

SILICON VALLEY WORKFORCE INVESTMENT NETWORK'S

JOBS WITH A FUTURE

DESIGNING HEALTH CARE CAREER LADDERS THAT WORK

LOUISE AUERHAHN
BOB BROWNSTEIN
SARAH ZIMMERMAN

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PREPARED BY:

WORKING PARTNERSHIPS USA

THE WORKFORCE INVESTMENT ACT

In 1998 the United States Congress enacted the Workforce Investment Act to consolidate, coordinate, and improve employment, training, literacy and vocational rehabilitation programs in the U.S. The Workforce Investment Act is intended to meet the needs of the nation's businesses, job seekers and those who want to further their careers through local employment and training programs. To advance these objectives, locally organized Work-force Investment Boards (WIBs), consisting of members from both the private and public sectors have been set up throughout the country. These WIBs oversee the delivery and contracting of employment and retraining services for the regional job market they represent. In April 2000, the State of California designated Santa Clara County as a Workforce Investment Area. In July 2000, the City of San José, in partnership with Campbell, Gilroy, Los Gatos, Los Altos Hills, Monte Sereno, Morgan Hill, Saratoga and the unincorporated areas of Santa Clara County, created the Silicon Valley Workforce Investment Network (SVWIN) to act as Silicon Valley's regional WIB. It acts in collaboration with NOVA, the north county workforce investment board that covers Sunnyvale, Cupertino, Mountain View, Los Altos, Santa Clara and Palo Alto.

Locally managed, the WIN brings together job seekers, local employers, educators, labor representatives and program administrators to sustain and maximize the relationship between employers and the prospective labor market in this region.

TABLE OF CONTENTS

Executive Summary	ii
I. Introduction	1
II. Establishing Successful Career Ladder Programs: <i>The Challenge</i>	3
III. Best Practices for Successful Career Ladder Programs: <i>The Rationale</i>	5
IV. Five Strategies for Building Successful Career Ladders	7
1. Job Restructuring	7
2. Job Improvement	9
<i>BOX: Additional hurdles of long-term care providers</i>	12
<i>GRAPH: Concentrations of Entry Level and Middle Level</i>	
<i>Professionals by Provider</i>	12
Job Structuring and Job Autonomy in Long-Term Care	13
Best Practices in Long-Term Care	14
3. Wraparound Services	18
4. Regional Training Partnerships	21
<i>BOX: LOCAL INITIATIVES (RHORC and CTI)</i>	22
5. Recruiting Underrepresented Minorities	25
<i>BOX: CET</i>	26
V. Conclusion	27
Bibliography	30
Appendix	32
Acknowledgements	45

EXECUTIVE SUMMARY

INTRODUCTION: THE HEALTH CARE CRISIS

The failure to recruit and maintain adequate levels of personnel in the health care industry—and the related failure to reach political agreement on the levels and distribution of funding for health services—has reached disastrous levels. It resonates throughout our society from the White House to the local street corner. No constituency remains immune to the harm it generates. In this report, many elements of the staffing crisis receive specific attention, including the difficulties of the long-term care sector, the capacity of our health care system to respond to emergencies, the rapid escalation of health care premiums, and the inability of workforce development institutions to meet either employer requirements for sufficient trained personnel or the demands for adequate services from prospective employees.

Intro: The Crisis *continued*

In the long-term care industry, seniors, a particularly vulnerable sector of our society, ironically shoulder a disproportionately large share of the burdens imposed by the crisis. They must confront both the rising costs of elder care and the consequences of the chronic low pay of many workers in long-term care settings. The ability to age with dignity remains out of reach for many, despite new technologies that offer the possibility of extending our life span and improving the quality of living for the old and infirm. Achieving the goal of providing optimal services to those in their golden years has been hampered by the lack of funding for both advanced treatment and basic care. A scarcity of resources also has resulted in a deficiency of well-trained, well-paid paraprofessional staff for both long-term care centers and for in-home service programs. This shortage further compromises the quality of long-term care already impacted by high staff turnover.

Unresolved personnel problems in the health care delivery system also weaken our society's ability to maintain its security against diverse risks and contingencies. The inability to adequately staff and fund health centers constitutes a major shortcoming. In particular, the shortage of trained staff at hospitals indicates a truly disturbing inability to respond to emergencies, since hospitals will often be on the front line of defense during natural disasters, major accidents, or large scale attacks against civilian centers.

Another component of system disequilibrium is skyrocketing health care insurance premiums that cause hardship for both employers and workers. Employers find it increasingly difficult to finance the rising costs of health insurance for their workers and must face lower productivity, higher turnover, and loss of employee loyalty as a result. High premium costs imposed on workers mean employees and their families must choose between health care insurance and other basic necessities, often dropping their health insurance

and relying on overwhelmed emergency rooms or cash-strapped clinics for basic care.

As they attempt to respond to staff shortages and other aspects of this crisis, job counselors and workforce development institutions are hard pressed to make progress for two major reasons. First, counselors lack the funding and the policies to provide long-term training to a large number of applicants. Secondly, counselors are unable to counter the perception that many health care jobs are of poor quality, an image that serves as a serious barrier to efforts to encourage people to either enter or remain in the health care field. Although careers in health care are promoted as high quality jobs, the positions often fail to attract qualified applicants because of their hidden drawbacks: the lack of benefits or guarantees of full-time schedules. Without funding to provide extended training or the ability to offer greater security or better wages and medical insurance, counselors simply do not have the recruitment incentives necessary to help reduce the widening gap between supply of, and demand for, health care personnel.

Unresolved personnel problems in the health care delivery system also weaken our society's ability to maintain its security against diverse risks and contingencies.

ROLE OF THE SVWIN

Given the fact that three of its constituencies experience the pressure of this crisis—job counselors, providers, and job seekers, the SVWIN has dedicated significant resources to confronting the major obstacles to expansion of the health care sector. The SVWIN first published a report on the priority challenges facing this industry and then brought together experts from the field to discuss these factors and to generate preliminary solutions. This second health care report advances that work by more deeply evaluating constructive responses to problems in those critical areas noted above—long term care, training, job-quality and rising costs of services.

The discussion that follows includes both a review of information from the initial SVWIN report (Health

Intro: The Crisis *continued*

Care Volume 1, or HC1) and a summary of findings from this current analysis. While the first report focused on describing the industry and analyzing problems that inhibit the sector from achieving high growth, this second study (HC2) offers solutions to those previously identified barriers. The solutions build on the idea that career ladder programs are fundamental aspects of successful workforce development initiatives. The report begins by exploring the particularly attractive aspects of career ladders that enable them to address many of the problems in the health care services industry. Then, it focuses on strategies specifically designed to create and strengthen career ladders in health care. Working to assist implementation of such strategies is a natural role for the SVWIN because of its focus on training as a mechanism to improve economic outcomes.

Increases in training programs, even increases to the extent sufficient to fill all open spots, cannot fully address the workforce shortage.

Santa Clara County unemployment rates that neared 10% in the spring of 2003, employment in health care services rose 2% from the previous year¹.

HEALTH CARE OCCUPATIONAL DESCRIPTION BY TYPE OF EMPLOYER

Because the WIN is an agency that provides counseling and training to workers and helps connect qualified applicants to employers seeking to resolve staff shortages, it requires periodic, accurate, and in depth occupational analyses of employment sectors. To meet this need, the previous report detailed the growth in health care services *employment* and specified where this growth has been concentrated. Within the aggregate growth of the industry, certain types of employment are expected to be most in demand. The analysis identified these occupations and the reasons for the sector's difficulty in filling this need.

Occupations reviewed included nurses,

physicians with specialties, pharmacists, LVNs, diagnostic imaging and radiology technicians, and other specialty technicians such as ultrasound, radiation, and nuclear medical technicians.

CHALLENGES FOR OUR COMMUNITY FINDINGS FROM THE FIRST SVWIN HEALTH CARE REPORT

HC1 provided the framework and background for a discussion of innovative solutions for the health care services industry. It addressed the reasons why the WIN should be involved in health care, painted a picture of where health care occupations are concentrated by type of provider, identified major problems the industry experiences that keep it from growing, and presented an initial set of recommendations and next steps. Each of these four points is reviewed briefly below.

WHY THE WIN SHOULD BE INVOLVED IN HEALTH CARE

A major reason for the WIN to be involved in health care is the sector's vitality as a source of jobs even at the height of the current recession. Although many industries in our valley are reducing the size of their workforces, generating one of the highest unemployment rates in the nation, health providers continue to recruit workers and expand their staffing levels. In contrast to

OBSTACLES TO GROWTH:

MEETING THE DEMAND FOR HEALTH CARE STAFF

To help devise responses to these shortages, the report delved deeply into the challenges associated with retaining staff already holding these positions and recruiting and training new personnel. ***One of its more surprising findings was a realization that increases in training programs, even increases to the extent sufficient to fill all open spots, cannot fully address the workforce shortage. Training alone is insufficient because the cause of severe staffing shortages is not simply a lack of qualified health care workers.*** In fact, the staffing problem is compounded by the decisions of skilled personnel to leave — either in a geographic sense or in terms of occupational preferences. Nurses in particular were found to be moving away from high cost regions

Intro: The Crisis *continued*

in the state or moving out of California entirely. They were also pursuing easier occupations offering more remuneration and/or less stress. This finding has helped focus the current report, HC2, on ways to attract and keep trained workers in the industry as well as on ways to create or improve existing training programs.

OBSTACLES TO GROWTH: ESCALATING COSTS

Following an analysis of occupational demand, the report concentrated in large part on the obstacles health care employers face when trying to attract or retain sufficient personnel to provide needed services. These impediments exist despite opportunities for recruitment presented by unemployment in other sectors during the recession. As the report noted, health care employers have a temporary advantage in the current labor market because the state's large pool of unemployed workers offers a less costly, more qualified group of applicants than what they would normally see under more prosperous conditions. However, the resources to take advantage of this opportunity—the funding to expand their workforces and provide an increased amount of service—may be almost impossible to secure. HC1

explored the reasons for these difficulties, including escalating costs of existing operations, increasing health care needs among seniors and other constituencies, greater competing fiscal demands on the public sector, and a shrinking tax base to support these multiple pressures.

The actions of other business leaders responding to the recession place additional burdens on the health care industry. Employers across many industries lack the funding or the will to invest in their workforce. When employers reduce their health insurance premiums, they force more people to buy private insurance when possible or rely on health clinics and emergency rooms. However, those same providers that are facing growing demand for their emergency services are experiencing state and federal governments' cuts in health care funding.

Similar problems occur in sub-sectors of the industry that do not depend on employer-sponsored insurance. For example, reductions in government spending are especially troubling for long-term care facilities, which are heavily reliant on Medi-Cal reimbursement and cater to a senior population that has relatively fixed incomes.

INITIAL RECOMMENDATIONS

The report ended with a series of initial recommendations. These included a list of steps that regional groups can take together to develop solutions to the identified problems, and a suggestion for further research on those best practices currently being implemented that have both contained costs and recruited and retained workers. Among the suggestions for mitigating the problems identified are the following proposals:

1. IMPROVING TRAINING PROGRAMS THAT ADDRESS THE NEEDS OF EMPLOYERS AND WORKERS

Develop training programs that focus on addressing workforce shortages; these should be based on input from regional meetings as well as proven best practices in other areas.

2. HELPING PROVIDERS MEET STAFFING RATIOS

Research and implement best practices that have been shown to improve staffing ratios by improving retention and easing recruitment. Regional groups composed of members committed to high quality staffing practices could also meet with state legislative delegations to discuss improved reimbursement strategies designed to help hospitals meet the new staffing requirements.

3. DEVELOPING BUSINESS AND GOVERNMENT PARTNERSHIPS

Seek to create forms of collaboration, such as a regional scholarship program with a loan forgiveness model that encourages graduates to remain in the area. Regional programs are more likely to be adopted when government funds all or part of the training, as individual hospitals or long-term care facilities use loan forgiveness to retain workers at particular sites.

4. ADDRESSING THE LONG-TERM CARE CRISIS

Coordinate efforts with organizations already committed to improving long-term care. The Workforce Investment Network would benefit from interaction with such potential partners as Governor Davis's "Aging with Dignity" Initiative, the Local Council on Aging, SEIU local 250 at nursing homes, and SEIU Local 715 and the In Home Supportive Services program. Another useful partner could be the County of Santa Clara's Social Services Agency Department of Aging and Adult Services (DAAS), which administers and oversees Adult Protective Services (APS), In Home Supportive Services (IHSS), the Public Administrator Guardian Conservator (PAGC), the Senior Nutrition Program (SNP) and Long Term Care.

Several of these recommendations are being pursued in other arenas. Some legislative strategies are focusing on maintaining and increasing resources to fund the demand for health care, while the structure of the system itself is also under debate. Building broad coalitions to support such legislation assists in influencing policymakers. When employers, training providers and unions together support specific legislation, it delivers a strong message that increasing health care funding is in the

interests of numerous sizeable constituencies, thus increasing the likelihood of success in Sacramento.

Of the various recommendations presented, the WIN is well positioned to focus on meeting training needs in conjunction with building broad partnerships. The best practices presented in the following report not coincidentally often rely on collaboration among workforce partners, unions, employers and workers.

HEALTH CARE REPORT II: DESIGNING HEALTH CARE CAREER LADDERS THAT WORK

The SVWIN offers this report on career ladders to address deficiencies in much of the existing published research on this strategy. On the one hand, a plethora of evidence exists demonstrating that solid career ladders are essential to addressing the job shortages so prevalent in the health care industry. However, existing reports do not indicate how career ladders can have positive effects that move beyond simply increasing the number of potential workers. In the following presentation, career ladder training programs are described as a mechanism capable of solving complex problems for all three of the primary constituencies of the health care sector—employers, employees, and patients. These programs are able to meet multiple needs because they contribute to attracting a larger pool of workers, because they help promote entry-level workers within health care, and because they reduce turnover and increase retention, saving costs and enhancing the quality of care patients receive.

Another deficiency in the literature fails to explain the relative scarcity of career ladder programs. Despite the now widespread belief that students receiving training from career ladder programs can improve their occupational outcomes, career ladder programs are relatively rare. Attempts to create such training programs often fail because they focus only on determining the occupational steps that coursework should fit, without examining other factors that contribute to a program's survival.

The literature on career ladders often reflects this bias, focusing principally on the steps required for a good training program and ignoring additional elements

needed to insure success. Much of the literature concentrates on defining career paths and identifying the training needed to move from one level to the next. Well-crafted definitions have been provided by a number of institutions and organizations in Santa Clara County and the State of California; they are invaluable to career counselors and training providers. However, despite the availability of this knowledge, local providers and colleges still are unable to develop programs to train entry-level workers for mid-level health care positions with any consistency or scale².

This report specifically addresses the second deficiency noted above; it considers how to create and fund successful training programs. To perform this task, the analysis moves beyond occupational details about career ladders, concentrating on elements important to successful operation of large-scale programs at colleges and at jobsites. It begins with

a review of the reasons for supporting career ladder approaches, pointing out the needs they are able to fulfill for employers and workers. The report then discusses five aspects of successful programs, with a special in-depth analysis of the long-term care sector. Finally, it includes an appendix with profiles of 10 case studies from programs throughout the country.

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FINDINGS: ELEMENTS OF SUCCESSFUL CAREER LADDER PROGRAMS

FIVE STRATEGIES FOR BUILDING SUCCESSFUL CAREER LADDERS

The following five strategies were selected from an exhaustive review of both training programs and employer-based career ladder programs, based on their ability to produce successful outcomes for workers, employers, and patients. Programs were considered successful for **workers** when they trained people for jobs that actually increased their wages and improved their work environment. They were deemed successful for **employers** when they reduced the time and money allocated for recruitment, training, and other human relations functions, including outsourcing. Finally, they were successful for **patients** when they enhanced the quality of health care.

1. JOB RESTRUCTURING TO CREATE OR CLARIFY CAREER PATHS

The purpose of job restructuring is to design and construct career paths for workers and to encourage them to invest in their own futures. Job restructuring involves setting clear, standardized requirements and levels of compensation for all jobs. Standardization assists in the formation of training courses that closely meet job requirements; it also contributes to the identification of career pathways and to the assurance that workers will be able to advance after successful completion of training. Job restructuring can also include adding intermediary positions to serve as stepping-stones on a career ladder at a specific jobsite.

When job improvements are coupled with job restructuring, the combined strategy often augments the ways that career ladder programs can lead to recruiting and retaining workers. Typically, workforce development programs focus on using training programs to move people up a career ladder. Their common expectation is that more people will consider health care as a profession when there are long-term job opportunities for entry-level workers. However, the strategy discussed here also emphasizes steps employers can take in the workplace that make lower-level positions more attractive in comparison to other fields and that encourage workers to develop skills in their current positions that enable them to provide better patient care.

2. IMPROVING JOBS AND THE WORK ENVIRONMENT

Job improvement involves offering additional pay for occupational classifications that require more training and the acceptance of additional responsibility. **Research shows that workers are much more likely to invest in training if the training leads to a job that is significantly more attractive than the one they currently hold³.** In addition to providing tangible incentives, improvements in the work environment can demonstrate to workers that employers value them and believe they can succeed at training, thus encouraging people to persist in lower level positions while they take classes to advance. In particular, incorporating this strategy into a human resources program leads workers to think of themselves as career professionals and to seek out professional development options.

3. WRAPAROUND SERVICES

The most effective career ladder programs couple better wages and a realistic expectation of advancement with support services to insure completion of training. Typically such assistance is referred to as “wraparound services.” Programs with wraparound services identify the obstacles that prevent a target population from completing a training program, and then they provide focused help to overcome them.

4. REGIONAL PARTNERSHIPS

Regional partnerships usually involve multiple providers that coordinate their work to address staff shortages. Roles for alliance members include contributing funds, designing and managing training programs, and developing wraparound services for trainees. The primary motivation for providers is to

increase the size of the region's health care workforce, especially in occupations that face a significant need for additional personnel. A regional approach also lowers the training cost for individual employers since a single firm will not have to pay for the entire program. While employers are not guaranteed that graduates of a training program will stay at their current site, the increase in the number of trained individuals available offsets this potential loss. Finally, while the costs of the training program are spread across employers and other funders, employers do have a voice in insuring that the programs meet their specific workforce needs by participating in the identification of occupations in which shortages exist.

5. RECRUITING UNDERREPRESENTED MINORITIES

This strategy concentrates on one aspect of the staffing crisis not yet mentioned—the fact that only a limited percentage of the population is willing to even consider health care as an attractive career, thereby reducing the pool of potential entrants. To increase the number of job applicants, recruitment efforts for health care personnel—and especially for nurses—need to reach people who are outside of the field, minority women and men in particular. Minority women do accept health care positions, but they are disinclined to pursue upper level training. Men, on the other hand, tend to eschew entry-level health care occupations as well as all nursing positions. Currently men make up less than 6% of the nursing population. Bringing underrepresented people into training for nursing positions can both increase the total number of applicants and can address the barriers that minority groups face in moving up career ladders.

The following table provides an overview of the objectives of each of these five strategies for the workforce development community within the context of an overall commitment to promote a high-road health care services industry in Santa Clara County.

STRATEGY	OBJECTIVE
JOB RESTRUCTURING	<p>Match employment and training, identify skills needed to move into higher paying jobs;</p> <p>Reward incremental advancement, enable career lattice motion to provide greater job mobility for workers and help employers more easily fill job openings</p>
IMPROVEMENT IN QUALITY OF WORK (PROFESSIONALIZATION)	<p>Increase retention, improve patient care, and refine soft skills that contribute to an increasing likelihood of successful completion of training and advancement</p>
WRAPAROUND SERVICES	<p>Enable workers to overcome personal difficulties in order to combine work and training; improve retention and completion rates in training programs</p>
REGIONAL PARTNERSHIPS	<p>Reduce costs to any single employer for developing training; increase scale of training; promote career lattice movement; decrease duplication and promote coordination of efforts among health care providers, trainers, and job counselors</p>
RECRUITING UNDERREPRESENTED GROUPS	<p>Expand the total population that considers pursuing a career in a health occupation</p>

While some of these elements were found to be more useful in certain sub-industry sectors, others were essential to any quality career ladder program. Job restructuring has been most feasible for large employers such as hospitals. In contrast, regional partnerships and job improvements that both enhance the quality of care and facilitate mobility are found to be just as important for long-term care employers with more limited career ladders and smaller profit margins as they are to large hospitals. In California, partnerships between long-term

care employers and unions also have contributed to improved quality of care and a more stable funding base for training. However, current budget cuts to Medi-Cal will make it increasingly difficult to raise wages and fund high quality care, especially for the elderly and vulnerable. During the next few years, applying these five strategies and maximizing the use of existing regional partnerships to incorporate the best programs possible will be critical steps for health care institutions.

ENDNOTES

1. EDD, current month employment projections.
2. See appendix for list of graduation rates by occupation and college in the county
3. Fitzgerald and Carlson, 2000. “But perhaps even more important, according to Nancy Mills, national work force coordinator at the AFL-CIO, is that people are willing to enroll in continuing education only when the connections to a better job and higher pay are guaranteed.”

INTRODUCTION

THE PROBLEMS

The present crisis in the economics of health care has reached epic proportions and resonates throughout our society from the White House to the local newspaper. It is a dilemma of both scale and breadth, affecting a huge number of people as well as a wide range of groups in the U.S., ranging from small and large employers to health providers, government officials and job training institutions. The nature of this crisis has been examined by the Silicon Valley Workforce Investment Network (SVWIN) in a series of arenas—in reports and in a conference in December 2002 that brought together providers, job trainers and policy makers.

This publication is the second half of a study on Silicon Valley's health care industry and workforce. The first health care industry report revealed escalating costs, an increase in health care needs among seniors and other constituencies, greater demands on the public sector, and a shrinking tax base to support those pressures. Noting that these service problems are particularly acute in the long-term care sector, the report determined that:

- California's expanding population, including a growing number of elderly as a percent of the population, requires a net increase in the amount of health services available;
- The elderly require more frequent medical attention using more costly technology at the same time that their personal capacity to fund these services has declined;
- Advances in technology provide additional effective treatments that both increase people's life span and raise provider expenses;
- The federal and state governments have experienced growing health care expenditures and, more recently, fiscal pressures to reduce spending.

Health care employers in particular are caught between decreasing revenues and increasing demands for services. Struggling to meet demand and contain costs, they feel themselves confronting an insurmountable barrier to attracting those skilled and semi-skilled employees needed to fill gaps in the health-care workforce.

The previous SVWIN report also discussed the workforce shortages in health care and the reasons for these shortages. **Its primary conclusion was that a serious lack of staff is inevitable when demand for healthcare specialties persistently exceeds the number of new graduates.** Hundreds of positions are expected to go unfilled under the current system. While the existing publicly funded college training programs play a crucial role in attempting to offset this problem, projections show overall effort lacks the capacity to meet the entire need, especially during a time of tightened budgets.

Serious staffing shortages place enormous pressure on training institutions and programs as employers continue to demand more health care professionals while trying to minimize costs. This second report responds to the calls for solutions to the workforce development crisis and to the need for cost savings while preserving high quality care. It builds on the work of such local initiatives as the Greater Bay Area Caregiver Training Initiative (CTI) and the Regional Health Occupations Resource Center (RHORC), which have offered examples of resources available to health care employers and suggested models of programs that can successfully develop career ladders.

THE SOLUTIONS

Career ladders are touted as the solution to a myriad of problems that health care employers face, from solving the health care staffing shortage to reducing escalating costs. However, they are usually found to be difficult to implement, or they fail to meet employers' and workers' expectations.

A primary objective of this report is to determine how to make career ladder programs successful. It identifies both the elements of strong career ladder programs and the obstacles that individual employees encounter when moving up a ladder. The report also reviews workforce development programs from around the country that demonstrate how best to enable employers and workers to use career ladder programs to control rising costs and stem the growing workforce shortage. Results from these programs include financial savings, improved quality of care, and the creation of career ladders that move large numbers of people into areas of job shortages. Complete case studies of 10 different programs nationwide are provided in the Appendix.

For employers particularly concerned about saving costs and applying some of the new principles found in this report, a resource guide on the WIN's web site provides information about funding sources for training programs and support services such as child care and transportation. Through this site and the multiple components of its health care solutions project, the Workforce Investment Network is seeking to support one of the most vibrant and vital sectors of our local economy. The guide can be found at http://www.svwin.org/b_howcanhelp.htm.

II. ESTABLISHING SUCCESSFUL CAREER LADDER PROGRAMS: THE CHALLENGE

WHAT IS A CAREER LADDER PROGRAM?

Ideally, career ladder programs establish a training curriculum that identifies progressive steps for upward mobility, often starting from entry-level positions requiring few skills. Such efforts set out “to enable low-wage workers to advance through a progression of higher-skilled and better paid jobs.” The focus, then, is identifying job opportunities in a particular field or at a site of employment that an individual worker can reach to gain higher earnings through greater training and experience.

WHY ARE CAREER LADDERS CRUCIAL IN THE HEALTH CARE SERVICE INDUSTRY?

Workforce development professionals throughout the country identify health care as an ideal industry in which to invest in career ladder strategies. Numerous other fields have experienced either a long-term decline of middle level positions or a steep loss of jobs following the downturn. However, the demand for health care services appears resistant to even a severe economic downturn, while health care services offer a wealth of both entry level and more skilled positions.

Career ladder programs are also touted for health care *because* of the difficulty of filling middle level positions. Since career ladders can be viewed as *the* key element to solving workforce development crises, an industry that desperately needs “middle-level” workers is primed for their usage. Theoretically, moving low-wage workers into higher paid jobs through training should both satisfy the desire to help low-wage workers earn higher wages, and meet employer demands for higher-skilled employees which are often greater than their openings for entry level jobs.

WHAT PROBLEMS DO HEALTH CARE CAREER LADDERS ENCOUNTER?

In practice, however, many career ladder programs generate insufficient workforce development outcomes. To date, the majority of career ladder programs offer no more than one or two rungs at either the high end or the low end of a career ladder. At the low end, career ladder programs in health care move unskilled workers to entry level positions, such as training CalWORKs recipients to become home care aides or certified nurse assistants. At the other end, they move workers who already possess significant skills and experience into higher level positions, such as LVNs to RNs. **This report identifies the “invisible wall” between these two levels—low skilled and higher skilled occupations—and offers ways to break down that barrier.** A review of successful models indicates a number of ways to strengthen and supplement career ladder programs. These strategies include improving the work environment, restructuring jobs and internal career ladders, providing support services to those pursuing further training, and connecting individual programs to regional partnerships.

III. BEST PRACTICES FOR SUCCESSFUL CAREER LADDER PROGRAMS: THE RATIONALE

THE POTENTIAL VALUE OF CAREER LADDERS

This story illustrates the power that a functional career ladder can play in the lives of employees. Career ladders are not just technical tools for workforce development practitioners; they are rays of hope for health care employers, patients and workers, as they can enable low-wage, low-skilled workers to move into higher paying, more well-respected jobs. For employers, they are tools to help solve problems such as covering their bottom line costs and filling labor shortages. They can achieve this when they make job sites more attractive, resulting in reducing turnover and improving recruitment and retention. Recently, these achievements have been noted to have additional positive effects on the quality of patient care especially because of reduced turnover.

In health care in particular, career ladder programs are expected to solve certain specific problems related to the workforce crisis. These include:

- Shortages of middle-level workers, including nurses, laboratory technicians, and pharmacists.
- High turnover and shortages of lower-skilled auxiliary health care workers, including certified nurse assistants (CNAs), home health aides and home care aides (HHAs and HCAs)—this problem is particularly acute in long-term care facilities.
- Difficult (and costly) recruitment at both lower skill and higher skill positions, a challenge compounded by the lack of people entering the profession as well as movement out of health care into other fields.

Career ladders *can* solve many of these problems, but often fail to do so. This report aims to identify the ideal settings for career ladders to flourish—the most fertile ground for career ladders—as well as what may poison the soil. Fertility here depends on the use of additional strategies to help workers overcome obstacles they face in participating in career ladder training programs. Successfully implementing these strategies is shown to result in easier recruitment, increased retention, and greater participation in training programs.

Even when they are operated effectively, for a number of reasons, career ladder programs alone will not solve certain difficulties posed by the health care workforce shortage. Strategies that rely solely on career ladder programs to fill job shortages, for example, ignore the fact that low-wage, low-skill jobs do not disappear because the

ACCOMPLISHMENTS OF A CAREER LADDER PROGRAM: ONE GRADUATE'S STORY

The director of the Shirley Ware Center, a Bay Area labor management career training program, related the following story to convey the extensive aid entry-level employees may require to advance.

Francine Taffet was a **file clerk** at Kaiser Permanente Medical. She entered the Shirley Ware **medical assistant training** class and even moved down from Napa to Sunnyvale for the class. The labor-management regional program enabled her to work and study part time while receiving full pay. She would not have been able to afford to take time off work to go to school as well as pay for the tuition. Currently she is making \$1.00 more per hour as a medical assistant and loves the work that she is doing.

Francine wrote to the class coordinator, "A quick note to let you know that I am having the best time of my life at work. Thank you all for your support. I was immediately embraced at my new work place and ended up with a wonderful nurse practitioner who has a great sense of humor. I am getting my humor back and it feels like the old days when I first started at Kaiser. I will never be able to thank you all but I promise I will always give my best and do right by my patients. My manager set me loose on my second day and I have been feeling like I always did this kind of work.

It was hard in school towards the end but I am glad you talked to us to encourage us not to give up. I learned a lot about how people operate on people with low self esteem. However my self esteem is building up. I just cannot thank you enough for picking me for the program."

occupants have moved on to better jobs. The employer's need for these positions is still critical. Because occupations such as home care aides (HCAs), home health aides (HHAs), certified nurse assistants (CNAs), orderlies, and attendants combine hard work and minimal compensation, both employees and employers continue to struggle with high turnover and difficulty in recruiting for these essential entry-level positions.

Similarly, career ladder programs alone cannot address the problem of an inadequate pipeline of people choosing health care careers. Currently, applicants for low-wage health care positions are mainly minority females, while nurses are primarily white females. Men do not usually select these health care occupations at all, so the population of applicants is reduced. The lack of men and white women applying for these entry level positions is in part a result of the low quality of these jobs, as well as the fact that career ladder programs do not commonly move people from low wage jobs all the way to nursing positions.

Another reason career ladder programs fail to meet employer expectations is that career paths at workplaces are not well coordinated with training programs. This lack of correspondence makes it difficult for workers to determine what training they need to advance at their place of employment. This report examines career ladders in both locations—not just the career ladders implicit in training programs, but also career ladders at employment sites. The most successful programs insure that training programs are compatible with workplace career ladders.

Finally, underlying many of these shortcomings is a fundamental problem—the dismal quality of low-end health industry jobs. These jobs are often characterized by poor compensation, long and uncertain hours, and a lack of respect. Improving the quality of these jobs can have a major positive impact on retention, turnover, employer costs, and the quality of patient care.

In conclusion, this report makes a number of recommendations based on five strategies identified as helping career ladders to be successful. It suggests that the workforce development community, in addition to taking the

typical approach of developing career paths through training programs alone, should also consider working with employers and employees to improve the quality of existing low- and mid-level occupations as a strategy to tackle shortages. It emphasizes the positive benefits of regional partnerships and outlines ways to recruit more

people into the health care field. The best practices discussed below illustrate potential models that could be adapted for use by the numerous regional health care players in Santa Clara County already engaged in efforts to employ career ladders.

IV. FIVE STRATEGIES FOR BUILDING SUCCESSFUL CAREER LADDERS

An extensive review of training and employer-based career ladder programs designed to solve workforce shortages or improve the quality of patient care indicates three factors are most closely associated with success. First, programs are successful for workers when they train people for jobs that actually increase their wages and improve their work environment. Second, they are successful for employers when they reduce the time and money allocated for recruitment, training, and other human relations functions, including outsourcing. Finally, they are successful for patients when they enhance the quality of health care. Five strategies have been identified as leading to these outcomes:

- Job restructuring
- Improving the work environment
- Wraparound services
- Regional partnerships
- Recruiting underrepresented minorities

While the first three of the above are essential to creating a successful career ladder program at a particular employer, the second two are fundamental for a regional solution, particularly one that addresses the workforce shortage beyond

stopgap measures. This report examines each strategy, describing the programs that have been most successful at employing them, and identifying the consequences of attempts to create career ladder programs without recognizing their importance. Throughout this report, **it will be essential to remember that none of these strategies accomplishes optimal results alone.** While the report highlights the five approaches individually in different case studies, **what constitutes a true best practices program is the combination of more than one of them in a coordinated effort.**

The discussion which follows is structured around these five strategies. First, the “job restructuring” and “improving the work environment” strategies will be examined. Following this analysis will be a detailed investigation of paraprofessional occupations and long-term care employers. These work classifications and employment sites are highlighted for two reasons. Long-term care facilities encounter unusually severe constraints as they attempt to initiate changes in workforce practices because of their limited sources of funding. In addition, when attempting to institute career ladder programs, this industry tends to experience greater chal-

lenges than hospitals such as more limited internal mobility for workers. Thus, a deeper analysis of this particular employment group can contribute to solving specialized problems they face that are often overlooked in health care career ladder studies with a more general focus. After this presentation, the remaining three strategies will be evaluated. Finally, to assist the reader in gathering more in-depth information on any of the programs mentioned in this report, an appendix offers detailed reviews of program profiles gained from interviews with management and operating staff.

1) JOB RESTRUCTURING

Career ladder programs are most often understood to be efforts at identifying more clearly ways to advance in an occupation by successively undergoing training and accepting increased responsibility and complexity of work. Typically, many of these programs take the job classification ladder at an employer or in an industry as a given and look to training institutes to identify the rungs and the skills necessary for each step. More innovative programs, however, actually involve employers, seeking to create or clarify job positions, to change job requirements, to create new senior levels, and to increase compensation for certain jobs—in a phrase, to engage in “job restructuring”.

The purpose of job restructuring is to design and construct career paths for workers and to encourage those workers to invest in their own futures. Job restructuring involves setting clear, standardized requirements and compensation for all jobs. Standardization contributes to well-designed training courses that meet job requirements, to the identification of career pathways, and to the assurance that workers will be able to advance upon successful completion of training. This undertaking can also involve adding intermediary positions to serve as stepping-stones at a specific jobsite.

One basic example of this restructuring can be found at a home care cooperative in New York that changed job responsibilities by converting part-time work to full time work. This program started with one of the most

difficult lower-level jobs in health care, home healthcare aides. It established full-time work assignments that offered workers access to extensive benefits as well as guaranteeing them full-time schedules. During the first five years, participants advanced to successive tiers that required additional training and paid higher wages. The scheduling system was arranged so that most workers had full-time employment, and a “guaranteed hours” program offered a guaranteed minimum number of hours weekly.

A more extensive example, described in detail on page 15-16 in the section on job improvement, occurred at the Apple nursing home chain. At Apple, management introduced three additional grades that led to higher-skilled and higher paying CNA positions. **The most comprehensive type of job restructuring, however, involves broadly rearranging much of the occupational hierarchy.** As will be noted below, a major transformation of this type was accomplished with striking results at a hospital in Cape Cod in preparation for instituting their new career ladder training program.

BEST PRACTICE

To build a functional career ladders program, the Cape Cod Hospital and the Hospital Workers Union SEIU 767 began by restructuring the hospital’s job classifications to create career ladders for all occupations. Initially, jobs were reclassified into one of twelve grades and later expanded to twenty grades. In several occupations, new positions with greater responsibility

and compensation were added. For each job, the Hospital set standard wages and qualifications, listed the number of people currently holding that job and the estimated annual job openings, and listed where training for that job could be obtained. In this way it established a clear path of advancement in each occupation.

However, the Cape Cod labor-management group did not organize the work into career ladders alone, but also into career “lattices”. Lattices are a career mobility structure that incorporates broader training options, enabling people to move into occupational tracks in other departments as labor market demands change. They are designed to expand flexibility of movement, increase the number of career pathways, and reduce recruitment and training costs. By using both “career ladders” and “career lattices”, Cape Cod workers can advance within their department or into a different department. For example, a medical records clerk (grade 7) could enroll in a phlebotomy traineeship and become a phlebotomist (grade 8). By making it possible for workers to shift departments and specialties as the demand for particular jobs change, the lattice structure helps the hospital fill needed jobs and gives workers a wide range of opportunities to advance their careers.

RESULTS

As a result of Cape Cod’s program, approximately 80% of all jobs are filled in-house through promotions facilitated through training. This accomplishment brings with it a considerable cost savings. It also helps to build a workforce of skilled and experienced caregivers. **Cape Cod Hospital has been named one of “America’s Top 100 Hospitals” for four consecutive years (96–99)**. Recognizing these benefits, other providers in the region, including Jordan Hospital, Caritas Good Samaritan, and Falmouth Hospital, are beginning to implement similar programs.

In this program and in the majority of cases of health care employers that achieved similar results, job restructuring would not have been as successful without being accompanied by improvement in compensation, benefits, and working conditions. The importance of this connection stems in part from limitations on the restructuring of health care occupations due to licensing and certification requirements. In addition, job restructuring alone would not significantly attract more people to the industry or encourage them to stay in low-wage positions. Third, job restructuring by itself can cause an increase in work by demanding more training without any return for workers—if it fails to provide an incentive. This linkage is discussed in greater detail in the following section which illustrates the resulting pitfalls of failing to effectively couple these two strategies. The section then highlights the characteristics of successful job improvement practices.

2. JOB IMPROVEMENT

Job improvement is one of the most crucial aspects of career ladder programs, especially for lower skilled jobs. This section begins with an overview of how job improvement policies both help make career ladders more successful and address health care staffing shortages. As will be shown, **job improvement has two distinct positive outcomes. First, it offers benefits for low-wage workers in their current positions. As a result, it leads to decreased turnover and improve-**

ment in the quality of care given by paraprofessional health care staff. Additionally, it can enable entry-level workers to succeed in climbing career ladders.

Job improvement involves offering additional pay for occupational classifications with more training and responsibility. **Research shows that workers are much more likely to invest in training if the training leads to a job that is significantly more attractive than the one they currently hold³.** Improving the work environment

in this market can demonstrate to workers that employees value them and believe they can succeed at training, thus encouraging workers to advance. Incorporating this strategy into a human resources program leads workers to think of themselves as career professionals and to seek out professional development options. It can also shift how people view the relationship between training and work. Typically workforce development programs focus on improving training programs to encourage more people to move up a career ladder. In addition, program managers may have the expectation that more people will consider health care as a profession because of improved long-term job opportunities for entry-level workers. However, the strategy discussed here emphasizes steps employers can take in the workplace to also make positions more attractive in comparison to other fields and to help workers desire to develop skills on the job that will enable them to provide better patient care.

FAILURE TO INCORPORATE JOB IMPROVEMENT AND ACHIEVE RESULTS

An analysis of inadequate career ladder programs illustrates the failures that result when training is not coupled with any job restructuring or work improvement. Such a problem existed at the nurse assistant training program of the Delaware Technical and Community College Workforce Training Department.

Funded by the Job Training Partnership Act, the college provided a free training program to students who met eligibility requirements; a 300-hour course for Nurse Assistants coupled with soft skills/ 'employability training.' The program also helped students with exam preparation and in their job search. Annually, 40–50 students graduated, and most students passed the state exam and found jobs.

However, completing training and securing certification has not increased wages, which remain low (\$5.25–\$6.25).

Tracking students six months after placement, program staff found that “one of the biggest problems is that the standards of quality and recognition of the importance of the nursing assistant’s work which are emphasized in the training program are not always maintained at the facilities where they work. Graduates find that a lot of compromises are made, and that nurse aides are not respected for their work⁴.”

Program staff identified developing a climate of respect for CNA professionals as a key component of a workplace that succeeds in attracting and retaining staff.

Program staff identified developing a climate of respect for CNA professionals as a key component of a workplace that succeeds in attracting and retaining staff, suggesting that low wages were only part of the problem. This finding underscores information presented in the previous WIN health report, which noted that people leave these auxiliary jobs at a faster rate than other health professionals, not only because of the low pay, but also because of other factors that reduce the quality of the position. Thus, the serious staffing shortage in CNA and HHA positions can be attributed not only to a lack of people becoming trained, but also to the difficult workplace environment and the unsatisfying quality of these paraprofessional jobs.

More evidence of the importance of coupling an improved job environment with higher wages and incremental training can be found in nursing homes that

attempt to improve lower-level healthcare occupations by creating senior CNAs. In such programs, operators have attempted to create “super-CNA” positions, in which CNAs who undergo additional training or fulfill other requirements are designated as “level II CNAs” or “Senior CNAs”, with increased responsibilities and a raise of approximately \$.50/hour. Often these “super-CNAs” become responsible for mentoring new hires, overseeing programs to improve patient care and attending management activities. However, **the lack of emphasis on significant job quality improvements usually means the program falls short of modifying the work sufficiently to influence retention rates, since the minimal wage increases do not entice workers to**

undertake both new training and a significant work-load increase. More substantial job improvement programs coupled with increases in wages *and* more extensive opportunities for advancement are required.

BEST PRACTICES

Serious job improvement programs combine a number of different elements to change the nature of the work. The following list identifies important aspects of the most successful types of job improvement for both entry level and middle level health care professionals. These include:

- increasing salary, health insurance and retirement benefits;
- changing the physical work environment;
- changing the cultural work environment, including making the environment more family-friendly;
- adjusting schedules to better match workers' needs. The elements of successful schedules vary; they include flexible scheduling, guaranteeing a certain numbers of hours per week, and making overnight and weekend shifts optional;
- incorporating professional recognition and autonomy into the workplace in part by building worker participation into decision-making;
- modifying workloads and staff assistance to enable workers to provide improved quality of care (usually by increasing staffing ratios);
- increasing support of workers on the job through orientation for new hires, mentorship, team-building, and improved communication;
- reducing use of temporary placement nurses from registries and traveling nurse agencies.

The following example provides an illustration of a hospital that has successfully employed these elements to address its workforce shortage and to improve the quality of care. Incorporating all of these elements at one hospital has meant superior performance and greater worker satisfaction. Seeking to reduce the nursing shortage, the UC Davis Medical Center in Sacramento has imple-

mented many of the concepts identified in this report, thereby saving the hospital money and winning it a ranking among the best hospitals in the state.

CASE STUDY

The UC Davis Medical Center recently began focusing on staffing policies and work culture to better support nurses. They implemented three types of policies to improve the environment for health care professionals. First, they aimed to give nurses greater autonomy and responsibility for patient care. Innovations include recognition programs that provide awards and bonuses to nurses and nursing teams based on performance. Second, they have improved staffing ratios in accordance with changes newly mandated under state law much earlier than the required deadline. According to UCDCMC, nurse to patient staffing levels are among the highest in the nation. Third, they sought to provide more stability for workers and patients by reducing the outsourcing of medical staff. UCDCMC has a formal policy against using registry or travel nurses. Instead, the hospital has developed an in-house float pool of nurses who can work in any unit. Reduction of outsourcing has two distinct benefits. It lowers the cost to employers, especially the cost of recruitment when much of the recruitment is done in-house. At the same time, the policy ensures that permanent employees continually work with nurses who are familiar with the hospital's procedures and culture, rather than with outsiders. Reduction of outsourcing also offsets a trend that makes development of career ladders more difficult; over the last few decades in many industries, the increase in outsourcing has contributed to the obstruction of career paths through either the displacement of "rungs" or an increase in the distance between them⁵.

UCDCMC achieved a number of positive results from its policy changes. **The hospital currently has an RN vacancy rate of 7.3% and turnover rate of 8.18%, compared with 20% and 17% respectively for California. UCDCMC was the first California institution to be recognized as a "magnet hospital" for nurses, a designation awarded for the best nursing care nationally, and today it is one of only two magnet hospitals in the state.** For four consecutive years, UCDCMC has won the Consumer Choice Award of the National Research Corporation, indicating

that it was ranked as having “the best overall quality and image of all hospitals in the Sacramento area”.

Changes of this magnitude were instituted in part by a partnership between workers and management. A number of worker advocates at the UC system, including AFSCME 3299, CNA (the California Nurses’ Association), CUE and UPTE (the Union of Professional and Technical Employees), helped identify the appropriate combination of strategies to benefit all three target groups—employers, workers, and patients.

CONCLUSION

Employer participation to improve the quality of work has been found to be an element essential to strengthened career ladders because enhancing job quality extends beyond wages and benefits to include a wide range of issues in the physical and cultural environment. In practice, combining employer and employee perspectives is often achieved through labor-management partnerships that enable workers to voice concerns and make recommendations that actually change the

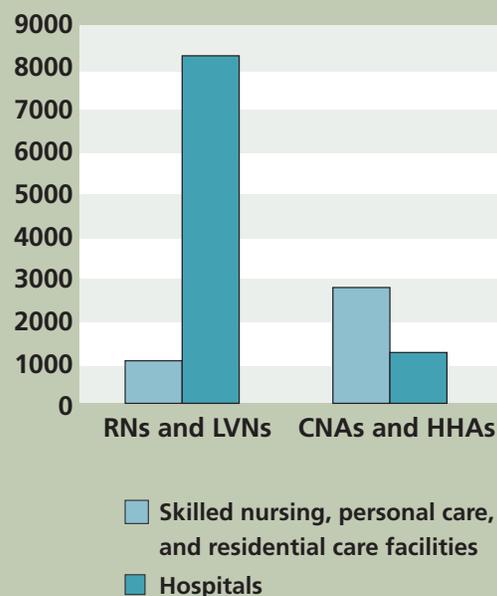
ADDITIONAL HURDLES OF LONG-TERM CARE PROVIDERS

Long-term care providers face some of the most severe workforce shortages and financial challenges of any health care employer. One of these is a burdensome turnover rate of paraprofessionals. In California, turnover for paraprofessionals is highest at home care agencies and long-term care facilities. According to a recent study, after three years less than half of the people originally working for these employers had remained in the health care industry.

Turnover rates at skyrocketing levels can be attributed in part to low wages and the barriers that employers in the industry face to raising wages. These financial challenges are a result of a number of factors, including the effects of unwise investments made by many long-term care facilities owners in the 1990s, coupled with the low levels of Medi-Cal reimbursements found in California, and compounded by recent federal cuts in Medi-Cal spending. The low reimbursement rates in turn result partly from an inadequate government commitment in relation to the large and growing need for senior and disabled care. As nursing home payments in California have made up an increasing percent of the state Medi-Cal budget, California has sought to drastically cut its costs, now making it among the last in per capita Medicaid expenditures in the US.

Career ladders alone cannot reverse these trends. Career ladders at long-term care employers are less likely to succeed than at hospitals because internal career ladders in long-term care facilities such as nursing and personal care facilities and residential care units do not lead to sufficient higher level positions. There are substantially fewer RNs and LVNs employed at long-term care centers than at hospitals, while many more home care aides and certified nurse assistants are required to care for the increasing number of elderly patients in skilled nursing units and residential care settings. As a result, nurse aides and home health aides significantly outnumber LVNs and RNs at long-term care facilities, limiting the openings for movement up a career ladder.

CONCENTRATIONS OF ENTRY LEVEL AND MIDDLE LEVEL PROFESSIONALS BY PROVIDER



workplace and address their needs. Such partnerships normally involve both labor unions and management staff and may include additional training partners such as community colleges. Involving workers in job restructuring and problem solving has the added benefit of giving workers more autonomy and more respect. It reinforces other factors conducive to improved staff retention. It also has been observed to improve patient care, a subject that is examined more fully in the following section.

JOB STRUCTURING AND JOB AUTONOMY IN LONG-TERM CARE

This section focuses on practices that improve career ladders and help fill job openings in long-term care settings. **It is no coincidence that job improvement programs for CNAs and HHAs are concentrated at long-term care providers because their workforce is disproportionately comprised of these lower-end occupations.** These employers are hardest hit by the shortages in these fields. Moreover, since they confront slim profit margins they cannot simply raise wages to address high turnover as they lose staff to hospitals.

As is the case in hospitals described in the previous sections, improving job quality does contribute to reducing turnover in long-term care settings. However, because long-term care centers have fewer possibilities for career advancement, job restructuring that involves defining and lengthening career ladders is not an option. In consequence, employers in this industry often discover that their attempts at improving positions, usually by offering slightly higher wages and attaching an advanced title to the CNA, fail to attract a sufficient number of new workers. Because of these circumstances, best practices that could succeed in both reducing turnover and improving recruitment for lower-end positions would be exceedingly helpful to these providers.

One potential best practice is professionalizing lower-rung jobs, a valuable technique for improving the quality of

these occupations. Professionalizing in this context involves giving CNAs and HHAs more autonomy in the performance of tasks, more responsibility, as well as greater participation in decision-making about patient care combined with more patient involvement in their own treatment. The examples that follow demonstrate how professionalization contributes to the success of career ladder programs for these employees.

One potential best practice [for long term care providers] is professionalizing lower-rung jobs, a valuable technique for improving the quality of these occupations.

Two mechanisms for professionalization particular to long-term care can be used by employees to assist in filling positions. One way is to emphasize career lattices, a strategy which widens a career ladder to provide access to a greater number of occupational tracks⁶. Most career ladders for CNAs attempt to move them up to LVN or RN status at one end of the spectrum, or to super CNAs at the other. In contrast, career lattices incorporate motion from CNA or HHA to additional positions requiring similar or slightly advanced experience or training in a different career. Such options include physical therapy assistants, psychiatric aides, and medical records and administrative clerks. The State of California has posted sample career ladders for skilled nursing facilities that provide information about lattice opportunities. <http://www.edd.cahwnet.gov/eddwtfpmp.htm>

A second way to address job shortages for LTC employers is to focus directly on job improvement. However, long-term care employers can afford to make only slight progress in the most basic job quality strategy—increasing wages. For that reason, utilizing additional types of measures to improve job quality is most important if these employers are to encourage retention and improve recruitment. However, such measures, which include enhancing the work environment and increasing the respect paid to workers, are often not applied to CNA and HHA positions as these jobs are viewed to be too low-skilled to warrant such efforts.

One of the most useful approaches to job impact, as evidenced in the previous case studies, is to enable workers to have ongoing involvement in making decisions about job restructuring and the workplace. Another way to look at this involvement is to consider it as part of professionalization. Typically, the way to professionalize such low-skill jobs is by increasing the skills expected to perform the job and increasing compensation—demonstrating that the employer actually views the position as higher skilled.

But expecting more from people in these positions and compensating them for it is not just a way to improve the work environment and thus help reduce turnover. Professionalization also has two types of additional benefits for workers, patients, and employers. On the one hand, professionalization improves the quality of care by helping staff improve their soft skills such as effective problem solving. On the other, it enables those that do desire greater advancement to strengthen their capacity to succeed both in more challenging training programs and in future positions that demand more critical thinking. As one community college job trainer commented, “the biggest challenge to CNAs in their LVN training program is to get them to think like RNs”.

Some professionals that have attempted to develop successful training programs for low-skilled workers are skeptical of career ladders and see better job quality as the sole way to reduce turnover. For example, one workforce development specialist observes that “given the limited success of community-based career-ladder programs in health care occupations, improving the working conditions and pay of CNAs might be more effective than focusing on job ladders.”⁷ However, this view undervalues professionalization which can improve the success of career ladders and reduce turnover.

BEST PRACTICES IN LONG-TERM CARE

The following review of best practices covering certified nurse assistants, home care workers, and home health care workers⁸ highlights three models of job improvement and restructuring for long-term care employers. These models fall into two separate industry categories; CNAs tend to be employed by skilled nursing facilities

and work on site, and home care or home health care aides are either employed directly by clients or placed in homes through home care agencies. In the first model, exceptional CNA programs combine job restructuring with job improvement across multiple employment sites, maximizing possible upward mobility. A second model for home health care aides is centered around a cooperative agency that improves the quality of work and increases autonomy for workers. A third model developed in California, also for home care workers, is an independent care model with county agency oversight (IHSS). As will be shown, the genesis of the main differences between the best practice model for CNAs and the two best practice models for home care/ home health care workers is the fact that these long-term occupations are located in two distinct types of employment settings.

CERTIFIED NURSE ASSISTANTS

As mentioned above, CNA training programs alone do not often generate sufficient concrete returns for employers in terms of reducing turnover or increasing retention. **On the other hand, creating multiple grades within the CNA or similar occupations may be effective when instituted as part of a comprehensive program that improves the work environment, offers training opportunities, and gives employees more input into management and patient care decisions.** Not coincidentally, most of the successful CNA programs in our study come from long-term care facilities that have incorporated a wide range of strategies to improve the work environment.

One example of an effective strategy for CNAs is the approach administered by Apple Health Care, a nursing home chain in Connecticut, Massachusetts, and Rhode Island. Apple is implementing a set of policy and management changes to build “a worker- and resident-centered culture” in its 21 nursing homes. One of these changes is the introduction of three levels of training leading to higher-paying and higher-skilled CNA positions. Additional policies have been added to improve the quality of the job for all CNAs, including worker involvement in patient assignments, efforts to consistently assign CNAs to the same residents, CNA

participation in developing plans of care for their residents, and more worker input into management as well as into hiring decisions. As a result of this transformation, turnover has fallen from 60% to 30%. According to Apple's management, "implementing a comprehensive process that responds to worker feedback has been critical to their success in reducing turnover...No single change would result in significant improvements for residents and workers, and it is the cumulative impact of responding to multiple concerns that is shifting the organization's culture⁹."

The experience of Sisters of Bon Secours Nursing Care Center in Michigan also illustrates the importance of an integrated program. In the mid-90s, the center was struggling with high turnover rates and expenditures of over \$1 million per year on staffing agencies. The Wage Parity Initiative, begun in 1998, succeeded where earlier attempts had failed. The initiative included:

- raising all CNAs' wages to among the highest in the region
- improving health benefits and adding a pension plan
- annual merit raises, averaging 3%
- monthly attendance bonuses
- and establishing an experience-based wage scale with fourteen graduated levels.

The success of these changes was notable. Expenditures on agency staff fell by 70% in less than two years because of a reduced dependency on costly employment staffing agencies, and nursing home residents reported higher levels of satisfaction in a quality-of-care survey.

HOME CARE WORKERS

Home care is a growing field because it offers the potential to provide quality care for the elderly and disabled while enabling the care to be affordable for

government, clients, and workers. However, the future expansion of the model requires overcoming several serious obstacles. Funding for home care is still minimal, and the difference in job quality between home-based care and client care at skilled nursing units tends to be significant. CNAs and home health aides at nursing homes tend to have more job security, better pay and benefits, and more access to technology that can

reduce the risk of injury. Finally, clients of government-funded home care aides are frustrated by the low pay rates and the difficulty in finding and retaining qualified workers that low pay engenders. Thus, best practice models in this industry need to address a variety of problems. They need to address job security and stability for workers, they need to address pay and benefits, and they also need to address concerns of the clients that hire home care and home health care aides.

Two models have been developed for the home care home health care workforce that address these concerns. Both the home care agency cooperative and the creation of a public agency of record to employ home care aides aim to address problems of pay and quality for employees and patients as well as issues of stability and training for employers and contractors. The most successful programs also rely on career lattices and on professionalization to improve patient care, reduce

turnover, and make the jobs more attractive.

COOPERATIVE MODEL

Cooperative Home Care Associates in NY (CHCA) has been emulated nationally as a way to improve the quality of home health care while lowering worker turnover. Started in 1985, CHCA is a worker-owned agency engaged in training and developing career ladders for home health care workers. It screens applicants and upgrades the skills of home health aides, offering them longer training and higher wages than industry standards. It has experienced a 20% drop in employee turnover

Home care is a growing field because it offers the potential to provide quality care for the elderly and disabled while enabling the care to be affordable for government, clients, and workers.

from regional industry averages, and it offers employees a wide variety of benefits in an occupation that typically receives no benefits. Furthermore, all employees are offered the opportunity to become shareholders with significant participation in decision-making over the entire operation.

Despite its achievements, CHCA has not been able to fully resolve the severe occupational shortages in this field. One obstacle to recruitment lies in the external financing structure. The ability to raise wages is limited by the low federal reimbursement rates; low pay constitutes a major constraint on efforts to improve job quality.

Other challenges can be found in the limited opportunities to develop career ladders in this industry. While internal career ladder programs at CHCA successfully move workers up to administrative positions, the relative scarcity of these positions means most workers cannot realistically utilize such an option. An attempt to move these workers from entry level positions up through LVN positions failed.

A cooperative home health care program modeled after CHCA has begun to achieve more success with training for career ladders. The Golden Hills Academy in San Diego is striving to build more flexibility into their incumbent health care worker program. Participants are encouraged to pursue a dual certificate so they can work either as CNAs or as home health aides.

Because of the inherent limitations to an individual agency model, the cooperative model could benefit by combining with another strategy addressed later in this report, participation in a regional partnership. While more information will be provided in a subsequent section about regional approaches to health care workforce problems, the effect of regional approaches on home health care workers warrants mention. A successful model can be found in the District 1199C Upgrade and Training program in Philadelphia. The grander scale of this regional model enables it to train workers for a broad range of employers, reducing the need to establish career ladders at a single firm. As a reflection of its success in achieving career advancement for incumbent health care workers, roughly 60–65% of current trainees are already

health industry workers, while the remainder are entering the field or retraining after layoffs. The program has funding to train over 450 CNAs, 120 LVNs and 150 RNs. The District 1199C experience indicates that the combination of a career lattice program with a broad industry focus and increased wages can result in improved opportunities for existing workers as well as an increase in the number of health care workers in the region.

INDEPENDENT PROVIDER MODEL WITH INSTITUTIONAL SUPPORT

A completely distinct model for improving job quality and addressing workforce shortages for home care aides is found in California's In Home Support Services program (IHSS). This section highlights recent developments in IHSS that preserve the initial goals of the program while improving both care for patients and job quality.

Originally, the IHSS provided funding for elderly residents and the disabled to use the services of a visiting home care worker, making it possible for eligible seniors and other dependent adults to avoid institutionalization and continue living safely in their own homes. (Unlike the home health aides employed by CHCA, IHSS home care workers generally cannot provide medical treatment.) Later, the program shifted its method. Instead of using an agency to hire workers, clients were allowed to have a direct employment relationship with their home care aides. However, a number of problems with this relationship developed, continuing into the early 1990s. High turnover meant clients had to seek new aides frequently. Home care aides in turn often had trouble securing adequate wages as well as succeeding in piecing together satisfactory schedules. Successive reforms have now resulted in a new program format that mandates creation of a county or regional non-profit authority with an oversight board to help connect consumers to providers, to improve wages and benefits, and to provide a process for community review.

The new model generated significant results for a variety of stakeholders. All IHSS workers represented by SEIU and AFSCME earn \$9.50–\$10.50 with benefits¹⁰. Consumers that were originally worried about unions and public agencies injuring their personal relationship

with their home care aides received tangible benefits from the changes, including better trained staff, an easier process to find workers, and ongoing input into the design of the program.¹¹

Counties experience a program that reduces costs for the public sector—keeping people out of more expensive long-term care centers for more time and enabling people to stay at home. The new public authority also helps advocate for the interests of this population because it brings together consumers and workers to speak on behalf of the project as a whole.

In addition, communities obtain a higher quality of care. The program has improved the connection between clients and workers by centralizing information on worker availability and client needs, benefiting both groups. Consumers' control over their care is greater than if their cases were managed by an agency or a social worker with the power to hire and fire providers. Training and quality improvement measures established by the county have resulted in enhanced skill levels and improved services, as more workers easily access these options through the public authority.

This model offers a number of lessons for home care worker programs. One ingredient for success is found in the ability to connect with agencies that will pay more for better quality, which are usually union facilities or publicly subsidized clients. Another ingredient is the ability to offer wages above the industry standard. A third component is the provision of training and the opportunity to advance to other jobs. Finally, significant worker and patient involvement is essential. This is especially true for a health care setting in which these two people—worker and client—are together and independent of other patients or health care workers.

A willingness to participate in skill development is highly correlated with an increase in responsibility and decision-making over patient care, even in lower-skilled jobs.

CONCLUSIONS AND RECOMMENDATIONS FOR LONG-TERM CARE

Long-term care employers can gain greater benefits from strong career ladder programs because they face such serious workforce shortages. Professionalizing

lower-rung occupations through job improvement is a key strategy for these employers. It has been shown to improve retention of workers and to encourage them to both pursue and to succeed in training. A willingness to participate in skill development is highly correlated with an increase in responsibility and decision-making over patient care, even in lower-skilled jobs.

Both the cooperative model and the independent care model have provided home care aides with a supportive environment that simultaneously enables workers and patients to have greater control over the home care program. In the cooperative model, workers are members and serve on the board, while in the IHSS model, workers participate in county advisory committees. In the Apple nursing home chain, management structures have overhauled the patient care delivery of CNAs to incorporate much more extensive autonomy and the involvement of lower level health care workers.

Finally, career ladders at individual long-term care employers were seen to be limited. Therefore, programs involving a regional approach or an employer with multiple sites have been more successful because they are able to offer workers increased opportunity to move into higher quality jobs. Despite the slim profit margins and economic vulnerability of this industry (largely resulting from a reliance on public funds), most of these programs have been able to cut turnover by at least 50% even during the financial downturn.

3. WRAPAROUND SERVICES

Following the previous analysis of job restructuring and job improvement for long-term care occupations, this section returns to the review of the third of five elements of effective career ladder programs—wrap-around services. While the previous sections focused on jobs and workplace changes, the following section discusses support for people progressing up career ladders.

The most successful career ladder programs couple better wages and a realistic expectation of advancement with support services to insure completion of training. Typically the latter forms of assistance are known as “wraparound services.” Programs with wraparound services identify the obstacles that prevent a target population from completing a training program and they provide targeted help to overcome them. The direct

recipient of these services is usually the worker or student but may also include the employer.

The following list indicates the desired outcomes from wraparound services that can be included in a comprehensive career ladder program:

- Increased participation
- Increased completion and reduced dropout rate
- Greater long-term career planning by employees

Some of the most common obstacles to participation in career ladder programs and the services that have been developed to address them are described below.

OBSTACLE	SERVICES
<p>PROGRAM CANNOT FIND SUFFICIENT QUALIFIED APPLICANTS, OR THE STUDENTS LACK THE SKILLS THAT ARE A PREREQUISITE FOR SUCCESS IN THE CLASSES OFFERED</p>	<ul style="list-style-type: none"> ■ Offer training in basic skills, especially GED, ESL, and medical terminology classes; ■ Perform a personalized evaluation of each applicant to determine what skills s/he will need and help the applicant obtain these skills, e.g., by scheduling prerequisite or support classes prior to or in conjunction with more technical career-specific classes
<p>WORKERS CANNOT AFFORD TO PARTICIPATE, EITHER BECAUSE TRAINING COSTS ARE HIGH OR BECAUSE TRAINING REQUIRES WORKERS TO REDUCE WORK HOURS AND TAKE A CUT IN PAY</p>	<ul style="list-style-type: none"> ■ Offer scholarships; ■ Pay for books and materials; ■ Make training free or available at low cost; ■ Loan/tuition forgiveness: refund cost of program upon successful completion; ■ Maintain full pay and benefits for participants who work part-time and take classes part-time; ■ Offer paid educational leave (similar to paid vacation) based on accrued hours; ■ For low-income or unemployed workers, help them access social services; ■ For laid-off workers, provide extended unemployment benefits so they can undergo retraining rather than immediately finding employment in another field.

...CONTINUED FROM PAGE 18

OBSTACLE	SERVICES
<p>WORKERS DO NOT HAVE TIME TO PARTICIPATE OR PROGRAM CONFLICTS WITH THEIR SCHEDULES</p>	<ul style="list-style-type: none"> ■ Allow workers to take classes during or overlapping with shifts (e.g., one hour of class is taken on company time and one hour on student's own time); ■ Schedule classes when workers are free, often (but not always) at night, in the early morning or on weekends.
<p>WORKERS CANNOT ATTEND CLASSES DUE TO FAMILY RESPONSIBILITIES</p>	<ul style="list-style-type: none"> ■ Provide on-site childcare; ■ Offer childcare vouchers.
<p>WORKERS DO NOT HAVE TRANSPORTATION TO CLASSES</p>	<ul style="list-style-type: none"> ■ Locate classes near public transit; ■ Locate classes in or near workplace; ■ Arrange shuttle or special transit route to take workers to and from class; ■ Use distance learning technology, if available.
<p>WORKERS DO NOT KNOW HOW TO INTEGRATE PROGRAM INTO THEIR CAREER DEVELOPMENT</p>	<ul style="list-style-type: none"> ■ Publicize program widely and provide detailed information on potential career pathways, responsibilities and compensation for jobs at each level, training needed to move up each step and how to access it; ■ Offer individualized career counseling; ■ Institute advisor or mentorship program.
<p>WORKERS WHO SUCCESSFULLY COMPLETE PROGRAM CANNOT FIND JOBS IN THE OCCUPATION THEY TRAINED FOR</p>	<ul style="list-style-type: none"> ■ Create or coordinate with hiring hall or job-matching service; ■ When provider has openings, advertise jobs internally along with the training required. Allow workers who are not yet qualified to apply for the job, contingent upon successfully completing the appropriate training; ■ If this is a frequent problem, program may need an extensive overhaul, including closer collaboration with employers to determine what skills and occupations are needed. Workers will be reluctant to participate if a better job is not available upon successful completion of the program.

This chart should not be interpreted to mean that every successful career ladder program can or should offer all of these services. It should be used as a guide to help identify the services that a particular target group needs and to determine how best to offer them. In addition to determining the most useful services for a given population, wrap-around services must be well-publicized and easy to access. If scholarships or childcare are available, but the only way to find out about them is to ask the program director, very few workers will take advantage of them.

Many of the services noted above are useful particularly to women, an understandable characteristic in this industry since so many incumbent workers are female. Research by Joan Fitzgerald, professor and associate director of the Center for Urban and Regional Policy at Northeastern University, indicates that in the health care field many women, including low-income women, will not undertake additional training hours while working full-time jobs. Furthermore, part-time jobs that offer fewer benefits are not usually an economically feasible option even if only during a training period. However, if women are offered a subsidy or scholarship for study, guaranteed a connection to a better job and higher pay, and allowed to substitute training periods for work hours, then they are likely to agree to undergo the training.

CASE STUDIES

Three of the most successful health care job-training programs this study found also provide elements of wrap-around services, particularly mentoring, tutoring, and job-placement assistance. The Shirley Ware Education Center in Oakland, New York's 1199 ETJSP, and Philadelphia's 1199C TUF all offer extensive support services coupled with career training. These union-run services tend to focus on the actual problems of individual employees as well as on the industry challenges, helping to identify and overcome barriers that workers experience. For example, Shirley Ware educators partner trainees with staff in mentor situations, providing such services as individual tutoring by health care professionals.

If a regional program can be developed, as discussed in detail in the following section, employers can lower costs and take advantage of economies of scale. A regional union-management agreement for training that includes wrap-around services often enables *individual* employers to take advantage of a pool of training and support services, relieving that firm of the burden of running and funding a program completely alone. All three programs noted above offer services geared specifically to help students succeed, including child care and medical terminology ESL. All three also achieve a high retention and graduation rate, while maintaining flexibility through shifting the training offered as employers' staffing needs change.

CONCLUSION

In sum, programs implementing wrap-around services recognize the difficulty for health care paraprofessionals in coupling work and training, especially for people in lower-wage jobs. These programs help career ladders succeed by identifying specific needs of the target population and incorporating services to meet those needs. As a result, career ladder programs achieve much greater recruitment and retention rates. The following section, which reviews regional partnerships, incorporates another element that makes offering wrap-around services easier for employers. Because industry providers often find the cost of providing the broad range of training and wrap-around services necessary for career ladder success to be prohibitive, regional partnerships can be an invaluable component of career ladders by reducing these expenses.

4. REGIONAL TRAINING PARTNERSHIPS¹²

As has been noted, regional partnerships typically involve multiple providers that coordinate their work to address shortages in workforce development. Typical roles for members of such a partnership include contributing funds, designing and running training programs, and developing wrap-around services for trainees. The primary motivation for providers is to increase the size of the region's health workforce, especially in occupations which face significant staff shortages. Workers often receive training for occupations at other employers or in other fields, following a career lattice model. This section will delve deeper into the value of regional partnerships for both providers and employees.

A regional approach lowers the training cost for individual employers since a single firm will not have to pay for the entire program. While employers are not guaranteed that graduates of a training program will stay at their current site, the increase in the number of trained individuals available offsets this potential loss. Finally, while the costs of the training program are spread across employers and other funders, employers do have a voice in insuring that the programs meet their workforce needs by participating in the identification of occupations in which shortages exist.

Regional partnerships can be a key component of multi-provider career ladders for three reasons. First, they multiply the possible career options for individual workers while enlarging the recruiting pool for employers. Participating in a training program with a range of employers especially benefits those workers in settings with limited career advancement opportunities, such as long-term care facilities where upward mobility at specific job-sites is limited. Thus, regional partnerships expand the group of providers hiring graduates from a particular training program and thus broaden the possible career paths for individual workers by increasing positions available at multiple sites. The downside of this approach for employers is the possible loss of individual workers to other sites with greater job opportunities or more middle-range positions. However, the benefits of increasing the recruiting pool have been found to outweigh these costs.

Second, regional partnerships tend to assure a more reliable, long-term source of funding. Programs which depend on grants and public financing are subject to

changes in funders' priorities or to political factors, which may force a program to cut back or shut down just when it is needed most. Programs supported by a single provider are more stable, but may falter if the provider has budgetary difficulties. With a regional partnership, the cost of the program is shared so that no single entity bears it all. Furthermore, the partnership is funded by those firms and institutions that have the highest stake in its outcomes; it thus stands a better chance of surviving through economic cycles and downturns.

Third, a close partnership between a program and providers enables the training to be tailored to the needs of individual employers, as well as to the needs of the current and potential healthcare workforce. With timely information from providers on their workforce needs, the program can focus on those skills and occupations that are most in demand and can shift that focus if the labor market changes. Having a larger-scale regional focus instead of concentrating on a single provider also gives the program more ability to address long-term regional trends and to build multi-provider career ladders that would not otherwise be possible. However, a regional approach often requires additional coordination to accurately identify the scale of needed skills and develop sufficient job matching services.

A regional partnership operated by a third party, such as a labor union, is often most likely to play all of these roles and successfully operate a regional hiring hall or industry-based employment center. These centers help connect workers to the labor market, as well as streamline the hiring process for employers. By coupling a training program with high wages and benefits, wrap-around services, and a health care hiring hall, programs in both New York and Philadelphia have been able to deal effectively with the health care shortage to an extent unprecedented elsewhere in the nation.

Some successful regional training partnerships include:

- the Employment, Training and Job Security Program (ETJSP) in New York, a partnership between SEIU 1199 and over 300 providers belonging to the League of Voluntary Hospitals and Homes of New York, which serves over 20,000 workers annually;

- the 1199C Training and Upgrading Fund, supported by 61 Philadelphia-area providers in collaboration with Health Care Workers Union 1199C, serving 16,000 workers and community members annually; and
- Nurses Now, instituted by San Diego State University's School of Nursing (SDSU) with nine providers as partners, which has enable the nursing school to increase enrollment by nearly 200 students.

In some cases, the training program is run directly by a college or university, such as SDSU's Nurses Now. In other cases, including ETJSP and the Training and

Upgrading Fund, unions or labor-management committees direct the effort, often with cooperation from local colleges. In either circumstance, it is crucial that providers not only serve as a funding source but also work closely with the program's administrator to ensure both that workers are being trained for the occupations for which there is a genuine local shortage and that they are being provided with the skills that employers need. Union and labor-management programs often have an advantage in this regard, because the union enjoys a deeper knowledge of and association with the employers than do many other intermediaries¹³.

LOCAL INITIATIVES

Two local initiatives in the Bay Area warrant mention as innovative efforts to develop regional partnerships. The first is a regional network of community colleges throughout California that focuses on promoting health careers. The second is a group of diverse workforce development organizations that recruit low-wage workers for health care careers and establish career ladders as a solution to the health care staffing shortage. These organizational partnerships receive state funding through the Governor's Caregiver Training Initiative.

REGIONAL HEALTH OCCUPATIONAL RESOURCE CENTERS (RHORC)

The RHORC is an initiative created by the California Community College Chancellor's Office. It consists of a state-level office affiliated with the California Community College Economic Development Center that funds eight regional centers. The Santa Clara County office opened in 1997. The RHORC offers resources to local job trainers as well as individuals considering further health care training. In one example, they provide links to all of the health care classes by program and college at http://www.healthoccupations.org/cchealth/bb_college.cfm. In addition, the RHORC provides a way for community colleges regionally to consider the health care training needs of local service providers and employees and offer solutions across a network of campuses. To do this, the center partners with labor unions and businesses to identify needs and develop programs to meet them.

For example, the RHORC of Santa Clara County identified a regional need for pharmacists and surgical technicians, and in partnership with Skyline College and San Mateo College won a grant to build a surgical training center. As evidence of the accuracy of this assessment, Kaiser plans to send more than 100 people for training at the new facility.

The Santa Clara County Center has identified additional roles for their office and potential improvements in services. These include coordinating the efforts of partnership members to match job openings with training. In addition to improving the matching of job seekers to job openings, the RHORC looks to help solve problems health care employers may face in filling specific health care positions. Together with unions, employers and community college staff, they RHORC evaluates why vacancies disproportionately occur for certain job titles and how professionalization and benefits could improve recruitment and retention. The center also seeks to continue to leverage funding for additional workforce development partnerships among these groups.

LOCAL INITIATIVES

CAREGIVER TRAINING INITIATIVE (CTI)

The CTI, part of former Governor Davis's Aging with Dignity Campaign, is a \$2.7 million, 6-county collaboration to recruit additional job applicants and provide services to new and incumbent lower-skilled workers to improve their career-growth opportunities. To achieve these goals, the campaign seeks to promote regional partnerships among key stakeholders and service providers that compose the region's "worker supply chain." Because it seeks to support advancement for low wage workers into higher paying jobs as well as address occupational shortages across the industry, the initiative focuses on both worker and employer needs.

One aspect of workforce development that the CTI has found to be particularly useful is education in employment settings, such as work-based learning and on-the-job training. A recent CTI report that published a description of three of the most successful programs noted that all of them employed some aspect of on-the-job training. The report found that the most successful partnerships used these strategies to "accelerate the acquisition of virtually all other job-specific skills."

The same report noted that the participation of a number of healthcare partners in the CTI program has succeeded in increasing the levels of trainee completion as well as employee retention. In two of the three case studies, the Oakland Private Industry Council (PIC) played a key role by providing training referrals. It accomplished this by channeling displaced workers from manufacturing into health care programs at the Bellaken Garden long-term care facility and at the St. Paul's Towers life care retirement community.

The PIC provided two separate but related services for these employers. First, it screened potential applicants and referred them to the program, providing the employers with a pool of qualified candidates for entry-level positions. Secondly, the PIC provided case management to trainees at both sites during the skill development program. In performing these functions, the PIC reduced the HR cost of identifying participants for training and provided part of the support workers needed during the training. As a result, the expenses associated with establishing an on-site training program were lowered, enabling both providers to focus on training and implementation of a program usually difficult and rare for such small, long-term care employers. Project management emphasized the pre-screening function of the PIC that contributed to providing qualified candidates with true chances for success. "We were looking for help finding quality pre-screened trainees that we could build a mentoring program around," stated Jerry Warren, Executive Director at St. Paul's Towers.

Given the PIC's support, employers were more likely to participate in career ladder advancement planning and worker assistance. The existing health care personnel at both employment sites provided mentoring, and management also gave trainees direct career counseling. Although the programs required significant involvement by senior staff, the end result was to lower turnover, increase morale and motivation, and encourage individuals to pursue training and career progression by coupling support with realistic opportunities for advancement. In one year, Bellaken Gardens trained 10 people in CNA and other positions, and lowered staff turnover to 5%.

Although not a CTI project, the CTI report noted a third successful partnership with lessons to be learned for other CTI partners. The Shirley Ware Center, Kaiser Permanente, and Contra Costa College jointly created a career-ladder program to address the high turnover rate at Kaiser. This partnership designed numerous training programs focused on building career ladders to move workers from lesser skilled jobs into nursing, one of the most difficult positions to fill. Because the inclusion of Kaiser made it possible to

tailor the training to specific needs of the employer, managers were highly supportive of the program. Augmenting training with skills useful to a particular employer also contributed to retention of staff after graduation because trainees had been prepared to work for a specific health care provider. This program exemplifies the fact that job-based training is more effective when employers are closely involved in cooperation with worker organizations.

In addition to the challenges of identifying qualified candidates for training programs, employers are concerned with the loss of entry level workers to higher skilled jobs and the recruitment costs associated with replacing them. The Shirley Ware Center helped address this issue by listing openings, posting skill requirements together with training options to develop those skills, and identifying jobs that would become available as current employees advanced within Kaiser. These efforts were crucial to reducing employer recruitment and HR costs.

Kaiser's creative financial commitment to the program was another component of its success. Kaiser offers employees the opportunity to accrue Education Leave, much like sick time or vacation time, which has two positive outcomes: it increases retention, and it helps make training more affordable for low-wage workers. Kaiser was able to offer this benefit without being overwhelmed by the need to provide support services by partnering with the local union; the Shirley Ware Center provided tutoring, counseling, and mentorships with more advanced health care staff.

The success of all three of these partnerships reflects the value of collaboration among employers, workforce development agencies and educational institutions to develop stronger career ladders that artfully combine external instruction with internal, on-the-job training, mentoring, and promotion opportunities. As of October 2002, over 425 current or prospective caregivers had enrolled in training. The majority were single mothers seeking to improve their wages and achieve a career trajectory. "Many [faced] the classic challenges of low-wage workers and young parents: transportation, child-care, time management, and financial issues. Negotiating each of these hurdles proved to be a true collaborative exercise involving all of the key individuals in the life of the CTI participant."

CONCLUSION AND RECOMMENDATIONS

An additional opportunity for collaboration exists in developing a stronger relationship between the RHORC and the CTI. At a recent conference held by the SVWIN, senior administrators and participants of the two programs established contact. The sharing of resources and information about shortages are a logical next step to avoid duplication of activities and to secure benefits from economies of scale.

5. RECRUITING UNDERREPRESENTED MINORITIES

This section concludes the review of elements needed to craft programs that truly address the shortage of health care professionals. It concentrates on one aspect of the staffing crisis not yet mentioned—the fact that only a limited percentage of the population considers health care as an attractive career, reducing the pool of potential entrants. To increase the number of job applicants, recruitment efforts for health care need to reach people who are outside of the field, especially minorities and men. **“Racial and ethnic minority group members and men are severely underrepresented in the nursing profession,”** said Geraldine Bednash, executive director of the American Association of Colleges of Nursing in Washington, D.C. **“Currently, only 13.4% of registered nurses come from minority backgrounds although minorities comprise 30% of the U.S. population. The percentage of males in the profession is even smaller. Only 5.4% of all registered nurses are men.”** Minority women do accept health care positions, but they are disinclined to pursue upper level training. Men, on the other hand, eschew entry level health care occupations as well as all nursing positions—currently men make up less than 6% of the nursing population. Efforts to develop marketing campaigns to change the image of nursing as a women’s profession have been the most common way to address the lack of new male recruits into nursing.

This section focuses on programs targeted to recruiting minority women into middle-level health care professions. Bringing underrepresented people into training for nursing positions can both increase the total number of applicants and can address the barriers that minority groups face in moving up career ladders.

Focusing on a strategy to recruit underrepresented minorities to expand the pool of possible health care

workers is advantageous for a number of reasons. First, minority women lack opportunities to move from lower wage health care professions to the better-remunerated registered nursing positions held mainly by white women. Thus, supporting women who tend not to be successful at pursuing upper levels in health care enlarges the pool for nurses, one of the positions hardest to fill. Second, increasing minority representation in nursing and physician positions improves the cultural competency of medical services. It also helps improve the availability of services to regions with high minority populations. As mentioned in the previous WIN report, evidence suggests that minority physicians are more likely to work in areas with fewer medical services and higher percentage of minorities.

Minority women lack opportunities to move from lower wage health care professions to the better-remunerated registered nursing positions held mainly by white women.

This section highlights findings from two case studies that aim to expand the pipeline for people being trained as nurses. They created two distinct models to meet this objective. Project LINC, a Foundation-sponsored training initiative, provides extensive support to existing minority health care professionals to insure their success in graduating into a nursing program. The Samuel Merritt College Scholars in Service Program focuses on recruiting minority students to enter the BSN nursing program.

Project LINC was founded in 1992 by the Robert Wood Johnson Foundation to move entry level workers into LVN and RN positions, with a particular focus on recruiting minority and low-income students. About 85% of participants graduated from their programs, with over a third of the participants people of color and more than three quarters women. Thus, the program helped diversify the nursing workforce. Also, in some communities it helped low-income residents to become nurses in contrast to simply recruiting from the outside.

The Samuel Merritt College Scholars in Service Program had even more ambitious goals—seeking to recruit minority nursing students into the BSN program and encouraging them once they begin their studies. The program provides support ranging from financial and administrative to mentoring. The results are impressive—an increase in minority undergraduate students in the program as well as an increase in retention rates from 29% for African Americans and 63% for Latinos to over 80% for both constituencies. It should be noted that the Samuel Merritt program recruits students from community colleges who have already completed the prerequisites, rather than trying to move entry-level workers through years of training into the program.

Thus, efforts to increase minority participation in higher-level health care programs have been shown to work when they invest more resources at the college level and target recruitment to minority students at community colleges. Focusing on entry-level minority workers can also result in expanding the number of LVNs and RNs from diverse backgrounds.

Two challenges observed in the LINC program provide opportunities to improve such programs elsewhere. One difficulty stemmed from the program's reliance on a single funding source which resulted in loss of renewed support when the funder's priorities changed. Another challenge resulted from an external influence—restructuring and changes in managed care sharply reduced staffing levels for a period, appearing to bring an end to the staffing shortage and making it difficult for some training programs to find placements for their students. The programs that survived shifted training to other careers with high demand; however, this required a highly adaptive, flexible management. A lattice model helped some programs to withstand such changes in the economy, underscoring previous findings in this report that lattice models offer a way to stabilize training initiatives.

CENTER ON EMPLOYMENT TRAINING (CET)

CET's local Santa Clara County site helps prepare underserved minorities for health care professions. A national program with a home office in San Jose, CET was founded over 30 years ago to provide retraining to farmworkers seeking to improve their career prospects.

Currently it offers a Medical Assistance certificate for limited English and low-skill workers. Last year they had nearly 100 people in their Medical Assistance program, with at least 25 students at a time. The program also arranges class time to simulate a work schedule, with 5–6 months of full time training in settings that mirror health care employment followed by a one-month externship. Most of the training is paid for by the organization, and there is a substantial waiting list.

Part of CET's success stems from the composition and activities of its board. A significant group of local employers serve on the CET Board and help shape the courses offered to ensure that they meet the needs of firms seeking to hire additional staff. It is noteworthy that CET manages to achieve success despite the fact that so many of its students are mono-lingual Spanish speakers. The combination of the lengthy program and ESL offered within a workplace setting help overcome what is often an insurmountable barrier in typical training programs.

CONCLUSION

In two successive reports, the WIN has demonstrated the usefulness of career ladder programs in lowering administration costs, filling vacancies and reducing employee shortages, and improving patient care.

Successful career ladders give workers hope to progress to better jobs with higher wages and benefits, encouraging them to stay at particular sites of employment as well as to pursue training opportunities. Those outcomes also reduce HR expenditures. Through increasing the time employees spend with individual patients and at particular sites of employment, career ladder programs are also linked to improved work quality that benefits those in need of care.

This report has delved more deeply into career ladder strategies in order to analyze the barriers to designing and implementing them successfully. This intensive focus is of special value because ineffective career ladder programs may have serious consequences for the entire field of workforce development. **If career ladders are not effectively planned and managed, then they will not have the desired results (reducing turnover, filling positions, decreasing administrative costs), which can lead to a misplaced lack of confidence in career ladders themselves.**

By presenting evidence of how successful career ladders can achieve their goals, this report contributes to making other programs more successful. It identifies areas of trouble that career ladder programs might face and strategies to tackle and resolve them. It also demonstrates how partnerships among workforce development players contribute to the accurate determination of barriers to effective operation and the generation of realistic and appropriate solutions. Worker involvement, employer cooperation, and specialized training are three components that must be combined to produce optimal results.

To recapitulate, career ladder programs do not work by themselves. Their success depends on working in conjunction with other actors who provide support to these programs. This report altered the typical approach to career ladder discussion in a number of ways. First, it described characteristics of successful career ladders that involve changing the way they are defined or implemented *at particular work sites*. This approach is an improvement over the more traditional method of creating career ladders at training institutions for the individual to pursue incremental training without addressing corresponding career ladder structures at actual firms. Second, the report detailed the kinds of support needed to strengthen career ladders which include wrap-around services tailored to the individual trainees and employers. Finally, the report discussed ways to expand the scale of programs, both by creating regional partnerships to address organizational issues at a broad level and by increasing the pipeline for training applicants.

The following chart provides a review of the elements mentioned in this report and the purpose of each one.

RECOMMENDATION	OBJECTIVE
<p>JOB RESTRUCTURING</p> <p>IMPROVEMENT IN QUALITY OF WORK (PROFESSIONALIZATION)</p>	<p>Match employment and training, identify skills needed to move into higher paying jobs;</p> <p>Reward incremental advancement, enable career lattice motion to provide greater job mobility for workers and help employers more easily fill job openings</p> <p>Increase retention, improve patient care, and develop soft skills that contribute to increasing likelihood of successful completion of training and advancement</p>
<p>WRAPAROUND SERVICES</p>	<p>Enable workers to overcome personal difficulties to combine work and training; improve retention and completion rates in training programs</p>
<p>REGIONAL PARTNERSHIPS</p>	<p>Reduce costs to any single employer for developing training; increase scale of training; promote career lattice movement; decrease duplication and promote coordination of efforts among health care providers, trainers, and job counselors</p>
<p>RECRUITING UNDERREPRESENTED MINORITIES</p>	<p>Expand total population that considers entering careers in health occupations</p>

While some of these elements were found to be more useful to certain sub-industry groups, others are essential to any quality career ladder program. Job restructuring has been most feasible for large employers such as hospitals. Regional partnerships and job improvement that both enhance the quality of care and facilitate mobility are found to be just as important for long-term care employers with more limited career ladders and smaller margins as they are for large hospitals. In California, partnerships between long-term care employers and unions also have contributed to improved quality of care and a more stable funding base for training. However, current budget cuts to Medi-Cal will make it increasingly difficult to raise wages and fund high quality care, especially for the elderly and vulnerable. During the next few years, therefore, applying these five strategies and taking advantage of existing local regional partnerships to incorporate the best programs possible will be critical for health care institutions.

ENDNOTES

1. See appendix for calculations
2. Fitzgerald, Joan and Virginia Carlson. "Ladders to a Better Life", *The American Prospect*: Volume 11, Issue 15. June 19–July 3 2000.
3. Fitzgerald and Carlson, 2000. "But perhaps even more important, according to Nancy Mills, national work force coordinator at the AFL-CIO, is that people are willing to enroll in continuing education only when the connections to a better job and higher pay are guaranteed."
4. Author interview with Delaware College Training staff
5. Fitzgerald and Carlson, 2000
6. For details on the Cape Cod Program using a career lattice model, see pages 9–10 of this report.
7. Fitzgerald and Carlson, 2000.
8. In California, "home care aides" or "home care workers" generally refers to workers who provide personal services to elderly and disabled clients at their homes, from cooking and cleaning to bathing to transportation. "Home health care aides" may perform all these tasks, but they also administer basic medical treatment such as blood pressure checks and maintaining catheters, and must have more training and certification than home care workers. In New York and other states, "personal care aides" are the equivalent of California's "home care aides". "Home care" and "home care workers" is also sometimes used as an umbrella term for the entire industry, including home care/personal care aides, home health care aides, and nurses.
9. Author interview with program staff, Fall, 2002.
10. Results are based on information provided in "Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on Implementing California's Public Authorities" and <http://www.seiu.org>
11. Pamela Doty, A.E. Benjamin, Ruth E. Matthias and Todd M. Franke. "In-Home Supportive Services for the Elderly and Disabled: A Comparison of Client-Directed and Professional Management Models of Service Delivery." U.S Department of Health and Human Services and the University of California, Los Angeles, April 1999
12. See appendix profiles for details on each of the three regional partnerships mentioned in this section.
13. Fitzgerald and Carlson, 2000.
14. MedZilla Asks: "Why Are There So Few Male Nurses?" Medzilla, June 6, 2000. <http://www.medzilla.com/press61102.html>

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INTERNET RESOURCES

CAREER LADDERS IN HEALTH CARE: VISUAL MAPS ONLINE

http://www.careerladders.org/2000/Santa_Clara/emg_medtech_para_2000.pdf

For EMTs:

Entry: EMT/Paramedics, Home Health-Care Aides, Pharmacy Aides

Mid: Licensed Practical Nurses, Recreational Therapists, Medical Lab Technicians

Upper: Registered Nurses, Dental Hygienists, Pharmacists

<http://www.careerladders.org/1999/Santa%20Clara/10-nurseaidsc.pdf>

For Nurse Aides:

Entry Level: Home Health Aides, Nurse Aides, Medical Assistants

3 Years Experience: EMTs, Licensed Vocational Nurses, Surgical Technicians

5 years experience: Medical Aide Technicians, Registered Nurses

<http://www.careerladders.org/1999/Santa%20Clara/11-physicaltherapyscc.pdf>

For Physical Therapy Aides and Assistants:

Entry Level: Home Health Aides, Nurse Aides, Medical Assistants

3 Years Experience: Licensed Vocational Nurses, Physical Therapy Aides, Surgical Technicians

5 Years Experience: Physical Therapists, Occupational Therapists

SKILLED NURSING FACILITY: LATTICE/LADDER MAP

<http://www.edd.cahwnet.gov/eddwtfsnf.pdf>

ACUTE CARE HOSPITAL:

<http://www.edd.cahwnet.gov/eddwtfach.pdf>

APPENDIX

STRENGTHENING HEALTH CARE CAREER LADDERS: BEST PRACTICE PROFILES

JOB RESTRUCTURING AND IMPROVING THE WORK ENVIRONMENT

1. UC DAVIS MEDICAL CENTER (UCDMC)

LOCATION: Sacramento, California

FOUNDED: N/A

PROGRAM TYPE: Hospital: numerous programs improving the quality of nursing positions and addressing the nursing shortage.

PARTICIPANTS: UCDMC and affiliated institutions. UCDMC is part of the UC Davis Health system, which also includes the UCD Medical Group (a physician network) and the UCD School of Medicine.

FUNDING: UCDMC

PROGRAM SUMMARY: The program aims to provide a supportive environment and culture for nurses. To accomplish this goal, they have instituted a number of policies.

First, UCDMC formally discourages the use of registry or travel nurses; instead, they have developed an in-house float pool of nurses who can work in any unit.

A second program, “Bridges to Excellence,” allows nurses to take time off to observe other units. Through Bridges to Excellence, nurses who are thinking of changing units can see the new work firsthand.

A third training program is tailored to accommodate the varied schedules of nurses, offering courses in the evenings and on weekends. This program, the Center for Nursing Education, is part of the UC Davis Health System and offers continuing education courses for nurses, including distance education.

Additional recognition programs provide performance-based awards and bonuses to nurses and nursing teams.

Finally, UCDMC has consciously given nurses greater autonomy and responsibility for patient care. In one example, the UCD Children’s Hospital has adopted a primary care nursing model under which a patient is assigned to a small team of primary care nurses. A member of the nursing team coordinates the patient’s care every time s/he is admitted, increasing continuity of care.

RESULTS: UCDMC has an RN vacancy rate of 7.3% and turnover rate of 8.18%, compared with 20% and 17% respectively for California. The hospital is widely recognized for high quality of care; UCDMC was the first California institution to be recognized as a “magnet hospital”, and today it is one of only two magnet hospitals in the state. This prestigious designation, given by the American Nurses Credentialing Center, is awarded to health care organizations “that provide the very best in nursing care and uphold the tradition within nursing that supports professional nursing practice”.

BENEFITS TO PROVIDERS: The hospital benefits from low turnover and relative ease in attracting and retaining nurses. Even during the current statewide shortage, the hospital reports no difficulty filling nurse positions. These benefits translate into cost savings: the hospital saves on the cost of registry nurses and on expenses associated with high turnover and high vacancy rates. The hospital also benefits from an enhanced reputation which makes it a “destination” hospital, or one that people travel to from out of state when procedures are necessary.

BENEFITS TO WORKERS: Nurses in particular benefit from a positive and safe work environment that empha-

sizes stability, from support for career development, and from other quality of life enhancements. The Bridges to Excellence program supports nurses' professional development and career advancement. Quantitative research has shown that nurses at magnet hospitals experience fewer needlestick injuries and less "nurse burnout" than nurses at other hospitals. The in-house float pool means that employees continually work with nurses who are familiar with the hospital's procedures and culture rather than with outsiders. Finally, a child-care center for faculty and staff is under development.

BENEFITS TO COMMUNITY: The community of patients receives a higher quality of care compared to those at other institutions. The primary care nursing model and other programs help provide patients with greater continuity and keep them more informed and involved in their treatment.

UCDMC has for 4 consecutive years won the Consumer Choice Award of the National Research Corporation, indicating that it was ranked as having "the best overall quality and image of all hospitals in the Sacramento area".

CHALLENGES: UCDMC faces considerable pressure to cut costs, due both to the demands of HMOs and to the medical center's own financial situation. Under these circumstances, it is difficult for the hospital to maintain its high staffing levels, avoid layoffs, and continue its commitment to a high quality of care and its responsibilities as the region's only safety net hospital. Thus far, it has been able to preserve staffing ratios, but the UC Davis Health System closed four clinics in Stockton, Vacaville, Chico and Placerville in 1999–2000. Closures at other hospitals indicate that these fiscal challenges stem more from the general crisis in health care than from UCDMC's particular policies. Two other hospitals in the Sacramento area, Sutter Memorial Hospital and Mercy American River Hospital, were closed by their respective owners in 2000.

2. CAPE COD HOSPITAL/SEIU 767 CAREER LADDERS

LOCATION: Cape Cod, Massachusetts

FOUNDED: Early 1980s

PROGRAM TYPE: Creation of internal career ladders coupled with training

PARTICIPANTS: Cape Cod Hospital, SEIU 767

FUNDING: Cape Cod Hospital, SEIU 767

PROGRAM SUMMARY: The Career Ladders program was created through negotiations between SEIU 767 and Cape Cod Hospital to fill open positions by training and promoting existing workers when possible. Initially, this involved restructuring the hospital's job classifications to create career ladders for all occupations, "reclassifying existing hospital jobs into 12 grades cutting across occupational lines with corresponding wages, qualifications, projected annual openings and training opportunities." Also, new positions with greater responsibility and compensation were added in several areas. The occupational structure includes both "career ladders" and "career lattices", enabling workers to advance within their department, or by moving to a different department. Once these internal career ladders had been created, the labor-management committee created a program of training classes to enable workers to advance.

Three types of training are offered: on-the-job training, traineeships, and in-house courses. Basic education classes such as medical terminology and data entry are taught onsite between shifts, with employees allowed to take one hour off the end or beginning of a shift in order to attend the two-hour class. For more advanced positions, traineeships teach workers additional skills within their occupation; trainees are either given time off or allowed to hold two jobs simultaneously (totaling no more than 40 hours/week). For example, an x-ray technician might be taught through a traineeship how to do CAT scans, and eventually move to a better-paid position that utilizes that skill. Tuition reimbursement is available for courses not taught at the hospital that apply towards career advancement. Finally, the labor-

management committee publishes an annual job ladders book listing all jobs, the training needed to move between them, and where that training may be obtained.

RESULTS: Approximately 80% of all jobs are filled in-house through promotions, facilitated by training.

BENEFITS TO PROVIDERS: Both loyalty and skill level of employees increased at Cape Cod. The program has greatly reduced turnover and recruitment costs. It has also improved the ability to tailor training to the skills and occupations needed at the hospital. And the program makes it easier for employees to transfer between departments and specialties as the hospital's workforce needs change.

BENEFITS TO WORKERS: Job restructuring and standardization, along with an annual job ladders publication, lets workers plan multiple steps of career advancement. Entry-level workers who might lack qualifications for traditional job training are able to get the basic skills they need to advance to higher positions. Training and commitment to promotion from within enables workers to advance up the career ladder while remaining with Cape Cod Hospital. Training is free, with some classes requiring a nominal fee that is refunded upon successful completion of the course, and time off or flex-time for training is available. Finally, according to the union, Cape Cod employees are the highest paid healthcare workers in the region.

BENEFITS TO COMMUNITY: The surrounding community benefits from more skilled and experienced caregivers. Cape Cod Hospital was named one of "America's Top 100 Hospitals" for 4 consecutive years (96–99). The lower turnover results in long-term employment with good advancement potential, improving community cohesion. It also provides models for local providers. Other health care employers in the region, especially nursing homes, are beginning to implement similar programs.

CHALLENGES: Local 767 has found the biggest challenge to be achieving agreement between labor and management on which positions are most in demand, and thus agreeing on which training classes should receive priority. Management has been inclined to focus on programs that will move people into administration and management. But for the union, as well as for a majority of employees, the chief priority is to train workers in basic skills and focus on creating complete career ladders through which all workers can move. The union does not see management as opposed to this goal, but differences in perspective have necessitated some culture change on the part of managers to alter their vision of a career ladder program.

The program is just beginning to train people for LVN and RN positions, in an attempt to address the growing nurse shortage in the region. RN training was more complicated to design since RNs have a separate union from the rest of the Cape Cod workers. The commitment from both unions was essential because of the

"To workers, the 'career ladder' represents an opportunity to 'move up' in terms of both personal expertise—skill, knowledge, responsibility—and pay-grade. To hospital management, the career ladder represents benefits to both employer and worker; a means for ensuring a unified and productive workforce; and assurance that optimum quality care will be delivered by the hospital's direct service providers. In essence, it provides an opportunity for workers to realize their potential and receive appropriate recognition for their growth, and it renders the hospital a source of meaningful, career-oriented employment for the general community."

—excerpt from the *"Statement of Principle for the Union/Cape Cod Hospital Career Advancement System"*

challenges inherent in designing a successful model. CNAs face serious obstacles to becoming RNs, in part because the length and intensity of training needed is difficult to balance with holding a CNA job and the common responsibility of caring for a family.

REGIONAL IMPACT: Cape Cod is the biggest hospital in southeastern Massachusetts, so programs there influence workforce standards throughout the region. Other regional hospitals have begun to look to the Cape Cod career ladders program as a model, including Falmouth Hospital, Caritas Good Samaritan in Brockton and Jordan Hospital in Plymouth, which has made a commitment to promotion from within and has begun to offer tuition reimbursement and some on-site classes.

3. COOPERATIVE HOME CARE ASSOCIATES (CHCA)

LOCATION: New York

FOUNDED: 1985

PROGRAM TYPE: Cooperative worker-owned home care agency, engaged in training, job restructuring, and developing career ladder rungs for home health care workers

PARTICIPANTS: CHCA

FUNDING: Training paid for by grants and public welfare-to-work funds. Other components paid for by CHCA.

PROGRAM SUMMARY: CHCA is a for-profit, worker-owned cooperative and training program that contracts with New York health care providers to supply home health care aides to elderly and non-elderly people living with disabilities in the Bronx and Upper Manhattan. Its goals, epitomized in its philosophy of “Quality Jobs/Quality Care”, are to improve both the quality of the home health care occupation—a low-status job that typically provides poverty-level wages, no benefits, part-time or insecure hours, and very little training—and the quality of service for patients. It employs primarily low-income women of color and has a rigorous screening process for potential entry-level employees. CHCA’s strategy includes training, job restructuring, and career ladder components.

RESULTS: In 2000, CHCA had 600 employees, working an average of 36 hours/week. Turnover had fallen to 20%–30% annually from an industry average of 40%–60%. Employees receive wages of approximately \$8 an hour, \$1.60 higher than the NY average for home health care workers. All entry-level employees undergo CHCA’s four-week training, twice as long as that required by law. Two hundred trainees per year participate with a 65%–80% graduation rate.

BENEFITS TO PROVIDERS: Motivated workers with better training perform higher quality work, enabling the company to increase market share by appealing to a greater number of clients and to charge a higher fee to client companies by promoting itself as a high quality agency. Providers also benefit from reduced turnover and workers’ increased commitment to the job and the company. More than 25% of the workforce have been with the agency for over 5 years, and turnover in 2001–2002 continued to be less than 30%. As evidence of its success, many of CHCA’s practices have been adopted by other home health agencies in the country.

BENEFITS TO WORKERS: Workers are eligible to become owners (shareholders), giving them annual dividends and a vote on major decisions after three months of employment. About 65% of employees are owners, and a majority of the Board of Directors are employees. At nearly \$8/hour, the average wage is among the highest in the region for home health care workers, and the benefits package is extensive, including health insurance, life insurance, vacation and sick leave, and a 401(k) retirement plan. Over the first five years of their employment, workers also participate in a career ladder with clear levels of advancement and wage increases initiated in the first year. The scheduling system also reduces the instability typical for this occupation. Most workers have full-time employment, and a “guaranteed hours” program offers more consistent employment. CHCA provides a strong, structured support system for employees so that the status of, and respect for, home health aides is improved as well.

BENEFITS TO COMMUNITY: The program improves the quality and continuity of care for patients, leading to increased patient satisfaction. It actively works to model

and disseminate best practices in New York and other regions, looking to increase people's access to quality home health care. The program has been successfully replicated at HCA in Philadelphia and QCP in Manchester, New Hampshire. Three training and placement programs for home health care workers, Visiting Nurse Associate Training Institute in Detroit, Careers in Health Care of the Good Faith Fund in Pine Bluff, Arkansas, and Golden Care in San Diego, California have also been modeled on CHCA.

CHALLENGES: Although CHCA pays higher wages than other agencies, earnings are still low enough that many employees remain on some form of public assistance. Uncertainty of funding sources and low funding levels in general remain the biggest challenges to the program. One replication project, CHCB in Boston, closed in 1999 due to deep cuts in Medicare and Medicaid that impacted the homecare industry beginning in 1997. CHCA and affiliates are trying to address this problem in part by launching the Independence Care System, a long-term care agency for people with disabilities, which provides high-quality care and high reimbursement rates to its contractors including CHCA.

Attempts to build career ladders have had mixed results; CHCA's internal job ladders for home health aides are highly successful, but there are few higher-level positions (such as administrators and nurse supervisors) available within the organization. A small-scale program to train CHCA workers for RN and LPN positions failed. Finally, the 1996 welfare reform legislation decreased the number of welfare recipients recruited by CHCA, due to the new program's emphasis on immediate work rather than pre-employment training.

REGIONAL IMPACT: CHCA has been instrumental in working to improve the industry's job standards. It has advocated for increases in the Medicaid and Medicare reimbursement rates for home health care, since low reimbursement rates constrain providers from paying high wages.

4. IN-HOME SUPPORTIVE SERVICES (IHSS)

LOCATION: California

FOUNDED: 1973

PROGRAM TYPE: Reorganization of a publicly supported home care program. Initially, this program was established to enable elderly and disabled consumers to secure their care through an independent provider model, rather than through an agency. In 1992, the program was changed by SB 485, which mandated the creation of county-level oversight boards and public authorities. This combination of additional oversight with an independent provider model preserved the direct relationship between providers and clients, while making available increased financial support.

PARTICIPANTS: Medi-Cal recipients, home care workers, all county boards in California, Service Employees International Union

FUNDING: State, federal, and county dollars through Medi-Cal and other public funds

PROGRAM SUMMARY: This program originally provided funding for clients to use the services of a visiting home care worker, enabling eligible seniors and other dependent adults to avoid institutionalization and continue living safely in their own homes. Successive changes have now resulted in a program that mandates the creation of a county public or non-profit authority with an oversight board to help connect consumers to providers, to improve wages and benefits of workers, and to provide for community review of performance.

RESULTS¹: Living wages of \$9.50–\$10.50 with benefits paid to all IHSS workers represented by SEIU and AFSCME has lowered turnover. Consumers that were originally worried about unions and public agencies injuring their relationship with their home care workers received tangible benefits from the new changes, including better trained staff, an easier process of finding workers, and ongoing input into the design of the program. A Department of Health & Human Service study found that generous home health benefits such as those provided by IHSS which provided up to 283 hours per month of care for the most disabled, and on average

30–34 hours per week per caregiver led to higher patient satisfaction and correlated with improved health outcomes for clients.²

Counties possess a program that reduces costs to the public sector—keeping people out of more expensive long term care centers for more time and enabling people to stay at home. The newly created public authority also helps advocate for the interests of this population because it brings together consumers and workers to support the project as a whole.

BENEFITS TO PROVIDERS: In this model, the IHSS workers are considered to be both providers (i.e. employers) and workers. As providers, together with county agencies and clients, they have a better relationship with the community. Both the county and the clients they serve also benefit from reduced workforce turnover, and the provision of home care services in place of institutional care reduces total cost to the public sector.

BENEFITS TO WORKERS: Workers experience more stability on the job, better wages and benefits, and an arena in which to discuss concerns that are external to the relationship with the consumer and the consumer’s family.

BENEFITS TO COMMUNITY: The program improves the

connection between clients and workers. Consumers receive greater control over their care than they would have under other models where an agency or a social worker makes decisions about home care providers. Training and quality improvement measures established by the county can reach workers through the public authority, rather than through a dispersed network of independent providers.

CHALLENGES: Although many consumers prefer to hire family members, there is a fiscal disincentive to do so. The state and the county are not eligible to receive federal dollars for a client that hires a family member. In that situation, the state must assume 65% rather than 23.5% of the cost, and the county must assume 35% rather than 17.5% of the cost. Second, wages are still unsatisfactorily low. A raise in reimbursement rates is not likely given the current fiscal crisis for state governments.

REGIONAL IMPACT: In 2003 this program was expanded to apply to every region in the state of California. This decision will lower competition among consumers and among regions. It will also offer consumers and advocates easier ways to locate clients and providers throughout the state.

EMPLOYMENT CENTER WRAP-AROUND SERVICES

5. SHIRLEY WARE EDUCATION CENTER (SWEC): CAREER LADDER TRAINING PROGRAM

LOCATION: Oakland, California

FOUNDED: 1998

PROGRAM TYPE: Extensive training classes in two areas: entry-level and career upgrade training for Kaiser employees and potential employees, and an internal health and safety program geared to helping retain employees.

PARTICIPANTS: Service Employees International Union (SEIU) Local 250, Kaiser Permanente, Contra Costa Community College, Contra Costa’s Workforce Investment Board

FUNDING: Grants (public and foundation) are the primary funding source. They also receive resources from Kaiser Permanente, SEIU 250, and volunteers.

PROGRAM SUMMARY: The Shirley Ware Education Center (SWEC) operates three categories of programs: entry-level training for jobs such as homecare workers, EMTs, environmental services and clerical positions;

career ladder training for current Kaiser employees; and continuing education to improve health and safety in the workplace. The Career Ladder Training Program, funded by a federal H-1B Demonstration grant, trains Kaiser employees in order to move them into higher-skilled and better-paid jobs in Kaiser's Nursing Department, which suffers from a shortage of staff. The initial goal is to train 280 entry-level workers such as housekeepers, clerks, and aides for acute care and nursing positions and to train 30 LVNs for RN positions. Workers receive full wages and benefits during training. Other programs include training and placing welfare-to-work clients and other unemployed or underemployed persons as CNAs.

RESULTS: About 140 entry-level workers trained for nursing assistant positions and 50 LVNs trained as RNs through the Career Ladder Training Program (spring 2000–spring 2002). The CNA program enrolled about 350 students from January 2001–June 2002, 80% of whom graduated and began work as CNAs.

BENEFITS TO PROVIDERS: Kaiser has increased its ability to train and promote from within for occupations in which it has a workforce shortage. The program increases retention, facilitates recruitment, and contributes to achieving positive labor relations between workers and management. Retention is encouraged through an informal agreement signed by employees who enroll in the nursing assistant training, indicating a commitment to work for Kaiser for one year following training in exchange for forgiveness of their education loan.

BENEFITS TO WORKERS: Current employees receive full wages and benefits while training for a career upgrade. The center's programs are connected to form a nearly complete career ladder, extending from training for unemployed workers entering the health care industry up to training for LVNs to become RNs. Workers are able to apply for open positions within Kaiser even if they do not yet have qualifications, and then receive

training enabling them to move up to that position. Remedial assistance is also provided for workers who do not meet program entry requirements or who need additional support. Extra assistance for trainees is provided by current employees who voluntarily tutor students.

BENEFITS TO COMMUNITY: The program helps to improve the quality of staffing at Kaiser facilities, leading to better health care, while reducing the cost of care and of insurance.

CHALLENGES: The impermanence of grant funding is one of the biggest challenges for the program. The gap in the career ladder between nursing assistants and LVNs is another challenge, however, the center is seeking funding to address this matter.

A more specific challenge is the difficulty of developing training and placement programs for occupations for which there is commonly only one position per location, e.g., a physical therapist at an occupational clinic.

Incorporating internships into some training courses is difficult because in most health occupations a license or certificate is required to perform the work, thus restricting the duties that interns may perform before receiving certification.

REGIONAL IMPACT: The union believes that the major workforce difficulties facing providers in the region are a shortage of higher-skilled workers and low retention rates. SWEC's LVN and RN training programs have made some headway in addressing the former obstacle. Although the LVN-to-RN portion of the program is still small scale; the center is looking for funding to expand the nurse training initiative. To improve retention, SWEC believes that creating career ladders is key, enabling workers to advance while remaining with the same employer. SWEC has created career paths for lower-level Kaiser workers that did not previously exist.

6. HOSPITAL LEAGUE/SEIU 1199 EMPLOYMENT, TRAINING, AND JOB SECURITY PROGRAM (ETJSP)

LOCATION: New York

FOUNDED: Established 1969. Extended to current form in 1994.

PROGRAM TYPE: Training, employment services, and tuition payment in a variety of health occupations for health industry workers and displaced workers.

PARTICIPANTS: SEIU 1199, League of Voluntary Hospitals and Homes of New York (association of over 300 providers, aka the Hospital League), CUNY and community colleges

FUNDING: The primary source is provider-negotiated contributions. The program also receives grants and public funds.

PROGRAM SUMMARY: The program provides a range of services with a variety of funding streams developed through negotiations between SEIU 1199 and the Hospital League. The objectives are broad: to upgrade health-workers' skills, assist laid-off members, provide placement services, and identify changing trends in the industry. Training centers for 1199 members have been established throughout the region, coupled with partnerships with CUNY and other colleges which accept ETJSP tuition vouchers and provide needed classes. An Employment Center performs job placement and referrals. The funds cover training for basic skills, continuing education, ESL, classes to help current employees improve their work, occupational training leading to certification, and training or tuition reimbursement for nursing degrees and other health professions. Support services such as counseling and skill assessment are also available, as well as health and supplemental unemployment benefits for laid-off workers undergoing retraining.

RESULTS: Over 20,000 people participated during 2001–2002 in one or more of the organization's the programs. Fifteen hundred people graduated from ETJSP classes and programs in July 2002 alone. In 2001, 237 students were enrolled in the LPN (LVN) program.

A job-to-job training program prevented mass layoffs in 1996–99. Over 7,000 workers were retrained to fill posi-

tions currently in demand, 95% of whom achieved successful placements in new health care jobs.

BENEFITS TO PROVIDERS: The extensive training program has established a pipeline to help meet workforce needs which is flexible enough to match changes in the industry. Providers' close involvement ensures that workers are trained in needed skills. This arrangement has reduced turnover and saved recruitment costs for a wide range of employers.

BENEFITS TO WORKERS: The program helps current health industry workers access training to move up a career ladder and helps laid-off health industry workers to update their skills and find new jobs within the health care industry. Programs are customized to meet members' needs, enabling students to overcome obstacles to education and employment. Such focused attention includes childcare for nursing students and medical terminology classes for non-native English speakers.

BENEFITS TO COMMUNITY: The community receives better health care because of improvements in staffing levels and quality of service. The displaced worker program reduces unemployment, and the career ladder has the potential to move families out of poverty.

CHALLENGES: Programs to address the nurse shortage are promising but are in the development stage. Eligibility is limited to current 1199 members. The managers of the program have yet to concentrate on helping workers from outside the field to enter, a change which could expand the benefits of career ladders and ensure a future supply of entry-level workers as current workers move up to higher positions. (See District 1199C Training and Upgrading Fund.)

REGIONAL IMPACT: The impact on the regional labor market over the past thirty years has been considerable. The scale achieved by this program has had two fundamental impacts. First, it provides support to thousands of existing and new health care workers, drawing more workers into the field and raising the standards for the industry. Secondly, workers and industry providers have become a major political force, able to negotiate for increases in the state's health care spending because they have become a powerful advocacy group.

7. DISTRICT 1 199C TRAINING AND UPGRADING FUND

LOCATION: Philadelphia, Pennsylvania

FOUNDED: 1974

PROGRAM TYPE: Training, employment services, and tuition reimbursement in a variety of health occupations for health industry workers and displaced workers.

PARTICIPANTS: The primary participants are the Health Care Workers Union 1199C (NUHHCE/AFSCME), 61 Philadelphia-area providers, and the Breslin Learning Center. Other partners include colleges, health academies, schools of nursing and allied health, community-based organizations, foundations, other unions, and the Workforce Investment Board.

FUNDING: 55% of the fund comes from negotiated contributions from providers, and 45% comes from grants, primarily from the public sector.

PROGRAM SUMMARY: The Training and Upgrading Fund was created through negotiations between 1199C and unionized Philadelphia-area providers. It is governed by a joint labor-management board. The Fund provides career ladder training to health care workers, especially those facing layoffs or who have recently been laid off, enabling them to remain in the health care field and move into better positions. Over 40 classes are offered at its Breslin Learning Center. The program also provides tuition reimbursement of \$5,000 per year and scholarships of \$10,000 per year. In addition, it trains people to enter the health care workforce, in part through a welfare-to-work program called Project CARRE. Other services include a hiring hall and career counseling. Training and support programs are open to the community as well as to union members and range from literacy and GED classes to RN programs.

RESULTS: The Fund served a total of 16,000 people in 2001. These included 5,000 people trained for new positions—RN, LVN, CNA, mental health worker, claims processor, childcare worker, and a variety of other occupations. Roughly 60–65% of trainees are current health industry workers moving up, while the remainder are entering the field or retraining after layoffs. An H-1B

grant funded career ladder training for 458 CNAs, 126 LVNs, and 147 RNs. Over 350 people were enrolled in Project CARRE as of Spring 2001, with a one-year job retention rate of 75% for graduates.

BENEFITS TO PROVIDERS: The fund has established a pipeline to provide for workforce needs which is flexible enough to match changes in the industry. Retraining and advancement programs result in greater retention. The hiring hall facilitates recruitment.

BENEFITS TO WORKERS: The program helps current health industry workers access training to advance up a career ladder, enables laid-off health industry workers to update their skills and find new jobs within the health care industry, and provides a way for welfare recipients and displaced workers to enter the field. It offers scholarships and extensive free courses to help workers meet requirements through further training. It also provides wrap-around services including a wide range of career development services. Finally, the hiring hall eases the process of securing employment.

BENEFITS TO COMMUNITY: The community benefits from improvement in staffing levels and quality, leading to improved health care. Welfare-to-work and displaced worker programs reduce unemployment, and the career ladder has the potential to reduce poverty by offering ways for entry-level workers to train for higher paid positions. The programs are open to the community as well as union members—roughly 40% of program enrollees come from the community.

CHALLENGES: The main challenge is the sustainability of the grant funding that supports displaced workers. Employer funding for union members is reliable. Second, training displaced health industry workers for new occupations can be difficult, especially in a career lattice model with workers moving from occupations not involving contact with patients to those that do. Collaboration among multiple partners is critical to making the program successful, but “there will always be challenges” in trying to achieve cooperation between partners with different issues and perspectives.³

REGIONAL IMPACT: Program management staff interviewed believe the Training and Upgrading Fund has

had a “tremendous” impact on the region’s healthcare workforce, through preparing people for entry-level jobs and for higher-level jobs, building a reliable source of high-quality workers for employers, and helping to address the nursing shortage. The Fund trained at least 725 people to be nurses (CNA, LPN or RN) last year and recently won a new grant to train 1,500 additional nurses.

“The best possible, strongest partnership is unions and employers together. If turf issues can be resolved to make that happen, you have a very strong foundation to do high-road work. We’ve been able to do that with our 61 employers. But there will always be challenges.”

—Cheryl Feldman, Director, Learning Center Coordinator, 1199C Training and Upgrading Fund.

EXPANDING THE PIPELINE BY IMPROVING OPPORTUNITIES FOR MINORITY STUDENTS

8. PROJECT L.I.N.C.

LOCATION: Originally in New York City. Replication projects have been attempted at nine additional sites throughout the U.S.

FOUNDED: 1988, with replication efforts begun in 1992

PROGRAM TYPE: The program generated training along career ladder steps to move lower skilled health industry workers into LVN and RN positions. It focused in particular on recruiting minority and low-income students.

PARTICIPANTS: The Robert Wood Johnson Foundation, colleges, providers and provider associations, unions, U.S. Air Force.

FUNDING: The Robert Wood Johnson Foundation, local participants.

PROGRAM SUMMARY: This foundation-initiated project aimed at establishing regional career ladders to enable entry-level and mid-level health care workers to become nurses or allied health professionals. The basic format

involved creating or expanding RN and LVN programs and then recruiting current health workers to enroll in the program while continuing to work part-time with the equivalent of full-time salary and benefits. Extensive individualized support services were available for students. After graduation, nurses were required to work at their sponsoring institutions for up to four years. Recruiting minority and low-income students was a particular focus. Regional programs varied.

RESULTS: In New York City, 67 LVNs and 344 RNs graduated in 3 years. In the subsequent nationwide replication project, 934 participants enrolled in 8 states. 38% of these trainees were people of color, 84% were women, and their average income was \$21,588. About 85% of the students graduated from the programs.

BENEFITS TO PROVIDERS: The program increased the supply of nurses and other allied health workers in occupations with local workforce shortages. Also, it improved the employers’ ability to recruit nurses by promoting from within rather than through external

recruitment, thus saving costs of recruitment and orientation and reducing turnover.

BENEFITS TO WORKERS: Access to RN, LPN, and allied health training helped health care workers move up a career ladder. A work-study program enabled students to continue working and receive full salary and benefits as well as paid tuition and expenses through a loan forgiveness program for those who would work for sponsoring institutions after graduation. It also provided individualized support and counseling. In some areas classes were provided for nurses to advance into more specialized areas.

BENEFITS TO COMMUNITY: A high proportion of program participants were minorities, helping to diversify the nursing workforce and provide more culturally competent care. The program also encouraged collaboration between employers in the health care industry and other stakeholders. In some communities, it helped local residents to become nurses instead of encouraging recruitment from outside.

CHALLENGES: Project LINC was challenged in its efforts to recruit minorities and enroll them in its program; in many cases, only very limited numbers of minority entry-level healthcare workers were available to recruit. In addition, the replication programs depended heavily on funding from a single source, the Robert Wood Johnson Foundation, which ended in 1997.

Project L.I.N.C. also had difficulty adjusting the program to changes in the labor market for a number of reasons. When it was first established, significant health industry staffing shortages existed in the participating regions. Projections indicated they would become more severe over the next decade. However, restructuring and managed care sharply reduced staffing levels, appearing to bring an end to the staffing shortage and in some cases making it difficult for training programs to find placements for their students.

Programs attempted to adapt by offering training in other health professions with greater demand, especially allied health programs, or by retraining laid-off workers. However, retooling to offer training for these new positions was challenging, requiring a highly flexible

program. In addition, the fluctuations in the health industry made it difficult to predict what occupations would be needed, and “health care organizations were reluctant to commit resources to prepare workers for positions that might not be needed in one or more years.” (RWJF)

In consequence, several programs ended or downsized in 1997. The Ohio site was forced to withdraw from the program in 1995 because changes stemming from restructuring and managed care left it unable to recruit enough students. Currently, as shortages of nurses have once again reached crisis levels, this failure to sustain a long-term outlook can be recognized as a fundamental flaw, leading to the loss of programs that would now be of substantial usefulness.

9. SDSU NURSES NOW

LOCATION: San Diego, California

FOUNDED: May 2000

PROGRAM TYPE: Partnership to increase funding for RN training

PARTICIPANTS: San Diego State University, nine San Diego-area providers, The California Wellness Foundation, The California Endowment

FUNDING: The primary source is a commitment from providers to fund additional nursing faculty, with supplementary contributions from foundations.

PROGRAM SUMMARY: Nurses Now is a program run by SDSU aimed at increasing funding for its School of Nursing by partnering with local hospitals as well as with foundations. Hospitals and health care systems that join the partnership each commit to fund a new faculty member at the SDSU School of Nursing, allowing the school to accept additional students. The hospitals commit to fund the program for three years, after which the program will be re-evaluated. Nursing students generally work at sponsoring hospitals during and after the program, but they are not required to do so. Nurses Now differs, therefore, from Project LINC and other programs that use loan forgiveness to retain nurses in the region.

RESULTS: Nursing school admissions increased from an initial 50 up to 90 students per semester over 5 semesters in 2001–2002. The 2002 funding level allowed the school to increase enrollment by a projected total of approximately 200 students, doubling the school's capacity). Six partners have already committed to a second round of funding, so the program is funded through 2007.

BENEFITS TO PROVIDERS: Nurses Now will dramatically increase the supply of nurses in the region. Beginning in May 2003, more nurses will be available for providers to hire, helping to alleviate the severe workforce shortage they currently face. Also, increased hospital clinical rotations have put more nursing students in hospitals expanded the availability of student nurses in clinical settings to more hospitals, easing the immediate pressure created by the staffing shortage. The School of Nursing meets regularly with partners to discuss curriculum and training needs.

BENEFITS TO WORKERS: More workers have the opportunity to become registered nurses; previously, 60–70 qualified students were turned away each semester due to lack of faculty. A mentorship program being established will provide additional support to students, and some scholarships are available. Students also have greater employment flexibility because they are not committed to work at a particular provider after graduation.

BENEFITS TO COMMUNITY: The program helps address the regional nurse staffing shortage, contributing to improved health care.

CHALLENGES: The biggest challenge is increased pressure on the faculty and the infrastructure. The program has doubled the size of the school of nursing, but all of the new funds are used to hire more clinical faculty, with no additional resources for support staff, advisors, etc., straining these services.

REGIONAL IMPACT: Without a formal connection to existing career ladders or employers, few students come from the health professions; most enter the program directly from high schools or community colleges. The School of Nursing just started doing active recruitment

in high schools in the past year and does not recruit from health professions. However, recruiting sufficient students is not a problem for the school; they still have twice as many applicants as slots, even after Nurses Now doubled the number available.

If the program graduates 150 additional nurses per year, it will add 750 nurses to the workforce by 2007, making a significant impact in the San Diego labor market. But with an estimated 1000–1500 *current* vacancies for RNs in the area, program staff believe that Nurses Now alone cannot be a sufficient strategy. Other colleges are also trying to expand their nursing programs, including the junior colleges that offer associate degrees in nursing. Program officers feel to successfully address the nursing shortage, employers need to improve the work environment. Increasing the comparative attractiveness of nursing as an occupation will help to reduce turnover and attract nurses back to clinical nursing from administrative positions and from other states, where many nurses relocated after the aggressive downsizing by California's managed care programs in the early 1990s.

10. SAMUEL MERRITT COLLEGE SCHOLARS IN SERVICE PROGRAM (SISP)

LOCATION: Oakland, CA

FOUNDED: 1996

PROGRAM TYPE: Recruitment and support to increase the number of underrepresented minority nursing students

PARTICIPANTS: Samuel Merritt College, San Francisco Foundation

FUNDING: Samuel Merritt College, San Francisco Foundation

PROGRAM SUMMARY: Samuel Merritt College is a health sciences institution affiliated with Sutter Health and Alta-Bates-Summit Medical Center. Because African-Americans and Latinos are severely underrepresented in the California nursing workforce, as well as at Samuel Merritt, the school initiated the Scholars in Service Program to support and increase the number of minority students in the Bachelors of Science in nursing program. The program provides a scholarship, personal

advising on academics and financial aid, nurse mentors, and increased support from the college administration. Students are expected to show leadership within the school during the program and commit to work as nurses in medically underserved communities in the East Bay.

RESULTS: In the fall of 2002, 75 African-American and Latino students participated in the program, out of a total of 225 BSN students. The percentage of all undergraduate students belonging to underrepresented minorities has increased from 10% to 17%. Retention rates of BSN students have risen from 29% to 82.3% for African Americans and from 63% to 87.5% for Latinos.

BENEFITS TO PROVIDERS: Graduates work for providers throughout the greater Bay Area. The greater number of nurses from a variety of ethnic and national backgrounds enables providers to increase diversity and cultural competency.

BENEFITS TO WORKERS: Scholarships, pre-admission counseling, and extensive support services facilitate the students' ability to overcome barriers to entering and completing the BSN program. Students in the program receive recognition for achievement and leadership.

BENEFITS TO COMMUNITY: The nursing workforce will better reflect the diversity of the community. The support also increases opportunities for local residents to enter and succeed in a nursing program. Nursing students are expected (though not required) to work in medically underserved communities after graduation, and most do so.

CHALLENGES

Program staff report no major challenges; enrollment remains high and funding is adequate. However, although the proportion of underrepresented minorities in nursing has increased, it remains lower than the minority makeup of the surrounding community.

REGIONAL IMPACT: Staff believe that the program has “definitely” helped to produce a more diversified nursing workforce in the greater Bay Area.

Most students are recruited from local community colleges; the typical participant has completed the prerequisites at a community college and is seeking to transfer to another school for a health professional degree. The program thus does not appear to contribute significantly to enabling existing health industry workers to move up to nursing positions.

ENDNOTES

1. Results based on information provided in “Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on Implementing California’s Public Authorities” <http://www.paraprofessional.org/publications/CA%20PA%20Report.pdf> and <http://www.seiu.org>
2. Pamela Doty, A.E. Benjamin, Ruth E. Matthias and Todd M. Franke. “In-Home Supportive Services for the Elderly and Disabled: A Comparison of Client-Directed and Professional Management Models of Service Delivery.” U.S Department of Health and Human Services and the University of California, Los Angeles, April 1999
3. Interview with project staff, Fall 2002

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SILICON VALLEY WORKFORCE INVESTMENT NETWORK

Silicon Valley Workforce Investment Network (Silicon Valley WIN) is a comprehensive regional resource for employers, workers and job seekers. Silicon Valley WIN provides solutions and bottom-line results for complex workforce issues. Silicon Valley WIN provides businesses with customized, professional career services, helping companies and their employees manage career transitions and enabling employers to attract, train and retain skilled employees. Silicon Valley WIN exists to help businesses meet their workforce needs by providing outplacement, recruiting and training services. Silicon Valley WIN is dedicated to fostering the economic development of the region as the most effective way of providing jobs, a healthy tax base and prosperity for all.

WPUSA DESCRIPTION

Working Partnerships USA was formed in 1995 in response to the widening gap between Silicon Valley's prosperous employers and the well being of much of the region's workforce. Today, Working Partnerships is a unique collaboration among labor unions, religious groups, educators and other community-based organizations that crafts innovative solutions to the problems of the New Economy. Solutions developed by Working Partnerships include the arenas of health care, affordable housing, contingent work, and smart growth. Working Partnerships is also shaping the next generation of labor market intermediaries through the establishment of Working Partnerships Membership Association, a temporary workers' organization.

Silicon Valley Workforce Investment Network

60 South Market Street, Suite 470
San Jose, CA 95113
www.svwin.com

Working Partnerships USA

2102 Almaden Road, Suite 107
San Jose, CA 95125

p: 408.269.7872
f: 408.269.0183

www.wpusa.org