance in providing quality health care. Education should also address PCA and LNA relatively low wages and the funding issues which contribute to those low wages.

2. Continuing to use reimbursement mechanisms to increase wages wherever possible. Vermont currently uses provider taxes that are designated for wage increases for nursing homes and made available for wage increases for home health agencies. This approach is limited because of the federal cap of provider taxes. To bring wages into a competitive or livable range, other strategies will need to be explored.

3. Continue to use wage increases for shift differentials . DA&D should examine the use of wage differentials for the Consumer/Surrogate Directed Waiver and Attendant Services Programs.

4. Examine ways to provide guaranteed hours of work to achieve predictable income. For example, agencies might create staffing pools to enable employees to work across agencies or nursing homes. In addition, reimbursement rules might be revised to enable agencies to bill for scheduled client time, even if the client was not home when the worker arrived.

Provide Benefits

Possible strategies to provide benefits include:

1. Ensure that low income workers have access to health insurance via VHAP[5] and child care through TANF[6]. Employers should work to ensure that employees are aware of the resources and how to access them.

2. Explore the creation of a collective purchasing pool among providers to purchase health insurance for employees. Nursing homes and home health agencies may be able to reduce insurance costs through pooled purchasing.

3. Seek strategies to provide workers with vacation and sick leave, as well as retirement benefits. Since the majority of PCAs are part time workers, and one quarter of LNAs are part time workers, it is important to develop approaches that provide part time workers with pro-rated benefits.

4. Explore policy changes that would allow workers to maintain public benefits while working. This issue should be examined thoroughly to better understand the barriers and recommend changes in policy that will enable workers to continue to receive VHAP, subsidized housing, and/or child care assistance even if wages are increased slightly.

5. Continue to reimburse home care workers for travel and travel time, and explore ways to help home health workers cover transportation costs. Transportation assistance could include agency owned vehicles for use when employee's cars were not working or funds to assist with vehicle repairs and maintenance.

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5 VHAP is the Vermont Health Access Plan which provides medical insurance to Vermonters with qualifying incomes.

6 TANF is Temporary Aid to Needy Families, the new form of income assistance which replaced ANFC through welfare reform.

Improve Working Conditions

Specific strategies which may help improve working conditions include:

1. Explore the impact of staffing ratios. Examine the impact of staffing ratios on work demands, job satisfaction, and workers' ability to provide high quality of care.

2. Develop mechanisms to ensure consistent and flexible scheduling. In other states, some agencies use a unit or team based approach to self-scheduling.

3. Promote continuity in care. Continuity provides caregivers and clients/residents with an opportunity to establish good working relationships. Strategies may include permanent assignments or core teams for groups of clients.

4. Promote caregiver involvement in care planning. PCAs and LNAs work most closely with clients and residents, giving them useful information for care planning. Moreover, these caregivers want that knowledge to be used and respected.

5. Develop strategies to provide recognition, status and respect for paraprofessionals. Recognition can include anything from personalized business cards to formal recognition events, to use of workers' knowledge and expertise.

6. Develop caregiver associations to provide information and support. For example, workers might be supported in joining the National Association of Geriatric Nursing Assistants, or helped to develop their own Vermont based organizations.

7. Promote caregiver autonomy and responsibility. Workers feel valued and respected when given opportunities to work independently and to take on increasing amounts of responsibility as their skills improve.

Provide thorough orientation and opportunities for training

Based on the review of best practices and focus group data, the following strategies should be explored:

1. Work with the State Board of Nursing to review LNA training curriculum. A review should address issues such as including more "real life" experiences in training, as well as training to promote problem solving and communication skills.

2. Provide opportunities for apprenticeships and job shadowing. Working with referral sources, potential employees should be given opportunities to explore personal assistance service to gain hands on knowledge of the work.

3. Develop programs to interest youth in health careers (e.g., Daring to Care). Nursing homes and home health care agencies can work with educators to develop apprenticeship or employment programs that give youth an opportunity to explore personal assistance employment.

4. Provide continuing educational opportunities which nurture growth. For example, in service and continuing education courses could be offered which enable LNAs and PCAs to build skills and competencies in specific areas of care (e.g., use of technology).

5. Provide training on how to deal with difficult issues. For example, training could be developed on how to deal with behavioral problems, death and dying, family dynamics, or other issues which caregivers may

find challenging.

6. Provide training across care settings to allow cross over between nursing homes and home health care. Training caregivers to work across settings would make it possible for home health agencies and nursing homes to establish employee pools.

7. Develop mentorship programs. Mentorship programs should have specific training for mentors, defined objectives and skills, and an evaluation mechanism.

8. Provide scholarships and loan forgiveness programs. Financial assistance for needed training may help expand the pool of potential workers.

Develop Career Ladders

Creating career ladders would involve:

1. Create new job levels within the PCA or LNA professions, which recognize and require advanced skills and experience. Provide training through structured curriculum for each job level. Use objective criteria and an evaluation process to determine progress to each level.

2. Develop reimbursement strategies that enable agencies to create new job levels with increased wages and leadership opportunities at each level. With each increase in job level, there should be an increase in wages as well as responsibilities.

3. Expand opportunities for workers who may not be able to do physically difficult aspects of personal assistance (e.g., lifting, transferring). In developing career ladders, positions could be created for workers (e.g., older persons, PCAs or LNAs with back injuries) to provide elements of care that do not require physical strength.

G. Strengthen supervision and management

Some specific strategies would include:

1. Training in leadership and management for supervisors of LNAs and PCAs. Supervisors should be assisted in developing skills for creating strong and respectful relationships with caregivers.

2. Promote use of inclusive management styles. For example, management might use a team approach to ensure employee involvement in decision making.

3. Promote inclusion of paraprofessionals in care planning. As cited above, LNAs and PCAs often have the most detailed information about clients and residents. It is important to use that knowledge in care planning, and recognition of that expertise is a concrete way of showing respect for caregivers.

4. Promote the use of a coaching and problem solving approach to management. Workers respond positively to supervision that nurtures strengths and assists with improvement in areas of weakness.

Continue work of Paraprofessional Staffing Task Force

Continued work is needed to examine strategies and seek methods for implementation. Membership of the Steering Committee should be expanded to include LNAs and PCAs and more consumers.

Paraprofessional Staffing Study
Demand for Services and Labor Force Supply

August 21, 2000

1. Population (estimated number of Vermonters from which to project service demand):

   1. Most recent estimates (as of July 1, 1999) of the number of Vermonters (*source: U.S. Census Bureau, Population Estimates, March 9, 2000*)

Teens 15 to 19 years	43,814
Adults 20 to 64 years:	364,209
Adults 65 and over:	72,916

   2. Projections of Vermont adult population from 1995 to 2025:

Table 1: Estimated Number of Adult Vermonters on July 1

Age group	**1995**	**2000**	**2005**	**2015**	**2025**
18 to 24 yrs	54,000	58,000	62,000	58,000	55,000
25 to 64 yrs	313,000	334,000	349,000	358,000	340,000
65 + yrs	71,000	73,000	77,000	101,000	138,000

(*source: U.S. Census Bureau, Population Projections: 1995 to 2025, March 20, 1999*)

2. Level of disability (various sources of national data indicating the degree to which persons with disabilities and elders need and use personal assistance services):

1. The U.S. Census Survey of Income and Program Participation provides national data representing the current need for personal assistance with one or more Activities of Daily Living (ADLs) (i.e., getting around inside home, in & out of bed or chair, bathing, dressing, eating, using toilet) or Instrumental Activities of Daily Living (IADLs) (i.e., going outside home, keeping track of money and bills, preparing meals, light housework, taking prescribed medicines, using telephone)

Table 2: Americans with Disabilities:
Disability Status of Persons 15 years old and over: 1994-1995

	Number	**Percent**
Adults age 15 to 64		
Need personal assistance with one or more ADL	1,587,000	0.9%
Need personal assistance with one or more IADL	4,057,000	2.4%
Need personal assistance with one or more ADL or IADL	4,347,000	2.5%
Adults age 65 and over		
Need personal assistance with one or more ADL	2,219,000	7.1%
Need personal assistance with one or more IADL	4,929,000	15.8%
Need personal assistance with one or more ADL or IADL	5,126,000	16.4%

(*source: U.S. Census Bureau, Survey of Income and Program Participation, 1994-1995*)

2. The U.S. Department of Health and Human Services National Health Interview Survey provides national data on the proportion of adults 65 and older (not living in institutions) reporting problems with two or more ADLs (i.e., bathing, dressing, eating, transferring between bed & chair, toileting, and getting around inside the home)

Table 3: Persons 65 years and over reporting
Problems with Two or More ADLs: 1994-1995

Age Group	**Total Population**	**Number w/ ADL need**	**Percent**
65 to 74 years	18,355,635	576,320	3.1%
75 to 84 years	10,194,079	796,892	7.8%
85 + years	2,695,594	488,909	18.1%
65 + years	31,245,307	1,862,121	6.0%

(*source: 1994-1995 National Health Interview Survey on Disability (Phase I)*)

3. The National Long-Term Care Survey provides national data on the prevalence of chronic disability and institutionalization among persons 65 and older enrolled in Medicare.

Table 4: Disability and Residential Status of People 65 years and over
(number in thousands)

Disability Level	**1982**		**1989**		**1994**	
	Number	Percent	Number	Percent	Number	Percent
Non-disabled	20,537	76.3%	23,866	77.3%	26,136	78.9%
Community disabled	4,854	18.0%	5,321	17.2%	5,296	16.0%
IADL only	1,837	6.8%	1,808	5.9%	1,781	5.4%
1 ADL	1,145	4.3%	1,325	4.3%	1,300	3.9%
2 ADLs	583	2.2%	781	2.5%	803	2.4%
3 + ADLs	1,291	4.8%	1,407	4.6%	1,412	4.3%
Institutional residents	1,532	5.7%	1,685	5.5%	1,693	5.1%
Total Population	26,924	100%	30,871	100%	33,125	100%

(*source: Korbin Liu, Kenneth Manton, and Cynthia Aragon (2000) Changes in Home Care Use by Older People with Disabilities: 1982 - 1994, AARP Public Policy Institute*)

4. Proportion of the population living in nursing homes:

1997: 4.7% of Vermonters 65 and over reside in nursing homes (*source*: *The Social Well Being of Vermonters 1999, Agency of Human Services*)

1999: More than half of Vermont nursing home residents are 85 years or older

Table 5: Nursing Home Residents Vermont.

Resident Age	**Number**	**Percent of Residents**
under 65 years	253	5%
65 to 74 years	480	10%
75 to 84 years	1,530	32%
85 + years	2,597	53%

(*source: Vermont Department of Aging and Disability, July 20, 2000*)

C. Personal Assistance Services Demand (calculating the level of demand for personal assistance services based on population estimates and levels of need):

1. Recent research indicates that disability rates appear to be on the rise among the working-age population[7], while the rates seem to be on the decline among elders[8]. If we look specifically at the proportion of persons needing personal assistance, rates for elders appear to be declining slightly (see Table 4, and Figure 1) Rates for working-age persons increased during the early 90's and may be leveling out (see Figure 1).

Figure 1: Proportion of U.S. Population Needing Personal Assistance
National Health Interview Survey: 1983 - 1994

[7] H. S. Kaye, M. P. LaPlante, D. Calrson, and B. L. Wenger (1996) *Trends in Disability Rates in the United States, 1970 1994*. U.S. Department of Education, National Institute on Disability and Rehabilitation Research (Abstract 17)

[8] R. Woodbury (March 1999) *The Declining Disability of Older Americans*, Research Highlights in the Demography and Economics of Aging, National Institute on Aging.. and, T. Waidmann and K. Manton (1998) *International Evidence on Disability Trends among the Elderly*

2. To calculate the number of Vermonters needing personal assistance services, we can multiply population estimates by rate of need for services. The U.S. Census Survey of Income and Program Participation (SIPP) data provide one estimate of the need for services among persons 15 years and over. The National Long-Term Care Survey (NLTCS) provides an additional estimate for persons 65 or older.

Table 6: Projected Number of Vermonters Needing Personal Assistance

	Percent	Projected Numbers		
Adults age 15 to 64 (SIPP)	**of Pop.**	**2000**	**2005**	**2015**
1+ ADL	0.9%	3,528	3,699	3,744
1+ IADL	2.4%	9.408	9,864	9,984
1+ ADL or IADL	2.5%	9,800	10,275	10,400
Adults age 65 and over (SIPP)				
1+ ADL	7.1%	5,041	5,467	7,171
1+ IADL	15.8%	11,218	12,166	15,958
1+ ADL or IADL	16.4%	11,644	12,628	16,564
Adults age 65 and over (NLTCS)				
IADL only	5.4%	3,942	4,158	5,454
1 ADL	3.9%	2,847	3,003	3,939
2 ADL	2.4%	1,752	1,848	2,424
3+ ADLs	4.3%	3,139	3,311	4,343
ADL and IADL (total of IADL/ADL grps)	16.0%	11,680	12,320	16,160
Instutitional resident	5.1%	3,723	3,927	5,151

3. Persons in need of personal assistance receive that assistance from various family members (spouse, children, parents), non-family members, or paid helpers. The proportion of persons who receive their assistance from paid helpers may help us more closely estimate the need for paid staff such as LNAs and PCAs. Table 7 presents the NLTCS data, while Table 8 provides SIPP data.

Table 7: Receipt of Personal Assistance Services for Persons 65 and over by Source of Assistance, 1994

Disability Level	**IADL only**	**One ADL**	**Two ADLs**	**3+ ADLs**
Only paid helpers	9.5%	10.7%	7.3%	3.8%
Only unpaid helpers	78.3%	64.9%	62.8%	50.0%
Both paid and unpaid helpers	12.2%	24.4%	30.0%	46.2%

(*source: National Long Term Care Survey, 1994*)

Table 8: Receipt of Personal Assistance Services by Source of Assistance: 1994-1995

	Persons receiving assistance with ADLs or IADLs		Persons receiving assistance with ADLs	
Age Group	Number	Percent	Number	Percent
15 to 64 years				
First Helper (total)	4297	100%	1575	100%
Relative	3579	83%	1359	86%
Non-relative	550	13%	149	9%
Paid help	168	4%	67	4%
Second Helper (total)	1269	100%	607	100%
Relative	969	76%	460	76%
Non-relative	221	17%	93	15%
Paid help	79	6%	54	9%
65 years +				
First Helper (total)	5046	100%	2202	100%
Relative	3952	78%	1746	79%
Non-relative	468	9%	151	7%
Paid help	626	12%	305	14%
Second Helper (total)	1636	100%	938	100%
Relative	1019	62%	557	59%
Non-relative	223	14%	130	14%
Paid help	394	24%	251	27%

(*source: U.S. Census Survey of Income and Program Participation, 1994-1995*)

4. We can take these data to another level of projection by multiplying the proportion of persons receiving paid help by the projected number of persons needing personal assistance services. This level of projection, of course, must be considered with caution as it is several steps out from concrete numbers, and relies on national figures to make statewide estimates. Nevertheless, it may provide a useful tool in estimating the need for LNA and PCA positions.

   The projected figures in Table 9 are again based on SIPP and NLTCS data. For the SIPP data, the percent of persons receiving paid help as first and second helper were totaled to arrive at the percent of helpers (e.g., 15 to 64 year olds receiving paid help with ADLs was 4% for first helper + 9% for second helper = 11%). These percentages were then multiplied by the projected figures presented in Table 6.

Table 9: Projected Number of Vermonters Receiving Personal Care Assistance from Paid Helpers

Adults age 15 to 64 (SIPP data)	Percent Paid helpers	Projected Numbers 2000	2005	2015
1+ ADL	13.0%	388	407	412
1+ ADL or IADL	10.0%	980	1,028	1,040
Adults age 65 and over (SIPP data)				
1+ ADL	41.0%	2,067	2,241	2,940
1+ ADL or IADL	36.0%	4,192	4,546	5,963
Adults age 65 and over (NLTCS data)				
IADL only	12.2%	481	507	665
1 ADL	24.4%	695	733	961
2 ADL	30.0%	526	554	727
3+ ADLs	46.2%	1,444	1,530	2,006

5. Taken together, these data indicate that at present, there are between 5,000 (SIPP data) and 3,000 (NLTCS data) Vermonters receiving paid personal assistance services. These figures increase to by about 500 individuals in five years, and another 1,000 to 1,500 in the following five years. That is, by the year 2015, the number of persons receiving paid personal assistance services may be from 4,500 to 7,000.

D. Labor force (workforce supply to meet the demand for services):

1. The Bureau of Labor Statistics estimates that nationally there will be a 76% increase in the number of home health aide jobs from 1996 to 2006[9]. Vermont will see a 23% increase in the number of home health aides (from 1,650 in 1996 to 2,050 in 2006), with an average of 60 annual openings for home health aides.

   From 1990 to 1997, there was a 171% increase in the number of home health employees in Vermont, from 960 to 2,602[10] Vermont Department of Employment and Training data[11] indicate that there were 2,387 jobs in home health care services during the third quarter of 1999. This actually represents a 5.6% decrease from the year before.

   Data for nursing aides is less clear. The BLS data include nursing aides along with orderlies, and attendants. Together, BLS predicts a 26% increase in Vermont employment for these positions combined, from 2,800 in 1996 to 3,550 in 2006, with an average of 110 openings annually. Vermont DET data indicates that in the third quarter of 1999 there were 4,719 jobs in the nursing and personal care facilities. This figure is up 1.7% from one year before.

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[9] Bureau of Labor Statistics, Employment Projections, August 1998.

[10] Health Care Financing Administration, *A Profile of Medicare Home Health: Chart Book*, August, 1999. Publication No. HCFA-10138.

[11] *Vermont Labor Market Bulletin, Third Quarter, 1999*, March 2000

2. Current labor force data available through the Bureau of Labor Statistics (June 2, 2000) indicates that the current Vermont labor force is composed of 339,300 individuals, 331,000 of whom are currently employed. About 2% of this labor force were in home health care service or nursing and personal care facilities.

The Bureau of Labor Statistics provides projections for the national labor force. From 1998 to 2008, it is expected that the labor force will increase by 12.3%. The greatest increases will be among older workers (see Table 10).

Table 10: Percent Change in Workforce Numbers
1998 to 2008 (BLS, November 1999)

Age group	**Percent Change**
16 to 24 years	15.1%
25 to 54 years	5.5%
55 years and older	47.9%

Taken together, these data indicate that there may be around a 20% increase in the need for personal assistance service providers while the labor force will increase by 12%. The only category of workers who will increase significantly more than the need for LNAs and PCAs are adults 55 years and over. Data is needed on the current LNA and PCA workforce demographics to determine whether or not this older workforce is indeed the pool from which we might best expect to recruit LNAs and PCAs.

Paraprofessional Staffing Study

Focus Groups Summary

Presented to:

Paraprofessional Staffing Study Steering Committee
Vermont Department of Aging and Disabilities
Waterbury, Vermont

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INTRODUCTION

The Vermont Department of Aging and Disabilities has convened a Steering Committee to study the current staffing shortage in personal assistance services. The Steering Committee is charged with gathering information on this crisis in available care, and then develop recommendations for action.

As a first step in gathering needed information, focus groups were conducted to learn more about specific issues impacting the recruitment and retention of PCAs (personal care assistants) and LNAs (licensed nursing assistants). A total of five groups were held, one each with persons employed as LNAs and PCAs; another with nursing home and home health agency staff responsible for supervising LNAs and PCAs; another with consumers who hire their own personal assistance service providers; and, finally, a fifth group with high school students who are interested in health care careers.

Focus groups were held in different parts of the state: PCAs in Colchester, LNAs in Rutland, administrators in Randolph, consumers in Waterbury, and students in White River Junction. Each group had about 8 to 10 participants, with the exception of the consumer group which had 4 participants.

The following discussion summarizes information gathered through the focus groups. Information gathered from each group has been combined, both to identify overarching themes and to protect the confidentiality of focus group participants.

RECRUITMENT STRATEGIES

Participants in all focus groups agreed that the most successful recruitment strategy was word-of-mouth referrals from friends, family members, or peers. In some cases, PCAs and LNAs find out about the paid work opportunities by first helping a family member. Some agencies provide financial incentives for employees to refer a friend, others actively seek referrals on an informal basis.

While most focus group participants agreed that advertisements in local newspapers were minimally effective, some participants reported that ads including information about free training, or pay during training did generate good response. In some cases, workers learn of positions through the Department of Employment and Training (DET), Vermont Refugee Resettlement Program, and nursing schools.

Some organizations (primarily facility based programs) have had success working with high school training centers and guidance counselors to recruit high school students or graduating seniors. High school students reported that the best way to get information to them would be through speakers in their classrooms, directed mailings, internet communications (e.g, e-mail, chat rooms) or television advertising. These students said they would want to learn about the work and daily routines involved in being a PCA or LNA, as well as potential salaries and benefits. They wanted opportunities to shadow LNAs or PCAs. Students were particularly

interested in opportunities for training, career advancement, and scholarships.

High school students emphasized the importance of early exposure to these job opportunities. By senior year, they explained, students have often decided their career path. The students' teacher noted that it is difficult to find placements for junior level students since most facilities prefer working with the more mature senior level students. She also noted that while high school students are frequently not at all interested in working with elders, if they are given opportunities to develop relationships with elders, these attitudes generally change.

MOTIVATION TO PROVIDE PERSONAL ASSISTANCE

Members from all focus groups said that a key motivation was the desire to care for others. People doing this work like people and want work that allows them to do something meaningful. Some people enter these positions because of an interest in health care, frequently with an eye to career advancement. The position may serve as an entry into a health care career such as nursing.

Personal assistance positions provide needed employment, with minimal skills or prior training. For some persons, the positions fulfill Welfare to Work requirements. For others, the position provides a second job or helpful additional income for family. Training and the opportunity to clarify a specific employment goal motivate some workers. For example, one administrator noted that many of the workers in her facility have not had other employment experiences. They may be young people just out of high school or adults just entering the work force. These workers are not certain of their employment goals, and work as a PCA provides the opportunity to learn about career options, including training as a LNA.

Depending on the position, particularly when providing services to individuals in their own homes, hours are flexible and can match the needs of the worker. In all settings, the work may be close to home, making it more convenient and feasible to get to work. These issues were of particular important to workers with family responsibilities.

In the focus groups, we asked what keeps people coming to work each day as PCAs and LNAs. A variety of motivating factors were cited.

Most frequently, participants cited the opportunity to feel needed doing work that makes a noticeable difference in others lives.

> *Well there are things in life that you're good at and aren't, and that's one of the things I'm good at. I'm good at taking care of people, and I love doing it. I just keep going because it is something I can do.*

In a similar vein, participants mentioned the positive feedback PCAs and LNAs receive for the work they do, and the relationship developed with clients/patients.

> *Seeing their happiness and feeling their reaction to you because you have been there for them. I think that is the reward.*

It made her week for me to show up and just for her to have somebody to talk to and a distraction from her aches and pains and problems and that kind of thing. I think that for me, they appreciate that so much. It makes you feel like you're really making a difference in somebody's life.

A further reward often mentioned, was the ability to see clients or patients make progress (e.g., patients on rehabilitation unit going home, clients at home increasing their activities).

For LNAs and PCAs working in people's homes, the opportunity to be autonomous is a great motivator. These workers enjoy feeling like their own boss.

For many, it is important that the work have variety and challenges. For some, this means working with different clients, for others it means learning new skills and mastering technology. For example, some PCAs and LNAs said they enjoyed the challenges that came with working with new people all the time: learning their preferences, ways of communicating, and so one. For others, this was a difficult challenge, not a rewarding aspect of the job. Administrators talked about the excitement they saw when workers were given opportunities to learn new skills such as particular health care technology.

For some people, the job provides needed income or extra income. Although for others, the money is not the motivating factor.

If you need to make a living, this is not a thing to be doing. You couldn't make a living out of this. Nobody could live on it. You have to do it because you want to do it.

BARRIERS TO RETENTION

Compensation

When asked about barriers to continued employment as a PCA or LNA, top on the agenda for all participants was the issue of compensation. Low wages were mentioned in all contexts, and at many turns of the discussions. All participants agreed that PCAs and LNAs are not compensated enough for the work and responsibility they handle. Wages are not sufficient to support a family; so many PCAs and LNAs must hold more than one job to make ends meet. Additionally, there were many comments about the lack of benefits for most workers. Benefits of particular importance are health care insurance and vacation time. Attempts to recruit new employees with incentives and bonuses often backfired into resentment among long term workers who found themselves working for little more than their new peers. Long term workers want compensation and recognition for their longevity.

Working Conditions

Working conditions came second in the list of barriers. Under-staffing was identified as a key problem in retention. With insufficient staff, those who are working must carry bigger, more stressful loads, and often do not have time to provide the level of care needed. Workers are asked to put in more overtime, and to provide more services in less time.

What I'm hearing a lot, its one thing to come and do my hours that you've asked of me, but the amount that we've been asking lately for people to come in and pull an extra shift, please help out, we're short, we don't have the staff, its exhausting them...they have the dedication but they're saying I physically cannot do anymore.

....and that's what bothers me. I go home and I didn't do so and so's nails today. And you think about that when you're on your way home. Oh I didn't do this.

For many people, working weekends, early morning and late evening hours is difficult, while it suits others. Staff shortages mean pressing workers for whom such hours do not work into mandated schedules that do not meet their needs. Moreover, the work is physically demanding, and can result in injuries, particularly when workers are overextended.

The low wages in these positions contribute to a significant need for consistent, predictable number of paid hours each week. However, particularly in home health agencies, client needs vary and so too do the hours assigned to workers. For example, a worker who relies on 40 hours a week of paid labor to make ends meet may find herself with only 30 hours of paid work in one week, 35 hours in another. This inconsistency makes it impossible to rely on these wages to support oneself or a family.

A major cause of frustration, or satisfaction, expressed by focus group participants was the amount of time workers had to provide service, including sufficient time allotted for travel, completion of tasks, and lunch breaks. Most did not want to spend time on paperwork and found too much paperwork to be a drain on time they would prefer to spend delivering services. Some of these frustrations rose from staff shortages. For example, without sufficient staff it is difficult to get everyone on a unit up, dressed and ready for breakfast within a short period of time. Other time concerns arose from management. For example, PCAs reported having to travel perhaps 30 minutes from one client to the next, but the agency had not budgeted time for travel into the scheduling. Another concern was scheduling too many tasks into short time periods so that those tasks could not be completed with the level of care providers wished to extend, or without the opportunity for casual interactions and discussions that clients and workers often valued.

Staff Support and Development

There were several elements of PCA and LNA work that led to concerns about workers receiving adequate staff support and opportunities for development. For example, many participants discussed the challenges inherent in establishing new relationships between personal assistance providers and clients, especially if new clients do not want services. Safety issues for home based services were also raised from both provider and client perspectives. Consumers want to know that persons coming into their homes will not present any threat to their safety as much as providers want to know they will be safe entering client homes. These concerns may raise barriers to employment without staff support strategies that help staff and clients/patients establish relationships in an atmosphere of respect and safety.

In addition, participants emphasized the importance of people doing difficult and challenging work feeling recognized for the emotional challenges as well as supported in doing the work. Students, when asked what might make it difficult to work as a LNA or PCA, cited emotional issues most often. They felt it would be difficult to face death, witness pain, and deal with emotional attachment to patients/clients

...because it can't not affect you emotionally...you can't handle it all yourself...you need some support system somewhere and I would think that's even more so if it's a family member because there's added emotional issues.

Several participants talked about challenges present when establishing relationships between PCAs or LNAs and families. Family members may not have realistic expectations of what LNAs and PCAs can and cannot provide, either in home or facility based settings. Staff do not feel supported when management or administrative level staff have not clearly informed family members about what they can and cannot expect from PCAs or LNAs. For example, a PCA may visit a home and find the client's spouse expecting services. Or, a LNA may have to care for several individuals in a nursing home, and one resident's children cannot understand why their mother is not getting the level of attention they believed the facility offered.

Insufficient communication between workers and administrative staff may lead to various problems. For example, LNAs and PCAs report frustration in not being able to reach supervisory staff quickly to address problems as they arise. LNAs and PCAs need to feel that their experience is validated, their input valued, and management staff support them as they deal with demands from clients/patients and families.

We are always the first to take a cut. We're the first to be reprimanded. We're always the first to have to budget our time. Let them know exactly where we are. And we're the first to get yelled at.

And sometimes you feel like the bottom of the barrel and you're just the little peon that nobody really pays attention to.

...they make these great big promises and then they're not there when the families find that these promises aren't always fulfilled because of staffing issues or whatever. And who are they going to yell at? They're going to yell at us.

Worker's Issues

Finally, individual workers must deal with a range of personal issues that interfere with their ability to continue employment. Competing demands on limited time came up often in discussion. Family needs, including time with children, access to child care, and illness among family members, can interfere with the ability to come to work. Transportation was also a key issue. Wages in these positions are very low, and often barely enough to keep a car running reliably. Winter weather was often cited as having a significant impact on transportation, as has the increased cost of fuel. As already mentioned, the work is emotionally taxing and involving. Given the low wages, many workers are doing other jobs and filling in extra hours providing personal assistance. When they arrive to work, they may already be tired and stressed from their other employment.

RETENTION STRATEGIES

Focus group participants offered several suggestions for improving retention. Not surprisingly, the most frequent suggestion was to raise wages and provide benefits. In addition to health care insurance and time off for sick leave and vacation, a variety of other benefits were identified as attractive: training and educational opportunities, tuition reimbursement, inclusion of family members on health care policies, retirement accounts, and room and board for providers working in homes. There was also some discussion of financial incentives for extended or off hours.

Several participants felt the turnover rate was in part due to poor screening. They suggested improved screening by using physical exams and aptitude tests prior to training. Another strategy that some participants reported as successful was to hire new staff as PCAs and if there proved to be a good match, then the organization would provide LNA training.

A number of specific strategies were suggested toward making the work environment pleasant and relationships positive. For example, managers and supervisors operate with open door policies, are easy to reached, and know workers by name. Rather than punishing workers for inappropriate or inadequate conduct, the emphasis is on coaching employees toward doing their best work. Moreover, participants emphasized that it is important for workers to know their concerns are heard and taken seriously by management level staff.

> *I think everybody in management should have to go out in the field with us and do our jobs.*

PCAs and LNAs report feeling valued when their expertise and knowledge about individuals is seen as important. Strategies for ensuring these workers that their input is valued include PCA and LNA involvement in treatment teams, staff meetings with RNs, and care planning.

> *We become the friend and confidant, not the other people coming in from the agency. We know more about these people than anybody else does.*

A common theme in the focus groups was the fear that management staff were more focused on meeting the financial needs of the organization than on ensuring high quality patient care. For example, staff wanted sufficient time for home visits or with each patient to allow them to take the time needed to have conversations, attend to a special need, and in other ways provide caring and nurturing services. Workers were concerned that management level staff may promise more than the workers can deliver in order to generate needed business. They felt it very important that new clients and families have accurate information about the type and quantity of available services. Moreover, workers wanted management level staff support in being able to provide promised services. For example, if a PCA is to visit two clients in a morning, the second client should be scheduled late enough to allow the PCA to complete tasks for the first, and then travel to the second.

In order to help workers address life circumstances and responsibilities, which may impinge on work, employers provide several types of supports or flexibility. For example, workers may be offered flexible scheduling, which can accommodate their needs, including single parents with young children. Workers may be allowed to cash out vacation time when in financial crisis. Some organizations provide employee loan programs to assist with financial

emergencies. Others address transportation issues with loans for repairs, agency vehicles, reimbursement for bus fare or mileage, or subsidized auto insurance. Some facilities provide child care on site or assist in paying for child care. Several administrators reported success in establishing Employee Assistance Programs to provide confidential counseling.

PROPOSED STRUCTURAL OR POLICY SOLUTIONS

Many of the suggested strategies for improving recruitment and retention of PCAs and LNAs would require some level of structural or policy change in the care system. For example, several participants suggested rules changes to increase funding for PCAs and LNAs. There were some related discussions about the blurred lines between PCAs and LNAs, and suggestions that eliminating or clarifying the differences might help address the funding problem.

Consumers suggested that a pool of pre-screened PCAs be created so that one could go directly to the pool when seeking a PCA. The pool structure would include centralized recruitment and training, and a data base accessible to consumers or others seeking to hire PCAs.

Consumers also wanted to see expanded choices of home health agencies in each region of the state. They also suggested that individual consumers could pool care to provide workers with more hours, and consumers with more flexibility. For example, a group of three or four consumers could hire PCAs in common who would provide services to the group of consumers.

Current PCAs and LNAs, as well as students, wanted more opportunities for training, particularly shadowing experienced workers. Persons working in the field, in both home based and facility based care, felt that trainees need a better idea of what is really called for in doing the work and shadowing would provide that knowledge. Students, also, wanted to get a realistic idea of what the work entailed and favored shadowing as a strategy to do so. Another training strategy used by one agency is to train established staff to mentor and train new staff. This provides opportunities for longer term staff to build new skills while structuring in support for new staff. Such opportunities become part of a system that can support career planning that can include PCA or LNA as ultimate career goal.

Strategies for bringing in more workers were discussed. One idea was to work with businesses to recruit persons to provide personal assistance once a week to fill in the gaps. This would provide more of a volunteer opportunity for employees in other businesses.

Consumers suggested that wage differentials might also be useful. For example, assistants who serve as full-time care givers could receive one wage, including benefits and vacation time,while a higher wage could be offered to workers those filling in.

There were also suggestions for wider nets of recruitment, including workers from out of state, and even out of the country. Several participants suggested developing ways to recruit more men into the field. They felt that wages would improve if more men were in these positions.

CONCLUSIONS

Information gathered through the five focus groups provides insights into recruitment and retention issues for PCAs and LNAs.

Focus group participants identified word-of-mouth referrals as the most effective recruitment strategy. Additionally, participants noted that free or on the job training is another useful strategy. Information gathered about and from students suggests that a variety of strategies might be useful toward building interest in employment as a PCA or LNA.

A key motivational factor for persons working as PCAs and LNAs is the desire to care for others. This factor not only draws individuals into the work, but keeps them there. PCAs and LNAs enjoy being able to do useful work that makes a difference in people's lives. Many enjoy the opportunities to learn new skills and meet challenges.

The focus groups also revealed a range of barriers to retention. Compensation is a key issue. All participants agreed that wages were too low and benefits often non-existent. Compounding concerns with compensation, were difficulties caused by staff shortages and insufficient time to provide quality care. Workers were more likely to feel positively about their jobs when they received recognition and support from management, and had educational and training opportunities.

Focus group participants suggested a number of strategies toward improving recruitment and retention of PCAs and LNAs. These begin with increased wages and extension of benefits, and moved toward staff support and development. Additional proposals involve changes in structures and policies, such as changing the funding infrastructure and expanding training and education.

Issues identified in these focus groups have been incorporated into a set of survey instruments. The surveys, tailored for workers, administrators, and consumers, will be widely distributed. Results will be used to assess how degree to which issues raised by the focus groups represent the larger populations. Data from both focus groups and surveys will then be used by the Steering Committee toward developing recommendations for action.

The last word belongs to consumers who use the services of PCAs and LNAs. After all is said and done, these consumers were very clear that real, targeted action is needed to address the PCA and LNA staffing shortage.

> *This is a grassroots type thing. It'll blossom over time and what drives it is money. It's going to be money. We need money. They need money. And when you're talking about money then you got to get into government...and if you want to see the laws made and you want to be there to support your cause--you can't. Because the US Capitol is not equipped for handicapped people.*

Department of Aging and Disabilities
Paraprofessional Staffing Study
Notes on Best Practices
January 22, 2001

Defining the problem:

Demographic measures project increased demand for services, with decreasing supply of workers (currently positions filled primarily by women 25 to 54 years, this segment of the population is decreasing while LNA and PCA positions are among fastest growing) (refer to August 2000 report)

Economic factors contributing to staffing shortage:

Strong economy with low unemployment means competitive labor market. Workers can earn similar, or higher, wages with benefits at less stressful and difficult jobs. For example, North Carolina study (2000) found that active aides earned a median annual income of $11,358 compared to an annual median of $14,425 inactive aides. Moreover, active aides worked for an average of 1.89 employers in a year, as compared to 1.05 employers for inactive aides.

In Vermont, Vermont Assembly of Home Health Agencies report following wages and benefits as of October, 2000: LNA average $9.21; PCA average $7.57. Agencies report that 71% of LNAs receive employee benefits, while 20% of PCAs receive benefits (specific benefits not outlined).

Third party payers contribute to rigid cost constraints. For example, when third party payers base wage increases on current wages with small cost of living adjustments, increases are generally too small to make wages competitive. Many argue that third party reimbursement rates are inadequate to bring up wages significantly.

Impact of shortage on quality of care:

In a study of nursing homes, Dresser, Lange, and Sirkus (1999) found that low turnover and high retention rates were associated with higher quality of care (as measured by Federal regulation deficiencies, fewer pressure sores, number of complaints).

Staff shortages result in reduced quality of care including:

A. rushed or delayed care , including shortened home visits
B. loss of continuity (relationship of trust between caregiver and client vital to quality care); high turnover and under-staffing compromise relationship building process (caregivers are not replaceable parts, if treated as such more likely to treat clients as objects (Mor, 1995)
C. higher risk of injury (stretched thin workers)
D. loss of experienced care givers
E. extra burdens, stress on continuing workers (greater likelihood of injury to worker, frustration with inability to prove high quality care)
F. high turnover

Range of Issues Contributing to Staff Shortages

Overview of current studies and reports:

A. *Evaluating the Work Satisfaction of Paraprofessionals in Home Health Care*, R. Laferriere, J. Bigelow, & A. Hallet, *Home Health Care Management and Practice*, February 1996. Worker groups and exit interviews with small sample from Caledonia Home Health indicated need to improve work environment in following areas:
   * Pay scale and benefit review
   * Development of advanced skills-building training program
   * Improvement of work-safe environment
   * Assessment of ways to decrease travel time
   * Improvement in communication among all disciplines

B. *Certified Nurse Assistant Recruitment and Retention Project.* Iowa CareGivers Association, September 1999, found four top concerns of CNAs:
   * working short staffed
   * wages and benefits
   * relationships with supervisors
   * education, training, and orientation

C. *Report of the Workforce Development Workgroup*, Wisconsin Department of Health and Family Services, May 1999, identified the following primary reasons for difficulty in recruitment and retention of direct care workers (including Certified Nursing Assistants, Personal Care Workers, and Supportive Home Care Workers):
   * low wages and inadequate or no benefits
   * difficult work and working conditions
   * shift work requiring evening and weekend hours
   * working in isolation without feeling part of a team
   * lack of supervisor support
   * feeling work is not valued by agency or community
   * child care and transportation difficulties
   * short staff means existing workers cover more tasks and hours

D. New York Association of Homes and Services for the Aging (NYAHSA), *Public Hearing Testimony: Nursing Home Quality of Care, Staffing, and Regulation*, December, 2000 and *The Staffing Crisis in New York's Continuing Care System: A Comprehensive Analysis and Recommendations,* March 2000. Factors contributing the staffing crisis:
   * wages and benefits not competitive with other employment sectors
   * inadequate third party reimbursement rates which keep wages low
   * direct competition from other health care providers for workers
   * direct competition from other businesses for workers
   * lack of social supports, especially child care and transportation
   * limited opportunities for training, education, career mobility
   * restrictive immigration policies which limit the labor pool
   * workload and working conditions

H. *Health Care Workforce Issues in Massachusetts*, 2000 Massachusetts Health Policy Forum, June 2000. Factors contributing to the staffing shortage:

- insufficient and declining wages ("price" of labor too low to be competitive with other employment sectors
- lack of health insurance for workers (no coverage for part-time workers, and high premiums for full time workers)
- insufficient training and career advancement (initial training not adequate to ensure new workers skilled and comfortable; no opportunities for career advancement within the job and few opportunities to develop skills and knowledge to advance to other levels within health care)
- dangerous workloads (understaffing leads to greater risks for clients and workers who must provide more care in less time)
- poor management and supervision practices (Management practices that leave workers feeling undervalued, that do not provide opportunities for involvement in decision-making, and do not use team building, permanent assignments or other successful managerial approaches. Supervisors without time or expertise to coach or mentor workers, or to deal with off-the job poverty associated employment barriers workers face.)

H. *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers,* North Carolina Division of Facility Services, September 1999. Factors bearing on worker shortages:

- low wages and few, if any, benefits
- no career path
- physically demanding work
- lack of opportunity for meaningful input into patient care
- inadequate recognition and appreciation
- inadequate exposure to "real life" job demands during training

Summary of issues contributing to staff shortage

A. wages and benefits

- labor price not competitive (wages often near poverty level, not at liveable wage, that is a wage sufficient to enable an individual or family to cover all living expenses such as housing, food, transportation, child care, medical care, clothing without the need to use public subsidy programs)
- lack of benefits, including affordable health insurance, paid vacation
- home care workers often without guaranteed work hours resulting in lack of guaranteed weekly pay
- no compensation for travel expenses or travel time
- travel time not built into schedules
- costs for child care (costs prohibitive with low wage income) and transportation (with low wage, only older vehicles affordable to purchase, but older vehicles are less reliable and require more repair, which may make employment cost prohibitive for worker, or require more frequent absences)

B. job design and working conditions (**workers report to be as important as wages**)

- dangerous workloads (short staffing requires more care in less time putting both worker and client at higher risk)
- stress (staffing shortages also increase stress since workers are required to do more in less time and often feel constrained in the ability to provide the quality of care they wish to provide; in addition, work is stressful in and of itself in that workers deal with issues such as family conflicts and demands, death and dying)
- work is difficult (related to stress, work is physically demanding, and emotionally taxing)
- dead end status (no career ladder; few advancement opportunities)
- shift work (workers often expected to work evenings and weekends which create difficulty in meeting their own personal needs, such as caring for children)
- not feeling valued, input not valued (not included in assessment and case planning; feedback not sought nor are workers part of regular case discussions)
- inconsistent scheduling
- lack of permanent assignments
- high staff to client/resident ratios
- working in isolation, not part of a team (may apply in both home health care and nursing home settings)

C. training, orientation, educational opportunities

- training that doesn't include exposure to "real life" demands (for example, the number of patients one worker must help get up and dressed in the morning; or the type of requests home health clients may make of workers and how to respond to those requests)
- inadequate orientation

D. supervision and management

- nurse supervisors often without training in management and supervisory skills
- relationship with supervisor cited as key to job satisfaction (Iowa, 1999); often lack of support from supervisors
- issue of respect and value cited in several studies as key
- low paid, entry level employees taken for granted
- hierarchy rigid, lack of teamwork approach
- lack of opportunities for caregiver feedback and input on case planning, scheduling, etc.
- lack of careful screening of new caregivers

Low turnover models:

A. Badger Prairie Health Care Center (cited in Dresser, et al., 1999): Report 2% annual turnover. This nursing home is characterized by high wages; excellent benefits (including retirement); commitment to employee involvement in decision making; high staffing levels and amount of training and orientation; aides participate in various committees; during floor meetings supervising nurse listens to and acts on input; aides part of problem solving process; union shop. Caregivers report that one reason they stay is the quality of care they are able to provide in this nursing home.

B. Elder care of Dane County (home health) (also cited by Dresser): guarantees 40 hours of pay whether or not there is 40 hours of work (funded by capitated contract with Medicaid and Medicare), aides don't feel rushed but rather able to provide quality care.

C. Cooperative Home Care Associates in NYC (cited in M. Wilner *Recruiting Qualified Home Care Aides: New Candidate Pools,* CARING Magazine, April, 1999 and *Recruiting Quality Health Care Paraprofessionals,* Paraprofessional Healthcare Institute, August,2000): worker owned cooperative, focus on careful screening, extensive training, good wages and benefits, option to buy stock in agency; support and communication (strategy of high investment in workers) results in low turnover (18% annual rate, 75% of workers former welfare recipients). Recommendations:
- living wage with benefits
- guaranteed hours of work
- careful selection of mature, sensitive, and interested in caregiving
- four weeks of training (includes communication, problem solving, psychosocial development, and job readiness along with required clinical skills)
- trained supervisors
- peer support
- respect and pay increases for seniority, along with opportunities for advancement and growth

D. St. Alphonsus in Idaho (in Dresser): 0% turnover over 2 years, self-directed conglomerate of CNAs autonomously operate agency; integrating CNAs into decision making, serious consideration of CNA input in individual patient cases

E. Los Angeles, CA home health care approach (presented in report by Service Employees International Union in report to U.S. Department of Labor and US. Department of Health and Human Services, *Home Care Workers: A Briefing Paper*, May, 1999): LA formed public authority (Personal Assistance Services Council) to administer the home health program; responsible for acting as employer, providing training, and maintaining a registry (anticipate the registry will include recruitment, pre-screening, training, data management, basic referral and referral support, services to consumers and quality assurance)

F. NY City (also cited by SEIU) has Home Care Education Fund, a multi-employer benefit plan that is financed with a $.025 an hour employer contribution, with 32 separate agencies contributing; fund provides everything from literacy to college and is run by a Board composed of half worker and half management representatives

Proposed Solutions:

Improving Retention of Frontline Caregivers in Dane County, L. Dresser, D. Lange, A. Sirkus, Center on Wisconsin Strategy, March, 1999.

A. Factors which were associated with reduced turnover and increased retention:
- wages: agencies with above average wages had half the turnover rates of agencies with below average wages
- systems to award raises for experience and skills
- health care benefits; especially if short waiting period (less than 1 2 months) and low cost to employee
- strong and respectful relationships with other staff and supervisors; flatter hierarchy and more teamwork
- opportunities for advancement
- extensive initial training and orientation to ensure new employee comfortable and existing workers not left "picking up the slack"
- ongoing training both on and off site to meet the needs of employers and employees
- consistent and flexible scheduling
- staff meetings
- case conferencing
- opportunity to provide good quality care
- tuition reimbursements

B. Recommendations to promote above conditions:
- Improve supports for people in the job. Including C.N.A. (could be PCA or LNA) Associations, systems that encourage training, adequate initial training, joint committees with C.N.A.s (PCA/LNA) and other staff.
- Build career ladders across organizations. Including programming to build skills within C.N.A. (LNA/PCA) positions and so that workers can serve across nursing home and home health settings; publicity to improve reputation of frontline jobs; and use of career ladders (both within care giver jobs as well as into other health care positions) as recruitment tool
- Change Medicaid and Medicare reimbursement policies to reward organizations for lower turnover and to encourage increased staffing ratios, to compensate for training, and to require adequate compensation for workers.

Reduce Home Care Aide Turnover: Give Aides Real Jobs K. Schmidt and E. Kennedy CARING Magazine, August, 1998. Reduced turnover by responding to needs identified in survey of home care aides. **Needs in order of importance:**

1 working hours that fit schedule
2 information needed to do job
3 value and respect
4 number of working hours needed
5 friendly and supportive work environment
6 assignments close to home
7 paid time off
8 increased pay relative to seniority and performance
9 affordable health insurance
10 increased pay
11 convenient educational opportunities

Schmidt and Kennedy also outline a career ladder model for use within the home care aide job. There are four levels for home health aides. At each level there are specific training objectives and demonstrated skills. After completing each level, there are additional responsibilities along with increase financial rewards.

Who Will Care for Persons with Dementia? The Workforce Crisis A. Ortigara reports on study conducted by J. Straker at Scripps Gerontology Center, University of Ohio which found that low turnover nursing homes have some or all of the following:

- mentorship programs
- well defined and consistent orientation programs
- frontline worker involvement in care plan meetings
- primary nursing assistant assignments
- frontline worker career ladders
- employee involvement in hiring teams and exit interviews
- Certified Nursing Assistant councils
- continuous training and educational opportunities

NYAHS recommendations:

- Define "health care worker shortage areas" or modify existing definitions to target state and federal funds toward recruitment and retention of continuing care workers
- Broaden home health care worker health insurance initiative to include uninsured continuing care workers
- * support educational activities to bring new workers and encourage career ladders including: apprenticeship programs, loan forgiveness programs, scholarships, expanded work/study and vocational training, and eldercare rotations and paraprofessional skills instruction in nursing schools
- modify training requirements to better equip applicants to deal with relationships and other real-time demands of job; encourage career mobility within continuing care; and expand available workforce (e.g., nursing students working as CNAs)
- focus on scope of practice redesign by offering career ladders, enriched job, and permitting use of specially trained worker to assist with specific tasks such as nutrition and hydration

- research long run effects of staffing shortages and understand why people enter and leave professions, along with relative effectiveness of various recruitment and retention strategies

North Carolina Recommendations:

- State help facilitate discussion among providers to leverage collective purchasing power to purchase health insurance
- State include information about state supported health insurance for adults and children in letters to newly certified assistants
- Examine relationship between higher wages and retention rates
- Wage pass through as part of reimbursement rate
- Peg wage pass through rate to state's unemployment rate (wage pass through in base reimbursement rate would be adjusted downward if unemployment rates climbed, or conversely if unemployment rates lowered so competition for workers was even steeper than pass through rate would be adjusted upward)
- Consider establishing uniform reimbursement rates across state administered funding sources; multiple rates tied to different levels of service could help establish career ladder
- Consider limiting amount of indirect costs that can be included in the calculation of reimbursement rates; ensure minimum percentage of the provider's reimbursement rate is used for direct care
- Public education and awareness efforts

MA Health Policy Forum recommendations (PHI):

- Data collection, analysis and dissemination of labor market and health care utilization information (Information about health care consumption and supply of workers scattered over different areas such as health care, welfare, labor and workforce development. Further, information not collected in systematic way, and no cross over between areas of potential collaboration. Also need information available for public and consumers.)
- Make long-term care gateway for employment: create a welfare and workforce development fund for health care workers, provide targeted funding to assist individuals who face employment barriers (including TANF), support pre- and post-employment education (including workplace funds, loan forgiveness programs), and promote health sector analysis.
- Improve pricing (quality) of jobs (use wage pass-through to increase wages, reimburse providers to pay higher wages for shift work and step increases; provide benefits through collective purchasing, staff funds, and Children's Health Insurance Program; improve education and training with expanded pre-service training, specific care courses, career ladder, and crossover among care settings; improve workloads by increasing staffing ratio)
- Improve quality of jobs through industry practices (improve quality of management and supervision by training supervisors, build individualized, resident-centered, community-oriented care practices, use inclusive supportive management practices (teamwork, permanent assignments, clustered staffing and supervision, include direct care workers in planning care, support groups and team meetings, culturally competence, coach and problem solving, family-friendly. Also support Provider Consortia and Caregiver Associations. Provide opportunities for advancement: Career Ladders.
- Health Care Workforce Commission to provide oversight in planning, monitoring

and evaluating public policy options.

Iowa CareGivers Association recommendations for facility administrators and nurse supervisors:

- Be visible to staff
- Promote professionalism among all staff, including CNAs (LNA and PCA)
- Maintain high hiring standards
- Initiate or mentor CNA (LNA and PCA) peer support or networking group
- Encourage worker participation in educational programs outside the facility
- Implement CNA (LNA and PCA) mentorship training program and provide follow-up support to newly trained mentors
- Have appropriate and working equipment and adequate supplies at all times; seek counsel from workers on purchases and needs
- Include CNAs (LNA and PCA) in care plans
- Listen and respond to CNAs (LNA and PCA) regarding resident's condition or care, and get back to worker on what was done and how their observations were helpful
- Provide extensive employee orientation
- Provide continuing education program, insure veteran and new workers have same training
- Pitch in on the floor when short staffed
- Be sensitive to workers who grieve the loss of residents (allow representatives to attend funerals, hold memorials in the facility, offer grief counseling)
- Provide recognition and honor, involving residents in recognition programs
- Conduct public awareness campaigns to educate the public about the roles of CAN (LNA and PCA)

Minnesota Home Care Association (2000) recommendations:

- Substantial increase in level of funding for Medial Assistance and Waiver Programs to be more in line with cost of services.
- Establish Training and Certification Institute to provide initial orientation and training, ongoing in-service training, and a certification program. Available to agencies through varied methods: satellite, Internet, teleconferencing, hands-on training, interactive television.
- Market home care with video or other marketing materials to promote home care as a rewarding, professional career option.
- Establish a career track in home care. Credit work experience as well as training, that would allow advancement into nursing through competency based training.
- Explore a Universal Worker approach where a staff person could be cross trained by hospitals, nursing homes, assisted living facilities, and home care agencies, and be placed where needed the most.
- Agencies come together to purchase benefits at an affordable rate for employees and employers.
- Employee Leasing Corporation to hire home care employees full time and then lease persons back to one or more agencies. Corporation would be responsible for recruiting, hiring, training, orienting, and paying the employee. Employees would receive full time work and benefits.

<u>Summary of recommendations</u>:

A. Expand pool of possible workers (current limited pool)
   1. welfare to work; team with workforce development efforts
   2. establish partnerships with range of social service agencies, ensure that partners know criteria for candidates
   3. expand use of volunteers (Maine advocating to modify aspects of job to encourage seniors as part of workforce)
   4. Industry wide marketing to make paraprofessional care more attractive (public awareness campaigns)
   5. Recruit new population sub-groups (e.g., elders, immigrants)

B. Improve wages
   1. use pass-through with goal of creating liveable wage. (Vermont is starting tro use wage pass through with Medicaid reimbursements and provider taxes for nursing homes and home health agencies.) Use Medicaid and other funding sources, develop monitoring system (include initial plan, audits, and expanded cost reporting), identify sanctions. Two models used by 18 states:
      * set dollar amount for workers per hour, or
      * patient day percentage of increased reimbursement rate for wages
   2. targeted wage increases (for shift differentials (NY higher reimbursement for home based serves at night, weekends and holidays), job tenure, career ladders)
   3. increased reimbursement rates for increased performance by providers and staff (RI enhancement plan based on shift differentials, client satisfaction, level of patient acuity, level of provider accreditation, continuity of care, level of worker satisfaction)
   4. Reimbursement for travel and travel time (Washington state legislation for windshield time, time to travel to clients, funded with state reimbursement rate for personal care services)
   5. guaranteed hours of work for predictable income (Schmidt & Kennedy found workers valued guaranteed hours over other financial rewards; they guarantee 30 hours/week. If they lose a client, replace hours from pool of overflow used by part time workers)

C. Provide benefits
   1. Policies that enable low income workers to access health insurance via VHAP and child care through TANF
   2. Collective purchasing pool among providers to purchase health insurance for employees
   3. Pass through reimbursement to cover provider insurance costs
   4. Provide workers with vacation and sick leave, as well as retirement benefits

D. Working conditions
   1. Increase staff ratio so that workers have the time to provide high quality of care (HCFA threshold 2.9 hrs/resident day but virtually no nursing home meets this standard; NYAHSA argue for master staffing levels based on resident needs; flexible standards, adequate compensation to providers, adequate supply of direct caregivers to fill required positions)
   2. consistent and flexible scheduling; unit or team based self-scheduling
   3. Permanent assignments

4. workers involved in care planning
5. teamwork & team meetings
6. Increased autonomy and responsibility
7. Greater recognition, status, and respect for paraprofessionals (e.g., formal recognition, personalized business cards)
8. Improved job safety through training, equipment
9. Reduced reporting and record keeping burdens
10. family friendly policies
11. peer support groups
12. Emotional support and counseling (e.g., Employee Assistance Program)
13. Caregiver associations to provide information and support

E. Orientation and training
1. training include more real life experiences reflecting realities of job
2. apprenticeships and job shadowing
3. Programs to interest youth in health careers (e.g., Daring to Care)
4. expand curriculum to address problem solving and communication skills
5. well defined and consistent orientation
6. courses for specific areas of care
7. training in areas of high stress (e.g., aggressive clients, death & dying)
8 training across care settings to allow cross over between nursing homes and home health care
9. mentorship programs (formal programs with specific training for mentors, defined objectives & skills, and evaluation mechanism)
10. continuing educational opportunities; nurture growth
11. scholarships and loan forgiveness programs

F. Career Ladder
1. develop new job levels that recognize and require advanced skills and experience
2. train workers for new roles with structured curriculum for each level
3. objective measurable criteria and evaluation process for each level
4. reimbursement strategies that enable agencies to create new jobs with increased wages and leadership opportunities at each level
5. recruitment tool
6. Model provided by Schmidt and Kennedy (1998) which has four levels within home health aide job, from new hire to mentor

G. Supervision and management
1. Provide training in leadership and management for nurse supervisors
2. Promote more inclusive management styles (teams, involvement of aides in decision making)
3. Staff meetings for all staff
4. Paraprofessionals involved in case conferencing
5. Formal recognition of effective work to demonstrate respect and value
6. Management focused on coaching and problem solving rather than punitive approach
7. strong and respectful relationships; supervisors who listen and take input from caregivers seriously

Paraprofessional Staffing Study
Survey Data
March 12, 2001

Survey Participants:

Over 6,000 surveys were distributed to Personal Care Attendants (PCA), Licensed Nursing Assistants (LNA) in nursing homes and home care, industry administrators responsible for hiring and supervising, and consumers served by the Attendant Services Program or Consumer/ Surrogate Directed Medicaid Waiver Program participants responsible for hiring their own care givers.

Administrators:

A total of 38 Administrators responded to the survey, representing a 31% return rate. Most of these respondents (82%) were female, with an average age of 45 years (tables with more details on demographics appear below for all survey groups combined). There were no differences in age across job settings or type of position. Administrators reported a range of job titles across work settings:

I. Administrator's reported	Work Setting			
Job Title	Nursing Home	Home Health	NH & other	HH & other
Administrator	7		2	
Director of Nursing (DoN)	10	3	1	
HR Director (Assistant DoN)	3			
HR Director-Assistant Director		1		
Human Resources Director	1	4		1
LNA/Administrative Assistant	1			
LPN		1		
Paraprofessional Coordinator		1		
RN Paraprofessional Coordinator		1		
SDC	1			
Total	23	11	3	1

Most respondents had been in health care for an average of more than 20 years. HR directors had the longest tenure in their present positions.

Administrator	**years in present position**		**years in health care**	
current position	Mean	Std. Dev.	Mean	Std. Dev.
Director of Nursing (n=14)	4.79	*5.56*	22.29	*7.24*
H R Director (n=10)	10.07	*8.54*	23.54	*9.05*
Administrator (n=8)	5.63	*4.00*	23.50	*11.48*
Paraprofessional Coord. (n=2)	0.92	*0.35*	16.50	*12.02*
Other (n=2)	11.00	*5.66*	15.00	*5.66*
Total (36)	6.571	*6.64*	22.14	*8.80*

Administrator	**years in present position**		**years in health care**	
work setting	Mean	Std. Dev.	Mean	Std. Dev.
Nursing Home (n=21)	5.69	6.48	22.05	8.86
Home Health Agency (n=11)	8.78	7.78	23.10	6.81
Nursing home & other (n=3)	6.17	1.61	26.33	9.29
Home Health & other (n=1)	1.90	.	1.90	.
Total (n=36)	6.57	6.64	22.14	8.80

Most Administrators had either college or advanced educations. One respondent had a high school diploma and was now attending college classes.

	Highest Educational Level					
Administrator Job Title	Unknown	HS & classes	Technical	Bachelor's	Some Grad	Advanced
Administrator			1	2	3	3
Director of Nursing	2		3	6	2	1
Human Resources Director	2		1	4		3
LNA/Administrative Assistant		1				
Paraprofessional Coordinator			1	1		
Other			1	1		
Total	4	1	7	14	5	7

	Highest Level of Education					
Administrator Work Setting	Unknown	HS & classes	Technical	Bachelor's	Some Grad	Advanced
Nursing Home	2	1	5	10	1	4
Home Health Agency	2		2	4	1	2
Nursing Home & Other					3	
Home Health & Other						1
Total	4	1	7	14	5	7

Consumers:

A total of 210 persons responded to the Consumer survey, representing a 39% return rate. The majority (77%) of respondents were served by the Attendant Services Program. Respondents were an average of 62 years old with a range of 20 to 102 years; 126 (61%) were female.

J. Consumer Groups	Frequency	Percent
Consumer/Surrogate Directed Medicaid Waiver	47	22%
Attendant Services Program	161	77%
No identified program	2	1%
Total	210	100%

When asked if either they or a family member uses personal assistance services, 10% responded "no."

Consumer respondents' report **Self or family member uses personal assistance services**	frequency	percent
"No"	20	10%
"Yes"	185	88%
no response	5	2%
Total	210	100%

Caregivers were recruited & hired through a variety of methods:

Care giver for consumers	frequency	percent
care giver family member only	45	21%
client finds/hires care giver only	28	13%
caregivers family & client hired	28	13%
caregivers family & HHA hired	15	7%
client finds, HHA hires care giver	8	4%
HHA provides care giver	17	8%
Residential facility care givers	6	3%
caregivers family, family & HHA hires	28	13%
HHA hires, client hires or locates	16	8%
other or missing	19	9%
Total	210	100%

Family members provided care to about half of the consumer respondents. Of these, only 21% reported that family members were not paid for their caregiving.

Family member caregivers pay status	Frequency	Percent
no response	99	47%
both paid and unpaid family members	28	13%
paid family members	60	29%
unpaid family members	23	11%
Total	210	100%

LNAs and PCAs:

A total of 448 PCAs (22% return rate) and 601 LNAs (17% return rate) completed the surveys. Nearly all respondents were female.

	Administrators		PCAs		LNAs		Consumers	
Gender	frequency	percent	frequency	percent	frequency	percent	frequency	percent
Female	31	82%	390	87%	587	96%	130	62%
Male	7	18%	58	13%	23	4%	79	38%
Total	38	100%	448	100%	610	100%	209	100%

PCAs were an average of 47 years old, while LNAs were an average of 40 years old.

	Administrators		PCA		LNA		Consumers	
Age	frequency	percent	frequency	percent	frequency	percent	frequency	percent
under 20 years	0	0%	10	2%	15	2%	0	0%
20 to 35 years	4	11%	100	23%	220	37%	14	7%
36 to 50 years	22	61%	142	32%	235	39%	36	17%
51 to 65 years	10	28%	143	32%	113	19%	65	31%
66 years and over	0	0%	46	10%	18	3%	94	45%
Total	36	100%	441	100%	601	100%	209	100%

Most PCAs and LNAs had high school diplomas or GEDs.

	Administrators		PCAs		LNAs		Consumers	
Highest Educational Level	frequency	percent	frequency	percent	frequency	percent	frequency	percent
unknown	4	11%	10	2%	25	4%	1	0%
currently in school	0	0%	9	2%	12	2%	3	1%
less than high school	0	0%	47	10%	41	7%	53	25%
high school or GED	1	3%	173	39%	316	52%	60	29%
technical school	7	18%	35	8%	40	7%	12	6%
some college	0	0%	97	22%	144	24%	31	15%
bachelor's degree	14	37%	51	11%	22	4%	23	11%
some graduate school	5	13%	14	3%	6	1%	10	5%
advanced degree	7	18%	12	3%	4	1%	17	8%
Total	38	100%	448	100%	610	100%	210	100%

Nine PCAs reported that they were still attending school. One 32 year old woman, hired by a home health agency, was working on a GED. Six respondents were college students, three working through home health agencies, two working through ASP for family members, and one working in a residential facility. The college students' age ranged from 18 to 42 years.

Twelve LNAs reported that they were still in school. Ten reported that they were in college. One respondent did not explain her current schooling, but was 19 years old and likely completed high school. One respondent said she was in a LPN program, and another was in a RN associates program. Seven of these 12 students were working in nursing homes (some full time and others part time), three were in home health, one in a residential facility, and one in both a nursing home and residential facility. Their ages ranged from 19 to 38 years of age.

Educational levels varied slightly across programs, for PCAs, with ASP workers having slightly higher educational levels than the other two groups.

PCA	Waiver		ASP		None Identified	
highest educational level	Frequency	Percent	Frequency	Percent	Frequency	Percent
in school	1	1%	3	2%	5	2%
less than high school	9	12%	19	14%	19	8%
high school or GED	33	43%	40	29%	100	43%
some college	16	21%	24	18%	57	24%
technical school	4	5%	14	10%	17	7%
bachelor's degree	10	13%	24	18%	17	7%
some graduate school	1	1%	5	4%	8	3%
advanced degree	1	1%	6	4%	5	2%
unknown	1	1%	2	1%	7	3%
Total	76	100%	137	100%	235	100%

LNAs in home health settings had slightly higher educational levels than those in nursing homes.

LNA	Home health		Nursing home	
Highest level of education	Frequency	Percent	Frequency	Percent
unknown	6	5%	15	4%
currently in school	3	2%	7	2%
less than high school	7	6%	30	7%
high school or GED	54	44%	229	57%
some college	34	27%	81	20%
technical school	9	7%	24	6%
bachelor's degree	7	6%	11	3%
some graduate school	2	2%	4	1%
advanced degree	2	2%	0	0%
Total	124	100%	401	100%

About half of the PCAs worked through the Consumer/Surrogate Waiver or ASP.

K. PCA groups	Frequency	Percent
Consumer/Surrogate Directed Medicaid Waiver	76	17%
Attendant Services Program	137	31%
No identified program	235	52%
Total	448	100%

Most PCAs worked in clients' homes, while the majority of LNAs worked in nursing homes.

	PCAs		LNAs	
Work Setting	Frequency	Percent	Frequency	Percent
Client's home, hired by client	150	33%		
Client's home, hired by HHA	195	44%	125	20%
Client's home, client & HHA hired	26	6%		
Nursing home only	1	0%	401	66%
Residential facility only	5	1%	10	2%
Multiple settings	30	7%	58	10%
Own home	18	4%		
Other or unknown	23	5%	16	3%
Total	448	100%	610	100%

The majority of PCAs worked part time as PCAs, while the large majority of LNAs worked full time as LNAs.

	PCA		LNA	
Current Position	Frequency	Percent	Frequency	Percent
Full time	124	28%	452	74%
Part time	181	40%	83	14%
Full time other work	9	2%	13	2%
Part time other work	11	2%	13	2%
FT LNA/PCA & other work	6	1%	24	4%
PT LNA/PCA & other work	74	17%	18	3%
Unknown	43	10%	7	1%
Total	448	100%	610	100%

PCAs serving under ASP were least likely to work only as full time PCAs.

	Medicaid Waiver		Attendant Services		No Identified Program	
PCA Position	Frequency	Percent	Frequency	Percent	Frequency	Percent
Full time PCA only	30	39%	25	18%	69	29%
Part time PCA only	27	36%	51	37%	103	44%
Other than PCA (FT)	1	1%	4	3%	4	2%
Other than PCA (PT)	0	0%	1	1%	10	4%
FT PCA & other work	0	0%	1	1%	5	2%
PT PCA & other work	9	12%	36	26%	29	12%
unknown or unclear	9	12%	19	14%	15	6%
Total	76	100%	137	100%	235	100%

LNAs working part time were more likely to be employed by home health agencies, while LNAs working full time were more likely to be employed by nursing homes.

	Current employment			
	Full time LNA only		Part time LNA only	
LNA Work Setting	Frequency	Percent	Frequency	Percent
Home health	79	18%	30	37%
Nursing home	324	72%	45	55%
HH and NH	10	2%	0	0%
HH & others	7	2%	3	4%
NH & others	16	4%	3	4%
Residential	8	2%	1	1%
Other	7	2%	0	0%
Total	451	100%	82	100%

LNAs working full time tended to be younger than PCAs working full time.

	PCA			LNA		
Current Position	Mean Age	N	Std. Dev.	Mean Age	N	Std. Dev.
Full time	47.63	123	*14.45*	38.79	444	*12.09*
Part time	47.34	176	*15.48*	46.70	82	*15.60*
Full time other work	46.78	23	*14.88*	38.08	13	*8.83*
Part time other work	41.43	21	*11.96*	42.85	13	*16.86*
FT PCA/LNA & other	45.33	6	*15.42*	35.19	16	*12.15*
PT PCA/LNA & other	44.12	67	*12.00*	43.83	18	*10.85*
unknown	52.21	24	*11.75*	37.87	15	*13.47*
Total	46.86	440	*14.40*	39.98	601	*12.96*

LNAs working in nursing homes were younger than those working in home health.

LNA Work Setting	Mean Age	N	Std. Deviation
Home health	46.90	123	*11.01*
Nursing home	37.60	395	*12.89*

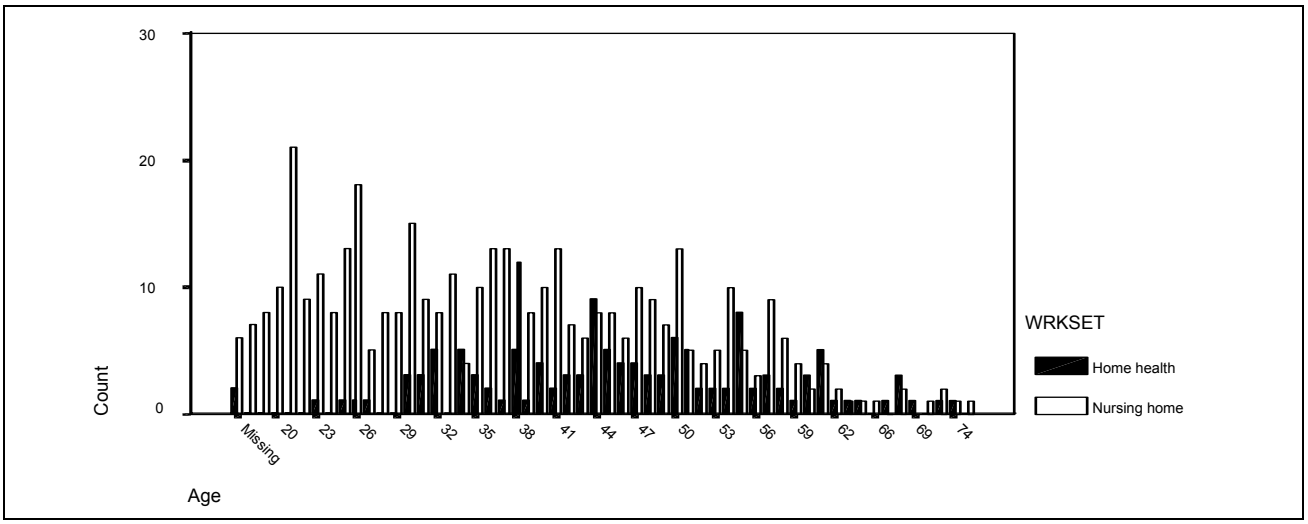

Figure 1: LNA Age Distribution by Work Setting

There was little difference in PCA age across work settings.

PCA work setting	Mean Age	N	Std. Deviation
Home, client hired	47.01	147	*13.90*
Client & HH hired	50.00	26	*12.63*
Home, HH employee	46.19	193	*14.93*
other	49.00	26	*15.76*

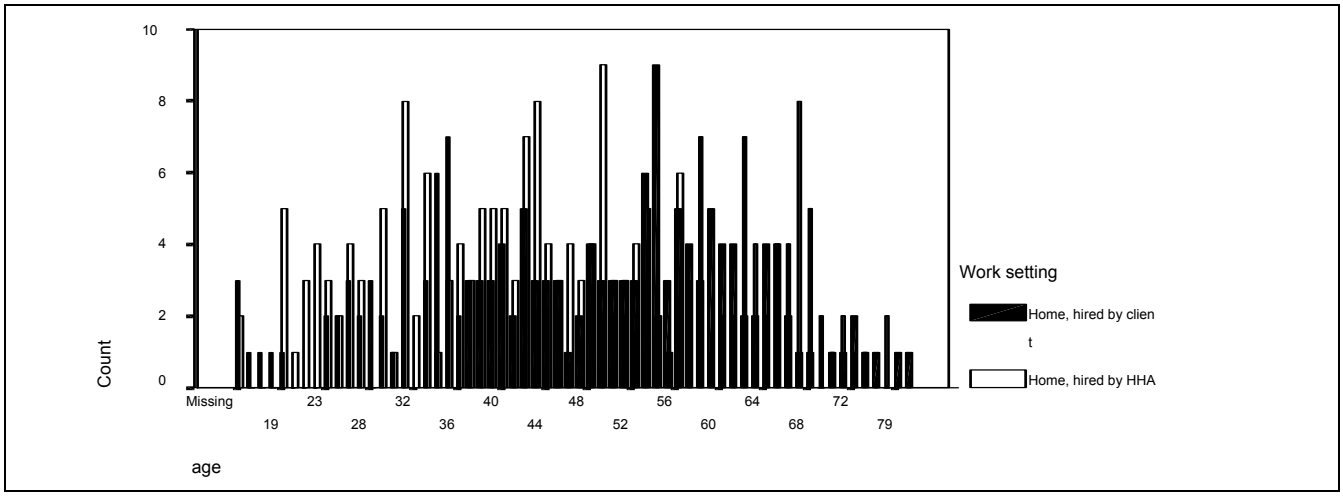

Figure 2: PCA Age Distribution by Work Setting

PCAs with the shortest tenure in the present position were part time workers, while LNAs with the shortest tenure in the present position were working positions other than LNA (this could include work that was no longer in the health care field, or other health care or personal assistance care).

	PCA		LNA	
	years in present position		years in present position	
current position	Mean	Std. Dev.	Mean	Std. Dev.
Full time	3.81	*5.27*	6.00	*5.93*
Part time	3.73	*5.29*	7.22	*8.05*
Full time other	6.59	*7.56*	5.42	*6.08*
Part time other	3.11	*4.50*	2.53	*2.08*
FT PCA/LNA & other	7.82	*10.74*	5.80	*6.86*
PT PCA/LNA & other	5.23	*7.67*	8.37	*8.03*
other	6.01	*5.73*	3.81	*6.55*
Total	4.27	*5.98*	6.11	*6.34*

Overall, LNAs had longer tenure in the health care field than did PCAs (note that about half of the LNAs did not respond to this item due to a typographical error on the survey.)

	PCA		LNA	
	years in health care		years in health care	
current position	Mean	Std. Dev.	Mean	Std. Dev.
Full time	5.08	*4.67*	9.60	*8.93*
Part time	4.76	*6.26*	9.09	*7.88*
Full time other	3.57	*3.97*	6.20	*5.26*
Part time other	3.49	*3.70*	7.22	*10.07*
FT PCA/LNA & other	8.17	*11.24*	8.74	*10.65*
PT PCA/LNA & other	4.58	*5.28*	9.60	*6.67*
other	7.10	*7.25*	10.34	*11.94*
Total	4.86	*5.63*	9.37	*8.80*

PCAs serving under the Consumer/Surrogate Directed Medicaid Waiver had slightly shorter tenure than those in the ASP, but longer than those without identified program.

PCA	years in present position		years in health care	
program	Mean	Std. Dev.	Mean	Std. Dev.
Medicaid Waiver (n=73)	4.07	*6.09*	5.00	*5.31*
ASP (n=121)	5.63	*7.57*	6.32	*7.02*
No identified program (n=213)	3.57	*4.68*	3.98	*4.60*
Total (405)	4.27	*5.98*	4.86	*5.63*

Client hired PCAs tended to have longer tenure than those hired solely by home health agencies.

PCA	years in present position		years in health care	
work setting	Mean	Std. Dev.	Mean	Std. Dev.
Home, hire by client (n=140)	4.68	*7.19*	5.46	*6.57*
Home, hire by client & HH (n=25)	5.39	*6.90*	6.88	*6.48*
Home, employ by HH (n=181)	3.55	*4.59*	3.79	*4.41*
Nursing home (n=1)	3.00	.	3.00	.
Residential facility (n=4)	0.70	*0.46*	7.38	*8.44*
Other (n=25)	6.80	*7.87*	5.94	*5.52*

Tenure for LNAs ranged very widely across settings. (Note that half of the respondents did not answer the question about years in health care due to a typographical error. After each setting two n's are listed: the first for responses to years in present position, and the second for responses to years in health care.)

LNA	**years in present position**		**years in health care**	
work setting	Mean	Std. Dev.	Mean	Std. Dev.
Unknown (n=5)	2.02	*2.50*	7.05	*5.80*
Home Health (n=121; 41)	7.44	*5.28*	8.81	*8.79*
Nursing home (n=395; 170)	5.92	*6.62*	8.97	*8.28*
Res. Facility (n=10; 5)	2.49	*3.09*	18.80	*9.98*
Other (n=8; 5)	3.63	*4.44*	5.20	*4.15*
HH & NH (n=16; 11)	5.92	*5.71*	13.42	*11.56*
HH & other (n=12; 7)	8.04	*7.55*	6.50	*5.71*
NH & others (n=22; 14)	6.09	*7.64*	10.05	*11.12*
Res. & others (n=6; 3)	1.06	*1.48*	23.33	*11.55*
Total (n=595; 261)	6.11	*6.34*	9.37	*8.80*

Recruitment Issues

Survey participants were asked how they either learned about their present position, or how they found persons to provide services. The most frequently cited method for reaching potential workers was through word of mouth or referrals from friends. Twice as many LNAs as PCAs learned about their positions through advertisements.

	Administrators		PCAs		LNAs		Consumers	
Publicizing positions	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
referrals, word of mouth	37	97%	272	61%	319	52%	125	60%
advertisements	37	97%	97	22%	265	43%	31	15%
DET referrals	15	39%	13	3%	23	4%	13	6%
HS guidance	9	24%	0	0%	8	1%	4	2%
other types of referrals	4	11%	99	22%	79	13%	61	29%
consumer doesn't hire care giver							35	17%

Persons serving as PCAs and LNAs primarily chose this work because of their desire to help others. While Administrators and Consumers agreed that this was a primary factor, they did so less frequently than did PCAs and LNAs themselves.

	Administrators		PCAs		LNAs		Consumers	
Reasons to choose PCA/LNA	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
help others	34	89%	359	80%	558	91%	154	73%
free training	5	13%			53	9%	18	9%
step to other health career	18	47%	55	12%	259	42%	52	25%
get needed job	26	68%	152	34%	169	28%	124	59%
pay to help family member	5	13%	109	24%	15	2%	51	24%
convienient location, flexible hours	18	47%	274	61%	257	42%	105	50%
work requirement	1	3%	8	2%	11	2%	8	4%

PCAs serving under the Consumer/Surrogate Directed Waiver or ASP more frequently said they chose the work in order to help a family member, than PCAs employed by home health agencies.

	C/S Directed Waiver		ASP		HH Waiver	
Reasons to choose PCA	Frequency	Percent	Frequency	Percent	Frequency	Percent
help others	63	83%	96	71%	200	85%
step to other health career	7	9%	9	7%	39	17%
get needed job	23	30%	35	26%	94	40%
pay to help family member	24	32%	56	41%	29	12%
convenient location, flexible hours	45	59%	74	54%	155	66%
Work requirement	2	3%	1	1%	5	2%

Beyond the desire to help others, LNAs in home health settings most frequently cited convenience, while those in nursing homes cited the position as a step in a health care career.

	Home health		Nursing Home		Multiple Settings		Other	
Reasons to choose LNA	frequency	percent	frequency	percent	frequency	percent	frequency	Percent
help others	120	96%	363	91%	53	93%	16	89%
free training	5	4%	38	9%	6	11%	3	17%
step in health care career	34	27%	183	46%	28	49%	12	67%
get needed job	36	29%	110	27%	17	30%	4	22%
pay to help family member	8	6%	4	1%	2	4%	0	0%
convenient location, flexible hours	72	58%	145	36%	29	51%	6	33%
Meet work requirement	7	6%	2	0%	1	2%	0	0%

Most PCAs who selected their work as a step to other health careers were not employed through the Consumer/Surrogate Directed Medicaid Waiver or ASP programs; rather most were employed by home health agencies.

	Choose work as step

PCA Program	to other health career	
	frequency	percent
C/S Directed Medicaid Waiver	7	13%
Attendant Services Program	9	16%
Home Health Waiver	39	71%
Total	55	100%

PCA work setting	Choose work as step to other health career	
	frequency	percent
Home, hired by client	11	20%
Home, hired by HH	34	62%
Home, hired by client & HH	1	2%
Residential facility	1	2%
Multiple settings	3	5%
Other	5	9%
Total	55	100%

LNAs were much more likely to be interested in their work as a step to other health care careers. The majority of these respondents worked in nursing homes.

LNA Work Setting	Choose work as step To other health care career	
	frequency	percent
Home health	34	13%
Nursing Home	183	71%
Multiple Settings	28	11%
Other	12	5%
Total	257	100%

When asked about useful retention strategies and important benefits, those wanting to use their present position as a stepping stone more frequently identified opportunities for training and education as important. PCAs did so a bit more frequently than did LNAs.

	PCA step to other health career				LNA step to other health career			
	No		Yes		No		Yes	
Respondent selected options	frequency	percent	frequency	percent	frequency	percent	frequency	percent
Retention strategy:								
opportunities for training, promotion	70	18%	20	36%	53	15%	62	24%
Benefits: training opportunities	66	17%	23	42%	61	17%	65	25%
Benefits: tuition reimbursement	34	9%	14	25%	27	8%	59	23%

Retention Issues

Motivation to work each day:

The survey asked respondents to identify the three top reasons that kept them coming to work each day (or that they thought kept PCAs and LNAs coming to work each day). PCAs and LNAs both said their three top reasons were rewards of caring for people, feeling responsible and knowing the job is important, and respect and caring from their clients/patients. While Administrators and Consumers also ranked these as important motivational factors, they also thought an equally important factor was need for the job. This factor was of much less importance to the PCAs and LNAs.

Motivation to	Administrators		PCAs		LNAs		Consumers	
Work Each Day	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
rewards of caring for people	25	66%	315	70%	467	77%	122	58%
Supervisors' recognition	12	32%	31	7%	39	6%	13	6%
know job is important	21	55%	302	67%	440	72%	109	52%
respect/caring from clients	20	53%	244	54%	334	55%	93	44%
flexible work hours	3	8%	145	32%	71	12%	77	37%
need the job	20	53%	95	21%	99	16%	93	44%
benefits with the job	8	21%	13	3%	111	18%	25	12%

Among PCAs and LNAs, there were few differences in motivation across type of program or work setting.

Retention Strategies:

Respondents were asked to select three strategies which would help the most in allowing PCAs or LNAs to continue their work. Although all groups most frequently cited increased wages, there were differences in other important strategies. PCAs wanted benefits, LNAs wanted more time with clients and extra pay for off hours.

	Administrators		PCAs		LNAs		Consumer	
Retention Strategies	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
raise pay	32	84%	327	73%	460	75%	151	72%
provide benefits	15	39%	252	56%	105	17%	122	58%
help with transportation	3	8%	95	21%	60	10%	43	20%
child care assistance	11	29%	30	7%	69	11%	17	8%
extra pay for longer hours, off times	8	21%	119	27%	165	27%	67	32%
employee loan program	0	0%	40	9%	56	9%	8	4%
more communication/coaching	11	29%	24	5%	76	12%	11	5%
support for emotional issues	3	8%	25	6%	67	11%	16	8%
more time with clients	13	34%	56	13%	243	40%	43	20%
training, education opportunities	10	26%	90	20%	115	19%	24	11%

There were slight differences among PCAs groups in the frequency with which specific retention strategies were selected. Those in ASP were less interested in help with transportation than those in the other two groups; Consumer/Surrogate Directed Waiver and ASP groups more frequently cited extra pay for longer hours and off times than did those in the home health agency PCA group.

	C/S Directed Waiver		ASP		Home Health Waiver	
PCA Retention Strategies	Frequency	Percent	Frequency	Percent	Frequency	Percent
raise pay	51	67%	100	73%	176	75%
provide benefits	45	59%	83	61%	124	53%
help with transportation	20	26%	22	16%	53	23%
child care assistance	1	1%	8	6%	21	9%
extra pay for longer hours, off times	26	34%	42	31%	51	22%
employee loan program	8	11%	11	8%	21	9%
more communication/coaching	3	4%	1	1%	20	9%
support for emotional issues	6	8%	2	1%	17	7%
more time with clients	8	11%	20	15%	28	12%
training, education opportunities	21	28%	20	15%	49	21%

LNAs working in nursing homes were much more likely to say they wanted more time with clients and increased pay for shift work, than did LNAs working in home health. LNAs working in home health more frequently cited training opportunities, benefits, and help with transportation, than did those working in nursing homes.

	Home health		Nursing Home		Multiple Settings		Other	
LNA Retention Strategies	frequency	percent	frequency	percent	frequency	percent	frequency	percent
increase pay	88	70%	310	77%	44	77%	14	78%
provide benefits	29	23%	58	14%	11	19%	4	22%
help with transportation	24	19%	28	7%	5	9%	2	11%
help with child care	4	3%	51	13%	9	16%	5	28%
increase pay for shift work	26	21%	119	30%	15	26%	2	11%
employee loan program	13	10%	36	9%	7	12%	0	0%
more communication/coaching	24	19%	47	12%	4	7%	0	0%
emotional support	17	14%	42	10%	3	5%	5	28%
more time with clients	26	21%	187	47%	22	39%	8	44%
training opportunities	37	30%	57	14%	14	25%	6	33%

Consumers using ASP were more likely to cite the need to provide benefits and extra pay for shift work, than were those using the Waiver.

	ASP		C/S Directed Waiver	
Consumer Retention	frequency	percent	frequency	percent
raise pay	117	73%	33	70%
provide benefits	101	63%	20	43%
help with transportation	34	21%	9	19%
child care assistance	14	9%	2	4%
extra pay for shift work	56	35%	11	23%
employee loan program	7	4%	1	2%
more communication/coaching	8	5%	2	4%
support for emotional issues	9	6%	7	15%
more time with clients	30	19%	13	28%
training, education opportunities	17	11%	7	15%

Administrators in home health agencies were far more likely to identify the need to provide benefits and educational opportunities, than were those in nursing homes. Nursing home administrators more frequently cited needs for child care assistance, extra pay for shift work, and more time with clients as the top three most important retention strategies.

Administrator	Nursing Home		Home Health Agency		Other	
Retention Strategies	Frequency	Percent	Frequency	Percent	Frequency	Percent
raise pay	19	83%	9	82%	4	100%
provide benefits	5	22%	8	73%	2	50%
help with transportation	2	9%	1	9%	0	0%
child care assistance	9	39%	2	18%	0	0%
extra pay for shift work	8	35%	0	0%	0	0%
more communication/coaching	6	26%	3	27%	2	50%
support for emotional issues	3	13%	0	0%	0	0%
more time with clients	9	39%	2	18%	2	50%
training, education opportunities	4	17%	6	55%	0	0%

LNAs and PCAs were asked about child care assistance in two ways: first, as one potential retention strategy ("child care available at my work, or help to pay for child care"), and second as a possible benefit ("child care on site or help paying for child care"). Of 448 PCAs, 19 (4%) identified child care assistance as one of both their top three retention strategies and benefits. Of 610 LNAs, 41 (7%) included child care assistance as one of both their top three retention strategies and benefits.

PCA Retention Strategy**:**	Benefit: child care assistance		
child care assistance	No	Yes	Total
No	400	18	418
Yes	11	19	30
Total	411	37	448

LNA Retention Strategy	Benefit: child care assistance		
child care assistance	No	Yes	Total
No	503	38	541
Yes	28	41	69
Total	531	79	610

PCAs and LNAs interested in child care assistance were at least 10 years younger than those not interested in child care assistance.

	PCA			LNA		
Retention: child care assistance	Mean Age	N	Std. Deviation	Mean age	N	Std. Deviation
No	47.96	412	*13.98*	41.16	534	*12.85*
Yes	30.61	28	*10.10*	30.54	67	*9.57*
Benefit: child care assistance						
No	48.13	405	*14.00*	41.44	524	*12.85*
Yes	32.17	35	*10.31*	30.03	77	*8.65*

PCAs working for home health agencies requested child care assistance more frequently than those serving under the Consumer/Surrogate Directed Waiver or ASP.

	Child Care Assistance			
	Retention		Benefit	
PCA Program	frequency	percent	frequency	percent
Consumer/Surrogate Directed Waiver	1	1%	5	7%
Attendant Services Program	8	6%	7	5%
Home Health Waiver	21	9%	25	11%
Total	30	7%	37	8%

LNAs in nursing homes were more likely to request child care than those working in home health.

	Child Care Assistance			
	Retention		Benefit	
LNA Work Setting	frequency	percent	frequency	percent
Home health	7	6%	4	3%
Nursing Home	61	15%	51	13%
Multiple Settings	8	14%	9	16%
Other	3	17%	5	28%
Total	79	13%	69	11%

Satisfaction Ratings:

Surveys included eight satisfaction rating scales (nine for PCAs). Respondents were asked to rate treatment by clients, by supervisors, work hours expected, and so forth on a scale of 1 to 5, with 1 = not at all satisfied and 5 = extremely satisfied. Overall, LNAs and PCAs were more satisfied with their working conditions and compensation than Administrators and Consumers expected. PCAs and LNAs were least satisfied with their wages. LNAs were also relatively dissatisfied with the time they had to work with clients and the demands of their work.

	Administrators		PCAs		LNAs		Consumers	
Satisfaction Ratings	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
treatment by clients	3.68	*0.70*	4.48	*0.72*	4.13	*0.83*	4.50	*0.60*
treatment by supervisors	3.68	*0.63*	4.21	*1.03*	3.52	*1.15*	3.66	*1.16*
hours expected to work	3.45	*0.80*	4.20	*0.97*	4.02	*0.96*	3.98	*0.98*
available time with client	3.16	*0.80*	4.30	*0.89*	3.14	*1.28*	3.97	*1.00*
demands of work	2.81	*0.81*	3.90	*0.98*	3.21	*1.04*	3.81	*0.97*
wages earned	2.51	*0.87*	3.00	*1.22*	2.43	*1.16*	2.99	*1.18*
benefits provided	3.27	*1.15*	3.76	*3.11*	3.41	*1.30*	2.15	*1.25*
training	3.64	*0.65*	3.78	*1.21*	4.00	*0.98*	3.64	*1.26*
working environment			4.26	*0.96*				

There were no differences in mean satisfaction ratings across groups of consumers. However, there were some differences among Administrators. Nursing home administrators expected workers to have lower levels of satisfaction with available client time, while home health administrators expected lower levels of satisfaction with benefits provided.

	Nursing Home		Home Health Agency	
Administrator Satisfaction Ratings	Mean Rating	Std. Dev.	Mean Rating	Std. Dev.
treatment by clients	3.83	*0.72*	3.45	*0.52*
treatment by supervisors	3.73	*0.55*	3.55	*0.82*
hours expected to work	3.46	*0.89*	3.45	*0.69*
available time with client	2.91	*0.87*	3.64	*0.50*
demands of work	2.78	*0.80*	2.90	*0.99*
wages earned	2.54	*0.86*	2.45	*1.04*
benefits provided	3.65	*0.88*	2.30	*1.25*
training	3.61	*0.72*	3.68	*0.56*

There were no differences in satisfaction ratings for PCAs across programs. Nor were there differences among PCA satisfaction ratings across employers.

LNA satisfaction ratings were similar with one exception: LNAs in nursing home settings were less satisfied with the time they had with clients than were LNAs in home health settings.

	Home health		Nursing Home		Multiple Settings	
LNA satisfaction	Mean Rating	Std. Dev.	Mean Rating	Std. Dev.	Mean Rating	Std. Dev.
treatment by clients	4.36	*0.80*	4.05	*0.85*	4.14	*0.74*
treatment by supervisors	3.88	*1.01*	3.40	*1.15*	3.58	*1.22*
hours expected to work	3.87	*0.84*	4.10	*0.97*	3.88	*1.00*
available time with clients	3.98	*0.90*	2.84	*1.28*	3.30	*1.19*
demands of work	3.56	*0.89*	3.10	*1.08*	3.23	*0.93*
wages earned	2.67	*1.21*	2.32	*1.12*	2.56	*1.18*
benefits provided	3.58	*1.19*	3.39	*1.31*	3.28	*1.31*
training	3.89	*1.01*	4.05	*0.94*	3.89	*1.13*

Important Benefits:

The survey included a list of nine benefits and asked respondents to select the three most important. All four groups agreed that the most important benefits were paid vacations, paid sick leave and health insurance (PCAs more frequently chose employee health while LNAs chose family health).

	Administrators		PCAs		LNAs		Consumer	
Important Benefits	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
employee health insurance	23	61%	182	41%	197	32%	117	56%
family health insurance	13	34%	150	33%	250	41%	81	39%
vacations	23	61%	260	58%	338	55%	116	55%
sick leave	15	39%	225	50%	315	52%	108	51%
Employee Assistance Program	3	8%	24	5%	38	6%	8	4%
training opportunities	9	24%	90	20%	126	21%	37	18%
tuition reimbursement	10	26%	49	11%	86	14%	17	8%
on site or help paying for child care	16	42%	37	8%	79	13%	31	15%
use of an agency car	1	3%	27	6%	21	3%	12	6%

Across programs, PCAs rated benefits at nearly the same levels of importance. PCAs serving under the Consumer/Surrogate DirectedWaiver more frequently identified training opportunities as an important benefit than

did PCAs in the other groups.

PCA Important Benefits	C/S Directed Waiver		ASP		Home Health Waiver	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
employee health insurance	29	38%	53	39%	100	43%
family health insurance	25	33%	52	38%	73	31%
vacations	44	58%	69	50%	147	63%
sick leave	36	47%	57	42%	132	56%
Employee Assistance Program	3	4%	8	6%	13	6%
training opportunities	22	29%	23	17%	45	19%
tuition reimbursement	8	11%	18	13%	23	10%
on site or help paying for child care	5	7%	7	5%	25	11%
use of an agency car	5	7%	5	4%	17	7%

PCAs employed by home health agencies more frequently identified employee health insurance and paid sick leave as important benefits.

PCA Important Benefits	Home, hired by client		Home, hired by HHA		Other	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
employee health insurance	58	36%	86	43%	38	44%
family health insurance	56	35%	67	33%	27	31%
paid vacation	91	57%	125	62%	44	51%
paid sick leave	72	45%	114	56%	39	45%
Employee Assistance Program	11	7%	10	5%	3	3%
training opportunities	32	20%	41	20%	17	20%
tuition reimbursement	19	12%	20	10%	10	12%
child care on site or help paying	13	8%	17	8%	7	8%
use of agency car	5	3%	17	8%	5	6%

LNAs in nursing homes and home health settings were in close agreement about important benefits. Those in home health settings cited training opportunities as an important benefit more frequently than those in nursing homes, while those in nursing homes more frequently identified the need for child care assistance.

LNA Important Benefits	Home health		Nursing Home		Multiple Settings		Other	
	frequency	percent	frequency	percent	frequency	percent	frequency	percent
employee health insurance	36	29%	135	34%	19	33%	7	39%
family health insurance	50	40%	165	41%	21	37%	9	50%
vacation pay	75	60%	222	55%	27	47%	9	50%
sick leave	54	43%	219	55%	27	47%	11	61%
Employee Assistance Program	5	4%	23	6%	9	16%	1	6%
Training opportunities	32	26%	79	20%	9	16%	6	33%
Tuition reimbursement	19	15%	52	13%	10	18%	4	22%
Child care assistance	7	6%	61	15%	8	14%	3	17%
Agency car	10	8%	6	1%	4	7%	1	6%

With the exception of child care assistance and tuition reimbursement, there were no differences in the average age of PCAs and LNAs who did and did not rate each of the benefits as among the three most important.

	PCA		LNA	
Important Benefits	Mean age	Std. Dev.	Mean age	Std. Dev.
tuition reimbursement				
yes	38.5	*13.6*	35.4	*13.8*
no	47.9	*14.1*	40.7	*12.7*
child care assistance				
yes	32.2	*10.3*	30.0	*8.6*
no	48.1	*14.0*	41.4	*12.9*

Reasonable Wages:

Respondents were asked to name a fair and reasonable wage for PCAs and LNAs. Administrators were asked to identify a wage for both groups and consumers were asked to name a fair wage for personal assistance services. PCAs were asked to name a wage for PCAs, while LNAs were asked for LNAs. Many respondents provided a range, and this was averaged into one figure. Some respondents specified that they were identifying a starting wage, while most did not.

	Administrators		PCAs		LNAs		Consumers	
Reasonable Wages	Mean	Std. Dev.	Mean	Std. Dev.	mean	Std. Dev.	Mean	Std. Dev.
PCA wage	$8.11	0.64	$9.60	1.50				
LNA wage	$9.86	1.23			$11.12	2.39		
Caregiver wage							$10.11	2.07

Consumers participating in the Waiver program suggested wages about $1.00 an hour higher than those in the other programs.

Consumer Program	Mean Caregiver Wage	Std. Deviation
no identified program	$9.75	1.77
ASP	$9.96	2.13
Waiver	$10.71	1.74
Total	$10.11	2.07

Administrators in nursing homes and home health agencies had similar expectations for wages.

	PCA wage		LNA wage	
Administrators Work Setting	Mean	Std. Dev.	Mean	Std. Dev.
Nursing Home	$8.11	*0.65*	$9.93	*1.35*
Home Health Agency	$8.24	*0.60*	$9.60	*0.74*
Nursing home & other	$7.25	*0.35*	$10.17	*2.02*
Home Health & other	$8.50	.	$10.00	.

PCAs serving in the Consumer/Surrogate Directed Waiver program thought wages should be slightly higher than those in other programs.

PCA Program	Mean PCA wage	Std. Deviation
Consumer/Surrogate Directed Waiver	$10.18	*1.95*
Attendant Services Program	$9.49	*1.49*
Home Health Waiver	$9.42	*1.25*
Total	$9.57	*1.49*

PCAs had similar expectations for wages across employers.

PCA Work setting	Mean PCA wage	Std. Deviation
Home, hired by client	$9.84	*1.81*
Home, hired by HHA	$9.34	*1.18*
other	$9.61	*1.39*
Total	$9.57	*1.49*

LNAs also had similar wage expectations across work settings.

LNA Work Setting	Mean LNA Wage	Std. Deviation
Home health	$11.35	1.97
Nursing Home	$11.05	2.55
Multiple Settings	$11.05	1.81
Other	$11.50	2.89
Total	$11.13	2.39

Expectations for wages increased with age in both PCA and LNA samples, until retirement age. At this point, LNA expectations fell sharply, while PCA expectations fell only slightly.

	PCA wage		LNA Wage	
Age category	Mean	Std. Deviation	Mean	Std. Deviation
under 20 years	$8.93	1.27	$10.14	1.17
21 to 35 years	$9.45	1.39	$11.01	1.87
36 to 50 years	$9.66	1.51	$11.38	3.07
51 to 65 years	$9.62	1.44	$11.22	1.82
66 years and over	$9.41	1.82	$9.98	1.55
Total	$9.56	1.49	$11.13	2.40