



# **Strategies to Invest in the Future of the Direct Care Workforce**



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## **New Hampshire Coalition for the Direct Care Workforce Members:**

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Jill Burke, Vice President of Long Term Supports; Granite State Independent Living

Robin Carlson, Direct Support Professional

Mary Ann Cooney, Deputy Commissioner; NH Department of Health and Human Services

Susan Covert, Facilitator; Consultant

Ellen Curelop RN, BS, CMC, President; Life Coping, Inc. Case Management

Laura Davie, Project Director; Institute for Health Policy and Practice, University of New Hampshire

Julia Eades, President; NH Community Loan Fund

Ellen Edgerly; Brain Injury Association

Tom Foulkes, Vice President Continuing and Corporate Education; NHTI Concord's Community College

Susan Fox, Institute on Disability; University of New Hampshire

Margaret Frankhauser, RN, MS, MPH, Executive Director; Community Health and Hospice, Inc.

Danielle Fuller, Director, Human Resources; Gateways Community Services

Dottie Gove, Home Care Program Director; Child and Family Services of New Hampshire, Inc.

Laurie Harding; NH House/ Armistead Caregiver Services

Rebecca Crosby-Hutchinson, Director; LSS In-Home Care Lutheran Social Services

Terry Lochhead, Consultant; Alliance for Retired Americans

Mary Maggioncalda, Administrator for Program and Policy Development; Bureau of Elderly and Adult Services, NH Department of Health and Human Services

Liz McConnell; Alzheimer's Association, MA/NH Chapter

Doug McNutt, Associate State Director for Advocacy; AARP NH

Alex Olins, Paraprofessional Health Institute

Kathleen F. Otte, Bureau Administrator; Bureau of Elderly and Adult Services, NH Department of Health and Human Services

David L. Ouellette; Council on Developmental Disabilities

Kimberly Persson, Research Associate; Institute for Health Policy and Practice, University of New Hampshire

Sally Varney, Quality Management Program Manager; Division of Community Based Care, NH Department of Health and Human Services

Margaret Walker; NH Board of Nursing

Susan M. Young, Executive Director; Home Care Association of New Hampshire

## KEY MESSAGES

With a population that is aging at a faster rate than the national average, New Hampshire needs a qualified direct care workforce capable of supporting our state's older citizens and those with disabilities to continue living in their homes and communities. The capacity of the state's direct care workforce currently is not adequate to meet this increasing demand for home-based supports and services.

The following are among the New Hampshire Coalition for the Direct Care Workforce's recommendations to address this issue:

- The New Hampshire Department of Health and Human Services should establish a rational rate setting and reimbursement process that will enable home care agencies to pay a livable wage to their direct care workers.
- New Hampshire stakeholders should work with its Congressional delegation to create federal reimbursement for the training of home and community-based workers. (Nursing facilities receive federal reimbursement for training their direct care workers.)
- New Hampshire home care agencies should implement a steady work week, create loan repayment programs for their direct care workers, and improve the quality of staff supervision.

## INTRODUCTION

With a population that is aging faster than the national average, New Hampshire can anticipate an increasing demand for healthcare and support services. Research shows that many Americans prefer home and community-based care facility-based services (HCBS). Further, providing care in home and community-based settings may be more cost-effective than institutional care. However, there is a real concern that resources for home and community-based care will be insufficient to meet demand in the coming years. This white paper explores the policy implications for New Hampshire as it confronts the challenge of how to attract and retain a direct care workforce capable of meeting the state's need for HCBS. It examines the state's current direct care workforce shortage and presents strategies for workforce retention. While direct care workers staff nursing facilities and other institutions, this paper focuses only on the direct care workforce employed in home and community-based settings.

Direct care workers provide essential HCBS for older adults and those who are chronically ill or have disabilities. The availability of this quality

direct care is a critical factor in supporting people so they are able to continue to reside in their own homes as their needs increase, rather than in residential facilities, such as nursing homes. In New Hampshire, the number of residents 65 and older is growing at twice the rate of the total population (Gittell, 2006). As the population ages, New Hampshire is expected to rely more heavily on HCBS for long-term care, as opposed to placements in nursing facilities and other residential settings (PHI, 2001). In order to ensure that quality home and community-based services will be available those who need them, the direct care workforce shortage must be addressed.

## BACKGROUND

New Hampshire has made concerted efforts to increase the accessibility of HCBS services. It was one of the first states in the nation to establish a statewide "single-point of entry" system for long-term care. This system provides information, counseling, and referrals to older adults and those who are chronically ill or have disabilities, helping them to access long-term care services, including HCBS. New Hampshire has been awarded federal grants to support the development of more flexible services and to improve accessibility to HCBS. In

2002, the State spent 9% (\$24 million) of its Medicaid funding on HCBS. Following the expansion of HCBS, 2007 figures show that HCBS spending increased to 13% (\$46 million) of the Medicaid long-term care budget, an increase of 44%. During this same time period, long-term care funding for nursing facilities decreased by 4% (Houser et al, 2009).

The shift in funding from institutional settings to home and community-based care represents a paradigm shift in how long-term care is delivered. The increasing demand for HCBS has resulted in a shortage of direct care workers. New Hampshire employers have experienced difficulty in recruiting and retaining direct care workers to provide HCBS, a problem that is expected to continue unless changes are made to address the quality of direct care jobs. Without an adequate and stable workforce, the State will not be able to meet the demands of the growing number of residents who need home and community-based services.

In 2007, the New Hampshire Community Loan Fund, as a state partner of the Paraprofessional Healthcare Institute’s (PHI) LEADS Institute (Leadership, Education and Advocacy for Direct Care and Support), convened representatives from the American Association of Retired Persons (AARP), the Home Care Association of New Hampshire, the Institute on Disability (IOD), and the New Hampshire Bureau of Elderly and Adult Services (BEAS) to discuss potential strategies for addressing the direct care workforce shortage.

Later that year, through a grant from the Centers for Medicare and Medicaid Services (CMS), BEAS invited Robyn Stone, DPH, an expert in healthcare and aging policy, to help launch a statewide effort to address the direct care workforce shortage. As a result, the New Hampshire Coalition for the Direct Care Workforce (NHCDCW) was formed. The Coalition, which meets bimonthly, is focused on understanding the demographics of the direct care workforce, educating legislators and policy makers regarding the needs of this workforce, and providing training and education on best practices

in the recruitment, training, and retention of direct care workers.

**TYPES OF LONG-TERM CARE**

Older adults and those with disabilities may require supports to meet their healthcare needs and assistance with personal care and activities of daily living (ADLs) (Super, 2002). Long-term care describes the range of healthcare and support services for people with disabilities or chronic illnesses. Long-term care encompasses both formal and informal supports and services and may be either medical or non-medical in nature. Most long-term care provides consumers with assistance in completing ADLs, such as dressing, bathing, and using the bathroom. Long-term can be provided in home and community-based settings, as well as in nursing homes and assisted living facilities (Medicare, 2009). Table 1 provides definitions of each type of care, based on criteria from the New Hampshire Department of Health and Human Services (NHDHHS).

**Table 1: Types of Long Term Care**

Type of Long Term Care	Description of Long Term Care Setting
Nursing Home Facility	Provides residency, meals, skilled nursing and rehabilitative care, medical services and protective supervision for eligible individuals who are ill, frail and need 24-hour supervision (NHDHHS, 2009).
Assisted Living Services	Provides care for adults who qualify for nursing home care and can no longer manage independent living in their own homes. Assisted living facilities provide support services based on the specific needs of the resident, and can include nursing care, personal care, homemaker services and medication management (NHDHHS, 2009).
Home and Community Based Services: Formal	Provides in-home nursing care, homemaker services, and respite care performed by an employee working for an HCBS agency (NHDHHS, 2009).
Home and Community Based Services: Informal	Provides in-home nursing care, homemaker services, and respite care performed by a close friend or family member, who is not paid to perform care (NHDHHS, 2009).

In 2003, the AARP conducted a survey of 805 randomly selected New Hampshire AARP members to inquire about their beliefs regarding long-term care options. Of the 805 respondents, 81% of those surveyed said that it was “very important” that people were provided with services that enabled them to remain in their homes (as compared to somewhat important, not important, or not sure). When asked about preferences for their own long-term care options, 70% reported that they would rather receive services at home than reside in a nursing home (6%) or in an assisted living facility (20%) (AARP, 2003).

Based on a multi-state analysis of Medicaid spending from 1995-2005, AARP found that states with established HCBS programs reduced their Medicaid spending over time (Mollica et al, 2009). These states were able to manage the growth in demand for long-term care services while maintaining control over their expenditures. Vermont’s experience with HCBS expansion is worth considering. In 2005, Vermont implemented “Choices for Care,” a long-term care Medicaid waiver. Under Choices for Care, older Vermonters and adults with physical disabilities who qualify for the waiver, are given an “allowance” of Medicaid dollars and may choose whether to receive services at home, in an assisted living facility, or in a nursing home. This program decreased the number of nursing home residents by 9% and increased HCBS caseloads by 155%. This included expanding HCBS services to 1,183 Vermonters in moderate-need of assistance. Choices for Care helped Vermont reduce long-term care spending growth by more than half of what was projected (State of Vermont, 2009).

Because direct care workers are generally paid lower wages than their nursing home counterparts, HCBS programs often save money. Additional savings take place as the number of HCBS hours required by individuals is significantly less than the 24 hour, 7 day per week care provided to patients in nursing facilities.

## THE HCBS DIRECT CARE WORKFORCE

Across all long term care settings nationally, direct care workers provide an estimated 70 to 80% of the paid hands-on long-term care and personal assistance received by Americans who are over the age of 65 or who have disabilities or other chronic conditions. The direct care workforce is comprised of approximately of 80-90% women. The majority of direct care workers is in the 25-54 age range (Harris-Kojetin et al, 2004).

**Table 2: Types of Direct Care Workers**

Type of Direct Care Workers	Job Description	Funding
LNAs	Must complete 100 hours of training and attain a license. Operate under the supervision of a nurse and provide assistance with ADLs such as eating, dressing, bathing, and toileting. Perform clinical tasks such as range-of-motion exercises and blood pressure readings. In some states, may also assist in administering oral medications (which requires additional training in NH) (NHDHHS, 2009).	Medicaid, Medicare, Private Insurance.
PCSPs/PCAs	Must complete 10 hours of training to work for agency-directed programs or licensed home health agencies. Provide non-medical assistance with ADLs and often help with housekeeping chores, meal preparation, and medication management. Help individuals go to work and remain engaged in their communities (PHI, Facts 3, 2009).	Medicaid.
Homemakers/ Companions	Provide services which do not involve physical contact with the individual, such as light housekeeping and meal preparation (PHI, Facts 3, 2009).	Social Services Block Grant (Title XX), Older Americans Act (Title III), or Medicaid HCBS, known in New Hampshire as Choices for Independence.

For the purpose of this paper, New Hampshire’s direct care workforce is comprised of three primary groups: Licensed Nursing Assistants (LNA), Personal Care Service Providers (PCSP)/ Personal Care Attendants (PCA), and Homemaker/Companions. Information about each category is provided in Table 2.

As previously discussed, demand for direct care workers in home and community settings is expected to increase significantly in the coming years. Although future demand cannot be predicted with complete certainty, demographic trends indicate a growing gap between the number of people who are likely to need care and the number of people who will be able to provide it. Finding qualified workers to fill these job openings will be challenging.

### DIRECT CARE WORKFORCE SHORTAGE IN NEW HAMPSHIRE

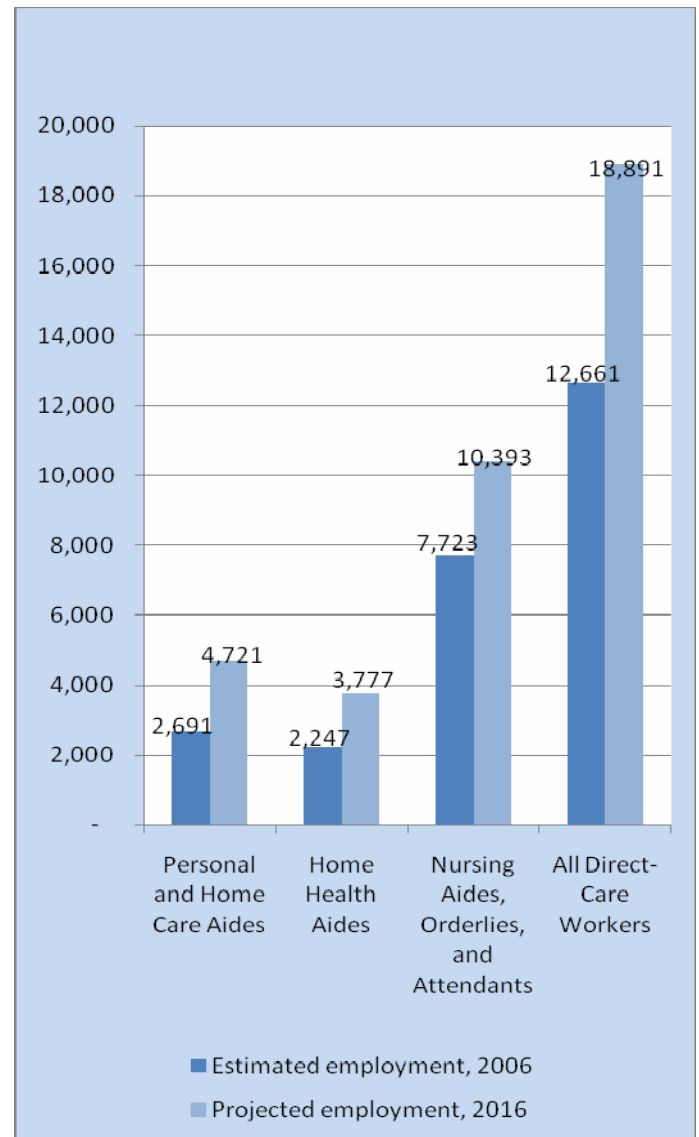
New Hampshire is a rapidly aging state. In 2000, New Hampshire was nationally ranked 42<sup>nd</sup> for the percentage of the population aged 65 and older. By 2030, it is estimated that New Hampshire will rank 17<sup>th</sup> in this category (U.S. Census, 2008). The number of New Hampshire residents 65 and older will have increased 138% in 30 years (U.S. Census, 2005). The group relying most heavily on the direct care workforce, those who are 85 and older, will have increased by 146% (U.S. Census, 2005).

According to 2007 estimates, there were approximately 26,000 working-age adults (ages 21-64) in New Hampshire who are living with a self-care disability. A self-care disability is defined as any disability—physical, mental, or emotional—that causes difficulty in dressing, bathing, or navigating the home (Erickson & Lee, 2008).

Employment security forecasters anticipate an increase in the need for direct care workers.

Occupational growth projections<sup>1</sup> from the New Hampshire Department of Employment Security (NHDES) for 2006-2016 show that direct care occupations—Personal Care Aides, Home Health Aides, and Nursing Aides/LNAs, Orderlies and Attendants—are expected to add over 6,000 jobs by 2016. This is a 50% growth rate over a decade (PHI Analysis, 2009), as shown in Figure 1.

**Figure 1: Direct care Workforce Growth in NH, 2006-2016**



<sup>1</sup> PHI’s employment projections analysis takes into consideration both new job openings and openings arising from replacements (retirements, and /or people leaving the profession). 2016 projections on the NHDES website do not factor in job growth due to replacements.

Personal Care Aides and Home Health Aides are also among the fastest-growing occupations in New Hampshire. Among occupations expected to generate over 1,000 jobs by 2016, Personal Care

Aides rank third, growing by 75%, and Home Health Aides rank fifth, growing by 68% (PHI Analysis, 2009). Table 3 provides more detail about this growth.

**Table 3: Projected Job Growth in New Hampshire**

Table 3: Projected Rank	Occupation Title	Estimated 2006 employment	Projected 2016 employment	Total openings: 2006-2016	Growth Rate
1	Counter Attendants, Cafeteria, Food Concession, and Coffee Shop	2,906	5,406	2,500	86%
2	Hosts and Hostesses, Restaurant, Lounge, and Coffee Shop	1,859	3,429	1,570	84%
3	Personal and Home Care Aides	2,691	4,721	2,030	75%
4	Waiters and Waitresses	12,170	20,780	8,610	71%
5	Home Health Aides	2,247	3,777	1,530	68%

The projected growth in demand for workers, however, is not matched by a commensurate growth in the supply of workers. PHI’s calculations, based on the New Hampshire Employment Security occupational projections, U.S. Census Bureau demographic projections data, and Bureau of Labor

Statistics (BLS) labor force participation data, show that growth in demand for direct care workers is expected to outpace the growth in the supply of available workers, women aged 25-54, who are the core labor pool for this workforce.

**Figure 2: New Hampshire’s Projected Direct Care Workforce Shortage**

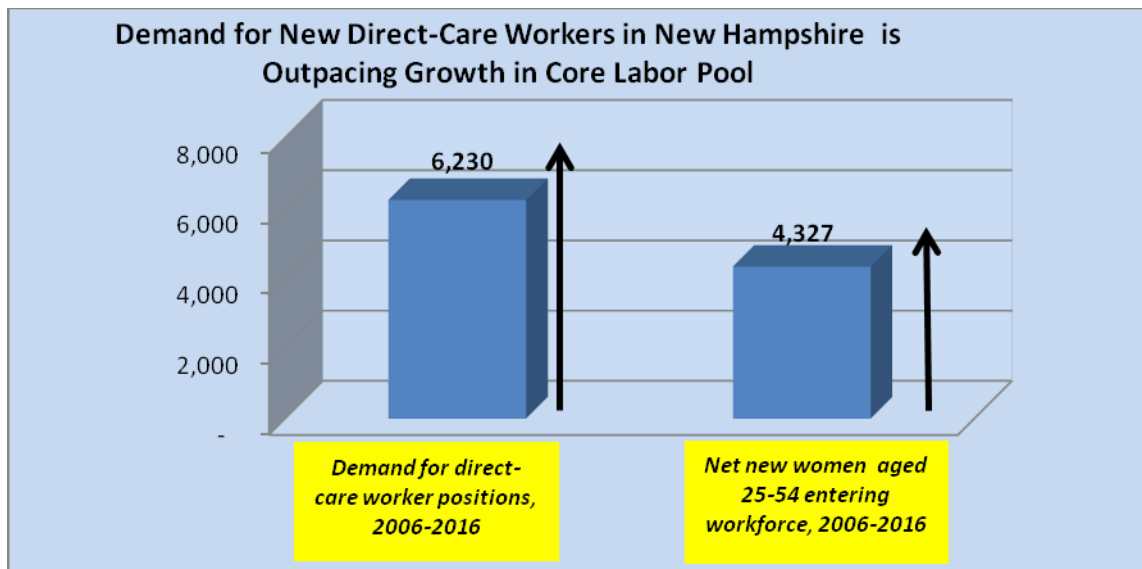




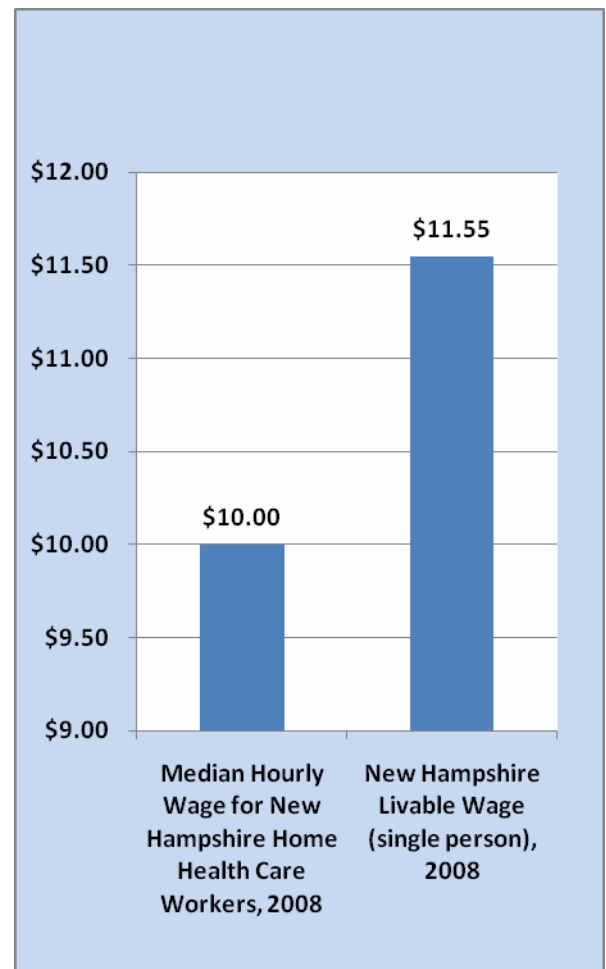
Figure 2 shows that from 2006-2016, the state will need an estimated 6,230 additional direct care workers, while the net number of new women, aged 25-54, entering the New Hampshire labor force is expected to be only 4,198 (PHI Analysis, 2009).

Fewer new workers are entering the long-term care workforce due to increased opportunities in other fields. As compared to 40 years ago, women in particular now are able to select from careers that pay far better and are less physically strenuous than direct care employment (Super, 2002).

PHI's calculations based on wage data from the BLS Occupational Employment Survey show that median hourly wages for New Hampshire's HCBS workers are lower than the state's livable wage, which is the estimated hourly wage that a New Hampshire resident needs to earn in order to meet basic needs such as housing, food, transportation, child care and healthcare (PHI Analysis, 2009). In 2008, the median hourly wage for Home Health Aides and Personal and Home Care Aides was \$10, while the state's hourly livable wage for a single person was \$11.55. These figures indicate that direct care wages are not adequate to meet the workers' basic needs. Low wages pose a major challenge in the recruitment and retention of this critical workforce.

A 2008 report published by the Carsey Institute at the University of New Hampshire indicates that of the forty occupations projected to grow the fastest from 2006 to 2016, only two occupations paid a median hourly wage below the state's 2007 livable wage: Home Health Aides and Personal Care Aides (Kenyan and Churilla, 2008).

**Figure 3: New Hampshire HCBS Worker Wage Compared to State's Livable Wage, 2008**



### ISSUES IMPACTING THE NEW HAMPSHIRE HCBS DIRECT CARE WORKFORCE

A 2008 survey developed by the NHCDCW, New Hampshire Institute for Health Policy and Practice and Carsey Institute at the University of New Hampshire, and implemented by the University of New Hampshire Survey Center, provides detailed information about the issues impacting the State's direct care workforce. The purpose of the survey was to quantify the current workforce demographics, capture wage and benefit ranges, and identify recruitment and retention issues for home and community-based direct care workers.

It is expected that survey results will help to guide the NHDCW and state policy makers in addressing New Hampshire’s HCBS direct care workforce shortage.

The New Hampshire direct care workforce survey was conducted in two parts: an employer component and a separate employee component.<sup>2</sup>

**Employer Perspective**

The Survey Center contacted all 60 New Hampshire agencies that employ HCBS direct care workers and 38 agencies responded. All three types of direct care workers were represented in this sample. A summary of the types of agencies is provided in Table 4.

**Table 4: Type of Agency**

Type of Agency	Number of Agencies
Private, non-profit	22
Publicly owned and operated	3
Private, for profit	9
Associated with health system or hospital	5

According to the survey results:

- Almost three-quarters of employers reported offering health insurance benefits to employees. Most stipulated eligibility criteria, such as tenure at the agency and minimum hours worked per week, to qualify for health insurance benefits. Employers reported that the average monthly health insurance premium paid by employees for individual coverage is \$91.

<sup>2</sup> For more information about the NH Direct Care Workforce Survey, see Smith, 2009.

- 87% of employers surveyed reported that job retention was an issue.
- 81% reported a current need to hire direct care workers in order to meet service demands
- Eight in ten employers reported reimbursing for mileage. Of the agencies providing mileage reimbursement, the average reimbursement rate was \$.49 per mile with a range of \$.25 to \$.585 per mile.<sup>3</sup>
- When driving between consumer homes, some direct care workers were paid a wage below their usual hourly rate and sometimes as little as minimum wage.<sup>4</sup>

**Employee Perspective**

The second component of the survey focused on HCBS direct care workers. The total number of respondents was 579. Table 5 displays the demographics of the survey respondents.

**Factors Influencing Job Satisfaction**

When direct care workers were asked what would improve their jobs, the greatest number identified increased pay, increased access to benefits, and more paid leave. Over three-quarters of the group identified the desire for higher pay, almost half expressed a need for increased access to benefits, and almost one-third reported a desire for more time off.

**Hours & Wages**

Less than one-third of direct care workers were employed by one employer on a full-time basis (35 or more hours per week). Over 15% reported working multiple jobs to achieve full-time work. This approach was effective in regards to increasing one’s income, however, it did not increase benefits as full-time hours were not met at one company.

<sup>3</sup> In June 2008, the federal mileage reimbursement rate was \$.505 per mile. This figure jumped to \$.585 per mile in July 2008.

<sup>4</sup> Federal law requires employers to pay their employees for time spent on work-related travel.

Over 46% of direct care workers had more than one job. On average, direct care workers worked 33 hours per week with 24 of the hours associated with direct care work.

**Table 5: Demographics of Respondents to the Direct Care Worker Survey**

Sex	90% female
Average Age	48 years old
Married	58%
Minor children living in-home	33%
Single mothers	11%
Education:	
High School Diploma or less	47%
Some college experience	40%
Associate’s or bachelor’s	13%
Family income less than \$30,000	52%

The median hourly wage for HCBS workers was \$10 for part-time workers and \$10.25 for full-time workers. Among the categories of direct care workers, LNAs earned the highest median hourly wage at \$11.77. PCSPs/PCAs earned a median hourly wage of \$10.00 and homemaker/companions earned a median hourly wage of \$8.98. These wages were not dependent on educational level. A direct care worker without a high school diploma earned the same wage as a worker with a college degree. Assuming that a full-time direct care worker worked 40 hours per week for 50 weeks per year, at the median hourly full-time rate of \$10.25, she earns \$20,500 per year. In comparison, the median annual salary in New Hampshire (in all job categories) is currently \$40,000 (Smith, 2009).

**Health Insurance**

Over one-third of direct care workers did not have health insurance. Survey responses from direct care workers indicate that the primary reason for this was that the premiums on employer sponsored plans were too expensive. Other primary responses indicated that employers did not offer insurance or that employees were ineligible to qualify for employer sponsored insurance plans.

Less than one-fifth of direct care workers participated in employer sponsored health insurance. Using the monthly health insurance premium of \$91 for an individual, over the course of a year, an employee earning \$20,500 spends more than 5% of her income on health insurance.

**Paid Leave**

Only one-third of HCBS workers report receiving one or more types of paid leave. Employees who receive paid time off benefits, as with the health insurance benefit, must meet eligibility criteria such as tenure at agency and minimum hours worked per week.

**IMPROVING DIRECT CARE JOBS: WORKFORCE RETENTION STRATEGIES**

There is evidence demonstrating direct care needs will increase in the near future and that demand will outpace supply. The increased demand is due to the rapidly aging population in New Hampshire. The decreased supply of direct care workers is caused by a combination of factors: the aging of the current workforce, wages that are below the State’s determined livable wage, and unaffordable or unavailable benefits. The strategies below outline initiatives that speak to the three systems needing change in order to address this multi-faceted problem— state government, federal government, and local agencies.

**Identified Problem:** The State of New Hampshire Medicaid reimbursement structure does not compensate agencies to adequately provide direct care workers with a livable wage and access to sufficient benefits.

**The Coalition suggests the following initiatives to address this problem:**

**Change the reimbursement structure.** Explore the establishment of a reimbursement incentive structure that pays agencies according to the level of wage and benefits that they provide to their direct care employees. Possible solutions include developing a tiered approach or a pay-for-performance model that would increase agency reimbursement as agencies improve employee wages and benefits. This restructuring could include such benchmarks as providing: a salary that meets the livable wage, access to affordable health insurance, paid leave, mileage reimbursement at the federal rate, and increasing travel pay to meet base rate of pay.

**Establish a rational rate-setting process.** Explore the establishment of a rational rate-setting process under New Hampshire Medicaid that examines the true cost of providing quality direct care. In developing rates, agency overhead - wages, benefits, administrative costs - should all be considered. Current reimbursement rates are inadequate, leaving employers unable to offer livable wages or provide adequate benefits. Provider agencies are forced to supplement direct care positions through other funding streams. Rhode Island has utilized a rational rate setting strategy for several years. Rhode Island provides a base rate of reimbursement for each 15 minute unit of time that an employee spends providing care. It increases the base rate of reimbursement when specific performance measures are provided. Measures utilized in Rhode Island include client satisfaction, continuity of care, worker satisfaction, accreditation, patient acuity, staff education and training, and shift differential. Rate increases can range from \$.50 to \$1.50 per hour (PHI, 2008).

**Identified Problem:** Federal reimbursement rates for agencies providing education, training benefits, and career advancement opportunities for direct care workers are biased towards institutional settings.

**The Coalition suggests the following initiatives to address this problem:**

**Provide tuition support.** Currently, the Centers for Medicare and Medicaid provide reimbursement to agencies that train direct care workers for employment in institutional settings. Agencies providing training to direct care staff who work in home and community-based settings are not reimbursed for the cost of training. Federally funded reimbursement should be available to home and community-based service agencies for training direct care workers. Opportunities to improve skills and increase career advancement will aid in retention of this workforce. Changes at the federal level will be needed to address this issue.

**Fund peer mentor training programs.** Research has shown that direct care workers who are trained as peer mentors provide effective support to new workers and decrease employee turnover rates. Due to the strenuous nature of direct care and the social isolation of home-based care, many workers leave their jobs during the initial weeks or months of work. By sharing their knowledge and skills, mentors can answer questions, acclimate workers to the job, and help new employees discover the rewards of providing quality direct care. A federally funded reimbursement program aimed at training veteran direct care workers to become peer mentors should be developed. Agencies have already begun implementing this strategy. Those providing a higher rate of pay to peer mentors have been most successful in implementing the program (PHI, 2009, Building Skills).

**Identified Problem:** New Hampshire's home care agencies have difficulty supporting and retaining their direct care workers.

**The Coalition suggests the following initiatives to address this problem:**

**Implement a steady work program.** A steady work program is designed to stabilize the fluctuating work-week experienced by direct care workers when the individual they are supporting enters the hospital or passes away. A steady work program replaces an employee's lost wages for up to two months in situations when her hours are decreased by at least 20%. The employee could be asked to perform tasks other than those of direct care work and might work outside of her normal schedule. If no work can be found, she will still be paid. This program was successfully piloted at Quality Care Partners (QCP), a home care agency, in Manchester, New Hampshire. The expansion of a steady work program across the state could be a winning retention strategy for the home and community-based workforce (PHI, 2001).

**Establish an employee loan program.** An employee loan program offers access to immediate, interest-free loans. QCP provides this service to their employees and the program has been popular with its direct care workers. Utilizing the agency's reserves, employees can access loans of up to \$250 after being employed by the agency for 90 days and are in good standing with the company. Loans are paid back in \$25 or \$50 installments via automatic withdrawal from the employee's paycheck. If the employee leaves QCP prior to paying the balance, the remainder is obtained from their last pay check. In the ten years the program has been in place, QCP has lost less than \$500. In 2007 and 2008, they loaned \$11,215 without any loss. While employee loan programs do not increase employee income, they do provide a no-interest alternative to other lenders. In addition, these programs can be offered at hardly any cost to the agency.

**Incorporate a coaching supervision training program.** Training in Coaching Supervision for facility managers has been found to improve the work environment for direct care workers in institutional settings (PHI Supervision, 2007). Given the similarities of the workforce, it is likely that expanding this initiative for supervisors in HCBS would be beneficial. Licensed nurses and other supervisors learn to support direct care staff while still holding them accountable. By building constructive, positive relationships, managers and supervisors show respect for staff, while at the same time helping them to become better communicators and more effective at problem solving (PHI Supervision, 2007). New Hampshire can build on the PHI Coaching Supervision program, which is currently being implemented at a few long-term care agencies in New Hampshire.

## CONCLUSION

In order for New Hampshire to provide quality home and community-based services the state must be able to attract and retain an adequate direct care workforce. Projections show New Hampshire's population is rapidly aging at the same time that the pool of direct care workers is not adequate to meet the demand. The implication of this projected workforce shortage could mean that older adults and those who are chronically ill or have disabilities will have significantly fewer options for where and how they receive the care that they need. The State must act. The New Hampshire Coalition on the Direct Care Workforce will work with stakeholders to develop and implement the strategies proposed in this paper to improve the recruitment, training, and retention for this critical workforce. The Coalition welcomes the opportunity to collaborate with the Department of Health and Human Services, the State Legislature, direct care employees and employers, and other key stakeholders to address this crucial issue.

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