

**BOARD OF HIGHER EDUCATION**  
**REQUEST FOR COMMITTEE AND BOARD ACTION**

**COMMITTEE:** Academic Affairs

**NO.:** AAC 14-63

**COMMITTEE DATE:** June 10, 2014

**BOARD DATE:** June 17, 2014

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**ALLIED HEALTH –DIRECT CARE WORKFORCE PLAN**

**MOVED:** The Board hereby accepts the Allied Health-Direct Care Workforce Plan, as presented by the Department of Higher Education. The Board calls upon the Presidents and the campuses to follow up along the lines outlined in the document, and calls upon the Commissioner to report back to the Board by June 2015 on progress implementing the plan.

The Board reconfigures the Healthcare Advisory Committee structure as follows: The Healthcare Workforce Advisory committee, which includes representatives of healthcare employers and educators and provides guidance to the DHE, will include two working groups: the Nursing Working Group, and the Allied Health Working Group.

**Authority:** M.G.L. c. 15A, § 9 and 6; Section 2 of Chapter 38 of the Acts of 2013 (Line Item 7066-0020)

**Contact:** David Cedrone, Associate Commissioner Economic and Workforce Development and STEM



## Background Briefing: Allied Health-Direct Care Workforce Plan

June 2014

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### Status

Introduction to Allied Health-Direct Care Workforce Plan discussed at the May 2014 BHE meeting. The Workforce Plan on which the BHE is voting in June expands on the initial thinking in this introduction. The June 2014 motion (1) Accepts and endorses the Allied Health-Direct Care Workforce Plan, (2) Reconfigures the Healthcare Advisory Committee structure, and (3) Charges the Commissioner with returning to the board by June 2015 to report on progress implementing the plan.

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### Context



▲ KEY OUTCOMES 1 & 4: ▲

### College Participation & Workforce Alignment

Direct care jobs represent an entry point for career pathways to health care professional occupations requiring postsecondary degrees. The Allied Health-Direct Care Workforce Plan addresses the health care sector's need for an expanded Direct Care workforce within the context of Vision Project goals.

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### Key Issues for BHE Consideration

#### Characteristics of Direct Care Workforce:

- **Jobs:**
  - **Medical Assistants, Certified Nurse Assistants** (trained in higher education certificate programs, gateways to other professional allied health occupations)
  - **Home Health Aides, Personal Care Aides** (trained outside of higher education in not-for-credit programs, gateways to Medical and Nurse Assistants and more)
- **Employers:** Nursing and residential care facilities, ambulatory healthcare services, patients and family members

- **Demographics:** Ranges from 32–48% persons of color depending on job; will increasingly be filled by new immigrants. In comparison, 12% of registered nurses are persons of color.
- **Salary:** Average \$29,400<sup>1</sup> (\$5,500 below MA per-capita median<sup>2</sup>); many entry-level salaries are below poverty level
- **Education:** Entry level jobs generally do not require credit-based certificate or a degree. Pathways lead to a range of professional occupations that can require an associate through masters degree and beyond.

**Growing field:** Massachusetts' Direct Care workforce grew 33% from 2002 to 2012, while the Health Care and Social Services workforce grew 21%, and the larger economy grew 1%.

**Racially/ethnically diverse workforce:** Tending to this workforce will help to diversify both this tier and, workforce if these workers are able to advance in their education, higher tiers of Massachusetts' health care and careers.

**Role of for-profit institutions:** The majority of Medical Assistants, a gateway to professional allied health occupations, are currently educated by for-profit institutions.

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## Additional Resources

**June 2014:** *Allied Health-Direct Care Workforce Plan – in mailing*

**May 2014:** *Introduction to Industry Workforce Analysis: Health Care Sector – Allied Health* <http://bit.ly/1sbLBxK>

**December 2012:** *Nursing & Allied Health Workforce Strategic Plan* endorsed by BHE <http://bit.ly/1mvoVtk>

**The Vision Project:** [www.mass.edu/visionproject](http://www.mass.edu/visionproject)

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## Authority

- M.G.L. c. 15A, § 9
- Section 2 of Chapter 38 of the Acts of 2013 (Line Item 7066-0020)

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## Staff Contact

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<sup>1</sup> Unless otherwise noted, data is from *Introduction to Industry Workforce Analysis: Health Care Sector – Allied Health*, May 2014.

<sup>2</sup> U.S. Census, American Community Survey 2013

# Massachusetts Allied Health – Direct Care Workforce Plan

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## Executive Summary

Massachusetts, like the nation, is facing the challenge of providing high-quality and affordable, individual-centered health care to all members of our society, serving a population that is aging and becoming increasingly diverse. To address this challenge, the education and training, workforce development and health care provider community must build a workforce pipeline sufficient in capacity and capability to (1) address the health care needs of the unique population of individuals in each region of the commonwealth, (2) deliver contemporary health care services based upon industry-defined skill competencies that span the care continuum, (3) meet the job requirements of employers in rapidly evolving and emerging care delivery settings, and (4) provide seamless academic and career pathways for workers to enter the industry and progress in their careers through higher-levels of education.

Our health care system is transforming from a focus on acute-care hospitals to community-based settings as the central focus of health care delivery. As a result of this transition, demand for direct care workers is growing rapidly and this growth is projected to continue for the next decade. Direct care jobs represent entry-level access points to health care careers for many adult as well as traditional-age students who aspire to advance to higher-level jobs paying family sustaining wages, over time, and provide an opportunity to increase the college going rate for many students.

As our society continues to diversify and the health care profession pursues the principle of “patient centered care” it is essential that the health care provider community reflect the patient demographic that it serves. Today the direct care workforce has much greater racial and ethnic diversity than the incumbent nursing and allied health professional occupations. Therefore, over-time, this pipeline of workers will diversify the health care profession through the progression of workers to higher level jobs that require more advanced education and the credentials of credit bearing certificates and degrees.

Entry-level direct care support jobs are accessible with a modest amount of post-secondary training, often non-credit programs, and as such present a vital pathway to above minimum wage work and careers that can provide family-supporting wages. The workforce that seeks out these jobs presents many challenges as candidates often lack fluency in English and generally lack a foundation in numeracy and the application of technology as a tool for health care delivery. It is important to note that some students in this pipeline are functionally literate in the language of the communities they seek to serve and others hold health care certifications in their home countries that only need validation, locally. Therefore, this workforce requires an array of support services, including access to financial aid, to become ready for job training programs and will need stackable, articulated coursework to further develop their knowledge, skills and abilities for advancement to higher level certifications and college degree programs.

Higher Education and job training programs, including those delivered by community-based organizations working in partnership with community colleges, must be aligned to the competency requirements of employers in key industry sectors and deliver predictable student learning outcomes. The current array of training and certificate/degree programs that address direct care jobs are not well aligned to meet employer expectations regionally and statewide. Nor are these programs based on common core-competencies to promote seamless and accelerated career progression of workers. Further, these non-credit training programs must also articulate to credit-bearing certificates and degrees to ensure seamless academic progression for workers and students. Just as credit transfer is a priority for students who progress from 2 year to 4 year programs in higher education institutions, it is equally important that non-credit training “stack” to for-credit coursework, certificates and degrees, providing portable building blocks that reinforce student learning outcomes and progression to higher levels of education and careers.

Many agencies of state government as well as industry associations, non-profit organizations, employers and labor representatives influence the landscape of direct care workforce development. While no one organization or institution can or should fully address all of the challenges of this workforce, education is a common thread and therefore DHE has convened a comprehensive discussion and planning initiative to build a robust and sustainable health care workforce pipeline. For some important elements of this work, other organizations will naturally be called upon to take the lead and, as appropriate, advocate for solutions to vexing problems that face this workforce.

Finally, there are multiple sources of funding and other resources that must be coordinated to create curriculum and program alignment and to achieve scale of implementation and sustainability over time. A broad community has contributed to the development of this workforce plan and will be instrumental in their continued contribution through an advisory committee structure. This community will guide investments through a clear set of workforce development priorities to build and sustain the necessary capacity of the direct care workforce.

This plan concludes with actionable recommendations developed by a representative working group who are deeply engaged and committed to enact short term projects and mid to long term strategies necessary to address the challenges of the direct care workforce and to meet the health care needs of the citizens of the Commonwealth.

## **Introduction**

The Department of Higher Education's (DHE) Vision Project addresses the need to align education and training programs offered by the state's 29 public higher education institutions to meet the workforce requirements of Massachusetts' leading innovation and economic sectors: Health Care, Technology, Life Sciences and Advanced Manufacturing. Employers in these sectors provide high-quality careers for many residents of the Commonwealth and represent employment growth potential that will benefit even more members of our community in the future. These industries are each experiencing significant change due to somewhat different market forces, yet one result is consistent: current workers are challenged to keep pace with constant and often rapidly-changing job competency requirements and prospective workers (students) must be prepared with industry relevant knowledge, skills and abilities to productively contribute on their first day of work and to continue learning throughout their careers.

## **Health Care Reform and Workforce Development**

In the next decade, the number of people age 60 or older in Massachusetts will increase by more than a quarter of a million, to nearly 1.6 million people. It is estimated that at least two-thirds of these individuals will require assistance in meeting their long term care support needs at some point in their lives<sup>1</sup>. This demographic shift in which the population of older adults requiring care grows faster than the population of working-age adults will further increase the demands on and requirement for front-line health care workers.

Massachusetts, like the nation, is facing the challenge of providing high-quality and affordable, individual-centered health care to all members of our society, serving a population that is aging and becoming increasingly diverse. To address this challenge, the education and training, workforce development and health care provider community must build a workforce pipeline sufficient in capacity and capability to (1) address the health care needs of the unique population of individuals in each region of the commonwealth, (2) deliver contemporary health care services based upon industry-defined skill competencies that span the care continuum, (3) meet the job requirements of employers in rapidly evolving and emerging care delivery settings, and (4) provide seamless academic and career pathways for workers to enter the industry and progress in their careers through higher-levels of education.

## **Allied Health Workforce**

In developing the first release of Massachusetts' Health Care Workforce plan (2012), the Department of Higher Education (DHE) addressed nursing as the first priority due to the pivotal nature of nurses both as care providers and leaders of inter-professional health care teams. Over the past year, the DHE engaged an Allied Health working group including campus, industry and employer representatives to

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<sup>1</sup> Massachusetts PHCAST Final Evaluation Report, Bercaw, L., Winchester, L (2014) (note: website to be forwarded)

develop a shared understanding of the allied health workforce priorities and provide a planning framework to complement the nursing workforce plan.

About half of the people who work in the Healthcare and Social Assistance Sector can be categorized as health care professionals (requiring at least an associate degree) or health care support workers (requiring a certificate of completion of a job training program). Health care professionals include occupations such as; registered nurse, radiologic technologist, laboratory technicians, respiratory therapists, diagnostic medical sonographers and more. Health care support workers include occupations such as certified nurse assistants, home health aides, medical assistants and dental assistants. The remaining half of the workforce is comprised of non-health care occupations including administrators, managers, social service workers and food preparation workers (Chartbook<sup>2</sup>, pg 22).

Registered Nurses represent the largest occupational grouping of the professional healthcare workforce numbering approximately 87,000 (2011) and are the focus of the *Nursing Workforce Plan* (2012). Radiologic Technologists (6,600), Dental Hygienists (6,000) and Laboratory Technicians (6,000) are the largest of the allied health professional occupations, followed by Respiratory Therapists (2200), Physical Therapy Assistants (2300), Nuclear Medical Technologists (660) and other specialties in occupational categories of approximately 2,000 or less, each (Chartbook, pg 29).

These professional occupations are each important elements of the allied health workforce and also represent career progression opportunities for many entry level workers who aspire to become a “nurse” and who may not be fully aware of the broader range of occupations within the allied health field. In building a pipeline of health care support workers who, over time, can progress to higher-level career opportunities, we will address near-term workforce shortages in these occupations while providing pathways to future opportunities for entry level workers who want to progress in their careers.

Although allied health professional occupations often present critical demand/supply gaps when vacancies occur, they have not been identified by the employer community as representing the near-term highest priority for allied health workforce development. As health care reform is transforming the care delivery model to place an increased focus on community-based care, and as demographic changes are significantly increasing demand for health care services, the direct care segment of the health care support workforce has been identified as the top priority now and for the foreseeable future.

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<sup>2</sup> Commonwealth Corporation and MA Department of Higher Education. 2013. Massachusetts Healthcare Chartbook. [http://www.mass.edu/currentinit/Nursing/Docs/Mass\\_Healthcare\\_Chartbook.pdf](http://www.mass.edu/currentinit/Nursing/Docs/Mass_Healthcare_Chartbook.pdf)

## Direct Care Job Growth

Direct Care workers, including **certified nurse assistants, medical assistants, personal care and home health aides**, are the largest and most rapidly growing segment of the allied health workforce and represent the new “front line” of health care delivery – community-based care. As shown in Table 1, job growth in the Health Care and Social Service sector outpaced total employment growth in the period of 2002 to 2012 and the direct care workforce grew 50% faster than the Health Care and Social Services sector, overall.

**Growth of Employment in the Health Care Industry and Direct Care Jobs, Massachusetts - Table 1**

	2002	2012	Avg. Annual Job Growth 2002-2012	2020 Projected	Projected Avg. Annual Growth Rate 2010-2020
Total Employment (all sectors)	3,200,230	3,242,273	0.01%	3,833,720	1.3%
Healthcare & Social Services Industry	440,850	541,131	2.1%	630,325	2.1%
Direct Care Workers	67,200	93,220	3.3%	124,123	2.8%

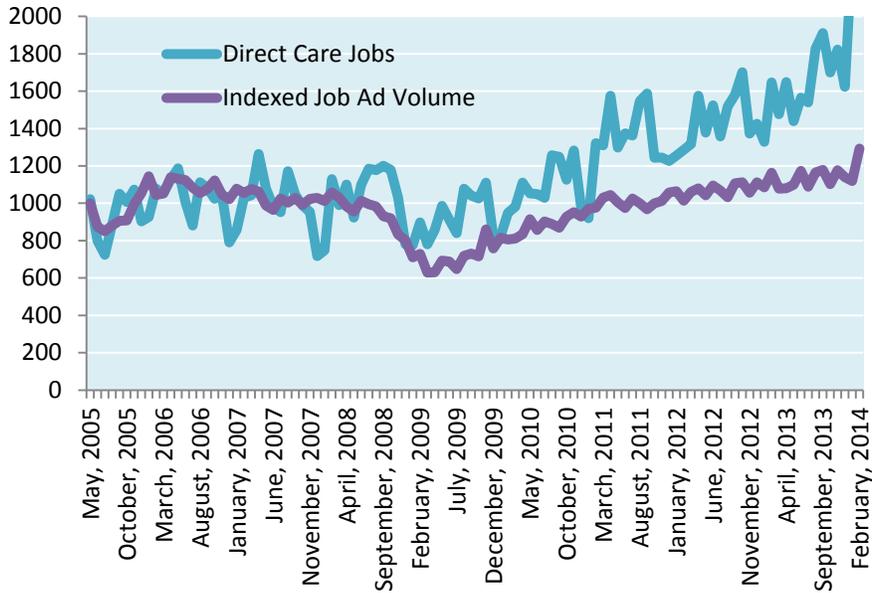
Source: U.S. Bureau of Labor Statistics, Quarterly Census of Employment and Wages, NAICS 62 health care and social assistance, 2002-June 2013, and OES 2002-2012; Massachusetts Executive Office of Labor and Workforce Development, Industry and Occupational Projections 2010-2020.

*It should be noted that anecdotal reactions to these data by employers and industry representatives suggest that the projected rate of growth in the following charts does not reflect transitions that are already occurring in the industry and that the growth curve may be significantly steeper for direct care jobs over the coming decade. In addition, high turnover within direct care occupations place additional recruitment and new employee orientation burdens on employers above and beyond the challenges of growth.*

This growth in direct care jobs is further reinforced in online job-postings which have outpaced overall job ad volume since 2009 (Chart1). Direct care jobs are projected to continue to grow reaching 20% of Health Care and Social Services jobs by 2020 (Chart 2). The Executive Office of Labor and Workforce Development projects that growth in employment will be moderate to strong in all regions. A regional breakdown of projected job growth is provided in Table 2.

### Online Job Postings, Massachusetts – Chart 1

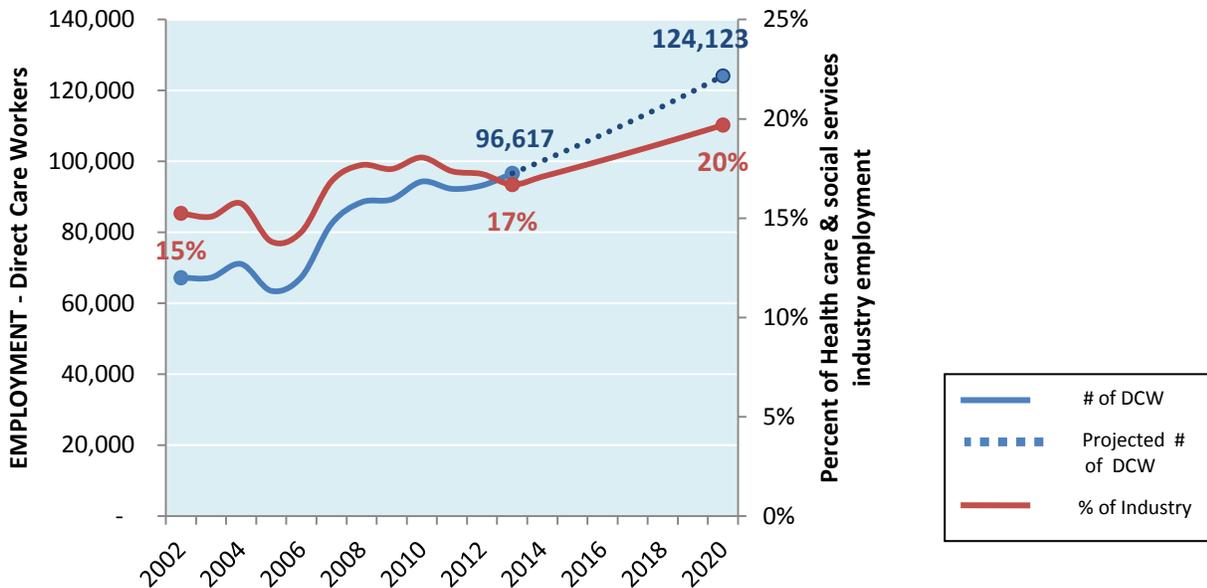
Job Postings for Direct Care Jobs have Grown Faster Than Jobs Overall in the Last Ten Years.



The Conference Board HWOL. New Unique Ads for Medical Assistants, Nursing Assistants, Home Health Aides, and Personal Care Aides. 2013-11-19 to 2014-03-18. Total job posting volume indexed with May 2005=1000.

### Growth of Direct Care Jobs, Massachusetts - Chart 2

Direct Care Jobs are a rising share of employment in the growing Health Care and Social Services Industry



Source: Bureau of Labor Statistics / Massachusetts EOLWD. Occupational and Industry statistics and projections.

**Massachusetts Regional Projections for Selected Direct Care Occupations – Table 2**

	Projected Growth 2010-2020	Estimated Employment 2010	Projected Annual Openings for New Workers <i>(Excludes Job Changers within an occupation)</i>				Total
			Home Health Aides	Nursing Aides	Personal Care Aides	Medical Assistants	
Berkshire WIA	<i>moderate (&lt;20%)</i>	2,357	22	19	18	5	64
Boston WIA	<i>High (&gt;30%)</i>	14,163	217	201	127	114	659
Bristol County WIA	<i>High (&gt;30%)</i>	4,483	34	93	65	22	214
Brockton WIA	<i>moderate (&lt;20%)</i>	2,769	28	23	14	7	72
Cape & Islands WIA	<i>High (&gt;30%)</i>	2,902	70	98	70	19	257
Central MA WIA	<i>High (&gt;30%)</i>	7,151	114	123	63	38	338
Franklin/Hampshire WIA	<i>High (&gt;30%)</i>	2,621	29	50	29	6	114
Greater Lowell WIA	<i>High (&gt;30%)</i>	2,575	32	42	32	11	117
Greater New Bedford WIA	<i>20%-30%</i>	3,244	33	50	28	12	123
Hampden County WIA	<i>20%-30%</i>	8,333	61	79	115	33	288
Lower Merrimack Valley	<i>High (&gt;30%)</i>	4,119	61	65	94	19	239
Metro North WIA	<i>20%-30%</i>	10,055	111	118	116	53	398
Metro South/West WIA	<i>20%-30%</i>	12,637	138	133	139	38	448
North Central WIA	<i>High (&gt;30%)</i>	2,330	29	39	30	9	107
North Shore WIA	<i>moderate (&lt;20%)</i>	7,679	181	59	68	24	332
South Shore WIA	<i>20%-30%</i>	6,914	57	109	78	21	265
<b>Statewide Total</b>	<b>32%</b>	<b>94,324</b>	<b>1,161</b>	<b>1,349</b>	<b>1,165</b>	<b>445</b>	<b>4,120</b>

Source: Estimates prepared by DHE based on data from Massachusetts Executive Office of Labor and Workforce Development. LMI. Long-Term Occupational Projections. DHE allocated all employment to regions and calculated estimates for suppressed fields based on the region's share of NAICS 62 Healthcare and social service employment.

While both the Bureau of Labor Statistics projections and the trends in online job postings show that the highest growth rate in new direct care jobs is expected to be Home Health Aides and Personal Care Aides (Table 3), it is worth noting that the profile of online job ads for direct care workers (Chart 3) includes higher shares of direct care job ads for Medical Assistants (37%) and Nursing Assistants (42%) than reflected in the Bureau of Labor Statistics projected annual openings (11% and 33% respectively).

These data suggests that employers are seeking more highly skilled categories of direct care workers, consistent with the increasing complexity and challenge inherent in the requirements of these jobs. Despite more modest growth in employment, these are the positions that are often more difficult to fill.

**Direct Care Employment, Annual Openings, and Projections, Massachusetts - Table 3**

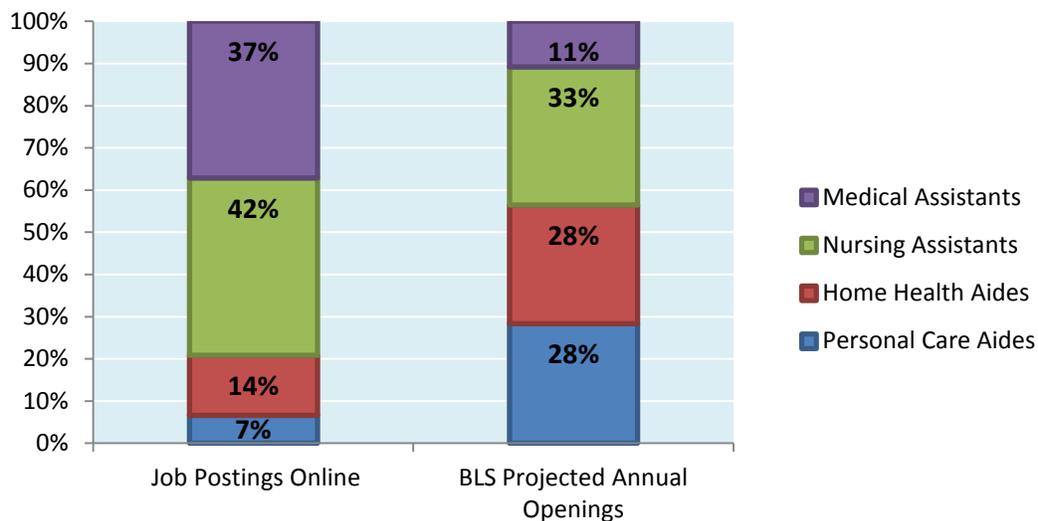
<b>Occupational Group</b>	<i>Jobs</i> <b>2012</b>	<i>BLS 2010-20</i> <b>Projected Annual Openings</b>	<i>Jobs</i> <b>Projected 2020</b>	<i>BLS 2010-20</i> <b>Ten Year Projected Growth</b>	<i>2012 Mean</i> <b>Hourly Wage</b>	<i>2012 Mean</i> <b>Annual Pay</b>	<b>Full Time Positions</b>
<b>Direct Care Workforce</b>	<b>93,220</b>	<b>4,120</b>	<b>124,123</b>	<b>34%</b>	<b>\$14.13</b>	<b>\$29,387</b>	
Medical Assistants	13,610	445	15,664	18%	\$17.89	\$37,210	63%
Nursing Assistants	40,530	1,349	49,883	19%	\$14.21	\$29,576	25%
Home Health Aides	18,900	1,161	26,800	54%	\$11.38.7 <sup>3</sup>	\$23,668	17%
Personal Care Aides/Attendants *	20,180	1,165	31,776	45%	\$12.68 <sup>4</sup>	\$26,500	14%

\*PCA employment tends to be under-counted due to classification issues. Starting in 2014 the federal Office of Management and Budget has clarified that Personal Care Attendants are to be classified in the occupation "Personal Care Aides." Sources: Employment from Bureau of Labor Statistics (BLS). 2012 OES. Other figures from Massachusetts, 2010-2020 Occupational Employment Projections. 2013 Massachusetts Job Vacancy Survey.

<sup>3</sup> Range of salaries from \$9.57 for homemakers to 13.19 per hour for home health aides. [www.careeronestop.org](http://www.careeronestop.org) and [www.onetonline.org](http://www.onetonline.org)

<sup>4</sup> Collective bargaining agreements will increase the annual salary to \$13.49 as of July 1, 2014

### Profile of Demand for Type of Direct Care Worker, Massachusetts – Chart 3



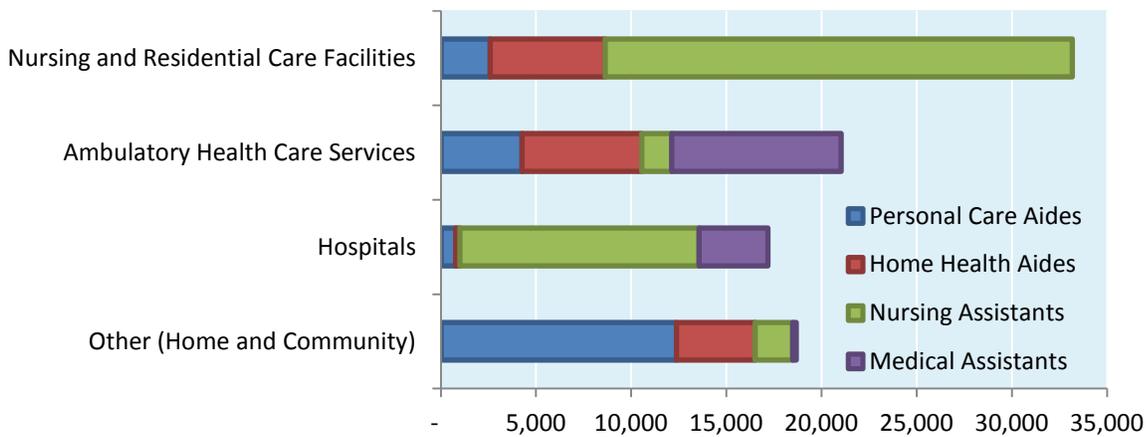
Sources: Job Posting Analysis from Help Wanted Analytics Nov 18, 2013-March 18, 2014. Annual Openings from Massachusetts 2010-2020 Occupational Employment Projections.

### Employment by Work Setting

Nursing and Residential Care Facilities (long-term inpatient) are the largest employer of direct care workers in Massachusetts and the industry segment projected to add the greatest number of direct care jobs, followed closely by Ambulatory (outpatient) services (Charts 4 & 5). Direct care workers employed by consumers in the home are the job category least well captured by currently available employment models yet may represent some of the largest future workforce demand. Workers providing direct care in a home or community setting show up as self-employed, employed by private households, or employed by a social assistance or administrative organization that assigns them to a client in a home<sup>5</sup>. Together these employ more direct care workers than hospitals.

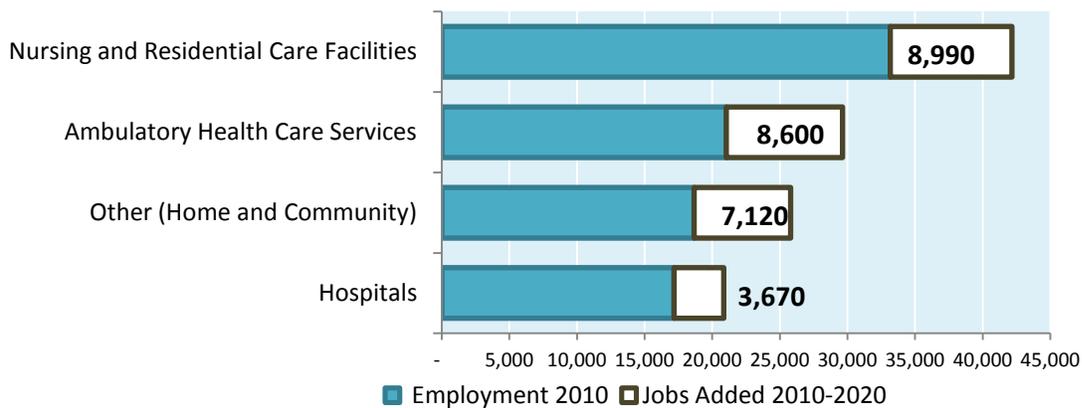
<sup>5</sup> <http://www.bls.gov/ooh/fastest-growing.htm>

**Direct Care Occupation by Employer, 2010, Massachusetts – Chart 4**



Source: Massachusetts Executive Office of Labor and Workforce Development. Occupational Outlook Handbook. 2010. Direct Care Workforce (Personal Care Aides, Home Care Aides, Nursing Aides, Orderlies, and Attendants, Medical Assistants).

**2010-2020 Projected Growth in Direct Care Workforce by Employer, Massachusetts - Chart 5**



Source: Massachusetts Executive Office of Labor and Workforce Development. Occupational Outlook Handbook. Direct Care Workforce (Personal Care Aides, Home Care Aides, Nursing Aides, Orderlies, and Attendants, Medical Assistants), 2010-2020 Occupational Projections. "Other" employers include private households, self-employed workers, social assistance and support services organizations.

## Workforce Attrition

In addition to the increasing need for direct care service driven by an aging population and expanded coverage resulting from health care reform, there is another less obvious demand on the workforce pipeline – attrition.

Caring for people, especially those disabled, elderly or young who are managing chronic and often complex medical conditions requires personal empathy as well as specialized knowledge and often physical strength. Many of these jobs, particularly those in the personal and home care categories provide only entry-level pay and often only part-time work. These jobs provide limited or no benefits and in those situations where the worker provides services at the consumer’s home, she/he must also provide their own transportation. As a result of these and other challenges, workers in these jobs exhibit unusually high rates of turnover. This presents a challenge for the person receiving services who desires consistency in a care giver and also for the employer if that is an agency or even another family member. High rates of turnover in the face of expanding demand for services further increases the cost of acquisition of this workforce, amplifies the cost of training (retaining) for the same position, and results in a higher separation cost as people leave these jobs on a higher than average basis.

## Direct Care – the New Frontline of Health Care Delivery

Health care reform initiatives are transitioning care delivery from acute care hospitals to community-based care settings. Direct care workers represent the new front-line of our health care system. On this front-line, these workers are expected to provide high quality, patient centered care while confronting a wide array of professional challenges, including: serving people with multi-faceted and often chronic medical conditions, addressing long term non-acute care needs and a range of disabilities (physical, mental and behavioral), overcoming cultural and language barriers when communicating with patients/clients and family members, adapting to physical and environmental constraints of the home setting and managing an array of electronic patient care technologies as well as on-line medical records - all while working independently with limited and remotely-based supervision and support.

## Direct Care Occupational Data, Care Settings and Core Competencies

Direct care workers are employed in each of the major health care settings, described in the Chartbook<sup>6</sup>, including: Ambulatory Care (outpatient), Hospitals (inpatient), Nursing and Residential Care Facilities and Social Assistance (social services). Increasing numbers of direct care workers are employed by the consumer (private households). Published data are available for four occupational categories considered as direct care, **Medical Assistants**, **Nursing Assistants**, and **Personal Care Aides** and **Home Health Aides (descriptions in Appendix A)**. In practice, the lines between these occupational categories are blurry and there are discrepancies and overlaps between the job titles and occupational codes referenced by employers, payers (i.e. MassHealth), employment statistics, and training programs.

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<sup>6</sup> [http://www.mass.edu/currentinit/Nursing/Docs/Mass\\_Healthcare\\_Chartbook.pdf](http://www.mass.edu/currentinit/Nursing/Docs/Mass_Healthcare_Chartbook.pdf)

At best, the available data provides directional trends of broad growth rates but is imprecise as a projection of supply/demand gaps.

Certified Nurse Assistants, (CNAs), Home Care Aides (HCAs) and Personal Care Aides (PCAs) provide approximately 70-80% of the paid, hands-on care provided to persons with disabilities or older adults who reside in home or community-based settings including nursing homes and private or group homes.<sup>7</sup> This workforce assists with activities of daily living (ADLs) which may include basic health care tasks such as taking and recording vital signs. Other duties include assisting with instrumental activities of daily living (IADLs) such as housekeeping, meal preparation, and shopping. In certain situations, independent consumers may direct the worker to perform more involved health care tasks such as catheter care, wound care, and medication management. These workers may also provide companionship or address behavioral health issues with the people they serve, though this is not their primary objective of care.

While Medical Assistants (MAs) work primarily in community health care facilities and physician practices, their role is changing rapidly as more practices institute care teams and requiring MAs to navigate electronic health records (EHR), perform clinical tasks to assist practitioners in providing patient care, and—for those who are bilingual, to provide medical interpretation for limited English proficient patients.

Patient Care Aides/Technicians (PCT) work primarily in the hospital setting, performing tasks similar to CNAs, such as assisting with ADLs, and also performing clinical tasks similar to MAs. The PCT typically has a CNA license and receives on-the-job training or attends a customized training.

*Please note, as new models of health care reform evolve across different care settings and many employers, the job titles and responsibilities of the direct care workforce will be continually redefined. In order to plan with some consistency, we must ground our analysis in categories of data that will be reported over time. As an aid to map rapidly emerging job titles to major categories of job data, we offer the following taxonomy of occupational title, job title and certification for direct care jobs (Table 4) although we acknowledge this will be out of date as soon as it is printed.*

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<sup>7</sup> (Paraprofessional Health Institute (PHI), 2011)

## Direct Care Occupations, Job Titles, and Certifications – Taxonomy Table 4

<u>Occupational Title</u>	<u>Other Job Titles</u>	<u>Example Certifications</u>
<b>Medical Assistant</b> 13,610 Employed 445 Annual Openings	<i>Practice / Clinical Assistant</i> <i>Phlebotomist</i> <i>Patient Care Technician (PCT)</i>	<i>Certified Medical Assistant*</i> <i>Phlebotomy Certificate</i> <i>CPR, EMT</i> <i>Basic Life Support</i>
<b>Nursing Assistant</b> 40,530 Employed 1,349 Annual Openings	<i>Patient Care Assistant</i> <i>Patient Care Technician (PCT)</i> <i>Dietary Aide</i> <i>Resident Care Specialist/ Assistant</i>	<i>Certified Nurse Assistant (CNA)</i> <i>Certified Practical Nurse, Long-term care</i> <i>Basic Life Support / Cardiac Life Support</i>
<b>Home Health Aide</b> 18,900 Employed 1,161 Annual Openings	<i>Home Care Aide</i> <i>Personal Home Care Aide</i> <i>Caregiver</i> <i>Respite Worker</i> <i>Resident Care Assistant</i> <i>Direct Support Professional</i>	<i>Certified Home Health Aide (HHA)</i>  <i>CPR</i> <i>First Aid Certification</i>
<b>Personal Care Aide<sup>8</sup></b> 32,000 Employed 10,000 Annual openings <sup>9</sup>	<i>Personal Care Attendant</i> <i>Personal Care Homemaker</i> <i>Homemaker</i>	<i>CPR</i> <i>First Aid Certification</i>

Source: Help Wanted Analytics. Employment from Bureau of Labor Statistics. 2012 OES. Annual Openings from Massachusetts, 2010-2020 Occupational Employment Projections and MassHealth. Annual openings estimates need for new workers entering the occupation to full positions created by growth or people permanently leaving the occupation.

\*There is not one standard certification for Medical Assistant.

## Emerging Job Titles

The following job titles referring to direct care workers are listed and described in the Massachusetts Home Care Career Ladder (Appendix B): Homemaker, Personal Care Homemaker, Home Health Aide, Supportive Home Care Aide - Two Tracks: Mental Health SHCA and Alzheimer’s SHCA , Hospice Aide and Companion. The MassHealth Personal Care Attendant is listed in this category in that the role and responsibility is similar and many seek opportunities to become home health aides.

Recognizing many workers do not adhere to one career lattice, the Direct Care Worker Lattice (Appendix C) developed under the a Personal and Home Care Aide State Training (PHCAST) grant project, funded by the Department of Health and Human Services, depicts Direct Care job categories, wages and education requirements. This career lattice includes the informal care giver, respite

<sup>8</sup> MA PCAs are employed by MassHealth Consumers and have no requirement for training or certification <http://www.mass.gov/eohhs/docs/masshealth/memlibrary/pca-consumer-handbook.pdf>. Salaries are determined through collective bargaining between the 1199 SEIU and the PCA Quality Workforce Council.

<sup>9</sup> As determined by MassHealth Fiscal Intermediaries and represents increasing turnover rates

volunteer, and MassHealth Personal Care Attendants. It recognizes that many workers within these categories desire opportunities to enter into formal health care settings through a nurse track. A number of other job titles currently in use, such as Caregiver, Direct Support Professional, and Patient Care Technician, map to jobs in more than one of the aforementioned occupational categories. Two titles not included, which demand equal recognition and training, are the Informal Care Giver and the Respite Worker.

Direct Care workers who are employed directly by the MassHealth (Medicaid) consumer are referred to as Personal Care Attendants (rather than Personal Care Aides as described by the Bureau of Labor Statistics). In the MassHealth consumer control model, this category of workers is hired, trained, and supervised directly by the consumer and follow consumer direction in all facets of care. There are no state requirements for this workforce; however many desire training and career latticing opportunities.

## **Workforce Talent Pool, Pipeline and Supports**

### **Entry level workforce – Immigrants**

Entry-level direct care support jobs are accessible with a modest amount of post-secondary training and as such, present a vital pathway to above minimum wage work and careers that provide family-supporting wages.

More than half of direct care support workers have a high school education or less. The current workforce, especially for personal care and home care aides, draws predominantly from females age 25-54 (average 42 years), a demographic projected to decline 7% between 2006 and 2016<sup>10</sup>. As the demand for health care services increase and the client population becomes increasingly diverse, immigrant communities will provide the pool of new workers seeking entry level jobs and, over-time, the pipeline of workers who will advance to allied health professional occupations which require more advanced education.

Nearly half of all current direct care workers live in households earning less than 200% of the Federal Poverty Limit and receive some form of public assistance.<sup>11</sup> A pilot study of 882 workers conducted by the MA PHCAST project demonstrated that more than 80% of participants were low income, calculated as 200% of the 2012 Poverty Guidelines.<sup>12</sup> The Massachusetts PHCAST Final Evaluation Report states, “A PCA, employed by an independent consumer employer, is paid \$12.98 per hour. Through collective bargaining agreements this wage will increase to more than \$13 per hour in 2014. On average, direct care workers, employed by an agency, earn fairly low wages in Massachusetts, typically around

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<sup>10</sup> Paraprofessional Healthcare Institute (PHI), 2009)

<sup>11</sup> (Paraprofessional Healthcare Institute (PHI) 2011

<sup>12</sup> Income thresholds calculated based on 200% of 2012 Poverty Guidelines. 77 Fed. Reg. 17 (26 January 2012).

\$12/hour.<sup>13</sup> Working full time, this salary yields a pre-tax income of \$24,960, below the national threshold qualifying as low-income. In Massachusetts, median family income was \$80,425 as of 2012.<sup>14</sup> Direct care workers earn significantly less than many other types of workers in the state. Direct care workers, often have limited or no opportunities for benefits, such as insurance or retirement. As a result, entry-level direct care jobs may not provide sufficient wages to raise families out of poverty, particularly in single-breadwinner households where direct care work is the only source of income. Additionally, many workers are employed by multiple employers (agency and independent consumers) working “full time” at more than 40 hours per week, but without the security and benefits accrued through a full time job.

While federal and state training dollars support individuals in becoming direct care workers, low wages force many to maintain public assistance to meet basic needs or have multiple jobs. In addition, turnover in this workforce is a serious concern. These business problems impose training, recruitment, and transition management costs and a quality of care problem with the loss of experienced workers and increasing stress for remaining workers. These turnover costs create a public resource problem born by third-party payers. The Iowa Department of Public Health Direct Care Workforce Initiative (2011)<sup>15</sup> estimates that “turnover of one direct care professional.... creates \$3,749 in direct expense for the employer”. Given that the median pay for a PCA in Iowa is \$10.27; whereas a Massachusetts PCA median pay is \$12.39<sup>16</sup>, the assumed projected costs will be higher for the Massachusetts employer.

We lack direct measures of turnover rates for the direct care workforce, but available national, regional, and state information suggests the number is upwards of 40% annually. Regional industry data for Home Health Service show quarterly turnover rates in the range of 10% per quarter.<sup>17</sup>

**Massachusetts Turnover Cost Calculations – Table 5**

2012 Average Hourly Wage	\$	13.48
2012 Average Annual Pay	\$	28,050
2012 Size of Direct Care Workforce		79,610
Cost of turnover at		
15%		\$84 million
30%		\$167 million
45%		\$251 million
60%		\$334 million

<sup>13</sup> Paraprofessional Healthcare Institute (PHI). (2008). Massachusetts' direct care workforce. Retrieved from <http://www.phinational.org/sites/phinational.org/files/clearinghouse/PHI-StateFacts-Mass.pdf>.

<sup>14</sup> U.S. Census Bureau. (2012). Median family income in the past 12 months. Retrieved from <http://www.census.gov/hhes/www/income/data/statemedian/>.

<sup>15</sup> <http://www.idph.state.ia.us/directcare/council.aspx>

<sup>16</sup> [http://www.careerinfonet.org/occ\\_rep.asp?optstatus=011000000&soccode=399021&id=1&nodeid=2&stfips=25&search=Go](http://www.careerinfonet.org/occ_rep.asp?optstatus=011000000&soccode=399021&id=1&nodeid=2&stfips=25&search=Go)

<sup>17</sup> BLS. Local Employment Dynamics. NAICS. Home Health Care Services. NY, CT, and NH turnover of stable jobs ranged from 9.4-10.4% per quarter in 2012. MA data are not available. Stable hires are those that last for at least a quarter.

Source: Methodology from Iowa Dept. of Public Health. Direct Care Workforce Initiative. Massachusetts data from BLS / MA LMI.

This workforce pool presents many challenges as candidates often lack fluency in English and generally lack a foundation in numeracy and the application of technology as a tool for health care delivery. It is important to note that some students in this pipeline are functionally literate in the language of the communities they seek to serve and others hold health care certifications in their home countries that only need validation, locally. Therefore, this workforce requires an array of support services, including access to financial aid, to become ready for job training programs and will need stackable, articulated coursework to further develop their knowledge, skills and abilities for advancement to higher level certifications and college degree programs.

## Diversity

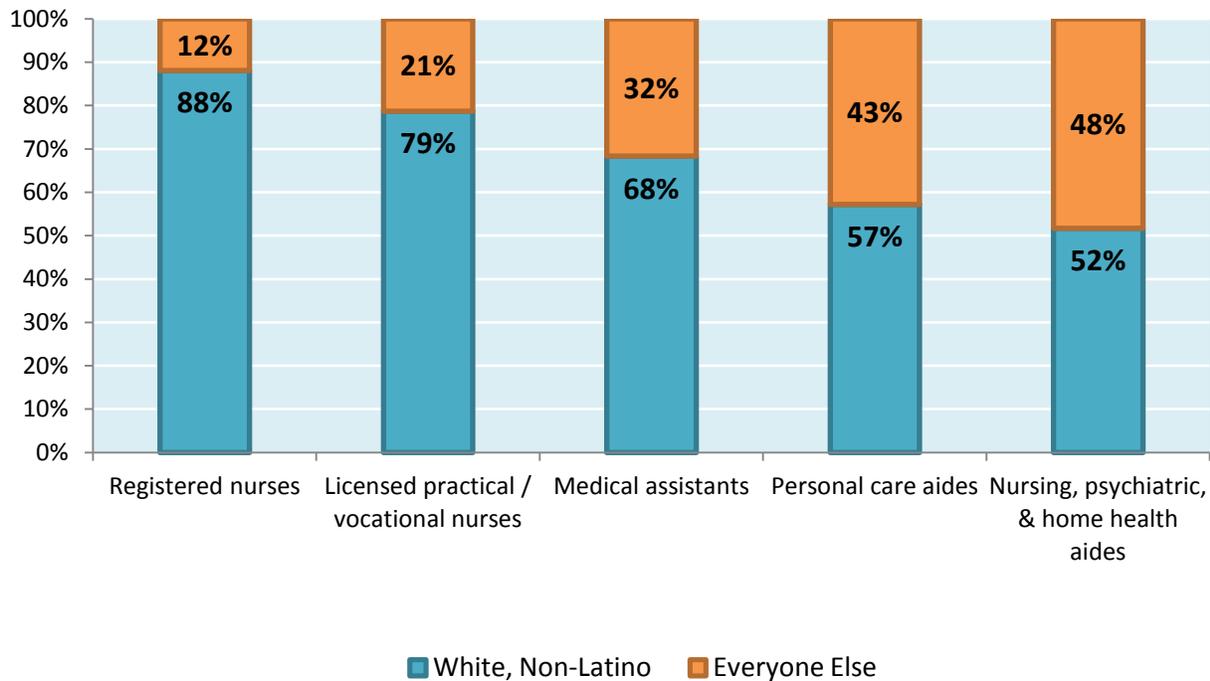
As our society continues to diversify and the health care profession pursues the principle of “patient centered care” it is essential that the health care provider community reflect the demographic that it serves.

Today the direct care workforce has much greater racial and ethnic diversity than the incumbent nursing and allied health professional occupations. The closest equivalent to the direct care workforce broken down in the American Community Survey finds 48% of Nursing, Psychiatric and Home Health Aides, 43% of personal care aides and 32% of medical assistants are either Latino or non-white, contrasted with 21% LPN’s and 12% RN’s (Chart 6). The profile of students completing credit certificates aligned with direct care roles at our community colleges is 38% Latino and/or non-white. Specific non-credit direct care training programs at the community colleges are known to have greater participation of Latino and non-white students.<sup>18</sup> By focusing on the educational and career progression of the direct care workforce, Massachusetts will increase the diversity of the overall health care workforce, matching the demographic of the patient population over time.

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<sup>18</sup> The Massachusetts Dept. of Higher Education lacks systematic data on non-credit completions.

**Workforce Diversity by Healthcare Occupation, Massachusetts – Chart 6**  
*Percent Latino or Non-White*



Source: American Community Survey. EEO9W 2006-2010. Employed in Massachusetts, Age 16+.

### **Selection, support services, retention and progression**

While many people are in need of entry level work, health care careers and direct care jobs are not necessarily a good “fit” for every candidate. As already noted, entry-level direct-care jobs often do not provide a family sustaining wage. However, they do offer the prospect of career advancement and future compensation increases. Health care careers require a unique compassion for serving people and empathy for those challenged by chronic illness or mental and physical disabilities. These are characteristics that can and should be assessed early in the training process to minimize lost time and resources in training for jobs that are an unlikely match. Immigrant workers often are not fluent in spoken and written English or foundation numeracy skills and therefore require contextualized curriculum and embedded remediation techniques to accelerate their progress and promote retention and completion. It is important to note that some members of the immigrant community have extensive prior health care education and certifications from their home country and only need English language and possibly some technology training to become proficient workers.

Therefore, this workforce often requires an array of support services, including access to financial aid that will support not-for-credit instruction necessary for entry into direct care job training programs. These workers will need systemic supports and stackable, articulated coursework to further develop

their knowledge, skills and abilities for advancement to higher level certifications and college degree programs that provide pathways to living-wage, sustainable and adaptable careers.

This combination of challenges facing the entry-level worker too often results in a high rate of attrition from training programs or from initial jobs. This has a serious impact on many fronts. First, individuals who receive services from direct care workers often develop a trusting relationship with the worker as their health care provider and the client's health can be jeopardized by such turnover. The worker can also be impacted by time and resources spent in training that don't result in sustained employment and the missed opportunity for future career progression. And finally, the employer, whether an agency or individual/family member, is impacted by the cost, time and quality of service provided when turnover results in the need for a replacement hire and retraining. Therefore, attrition must be minimized and especially when there is demand for many new workers and attrition only exacerbates that workforce gap.

While most of the direct care support training is provided by community-based organizations and not the higher-education system, clearly articulated pathways, stackable credentials and complementary support services that align and reinforce the partnership between levels of the direct care/allied health career ladder are strategies that reinforce student retention, completion and worker progression in direct-care careers.

## **Academic Curriculum and Career Pathways**

The workforce development challenge identified in the introduction to this plan is for Massachusetts to provide high-quality and affordable, individual-centered health care to all members of our society, serving a population that is aging and becoming increasingly diverse. The health care workforce needed to meet this challenge spans Allied Health support and professional occupations that complement the expanding role of nurses. Direct care occupations, categorized as Certified Nurse Assistants, Medical Assistants, Personal Care Aides and Home Care Aides; represent a rapidly evolving list of job titles working in many new care settings as well as traditional titles and settings for which the competency expectations of the job are shifting. And the demand for this workforce is growing rapidly, providing opportunities for a more diverse population of workers to enter and progress in new and rewarding careers.

The current system is challenged by out of date regulations governing care-delivery by practice setting, inconsistent curriculum and student outcome expectations across training and education providers, varying competency expectations by employers for similar occupational categories and portability of credentials across training and education providers.

A framework of curriculum and career pathways based on industry validated job competencies, consistent across the taxonomy of direct care jobs and health care delivery settings is necessary to develop and sustain the direct care workforce pipeline. Such a framework, codified in standards and

regulations, will provide for portability of knowledge, skills and abilities among different entry level training programs and jobs and will also provide for alignment of outcome expectations between education and employer partners. This will also provide for the seamless progression of students, both traditional age and adult learners who require entry, exit and re-entry points throughout the education system, from foundation skills training (English language and numeracy), through entry level workplace skills advancing to college level certificate and degree programs that lead to sustainable, living wage careers.

Such a curriculum and career pathways system requires collaboration across community-based training organizations, higher education institutions (community colleges), employers, labor organizations and industry associations. Representatives of these communities have a history of successful collaboration and through their contribution to the development of this plan now seek to bring to scale and to sustain successful strategies.

### Employer Expectations

Employers identify significant skill gaps among the current direct care workforce. Based on feedback from a sample of Western MA employers, gaps exist in technical skills as well as “essential” skills (Table 6) or those skills critical to securing and maintaining employment. While not representative of all types of direct care workers and all settings, these skill gaps include:

*Table 6: Sample of type of DCW Technical and Essential Skill Gaps*

Technical Skill Gaps	Essential Skill Gaps
<ul style="list-style-type: none"> <li>• Knowledge about body systems</li> <li>• Enhanced client assessment skills</li> <li>• Basic computer skills</li> <li>• Basic documentation skills</li> <li>• Awareness of acute illnesses</li> <li>• Client-centered care</li> <li>• Time management (e.g., CNAs moving from caseload of 4 residents in clinical education to 10 residents in LTC setting)</li> <li>• Cultural competency</li> </ul>	<ul style="list-style-type: none"> <li>• Responsible communications (no call/no show)</li> <li>• Dependability and reliability</li> <li>• “Industry fit” – empathy and desire to help</li> <li>• Workplace etiquette (e.g., use of cell phones)</li> <li>• Critical thinking</li> <li>• Multi-tasking</li> <li>• Conflict resolution</li> </ul>

Also, employer expectations for student outcomes from training programs often vary by employer and by institution. This lack of clarity regarding the competencies required of direct care workers results in significant variability of training and education programs which is confusing for students, frustrating for employers and results in inefficiency of workforce development which is unacceptable when demand is projected to outstrip supply. Medical Assistants (MA), for example, prepared in different programs graduate with widely different readiness skills. Some employers expect MAs to be trained in

Phlebotomy and EKG skills which is the norm for certain training programs and not others. Massachusetts does not have a standardized credential for medical assistants, patient care attendants/technicians or personal and home care aides<sup>19</sup>, and as a result, training programs vary widely for these occupations in content, duration and cost (Appendix F). Direct care workers in these occupations who seek to attain a recognized credential must advance to either a certified home health aide or certified nurse aide or take the national medical assistant certification test.

### **Industry requirements and regulation**

The current standards and regulations that govern the training and certification requirements of direct care workers are at best inconsistent, in some cases woefully out of date and in others are non-existent.

In March 2010, President Obama passed the Affordable Care Act (ACA), authorizing under Section 5507(a) funding for the Personal and Home Care Aide State Training (PHCAST). The purpose of this program was to address the direct care workforce demand by funding states to develop a core competency training program (see Appendix D) to prepare a competent direct care workforce capable of supporting and assisting an aging population. Prior to this legislation, no definition of core competencies existed for this workforce<sup>20</sup>. As a recipient of PHCAST funding, Massachusetts Executive Offices of Health and Human Services and Elder Affairs developed a 54 hour Americans with Disabilities Act (ADA) accessible curriculum<sup>21</sup> comprised of 13 stackable modules that addresses the 10 core competencies defined by the Affordable Care Act (see Appendix E). The curriculum embodies the adult learner centered principles and is available in four languages; English, Spanish, Portuguese (Brazilian), and Haitian Creole. Trainings were offered in five community colleges and seventeen (17) home care agencies/community-based training sites.

The value of the PHCAST training is demonstrated by the significant gain in skills and knowledge. The individual average percent change between the pre- and post-test in Year 2 is 19.17% demonstrating a

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<sup>19</sup> Home health aides are not certified in Massachusetts. Home health aides receive training certificate from training provider (Red Cross, propriety school or agency) which they must retain to show proof of training.

<sup>20</sup> For over 40 years, the MA Council has worked with the Executive Office of Elder Affairs to maintain a home care aide training curriculum which did include training requirements (although not call[ed] core competencies) for personal care aide and home care aides working in home care agencies. PHCAST administered through the Patient Protection and Affordable Care Act, Section 5507(a) include 10 core competencies that must be included as part of a core competency curriculum to train direct care workers. Massachusetts PHCAST, funded by US HHS Health Resource Services Administration (HRSA) developed a 13 core competency curriculum, which includes soft skills, to expand the knowledge and skill of the direct care worker. PHCAST incorporated the Council/EOEA curriculum, the Bristol Community College PCA curriculum, and the PHI national curriculum to develop core competencies throughout the direct care workforce. The PHCAST curriculum, participant handbook, assessment tests, skills videos and job recruitment videos were translated into 3 other languages, Spanish, Brazilian Portuguese, and Haitian Creole to support limited English proficient workers – including PCAs, DDS workers, etc

significant increase in knowledge. The hands on demonstration of skills resulted in 80% of the participants achieving a skilled and satisfactory score. The potential for career development building upon these common core competencies is significant (see the Career lattice (Appendix C)). The PHCAST core competencies have been reviewed by community colleges and workforce investment boards involved in the project and envisioned by some as core competencies for all health care career training programs.

As our health system continues to shift to a model focused on coordinated, client-centered care in the community, direct care workers will need both enhanced initial training to meet the more acute needs of today's home care clients and continued education to strengthen their skills allowing them to both enhance care and to help reduce preventable hospitalizations.

### **Competency-Based Workforce Alignment**

The challenge of aligning the state's education and training resources with the needs in the health care industry for direct care workers goes well beyond ensuring that curriculum is aligned, or that the capacity to train workers matches the hiring need in the industry. The complicating factor is that direct care positions are overseen by multiple state agencies and authorized by a variety of funding sources, each of which prescribe standards of training and /or curriculum. Some of these oversight bodies include the Department of Public Health for Certified Nursing Assistants; the Executive Office of Elder Affairs for home care aides (which include homemakers, personal care homemakers, home health aides) and direct care workers in Assisted Living Facilities; and the Department of Developmental Services (DDS) for direct services workers. Without alignment between job titles and functions, it is extremely difficult to determine net need for direct care workers in general. And a situation is created in which one type of direct care worker could be in short supply, while another type of worker with a similar skill set is widely available, but cannot be hired due to different program training requirements.

A solution to this dilemma discussed at the DHE convening in April (2014) is to review the core competencies for direct care workers developed through the Massachusetts Personal and Home Care Aide State Training (PHCAST) Initiatives, and to map these competencies to additional direct care worker positions, including certified nursing assistants, assisted living facility personal care workers, DDS direct support professionals, and others. The Massachusetts PHCAST core competencies (Appendix E) were built upon core competencies for direct care workers established by the US Department of Labor. After mapping and aligning the PHCAST core competencies to other direct care workers positions, the DHE could work with its state agency partners at the Executive Offices of Health and Human Services and Elder Affairs to develop standards of training and educational systems that are structured to develop workers with those competencies. Those workers could then take on a variety of positions. Specializations could be developed as needed to meet specialized needs within the health care system, but each would begin with a core set of competencies.

While issues of training standards and scope of practice are beyond the educational purview of the Department of Higher Education, DHE could provide this convening role. A collective effort by employers and the state agencies involved in training requirements and education is needed to effectively develop a skilled healthcare workforce.

### Community based training partners, articulated curriculum

While not all direct care workers come through certificate granting training programs that report completions to the National Center for Education Statistics, the following data (Table 7) provide a picture of the students earning credit certificates in career and technical high schools, community colleges, private colleges, and career institutes. A detailed breakdown of awards by institution is provided in Table 8 and a further breakdown of programs by Community College programs are detailed in Appendix G.

**Certificates Granted Related to Direct Care Jobs, Massachusetts, 2012 – Table 7**

	Medical Assistant	Other Allied Health	Health Aide	Nursing Assistant	Personal Care Aide	Direct Care Total
<b>Private Colleges and Institutes</b>	2,062	167	-	126		
<b>Public Community Colleges</b>	203	22	-	550		
<b>High Schools</b>	10	20	-	449		
<b>Total Certificates Completed</b>	<b>2,275</b>	<b>209</b>	-	<b>1,125</b>		<b>3,609</b>
<b>Annual job openings</b>	<b>445</b>		<b>1,161</b>	<b>1,349</b>	<b>1,165</b>	<b>4,120</b>
<b>Gap between training program completions and job openings</b>	<i>surplus</i>		<i>gap</i>	<i>gap</i>	<i>gap</i>	<i>gap of 511</i>

Source: NCES. IPEDS. 2012 Completions. CIP 51.0801 Medical Assistants; Other Allied Health is CIP 51.08 excluding Medical Assistants and veterinary health; 51.26 Health Aid; 51.39 Practical Nursing, Vocational Nursing and Nursing Assistants. Estimated annual job openings from growth and replacement from BLS / MA LMI 2010-2020 Occupational Employment Projections.

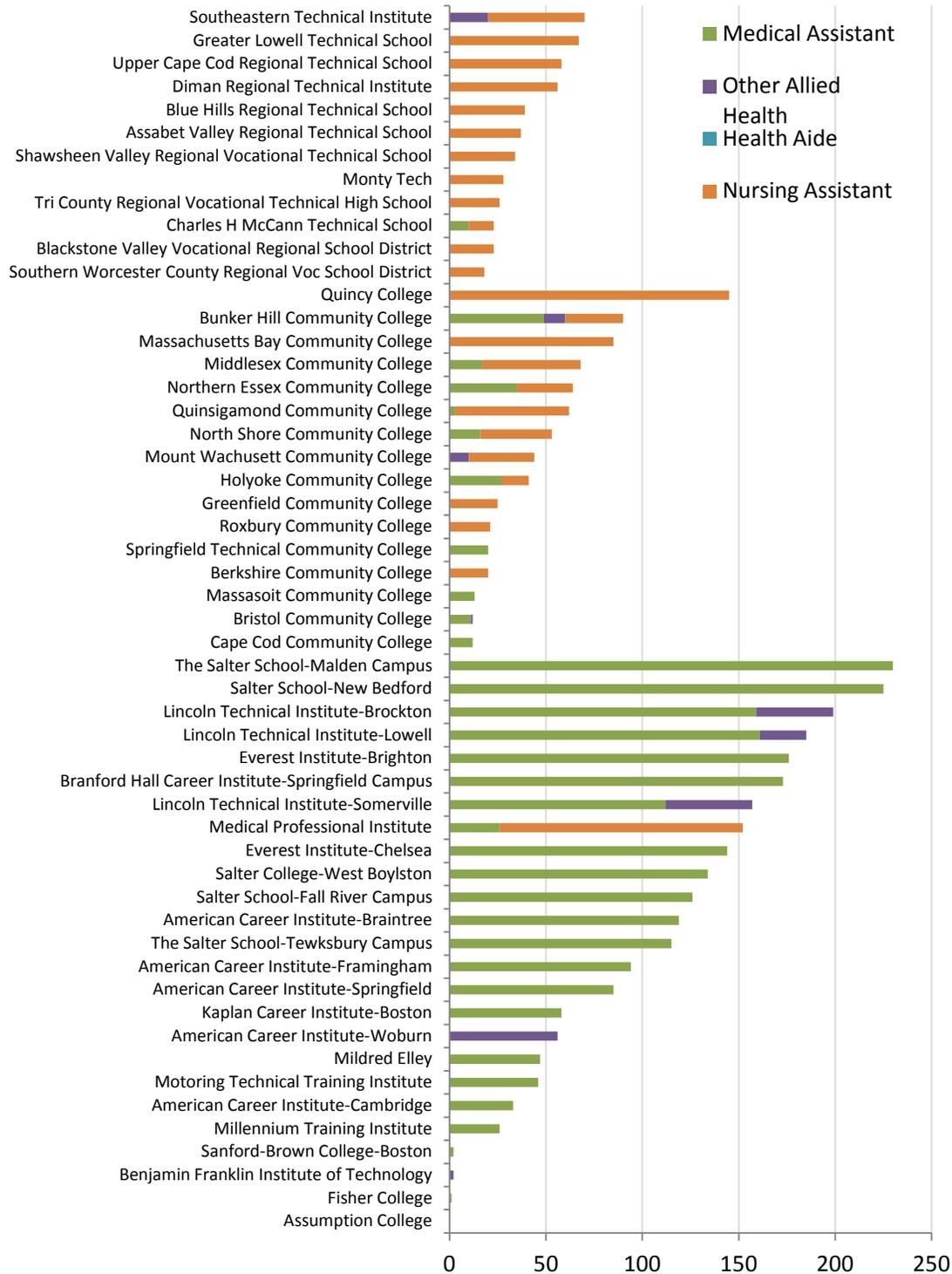
In addition to these credit-bearing certificates, there are non-credit training programs that are not counted in the above post-secondary education data. Massachusetts DHE data show 108 sections of non-credit courses related to direct care workers offered at public community colleges in 2013, but the Dept. does not, however, track non-credit program completions. In addition there are non-credit training programs offered by the Red Cross.

One thing that stands out in the data that requires further investigation is the over 2000 certificates granted for “medical assistants” mostly from private colleges and institutes compared to the BLS estimated 445 annual job openings for medical assistants. This partly reflects imprecise terminology with many Medical Assistant Training Programs focusing on the administrative tasks in a health care office to the exclusion of the direct care clinical competencies of a Medical Assistant, as defined by the Bureau of Labor Statistics (see O\*NET occupational information). Anecdotal reports on this point are conflicting as there are some suggestions that students graduating from MA programs have difficulty securing employment while other indicators suggest employers face shortages of qualified candidates.

There are also reports that students who seek to build upon an MA certificate and discovering that the earned coursework does not transfer nor “stack” toward additional certificates or degrees. Given the importance of these credentials to direct care jobs, these indicators require further investigation.

There is also no defined standard scope of practice for medical assistants, nor an exam to test specific competencies. Individuals completing medical assistant programs may be pursuing a variety of medical office administrative or direct care roles. Regional Technical High Schools and public community colleges have more students completing certificates leading to credentials as a CNA or LPN, and fewer medical assistant degrees. Many of the Medical Assistant programs are at proprietary schools with significant federal student loan debt to earnings ratios for students.

**Certificates Granted Related to Direct Care Jobs by Granting Institution, Massachusetts, 2012 – Chart 8**



Source: US Department of Education. NCES. IPEDS. 2012 Completions Survey.

## Funding Sources – Financial Aid, WIA, Grant Programs

### WIA Training Funds and Direct Care Occupations

Federal workforce training funds administered by Massachusetts are being used to train individuals to enter direct care work in all regions of the state. In 9 of the 16 regions 10% or more of training recipients are trained in direct care occupations, with high rates of verified post-training employment. Community colleges are among the training providers.

**Massachusetts Direct Care Workforce Related WIA Trainees, FY2014/Q3 – Table 8**

<i>Local Area</i>	<i>Home Health Aides</i>		<i>Medical Assistants</i>		<i>Personal Care Aides</i>		<i>Direct Care Trainees as a Percent of all Workforce Related Trainees</i>
	<i>Exited Training</i>	<i>Entered Employment</i>	<i>Exited Training</i>	<i>Entered Employment</i>	<i>Exited Training</i>	<i>Entered Employment</i>	
<i>Berkshire</i>	0	0	5	4	0	0	3%
<i>Boston</i>	1	1	31	22	0	0	12%
<i>Bristol</i>	70	53	90	76	0	0	42%
<i>Brockton</i>	1	1	12	11	0	0	11%
<i>Cape Cod &amp; Islands</i>	2	2	0	0	0	0	4%
<i>Central Mass</i>	2	2	20	20	0	0	9%
<i>Franklin/Hampshire</i>	4	4	0	0	0	0	8%
<i>Greater Lowell</i>	4	3	7	7	0	0	5%
<i>Greater New Bedford</i>	20	18	1	0	0	0	10%
<i>Hampden County</i>	28	24	20	15	0	0	8%
<i>Merrimack Valley</i>	3	3	28	24	0	0	10%
<i>Metro North</i>	12	7	25	22	0	0	7%
<i>Metro South West</i>	1	1	18	16	0	0	10%
<i>North Central</i>	14	13	19	17	0	0	30%
<i>North Shore</i>	6	5	16	16	0	0	11%
<i>South Shore</i>	16	14	6	6	0	0	15%
<b><i>Statewide Total</i></b>	<b>184</b>	<b>151</b>	<b>298</b>	<b>256</b>	<b>0</b>	<b>0</b>	<b>13%</b>

Source Data: Massachusetts ETA9090 FY2014 - Q3

\*The counts of individuals who Exited Training and Entered Employment on this report represent WIA participants trained in programs associated with the selected occupations. They do not necessarily represent employment in those occupations.

## The Challenge - Achieving Scale and Sustainability

Given the projected need for many more direct care workers to support the rapidly growing health care demands of the “baby-boom” generation, Massachusetts must align its education and workforce system and commit the resources necessary to build and sustain this critical workforce pipeline.

Alignment of the system must span community-based training programs, adult basic education (ABE) and English as a second language (ESOL) programs, career vocational and technical education (CVTE) and the community college system. To support this agenda, resources of many funding streams including private grant programs and publicly funded initiatives must be coordinated with partner organizations including:

- Employers – home care, skilled nursing and rehabilitation facilities, acute care, senior care options, assisted living, community health centers, primary care physician offices, hospitals
- State trade associations – MA Senior Care Association, Home Care Alliance of MA, MA Council for Home Care Aide Services, MA League of Community Health Centers, MA Hospital Association
- State agencies – Dept. of Higher Education, Dept. of Public Health, Executive Office of Labor and Workforce Development, Commonwealth Corporation, Executive Office of Elder Affairs, MassHealth, Division of Professional Licensure, Office of Private School Regulation (under the Office of Consumer Affairs and Business Regulation) and the Personal Home Care Aide State Training Grant program (PHCAST) under EOHHS.
- Health Planning Council (EOHHS), Health Policy Commission, Healthcare Workforce Transformation Fund Advisory Board, Massachusetts Healthcare Workforce Center and Advisory Council
- Training and Education providers – Community Colleges, Transformation Agenda Project, American Red Cross, public/private training programs
- Workforce Investment Boards /Regional Health Care Workforce Partnerships/One-Stop Career Centers
- 1199 SEIU Training and Upgrading Fund
- Consumer organizations – AARP
- Prior Extended Care Career Ladder Initiative (ECCLI)

## **Administration and Legislative Policy Initiatives**

The Allied Health/Direct Care Workforce plan reinforces a number of important current or recent policy initiatives of the Administration and Legislature.

### **Higher Education's Vision Project**

Massachusetts' health care system is transforming from a focus on acute-care hospitals to community-based settings as the central focus of health care delivery. As a result of this transition, demand for direct care workers is growing rapidly and this growth is projected to continue for the next decade. The Commonwealth needs a robust and well prepared pipeline of workers to meet the health care needs of all of our residents, now and into the foreseeable future, therefore Massachusetts' public higher education system must address its role in contributing to the supply of this essential workforce.

Direct care jobs represent entry-level access points to higher education for many adult as well as traditional-age students who seek to grasp the first rung on the health care career ladder and who aspire to advance to higher-level jobs paying family sustaining wages, over time. Direct care jobs then are a key lever to increase the college going rate for many students and represent access to the education/workforce pathway for the health care sector.

Job training programs, including those delivered by community-based organizations working in partnership with community colleges, must be aligned to the competency requirements of employers in key industry sectors and deliver predictable student learning outcomes. Further, these training programs must also articulate to credit-bearing certificate and degree programs to ensure seamless academic progression for workers and students as they progress academically and within their profession. Just as credit transfer is a priority for students who progress from 2 year to 4 year academic programs in higher education institutions, it is equally important that non-credit training "stack" to for-credit coursework, certificate and degree programs, providing portable building blocks that reinforce student learning outcomes and progression to higher levels of education.

The DHE's Vision Project calls for increased college-going rates of all students and especially those who are under-represented in high-demand/high-growth segments of the economy. The Vision Project also calls for more clearly defined student learning outcomes, increased graduation rates from programs representing key sectors of the economy, and improved program alignment with industry competency requirements. The focus on adult student participation in the direct care/allied health workforce directly addresses these important goals of the Vision Project.

### **Direct Care Workers Initiative (DCWI)**

Recognizing that home and community health care providers were battling similar recruitment and retention issues, the Direct Care Workers Initiative (DCWI) was established in 1999 to support changes in care giving and workplace practices to increase retention rates and improve the quality of long-term care. Coordinated through the Massachusetts State Office for PHI, DCWI also worked with policymakers

to enact policy changes aimed at ameliorating the labor crisis through initiatives such as expanding health insurance coverage for direct care workers. The efforts of DCWI, in collaboration with elder advocacy organizations, culminated in a series of measures known as the Massachusetts Nursing Home Quality Initiative. Legislative achievements from the initiative include: a Nursing Home Wage Pass-through, a Direct Care Worker Scholarship Training Program, and the Extended Care Career Ladders Initiative.

An example of significant stakeholder involvement is the PHCAST Advisory Council, representing consumers, community agencies, and many state agencies (DPH, DMH, DDS, EOLWD, MassHealth, and DTA). The community college (five are involved in the pilots) and workforce investment boards would like to integrate this training into their career lattice/ladder strategies; the employers of direct care workers (both agencies and consumers) want to continue to see the skills and knowledge of their employees increase, and there is interest in leveraging the lessons learned from PHCAST to other care and training programs (e.g. group homes, group adult foster care, DDS for direct service workers, and with DPH for CNAs).

## Recommendations

The Allied Health – Direct Care workforce plan has been informed through a long-standing collaboration with industry leaders, employers and representatives of the higher education community. The Department of Higher Education has performed in the capacity as “convener” of this community to: 1) articulate a comprehensive allied health – direct care workforce development strategy, 2) target specific actions that can be taken within the higher education system to align academic curriculum and program capacity with employer/industry requirements, and 3) engage partners who appropriately “own” actions that are critical to this strategy yet are beyond the scope and responsibility of the Department of Higher Education.

This community most recently convened on April 9, 2014 for a full day working discussion of the key elements of the plan (Appendix H). The following top level recommendations were developed by that community and will be further refined through the Allied Health Working Group (sub-committee of the Nursing and Allied Health Initiative – Advisory Committee), to clarify ownership and action going forward.

The goals and strategies presented below were compiled with input from a workshop held with key stakeholders representing a range of industry associations, network organizations, direct care worker employers, and community colleges or others from the educational realm. The goals listed represent broad categories, or areas of need, identified by the key stakeholders. The strategies include specific ways that key stakeholders suggested the goals could be addressed or achieved. It should be noted that several local and state level initiatives, such as the Personal and Home Care Aide State Training program (PHCAST), the Extended Care Career Ladder Initiative (ECCLI), and the Massachusetts Community

College Workforce Development Transformation Agenda (MCCWDTA) have begun to tackle many of the issues included in these goals and strategies. Prior to beginning any new work, further examination of the resources, data, and/or lessons learned from these various projects and initiatives should be undertaken.

### **Goal 1: Create Career Preview Opportunities**

**Explanation:** With evidence showing that the majority of direct care worker turnover happens in the first six months of employment, the argument that there is not enough adequate screening of applicants for the position may be a valid explanation. Selecting the right people for the job may be as critical as supporting aides to remain in the job. With this in mind, the strategies within this goal focus on providing job seekers with more information about the realities of a direct care position, as well as improved screening tools to assist in finding those individuals who will be a good fit in the job.

#### **Strategies:**

- Offer or Increase the Length of Clinical Experiences - It is suggested that increasing the amount of time, or requiring a minimum of clinical work outside of the classroom, may help to better prepare aides for their work, as well as give them a realistic view of what the job entails.
- Offer One-Day Direct Care Previews - A one-day direct care preview would serve as a way for individuals interested in pursuing a job as a direct care worker to learn more in-depth about the positions available and to receive a better understanding of the requirements of the job.
- Develop Recruitment Screening Tools - In an effort to decrease turnover, assess the pool of candidates to screen for criteria that is known to reinforce success or criteria that may result in premature termination.

### **Goal 2: Increase Career Awareness**

**Explanation:** Beyond turnover, another critical concern facing this workforce is the struggle to recruit new workers into the field. With the number of women aged 20-50 years old only expected to grow 9% between 2000 and 2030, the pool of female workers who typically fill direct care positions will be limited (Wright, 2005; Van Kleunen & Wilner, 2000). The industry will have to begin efforts to better recruit new workers into the field to fill these open positions. With severe direct care worker shortages already being reported in 37 out of 43 states that were surveyed; this issue will only get worse as the aging population requiring long-term care support grows (Smith & Baughman, 2007). Additionally, for those aides who are in the job, a major complaint is the lack of career advancement opportunities available. With limited or no perceived opportunity to move-up at their job, many aides vacate the field, leaving further openings that agencies struggle to fill.

#### **Strategies:**

- Develop a Direct Care Job Website - One strategy to improve recruitment is to make it easier for people to find and apply for direct care positions. Currently, each agency posts job openings on a variety of websites, with no central location to host the postings. Having a one-stop website for new and experienced aides to locate jobs would decrease the effort workers have to extend to locate and apply for jobs.
- Invest in an Information Campaign for Students (including Financial Aid Awareness) - Bringing a greater awareness to the growth within the direct care field to high school and community college students is a way to potentially increase the pool of workers. Additionally, reaching out to current direct care workers in the field to provide them with information about career advancement opportunities, as well as the availability of further training and education, is important for encouraging advancement. Letting them know about these options, as well as their accessibility through financial aid, may show aides that there are opportunities to advance within their own field.
- Build Direct Care Worker Career Pathways - Enhancing the opportunities for advancement is important as currently, direct care positions are often viewed as limited in career advancement

opportunities. Building stronger bridges between jobs and providing greater guidance on how to achieve forward mobility for those who want it will keep motivated aides within the field, instead of leaving to find opportunities elsewhere.

- Create Recognized Transferable Training - In building career pathways it is important to link job training models so aides do not have to repeat training in order to pursue further opportunities. For instance, if a medical assistant wants to work as a home health aide (HHA) they are required in most instances to attend the full 75 hour HHA training course, instead of being able to apply a portion of their medical assistant training. By creating transferable training that can then be honored within other job trainings, aides are encouraged to seek out additional training and invest in furthering their career.
- Offer Partial Scholarships for Students - A barrier many direct care workers have in pursuing further education is the cost. Many direct care workers live in poverty, relying on food stamps and other government assistance programs, leaving little money for pursuing additional education (Seavey & Marquand, 2011; PHI, 2011). Supporting aides who are committed to the field through scholarships to advance their education in healthcare would improve their skills and knowledge, as well as make them feel valued. One consideration may be to reestablish the CNA/HHA Scholarship Program funded through the ECCLI Initiative to provide nursing homes and home care agencies with funding to conduct entry level trainings would make a significant difference in encouraging more aides into the field.

### **Goal 3: Change Policy**

**Explanation:** The Department of Higher Education (DHE) acknowledges that the challenges facing the direct care workforce go far beyond those within the purview of DHE. As education is a central thread of workforce development, DHE has committed to convene state agencies, private sector and not-for-profit partners who govern the training and supervision requirements of this workforce, to address cross-cutting issues that are critical to building a stronger, more qualified workforce.

#### **Strategies:**

- Staff a Cross-Secretariat Task Force to Identify Barriers- A first step in making broader changes to address the challenges that face the direct care workforce is to engage additional government agencies in the conversation. Bringing together a cross-secretariat task force with the goal of identifying goals and overcoming the barriers to building and sustaining the direct care workforce pipeline will allow Massachusetts to take a more comprehensive approach to meeting this important workforce need.
- Launch an Advocacy Campaign to Improve Reimbursement and Wages - Low wages continue to plague the direct care workforce and have consistently been identified as having a negative impact on the aides' job satisfaction and contributing to turnover (Kemper, Heier, Barry, Brannon, Angelelli, Vasey, & Anderson-Knott, 2008; Wiener, Squillace, Anderson, & Khatutsky, 2009). Appropriate members of the industry, employer and workforce community must convene stakeholders to raise awareness about the reimbursement and wage challenge as a barrier to building and sustaining this workforce pipeline.

- Create an Innovation Fund to Support New, Untested, Promising Ideas – With such a broad array of options available to potentially improve the quality of the direct care workforce, as well as to address the issues of recruitment and retention, the opportunity to have funds available to employers and community colleges to test new, promising ideas may be fruitful. By building partnerships and collaborations on the ground-level, local colleges and private or non-profit organizations could come together to develop innovative ideas that could be piloted and replicated in the local community.

#### **Goal 4: Build the Business Case for Investing in the Direct Care Workforce**

**Explanation:** Private businesses must be convinced that investing in their workers through training, wages, and benefits will lead to higher retention and in the end, help their bottom line. This goal focuses on providing data and information to employers and agencies to help them recognize and realize the benefits of a well trained, stable workforce that will progress to higher level jobs over time.

#### **Strategies:**

- Convene an Education, Employer and Policy Collaborative - to discuss goals and strategies for improving the quality and retention of the workforce. Without the commitment from all key stakeholders, real significant change will be hard to achieve, particularly given the complexity of the challenges that face the direct care workforce.
- Articulate the Business Case for Investing in Direct Care Workers - Articulating why investing in their workforce makes sense for for-profit business' bottom line is critical to convince them to change their practices. Using data to illustrate how providing higher wages, more career advancement opportunities, and better supervisory support can decrease turnover, increase satisfaction, and in turn, save the organization money will give businesses that employ these workers the incentive they need to make changes that will benefit all parties involved.
- Create Regional Data Sets through the Workforce Investment Boards (WIBs) - A current challenge within the direct care workforce is the lack of data available to truly understand the supply and demand need of these workers in Massachusetts. Without this information at the local level, it is difficult to create an action plan to tackle these issues. By utilizing WIBs, a board that is already positioned as the expert on workforce development and demand, data could be collected from long-term care facilities and other agencies that employ direct care workers. This information would then be used for planning and fund allocation in regional areas around Massachusetts.
- Launch a Campaign to Educate People on the Value of the Direct Care Workers in the Healthcare System - Direct care workers often report not feeling respected or valued for the work that they do assisting clients and residents, particularly by other healthcare professionals (Ayalon, 2007; Morgan, Semchuk, Stewart, & D'Arcy, 2002). Developing and launching a campaign to raise awareness about the critical work that direct care workers do every day could serve two purposes: first, to increase the visibility of the workforce in hopes of encouraging new workers into the field, and second, to encourage others in the healthcare field to change the way they work with direct care aides. By bestowing respect on the aides for the work that they do, other

health care professionals will show the direct care workers that they are valued members of the healthcare team.

### **Goal 5: Invest in Development of Core Competencies**

**Explanation:** A challenge for the direct care workforce in Massachusetts is the varying training requirements that are mandatory for different direct care positions. Aides who wish to move within the healthcare system and work in varying settings are limited because of these rules. Developing core competencies that are consistent across settings and job titles are important for giving direct care workers more freedom to fluidly move from setting to setting. This is also beneficial to employers as it would save them time and money that is now spent retraining aides who otherwise could be working immediately. Currently, core competencies are available in various forms throughout the state, but there is a need to better define their purpose, scan what currently exists, and institutionalize them across long-term care settings.

#### **Strategies:**

- Align Core Competencies across Jobs and Build Consensus for Support - Among the core competencies that have been developed, there is a need to share these among various healthcare settings and organizations to begin to build consensus around their use and application. Ensuring that the core competencies are accurate and applicable for all settings is critical to their success prior to implementation.
- Pilot Core Competencies Curriculum and Offer Statewide Core Competency Courses - Once core competencies are agreed upon by the varying healthcare setting key stakeholders, piloting their use in practice will be important to ensure that their application works as anticipated. After the core competencies are piloted, it is encouraged that statewide core competency courses be offered through community colleges or other training venues in order to implement and institutionalize the new training.
- Inform Direct Care Worker Curriculum with the Employer Needs - As the development of training courses and educational classes for the direct care workforce continues, it is critical that the curriculum aligns with the needs of the direct care worker employers. As the needs of clients in the field shift, moving greater responsibility onto the aides, the preparation of direct care workers must keep up with this transition.
- Incorporate Life/Soft Skills into Direct Care Curriculum - One challenge often reported by employers is the direct care worker's need for further training in the area of life skills. These skills can include areas such as, communication, conflict resolution, professionalism, and more. As most direct care workers have limited formal education, 60% have a high school diploma or less, many lack the skills that are picked up by others throughout their educational development (Seavey & Marquand, 2011). By incorporating life and soft skills into all core training curriculum, employers can be assured that the aides they hire have received at least a baseline knowledge in these important skills.

- Align Job Descriptions and Standards of Practice - Beyond creating core competencies, further aligning job training and standards for direct care workers who work in varying settings throughout the healthcare network is a way to better allow fluid movement for workers across the healthcare spectrum. The numerous array of job titles and descriptions becomes murky even for those within the network, making them nearly impossible to understand for those outside. Creating consistency between jobs across settings would more easily align these positions for training purposes and for ease of employing workers in multiple settings.

## **Goal 6: Provide Employer Support**

**Explanation:** Once aides begin working within the organization, there are often important needs they have that their employer is not adequately meeting. For instance, 25% of direct care workers are unmarried with children, leading to a high probability of confronting child care issues that could affect their job (Wright, 2005). Managing their stressful personal lives, which can consist of medical and health challenges, child care issues, and/or financial stresses, can be difficult while also dealing with the on-the-job stressors of direct care work. Providing the high level of support that many aides need is beyond the capacity or the ability of their employer. Offering support to the employer through additional support roles or through training and education of the supervisors and managers could be important in helping aides succeed in their job.

### **Strategies:**

- Develop and Pilot a Case Manager Model - Case management has been successfully used in other training programs, such as with the PHCAST program. The purpose is to provide aides with additional support while they are going through the initial training to become a direct care worker. The case manager can assist with personal or work challenges that may emerge as the aide begins to adjust to the training demands and prepares to begin their new job as a direct care worker. Providing this extra support in the beginning can give new aides the assistance and guidance they need to manage stressors, like transportation challenges, issues with child care, and financial worries.
- Offer Post Placement Coaching - Following the completion of training, aides often continue to require additional support that is beyond the capacity of the organization where they work. Having access to case management services, mentorship, and career development guidance would offer the aide additional assistance to manage their personal life challenges, work issues that arise, and to counsel them on future career path opportunities.
- Offer Supervisor/Staff Management Training - A primary reason direct care workers report leaving their job is a lack of support being provided by their manager or supervisor (Bishop, Squillace, Meagher, Anderson, & Wiener, 2009; Chou & Robert, 2008; Eaton, 2001). New attention is being paid to better preparing these supervisors, giving them the tools to be better managers and leaders within their organization. Providing these managers with additional training to become better supervisors, will benefit aides and their employers.

## Allied Health Planning Task Force

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