




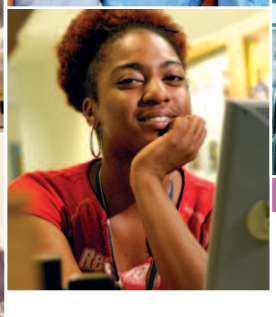

Invisible No Longer:

Advancing the Entry-level Workforce in Health Care

By Randall Wilson

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JOBS FOR THE FUTURE
CREATING STRATEGIES
for Educational and Economic Opportunity

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About Jobs for the Future

Jobs for the Future seeks to accelerate the educational and economic advancement of youth and adults struggling in today's economy. JFF partners with leaders in education, business, government, and communities around the nation to: strengthen opportunities for youth to succeed in postsecondary learning and high-skill careers; increase opportunities for low-income individuals to move into family-supporting careers; and meet the growing economic demand for knowledgeable and skilled workers.

About the Author

Randall Wilson, a member of JFF's Building Economic Opportunities Group, has 20 years of experience in research and program evaluation in the areas of workforce development and urban community development. Mr. Wilson has authored numerous studies on labor market issues and career advancement strategies for lower-skilled adults. Recent publications include *Career Ladders in the Massachusetts Long-Term Care Sector: Prospects for Job Mobility in the New Economy, The Social and Economic Costs of Employee Misclassification in the Massachusetts Construction Industry,* and a case study of Common Ground Community and the Times Square Job Training Program for JFF's U.S./UK seminar on the role of labor market intermediaries for improving job prospects for low-income individuals. He is completing a Ph.D. in public policy at University of Massachusetts Boston.

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EXECUTIVE SUMMARY

America's health care institutions face trouble on the human resources front. To deliver adequate care, our hospitals, nursing homes, primary care clinics, and home care providers need a well-trained workforce and a reliable "pipeline" of workers to fill vacancies and address shortages in critical areas. This need includes highly skilled professionals, but also in short supply, and subject to rapid turnover, are a variety of lower-skilled yet essential workers: nursing assistants, who perform most direct patient care, as well as home health aides, billing/coders, and many others.

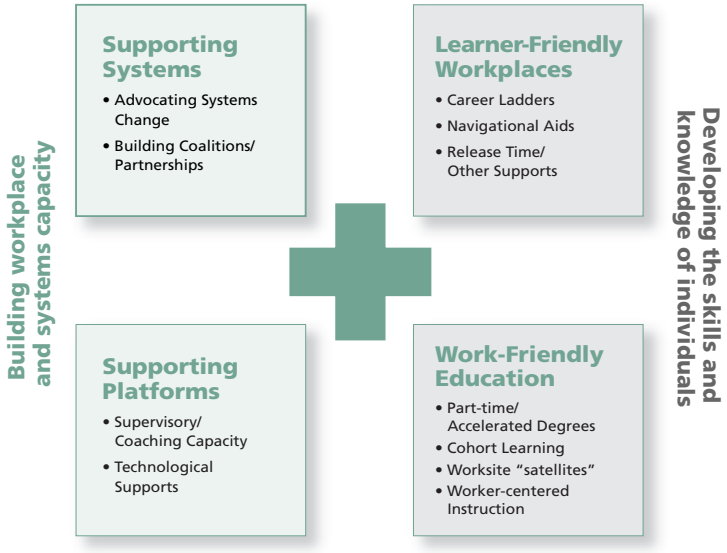
This workforce challenge is well known. Less familiar is the range of responses to meet it, particularly responses focused on entry-level health care workers and their quest for jobs leading to rewarding careers. New practices for serving this need come in a variety of packages—from partnerships that build career ladders and relieve staffing pressures in acute or long-term care facilities, to college or union-based programs that enable low-income health workers to increase their income significantly. These efforts are championed by community groups, unions, career centers, and corporate executives. The common thread is understanding that the entry-level workforce is critical to the nation's health care system and that learning opportunities and career advancement are in turn critical to workers' success.

Invisible No Longer: Advancing the Entry-Level Workforce in Health Care explores this wide variety of practices and reports on where there is progress, where further investments would pay dividends, and what lessons are emerging.

A Framework for Developing the Entry-level Workforce in Health Care

A growing set of activities, while often disparate in location and focus, is quietly converging in what can be labeled collectively as workforce development in health care. The field addresses the recruiting, screening, and preparation and placement of workers, but increasingly it focuses on services that help disadvantaged or inexperienced incumbents retain their jobs and advance in careers.

From inside the health care industry and outside it, initiatives are addressing a range of workforce challenges, from high turnover and labor shortages, to low skills and other barriers to individual mobility. In some cases, employers drive the initiatives, relying on human resources departments or staff educators to develop the skills of entry-level recruits and incumbent workers. Increasingly, though, the most distinctive workforce development activities are emerging through large, multi-sector partnerships, backed by government or private funders. Often, major hospitals and health systems participate in such partnerships.



A number of these initiatives stand out for a dual focus: supporting workforce development that leads to mobility for entry-level health care workers, while building the capacity of health care employers and providers to sustain such development. JFF has developed a framework for analyzing these investments in the entry-level health care workforce. It rests on two sets of observations about promising efforts in the health care sector.

Developing the Skills and Knowledge of Individuals: The lines between businesses and their education and training partners are blurring.

- ***Learning-friendly workplaces: ladders to better jobs.*** Learning-friendly workplaces create formal "ladders" for advancing worker skills step by step and compensating people accordingly. They also foster an informal culture that supports education as central to the experience of work. And they help motivate workers to invest in their own education and remain with an employer, knowing that their job offers a way up rather than a dead end.
- ***Work-friendly education: bridges to higher skills.*** Work-friendly education offers training in a time, place, and manner that dovetail with entry-level health care employment, creating "bridges" that connect education more effectively to the world of entry-level work.

Building Workplace and Systems Capacity: As projects mature and grow, they are supported by changes in organizations and in broader systems.

- ***Platforms for workforce development: change the workplace, not just the worker.*** Health care employers are building "platforms" that can sustain professional development for entry-level workers. These innovations may include training managers and supervisors in skills that help them coach their staff better, promoting experienced workers to positions as mentors, and creating work roles or team structures that encourage the use of higher skills. In some cases, employers use technological innovations, such as distance learning, as platforms to support worker development.
- ***Superstructures: building a support system for workforce development.*** Health care employers and other stakeholders collaborate to create "superstructures"—cross-firm support systems to adopt new practices, support them financially, and encourage their expansion and replication. These partnerships help to address the root causes of turnover, staffing shortages, and other problems. They also address public policy to develop resources for workforce development, organize support for better wages and working conditions, and press for regulatory changes and reforms.

Lessons for Advancing the Entry-level Workforce in Health Care

The four dimensions of JFF's framework for developing the entry-level workforce in health care suggest a variety of areas of focus for practitioners and funders seeking to improve the quality of health care work while improving the performance of health care delivery.

Lessons for Practitioners

Enlist and maintain employer commitment at multiple levels and times. Few—if any—workforce development initiatives in health care succeed without the leadership of two key constituencies: executives and lower-level managers and supervisors.

Enlist educational partners who understand the needs of lower-skilled workers. Institutions must embrace the mission of serving this population and maintain flexibility in how they offer courses, provide supports, and create linkages between credit and non-credit education.

Build in data collection from the start. Workforce development efforts must demonstrate short- and long-term benefits to all major stakeholders.

Maintain confidentiality for both workers and employers. Clear rules about confidentiality protect workers and build and maintain their trust in the program and providers.

Create a single point of contact for service providers. Organizations that recruit pre-employment candidates from the community need a single point of contact for placing candidates into health care workplaces with career path programs.

Lessons for Investors

Reliable, multi-year funding streams are essential. Investor commitment must be patient, deep, and broad for initiatives to navigate the many challenges to significant, sustainable change. Employer and workforce development partners may spend years getting to know and trust one another, setting ground rules for collaboration, and moving from broad goals or targets to specific training activities.

Remediation may require additional investments, as could the need to address low self-confidence and fear of failure. The most promising projects have addressed workers' barriers of skill, confidence, and knowledge of careers with a dual focus on both instruction and career support.

Invest in building the workforce development capacity of employers and of workforce intermediaries. To achieve sustainable change, investors on workforce development need to focus on fostering organizations and systems as well as improving the skills of individuals.

Achieving large scale is possible. Promising initiatives and strategies testify to a growing trend toward complex, multi-partner demonstrations that are mature enough to have shown results and evolved—adding new partners, shedding others; adapting to changing labor markets, funding streams, and operational challenges; and even taking small programs and practices to a significantly larger scale.

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INTRODUCTION

America's health care institutions—our hospitals, nursing homes, primary care clinics, and home care providers, among others—face trouble on the human resources front. To deliver adequate care, these providers need a well-trained workforce and a reliable "pipeline" of workers to fill vacancies and address current and projected shortages in critical areas. The latter include highly skilled professionals—nurses, radiological technicians, and pharmacists—but also in short supply, and subject to rapid turnover, are a variety of lower-skilled yet essential workers: nursing assistants, who perform most direct patient care, as well as home health aides, billing/coders, and many others. Further, schools and colleges face shortages of faculty to educate professionals and paraprofessionals, while facilities lack practitioners, especially at higher-skilled levels, who speak the languages and understand the diverse cultural norms of today's patient population.

These challenges are well known. Less familiar is the range of responses to meet them, particularly responses that focus on entry-level workers and the need to make their jobs into gateways to rewarding careers. New practices for serving this need come in a variety of packages—from partnerships that build career ladders and relieve staffing pressures in acute or long-term care facilities, to college or union-based programs that enable low-income health workers to increase their income significantly. These efforts are championed by community groups, unions, career centers, and corporate executives—and sometimes all of the above. The common thread is the understanding that the entry-level workforce is critical to the success of the nation's health care system and that learning opportunities and career advancement are in turn critical to workers' success.

Invisible No Longer: Advancing the Entry-Level Workforce in Health Care addresses the need to bring the wide variety of practices converging on these fronts into one conversation, to understand where there is progress, where further investments would pay dividends, and what lessons are emerging. With funding from the Hitachi Foundation, Jobs for the Future has collected and analyzed entry-level workforce interventions with four questions in mind:

- What are the most promising models of workforce development for the entry-level of health care?
- What key components of these models contribute to improving returns for health care institutions while advancing the careers of lower-skilled workers?
- What are the lessons for practitioners seeking to implement such practices in their organizations?
- What are the lessons for public and private investors concerning the highest leverage and most scalable practices?

PART I. The Health Care Industry

The health care industry is vast. It comprises 14 percent of U.S. Gross Domestic Product—the highest proportion of all the major industrialized economies—and over 13 million jobs. The labor force becomes even larger, nearing 15 million, when factoring in school nurses, physicians employed by insurance firms, and other health occupations in non-health care delivering industries (Salsberg 2003).

The demand for health care workers will increase in the coming years. Half of the 30 *fastest-growing* occupations in the United States are in the health field. Many of these require little or no formal education and training beyond brief, on-the-job instruction. Many other occupations, for example, phlebotomists, surgical technicians, or licensed practical nurses, require two years or less of college, technical certification, or both. By 2012, health occupations in all industries are projected to grow by more than 5 million, with nearly 3.3 million new jobs created, and another 2 million workers needed to replace those departing their jobs (Hecker 2004). Health services will account for one out of every six new jobs created during this decade. And among the 30 occupations creating the largest numbers of new jobs, five are projected to be health occupations. Of these, all but Registered Nurses are entry-level positions: nurse aides, home health aides, personal and home care aides, and medical assistants (Martiniano et al. 2004) *(see Table 1).*

These health care workers are employed in a variety of institutions, from world-renowned teaching hospitals to storefront clinics. A large number work in long-term care, skilled nursing facilities, and, increasingly, assisted living, continuing care, and home-based settings, among other sites. Over two in five jobs are in acute care facilities. A smaller share of the workforce is employed in primary care settings, such as doctors' and dentists' offices, and in medical laboratories.

Wherever they are located—major cities, smaller towns, rural areas—health care providers are often anchor employers: they treat *and* employ a population that is diverse in ethnic makeup, language, income, and educational level. And they are rooted in place and dependent on direct, personal interaction with customers.

Health care employment is not static, however. Fiscal uncertainties—owing to changing reimbursement arrangements, demands from managed care organizations, and other cost pressures—have led to bankruptcies and closed or cut-back facilities, notably in long-term care. And many of the past two decades of mergers and reorganizations of hospitals and clinics into large, multimember systems have resulted in staff cutbacks.

Demand for Entry-level Workers in Health Care

Invisible No Longer focuses on entry-level caregivers and support staff. Such workers, unlike nurses, lack the professional recognition, credentials, and clear career advancement paths available to higher-skilled professionals. They are far less likely to enjoy professional or educational development opportunities, and they can be "invisible" to casual observers of health care delivery. While higher-skilled caregivers are essential to frontline health care work, their education and advancement requires different strategies and resources than do workers with fewer credentials or professional training.

A central challenge for the U.S. health care industry is to meet the growing demand for its services. This growth is fed by many factors, chief among them an aging and more diverse population, rapidly changing technology, and rising expectations for care.

The population age 65 and over, close to 35 million now, is projected to more than double in size by 2030. The "oldest old," or those age 85 and older, could increase five-fold by 2040 (Stone and Wiener 2001). Meanwhile, elders now needing care are older, frailer, and more likely to contend

Table 1: Health Care Occupations with the Greatest Projected Growth and Requiring an Associate's Degree or Less

Occupational Title	Job Growth 2002-2012	Required Education
Registered Nurses	623,000	Associate's degree
Nurse aides	343,000	Short-term, on-the-job training
Home health aides	279,000	Short-term, on-the-job training
Personal and home care aides	246,000	Short-term, on-the-job training
Medical assistants	215,000	On-the-job training

Source: Martiniano et al. 2004

with multiple medical or cognitive impairments, placing greater demands on caregivers, particularly in long-term care. For instance, about one-half of all nursing facility residents live with dementia or related memory disorders (National Citizen's Coalition for Nursing Home Reform 2005). Technological innovations and new therapies have expanded the lifespan of the population, including those with chronic ailments. At the same time, baby boomers are aging, and they are more affluent, on average, than their ancestors and their expectations from the health care system are greater. Finally, services in home- and community-based settings are growing, partly fueled by technology that assists users with daily activities (Salsberg 2003).

All these factors will add to demand for both health care services and the direct care workers to provide them. Yet the key labor force that has traditionally filled direct care positions, women aged 25-54, is expected to increase by only 7 percent during this period (National Clearinghouse on the Direct Care Workforce 2004).

Uncertain federal and state policy environments complicate meeting these demands. Medicaid reimbursements consistently fall short of patient costs, which means that many nursing facilities end up either in financial jeopardy or seriously understaffed (Rubin et al. 2005). Cuts in Medicare reimbursements—dating from the 1997 Balanced Budget Amendment—have contributed to the financial squeeze on caregivers, including home health care agencies and hospitals. Major teaching hospitals and medical research institutes—particularly in regions with large health care industries—face additional problems as federal funding for basic science research declines (Mansfield 2000). Rising numbers of uninsured individuals exacerbate the problem, as health care providers and states absorb the cost of uncompensated care (U.S. Census Bureau 2005, Walker 2005).

Challenges to Supplying the Entry-level Health Care Workforce

Health care employers can respond to the demand for workers and a challenging fiscal environment in a variety of ways. One is simply by cutting costs. Another is to become both a "provider of choice" and an "employer of choice" by offering better care to patients and a better work environment for employees. While research has not shown a definitive link between the quality of jobs and the quality of care, JFF found many employer investments in building workforces at all levels that are professional, skilled, culturally competent, and stable. The need for a well-trained workforce *is* clear, and a great deal of research points to the importance of continuity of personnel in caregiving. This is especially true in long-term care settings, where daily observations of patient conditions and good caregiver/patient relationships are vital (Stone et al. 2003). That said, current standard practice—low wages and low levels of investment in the skills and advancement of those on the bottom tiers of the workforce—leave employees with little motivation to remain in their jobs (Banaszak-Holl and Hines 1996).

Shared Workforce Challenges

For employers, the large, growing, and essential entry-level workforce presents critical challenges, including severe shortages in some occupations and high rates of turnover and vacancies in general. These factors, in turn, can force

The Entry-Level Workforce in Health Care

The entry-level workforce is comprised of those who provide the most hands-on care to patients or have the most personal contact. It includes Certified Nursing Assistants, patient care assistants, home health aides and homemakers, housekeepers and environmental service workers, patient transportation staff, recreational aides, and dietary, nutrition, and food service staff, as well as the administrative workers who admit patients, coordinate units, and maintain records *(see Table 2)*. Entry-level direct caregivers make up over one in five acute care jobs and nearly half of all long-term care employment. If administrative workers are factored in, the percentages are even higher *(see Table 3)*.

Table 2: Composition of Entry-level Staff in Health Services, 2002

Occupational Group	Share of Entry-level Staff
Patient care	60.4%
Maintenance/housekeeping	17.7%
Food services	12.9%
Administration	6.4%
Transportation/security	2.6%

Source: U.S. Bureau of Labor Statistics (2004)

Table 3: Percentage of Staff in Entry-level Jobs, by Sector, 2002

Sector	Share of Entry-Level Staff
Acute care	17.9%
Ambulatory care	4.3%
Nursing and residential care	61.1%
Home health care	54.2%

Source: U.S. Bureau of Labor Statistics (2004)

employers to turn to expensive human resources practices and short-term solutions, such as hiring temporary replacements through agencies or other sources.

Nationally, over three-quarters of states report that vacancies of direct care workers are a serious problem (Harmuth and Dyson 2005). In long-term care, for example, annual turnover rates for nursing assistants average 71 percent and may exceed 100 percent. Every year, half of Licensed Practical Nurses leave their jobs (Biles et al. 2005). Such turnover disrupts the relationships necessary to provide quality care and imposes direct costs of at least $2,500 for each CNA replaced, and considerably higher for LPNs (Seavey 2004). Across all health care sectors, vacancy rates range from 21 percent for pharmacists and 18 percent for radiological technicians to 11 percent for Registered Nurses and 9 percent for housekeeping and maintenance staff (Salsberg 2003).

Second-Choice Jobs

The reasons for high rates of turnover and vacancies in entry-level positions are varied and complex. They include low respect, inadequate supervision, and a lack of autonomy (Bowers, Esmond, and Jacobson 2003). But the most important appear to be low wages, few (or expensive) benefits, and few opportunities for advancing to family-sustaining jobs and incomes (Wunderlich and Kohler 2001). Those at the bottom (e.g., nurse aides, support staff in dietary, laundry, or housekeeping) lack "middle rungs" on a career ladder—that is, intermediate steps on the path to higher-paying, higher-skilled occupations, such as LPN or technical and allied health positions. Often, the educational hurdles for entry-level staff are daunting, given low levels of formal education and limited English proficiency. Postsecondary degree programs tend to be lengthy and expensive, particularly for low-wage workers, usually female, who are often the sole support for their families (Yamada 2002).

In other words, poor working conditions lead to high turnover and hinder recruitment. The work, especially for nursing assistants, home health aides, and other patient care staff, is more difficult and demanding than comparably paid employment in food service or retailing, for example. Understaffing in health care facilities—as well as restrictions imposed by third-party payers—limit the time that aides can spend caring for individual patients (Kopeic 2000). Workers also consistently point to a lack of respect (from higher-level staff, as well as from patients and families) as a reason for changing jobs. Insufficient supervision, support, and mentoring for new recruits (or for long-term workers) contribute to turnover as well.

Health care employers, regardless of their particular niche within the larger sector, face a number of workforce development challenges. These include:

- Skill gaps;
- Faculty shortages; and
- The need for staffing diversity.

(JFF's research looked at "supply side" issues—that is, ways to improve the size and quality of the entry-level health care workforce. The myriad other factors affecting the quality of entry-level jobs and the financial capacity of employers and government to improve them are not the primary topic here. Nevertheless, long-term solutions to workforce challenges require tackling both supply side and demand side issues.)

Skill Gaps: Health care employers contend with skill deficits in critical areas. Chief among these are a lack of proficiency in English, not only for direct care staff but also for service workers who must interact with patients, families, coworkers, and supervisors. Low levels of literacy in English and math, as well as a lack of proficiency with computers, also hinder entry-level workers' performance and advancement. An additional area of concern comes from weaknesses in interpersonal or "soft" skills, such as the abilities to work in teams and to manage conflicts. A further challenge comes with the growing importance of knowledge of geriatric issues, including specific medical conditions associated with aging (Alexander, Wegner, and Associates 2004).

Beyond these specific needs, educational requirements are rising for health care practitioners overall. For example, some Boston hospitals have raised their minimum degree requirements for nursing candidates from Associate's to Bachelor's of Science in Nursing (BSN), while the demand for Licensed Practical Nurses has all but disappeared in the region's hospitals.

Faculty Shortages: A further supply challenge lies in capacity for educating and training the health care workforce. This problem challenges both formal training institutions and employers.

On the academic side, enrollment in Master's and Doctoral nursing programs has increased, but colleges have not kept pace with the need for nursing educators (American Association of College Nursing 2005). Limitations in faculty, classroom space, and clinical sites have caused Bachelor's nursing programs to turn away thousands of qualified applicants (Sroczynski 2003). For example, the Community College of Rhode Island has put

applicants for its LPN and RN programs on wait lists for up to three years after completing the core (pre-nursing) curriculum (Hall interview 2005).

As for employers, staff education capacities are often threadbare at best, especially for entry-level and lower skilled workers. This is in part a reflection of scarce dollars, as well as an absence of commitment to training all segments of the workforce. But it also reflects the multiple commitments required of managerial staff, who must often balance educational duties with a myriad of administrative tasks.

Need for Staffing Diversity: Recent research points to the importance of "cultural competence" in assessing patient needs and delivering care to diverse populations (Smedley et al. 2002, 2004). While entry-level workers are often racially and linguistically diverse, drawn from the ranks of recent immigrant groups, those in the middle and upper rungs of hospital and nursing home employment are predominantly white, native-born, and less likely to reflect the composition of the neighborhood or patient populations. Insufficient advancement opportunities for entry-level workers limit opportunities to serve community residents.

Distinct Workforce Challenges Among Health Care Sectors

While the major health care sectors face a number of common challenges, important differences affect the nature and severity of challenges and the capacity of employers, providers, and funders to respond to those challenges. These challenges relate to:

- Occupational composition;
- Work organization;
- Financing arrangements; and
- Workforce demographics.

Occupational Composition: Nurse aides and other direct caregivers play a major—but differing—role across health care sectors. Acute care facilities rely to a much greater extent on RNs and LPNs, who comprise close to one-third of hospital employment, while nurse aides, home health aides, and similar paraprofessionals comprise fewer than one in ten such jobs. In other settings, though, entry-level workers represent a much larger share of the health care workforce: 38 percent for nursing homes; 35 percent for home care agencies. Within the licensed nursing occupations, LPNs are more likely to work in nursing homes, where they often hold supervisory positions, than in hospitals (11 percent of long-term care employment versus 4 percent of hospital employment) (Salsberg 2003).

Hospitals and other acute care providers also have a more complex occupational structure than either long-term or home health care. Hospitals tend to be larger and have a greater variety of occupations; thus, they offer a wider variety of career pathways for entry-level workers. This means more openings at the lowest-skill levels (e.g., environmental services, dietary services, transportation) *and* at intermediate levels, in administrative, technical, and clinical occupations. The latter include allied health occupations (e.g., radiological and surgical technicians, diagnostic medical sonographers, physical therapist aides), as well as non-patient areas (e.g., billing and coding staff, microfilm librarians, unit coordinators).

Work Organization: Hospitals—with higher proportions of licensed nurses—have steeper hierarchies and more structured supervision than nursing homes, where most workers are nursing assistants or support workers. Home health aides and personal care aides, in further contrast, may operate with very little (and episodic) supervision.

Home health care workers are also more likely than hospital and nursing home workers to be employed part-time or as independent contractors (Yamada 2002). They are

typically paid only for time spent in the home, and not for travel, training, or other activities (U.S. Department of Labor n.d.). Also, home health aides and similar non-licensed caregivers lack a single "employer of record," such as an agency, with the resources and authority to invest in and govern conditions of work across scattered work sites (Reinhard 2001, Heinritz-Canterbury, 2002). This challenge will increase in significance with the move toward care that is more "consumer-directed" or under the direction of disabled or elderly persons living at home or in community settings.

Financing Arrangements: In all forms of health care delivery, employers face gaps between the actual costs of providing care and the levels of reimbursement offered by third-party payers under Medicaid, Medicare, and other publicly funded programs. However, there are major differences among the sectors in their reliance on particular paying arrangements and the implications of payment regimes for compensating workers and funding education and training. For example, Medicare reforms in 1997 placed greater limits on the ability to improve wages for home care workers.

In another example, bankruptcy rates are rising for nursing facilities, which rely more on Medicaid, than the home care or acute care sectors, constraining investments in entry-level professional development. On the other hand, acute care, while also limited by Medicaid reimbursement rates, relies far more on private-pay and Medicare than do the other health care sectors. In general, hospitals, while often financially straitened, operate on bigger margins than do long-term care facilities or home health providers. Thus, they tend to have more resources for developing an entry-level, frontline workforce.

A further variation in funding arrangements occurs in community health, affecting workers who provide health education, outreach, and other services to disadvantaged populations. Funding often comes from short-term grants focused on particular health topics, such as asthma, tobacco control, or HIV-AIDS. Limited and episodic funding means that community health work is unstable and lacks career advancement avenues. Indeed, higher earnings do not necessarily result from gaining further - education, experience, or job tenure; a community health worker with a Master's Degree may earn no more than one with a high school diploma or less education (Ballester 2005).

Workforce Demographics: Important differences within the entry-level workforce must be factored in when designing systems to support workplace learning, which can provide people with a "second chance" to gain postsecondary credentials of value in the labor market. For example, nurse aides in long-term and home health care are on average poorer, less likely to have health insurance, and more likely to be receiving food stamps than their peers in hospitals. Home health care aides are about twice as likely to be immigrants as are acute care-based aides: 23 percent versus 12 percent (Scanlon 2001, Yamada 2002). Perhaps most important in regard to their advancement potential, they have less education as well. One in four home care and nursing home aides has less than a high school degree, compared to about one in twelve such workers in hospitals.

Nor are conditions monolithic within health care sectors. Large, urban, teaching and research hospitals are organized differently and operate with greater resources for personnel development than are community hospitals. The former are also moving to require higher credentials, such as Bachelor's (or even Master's) degrees for nurses and Ph.D.s for physical therapists. In some large teaching hospitals contacted for this study, managers were also more prone than those in other acute care facilities to seek a high school degree for entry-level support positions.

PART II. Addressing the Workforce Challenges: An Overview of Recent Major Initiatives

No magic bullet will cure all that ails our nation's health care workforce. However, a growing set of activities, while often disparate in location and focus, is quietly converging in what can be labeled collectively as workforce development in health care. The field addresses the recruiting, screening, and preparation and placement of health care workers, but increasingly it focuses on helping disadvantaged or inexperienced incumbents retain their jobs and advance in careers. It encompasses on-the-job training, coaching, and support for continued education.

From inside the health care industry and outside it, workforce development initiatives are addressing the many problems discussed here, from high turnover and labor shortages, to low skills and barriers to individual mobility. In some cases, employers lead such initiatives, relying on their human resources departments or staff educators to develop the skills of entry-level recruits and incumbent workers. Increasingly, though, the most distinctive and effective workforce development activities are emerging through large, multi-sector partnerships, backed by government or private funders, both nationally and at a regional or municipal level. Often, major hospitals and health systems in larger cities participate in such partnerships.

The initiatives in this section and in Part III are notable for their scale and ambition in addressing entry-level workforce development in health care and their focus on supporting both the mobility of individual workers and the capacity of employers and providers across the workforce system. They also illustrate the range of institutions involved in the health care workforce.

Federal Initiatives

Several recent, national initiatives are federally funded and seek to improve the health care job pipeline, particularly to alleviate shortages in professional occupations, such as Registered Nurses and pharmacists, while also addressing issues related to the entry-level workforce.

The U.S. Department of Labor launched its *High Growth Training Initiative* in 2004 to address workforce shortages and other challenges. The department targeted health care as one of twelve rapidly growing sectors to receive attention, investing over $43 million. One of the most ambitious efforts is a five-site demonstration to develop "career lattices" for educating Certified Nursing Assistants and Licensed Practical Nurses, as well as for accelerating LPNs' acquisition of RN credentials. It is managed by the Council for Experiential and Adult Learning (Cohen et al. 2005). The term career lattice recognizes that careers do not always take straight or vertical paths; for example, participants in the CAEL program make lateral moves between health care occupations, including moves into or out of nursing.

The U.S. Center for Medicare and Medicaid Services initiated *Systems Change Grants for Community Living* in 2001 to improve local long-term care systems that support the ability of ill or disabled consumers to live and participate in their communities. Grantees are encouraged to focus on workforce strategies (e.g., recruitment, wage improvement, training, career ladders) to expand home- and community-based care services (Anderson et al. 2004).

Other federal employment and training programs, while not targeting health care, have assisted a variety of initiatives based in hospitals, community health clinics, and long-term care facilities. For example, the Department of Labor's H1-B and Welfare to Work programs have funded training and large-scale employer and educational partnerships in many regions.

Foundation Initiatives

Foundations have begun to make significant investments in the entry-level workforce arena. Since 2002, the Robert Wood Johnson Foundation's Better Jobs, Better Care Initiative has addressed both public policy and workforce practices to improve the quality of long-term care. It has supported researchers and long-term care providers in promoting practices that help retain and attract direct care

workers in residential and home- and community-based settings. Researchers are examining such issues as the human resources practices and leadership patterns that affect the ability of nursing home workers to provide good care. Other philanthropic investors, including the Annie E. Casey, Langeloth, and Packard foundations, have also targeted the health care workforce.

On a regional and urban level, foundations have played a role—often a leading role—in an impressive range of workforce projects organized by health care employers, workforce investment boards, community colleges, community-based organizations, health care associations, quality improvement organizations, and labor unions. These efforts attest to the growing scale, depth, and maturity of advancement initiatives for entry-level workers. Often, they center on one or more acute care facilities or systems. Some also incorporate other providers, including long-term care or home health care. They include the McKnight Foundation and the Allina Health Systems Foundation (Minnesota); the Boston Foundation and Hyams Foundation (Massachusetts); and others.

The East Metro Health Careers Institute, in St. Paul, Minnesota, is a partnership among all four of the city's hospitals, two community colleges, and a public workforce training agency. Created in 2001, the institute targets incumbent health care workers and candidates in transition from welfare to work. Initial challenge grants from regional foundations were matched by health care employer contributions.

The Health Care Research and Training Institute and *Partners in Career and Workforce Development*, both anchored by major Boston-area teaching and research hospitals, are large-scale, career ladder initiatives. A community-based intermediary partner (Jamaica Plain Neighborhood Development Corporation), founded and manages the institute, while PCWD is led by a regional health care employer (Partners HealthCare). Both build on the training programs of their member hospitals, continue to grow, and are part of SkillWorks, a major, citywide workforce development initiative supported by a broad funding collaborative of municipal and private funders.

The Santa Cruz Health Careers Partnership is a wide-ranging consortium established by Cabrillo College, a community college serving Santa Cruz County, California. The partnership members include hospitals, nursing homes, and home health providers, as well as the area's workforce board and welfare-to-work agency.

The Baltimore Alliance for Careers in Health Care is a workforce intermediary created in 2003 to address workforce shortages in health care and the need of unemployed and underemployed workers for training and jobs. Among the coalition's 70 members are local government, large hospitals, including Johns Hopkins and Mercy Medical Center, two-year and four-year colleges, regional and municipal workforce agencies, and a range of nonprofit organizations.

Flint (Michigan) Healthcare Employment Opportunities targets low-income residents in the city's "renewal community," offering them health care training and career ladders to higher-skilled positions. Local hospitals, unions, community-based organizations, and community colleges convened the partnership to serve worker and employer needs and to restructure the industry's hiring, retention, and promotional practices.

Employer Association Initiatives

Employer associations have sponsored or participated in a number of health care workforce partnerships. The U.S. Chamber of Commerce, Center for Workforce Preparation, teamed with the VHA Health Foundation in supporting Community-wide Career Ladders for the Health Care Sector. In St. Paul, Minnesota, Sacramento, California, and Washington, DC, this initiative promoted multi-employer partnerships focused on developing health care career ladders and an infrastructure to sustain them (VNA Health Foundation 2003). The Greater Cleveland Growth Association (the Chamber of Commerce for northeast Ohio) engaged area hospital systems, nursing homes, and

clinics in partnerships for designing career ladders in nursing and technical fields (Mills and Prince 2003).

State Initiatives

Many states have mounted ambitious efforts to address workforce issues in acute care and long-term care. A 2004 survey found that over two-thirds of the states were funding career ladder projects or similar initiatives to address vacancies among direct care workers in long-term care (Dyson and Harmuth 2005). One of the most far-reaching is the Extended Care Career Ladders Initiative in Massachusetts. Established in 2000, ECCLI supports career advancement partnerships in nursing homes and home health agencies, both to stabilize a high-turnover, low-wage workforce and to change the practice and organization of caregiving to a more patient-centered model. As of 2005, nearly one-fourth of Massachusetts nursing facilities were participating in ECCLI.

Other Local and Regional Partnerships: Workforce Investment Boards, Unions, Educators, and Employers

Workforce Investment Boards and other publicly funded entities are playing an aggressive role in developing the entry-level workforce in health care. For example, WIBs in Seattle, Tacoma, Boston, and Chicago have assembled partners, provided planning assistance, and offered direct services to workers, jobs seekers, and businesses. Labor-management partnerships, using employer-financed funds and other funding sources, have fostered hospital- and nursing home-based career ladder projects in Philadelphia, the San Francisco Bay Area, Connecticut, and the New York Metropolitan Area. Community colleges across the country have forged close ties with employers and other workforce partners, fostering worker mobility. Employers, too, have spurred and managed large career initiatives for entry-level health care employees; among these employers are Tucson Medical Center, Partners HealthCare, the Truman Medical Center, Johns Hopkins Medical System, Hospital Corporation of America, and Evangelical Lutheran Good Samaritan Society.

PART III. A Framework for Developing the Entry-level Workforce in Health Care

The initiatives described in Part II stand out for supporting workforce development that leads to mobility for health care workers, while building the capacity of employers and providers across the workforce system to sustain such development. The most promising of the efforts, JFF's research suggests, appear to make the workplace more supportive of learning, and education and training organizations more supportive of workers. While this is not a hard and fast distinction, it suggests different emphases, as well as different primary actors.

JFF has developed a framework for analyzing such investments in the entry-level health care workforce. This framework rests on two sets of observations about promising work in the health care sector *(see Figure 1)*.

Developing the Skills and Knowledge of Individuals: The lines between businesses and their education and training partners are blurring.

Learning-friendly workplaces: ladders to better jobs

Learning-friendly workplaces create formal "career ladders" for advancing worker skills step by step and compensating a person accordingly. They also foster an informal culture that supports education as central to the experience of work. And they help motivate workers to invest in their own education and remain with an employer, with the knowledge that their job offers a way up rather than a dead end.

Work-friendly education: bridges to higher skills

Work-friendly education is fostered by offering training in a time, place, and manner that dovetail with entry-level health care employment, creating "bridges" that connect education more effectively to the world of entry-level work. Work-friendly educational institutions and training programs enable employees with scarce time and considerable family obligations to attain credentials that are valued and recognized in the labor market. Child care, transportation, counseling, and other supports help them overcome barriers to balancing work and family life.

Building Workplace and Systems Capacity: As projects mature and grow, they are supported by changes in organizations and in broader systems.

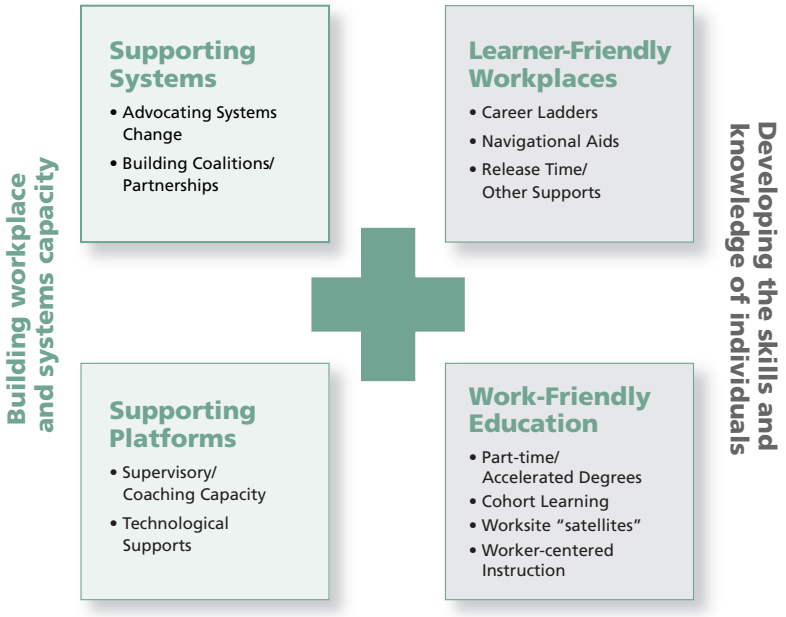
Platforms for workforce development: change the workplace, not just the worker

Health care employers are building "platforms" that can sustain entry-level worker development. These innovations may include training managers and supervisors in skills that help them coach their staff better, promoting experienced workers to positions as mentors of new staff, and creating work roles or team structures that encourage the use of higher skills. In some cases, employers use technological innovations, such as distance learning, to support worker development.

Superstructures: building a support system for workforce development

When health care employers and other stakeholders collaborate to adopt new practices, support them financially, and encourage their expansion and replication, they create "superstructures," or cross-firm support systems. Partners in these superstructures can include colleges, unions, community-based organizations, Workforce Investment Boards, career centers, and other state and local government agencies. These partnerships help to address the root causes of turnover, staffing shortages, and other problems. They also address public policy to develop resources for workforce development, organize support for better wages

Figure 1. A Framework for Health Care Workforce Development



and working conditions, and press for regulatory changes and reforms in workplaces and training institutions.

The categories in the framework offer a way of understanding the particular emphasis of an intervention, as well as a set of criteria for assessing program quality and determining which supports promote success at meeting those criteria. The lines separating these categories of activity are not rigid. Clearly, many major initiatives in hospital systems, nursing homes, community clinics, and home health agencies draw on multiple dimensions. Indeed, the most effective models engage in activities in some or all of the categories and actively relate them to one another. A survey of workforce efforts in health came to a similar conclusion, noting the value emerging from mutually reinforcing practices: promoting individual career growth, creating structures to promote informal learning, and using technology and external partners to support learning (Adler et al. 2004).

Learning-friendly Workplaces: Ladders to Better Jobs

Health care employers that are "learning friendly" provide their employees with the resources to advance to higher-wage and higher-skill jobs. These approaches take several forms. The most visible are formal "ladders" that provide structured paths from one job to another—or within the wider labor market and educational system—and inform individuals how to progress up them. For example, workers advance along specialized tiers or "rungs" that correspond to the mastery of particular skills in the nursing homes participating in Massachusetts' Extended Care Career Ladder Initiative and in the hospitals engaged with the Department of Labor-funded Career Lattice apprenticeships for CNAs. These skills might be care of the dying or memory impaired, restorative care and rehabilitation, or mentoring and leadership of less experienced peers. Incremental wage increases, as well as changes in job descriptions and duties, come with each step. Other ladders extend across occupational areas (e.g., nurse aide to recreational aide) or upwards from paraprofessional to professional, credentialed roles (e.g., CNA to LPN to RN).

Workforce innovators are also extending ladders into the community, where lower-skilled workers are recruited and trained, placed in entry-level positions, and provided with services to help them retain their jobs and move along a career path. Project SEARCH, associated with Cincinnati Children's Hospital and the Great Oaks Institute, has created ladders that are open to highly disadvantaged workers—including those with disabilities, as well as low-skilled and low-income candidates more generally. The Baltimore Alliance for Careers in Healthcare is implementing a "pre-allied health bridge program" to provides literacy and basic skills courses leading to placement in jobs and potential for further career advancement. Boston's Health Care Research and Training Institute, a collaboration of teaching hospitals, community colleges, and community-based organizations, recruits community residents, as well as incumbent workers, to ladders in clinical, administrative, and technician tracks.

Two approaches to creating learning-friendly workplaces predominate: *career navigation assistance* and a variety of *support services*.

Career Navigation

Learning-friendly workplaces provide entry-level workers with considerable aids for career navigation, including skills assessment, job counseling, and job coaching. Such workforce services are especially important for lower-skilled workers, who may never have imagined the possibility of advancing to higher-skilled positions and who lack basic information or tools on how to get there. Experienced coaches can not only provide information on jobs but also assist workers in organizing their working and personal lives to accommodate studies. In Tacoma, Washington, the region's Workforce Development Council leads an initiative that has partnered with employers to place job counselors in local hospitals for one to two days per week.

Navigational aids—"maps"—support these efforts by making potential moves and training requirements more visible. For workers at Clarian Health Partners in Indianapolis, the Career Quest program combines career advising with the visual assistance of a map of possible courses and a "passport" for documenting the courses taken (Adler et al. 2004). Similarly, the Career Advancement System for Cape Cod Hospital maintains a worker handbook, updated annually, that sets out jobs, qualifications, and opportunities for upgrading skills on site or at a community college.

Supports for Attendance, Financing, and Balancing Work and Family Life

Administrative and personal supports for work-based advancement are proven components for aiding learning. These supports include flexible schedules, release time to attend trainings or classes, and assistance with transportation, child care, and life issues ranging from ailing family members, to substance abuse, to domestic violence. Also critical are arrangements for tuition assistance, whether provided up front, offered as loans, or as reimbursements. Learning-friendly workplaces are also aggressive in helping students identify outside sources of tuition assistance (e.g., federal grants or loans) for completing degree and certification programs. Exemplary models, such as Cooperative Home Care Associates, an employer of home health aides in the Bronx, recognize that retention and advancement are not single steps but what CHCA calls "a series of small transitions," some less predicable than others. CHCA provides structured supports such as employment counseling, supportive supervision, and peer mentors (National Clearinghouse on the Direct Care Workforce n.d.).

Results: Learning-friendly Workplaces

Extended Care Career Ladders Initiative: At nursing facilities participating in the first three years of the initiative, the median job vacancy rate fell from 10.8 percent to 1.4 percent, compared to a decline from 15.4 percent to 7.1 percent for all long-term care facilities (Singh 2004).

Health Care Research and Training Institute: 91 percent of supervisors report better job performance, communications, and customer service skills among their entry-level staff (Jamaica Plain Neighborhood Development Corporation 2002).

Work-friendly Education: Bridges to Higher Skills

Postsecondary credentials provide one of the surest routes to a family-sustaining wage (Grubb 2001, Crosby 2003). But gaining those credentials can be difficult for a person in a low-wage job, raising a family, and lacking the prerequisites to enter college.

Part-time and Accelerated Acquisition of Credentials

Community colleges have a long history of offering customized training for employers, including those with lower-skilled workforces, and many offer basic or remedial education that prepares individuals to study toward a degree or other credential. However, community colleges are beginning to learn how to help low-skilled learners to make the transition from one part of the institution to another. A growing number of community colleges—and other organizations as well—are responding with flexibility and other innovations that meet worker and employer needs to improve the paths to health care credentials.

Community College of Denver and the Philadelphia-based Training and Upgrading Fund of District 1199C (American Federation of State, County and Municipal Employees) offer nationally recognized and demonstrably work-friendly programs (Goldberger 2005). Each culminates with a Licensed Practical Nursing credential and enrolls students whose incomes, academic background, or life circumstances might seem to prevent such achievement. Both are part-time programs with evening and weekend classes. CCD offers courses at the participating hospitals and nursing facilities and draws students from the ranks of nursing assistants and administrative, dietary, and housekeeping staff. The Philadelphia "Practical Nursing" program takes place at the union's training facility, the Breslin Center, as well as at the facilities of health care employers who contribute to the training fund.

Both programs are distinguished by the depth of academic and counseling support they offer to ensure student success, even for those with very low skill levels. Entering students typically begin with preparatory classes to raise math and reading levels to meet program standards, as well as self-paced basic education, including ESL if necessary. They also receive group tutoring and assistance in such areas as test taking and study skills.

A key to the work-friendliness of such programs is their customization for incumbent workers. Part-time LPN students in Denver Community College's "Learning Lab"

progress into college-level work in half the time normally demanded for developmental education.

Learning with a Cohort

"Cohorts" offer a community of peer support among groups of learners who may have been out of school for many years or who have had negative educational experiences. Small classes, allowing personalized instruction and progression with a single, cohesive group, contribute to high success rates for students in AFSCME's training program in Philadelphia. The University of Chicago Hospital offers a lengthy continuum of health certificate and degree programs in association with two- and four-year colleges, with each program geared to movement with one's cohort of peers. Research conducted at the hospital found that 90 percent of those participating in degree programs through cohorts retained their jobs two years after degree completion, compared to 50 percent for those progressing independently (using only tuition assistance) (Adler et al. 2004).

Workplace Satellites

Some health care institutions go a step further with worksite courses by creating satellite campuses tailored to the entry-level workforce. As part of the Extended Care Career Ladders Initiative, Genesis HealthCare, a national chain of long-term and rehabilitative care providers with facilities in western Massachusetts, and the InterCare Alliance, a consortium of nonprofit care facilities in the Worcester region, have partnered with community colleges to establish part-time, on-site, LPN programs for lower-level staff. Common to both programs is the participation of WorkSource Partners, a Boston-based intermediary that helps educators make their programs worker friendly. WorkSource provides program design, career coaching, and case management services that prepare participants for rigorous college-level studies. This model of health care training—dubbed "Regional Advancement Centers"—aggregates student demand for education from consortia of nursing homes in selected regions. The result is a large enough scale to make satellite nursing programs feasible (Goldberger 2005).

Worker-friendly Instruction and Curricula

In worker-friendly education, curricula and pedagogy are suited to non-traditional learners. Cooperative Home Care Associates and its research and advocacy partner, the Paraprofessional Health Care Institute, prepare home health care workers through "learner centered" approaches that stress experience, interactive learning that uses role plays and case studies, and coaching-based methods of supervision that engage workers in solving performance problems (National Clearinghouse on the Direct Care Workforce n.d.). Also valuable are curricula that ground English for speakers of other languages in the experience and vocabulary of health care of work. One of the more notable cases is the vocational ESL program of Cabrillo College, which includes introduction to health careers, modules based on specific health care tasks, and connections to Certified Nursing Assistant and home health care certification (Chisman and Spangenberg 2005).

Results: Worker-friendly Education

Worcester's InterCare Alliance: Initial graduation rates for its LPN program and "Educational Bridge Program" were 75 percent, compared to a normal rate of 50 percent at the participating community college's practical nursing program (Singh 2005).

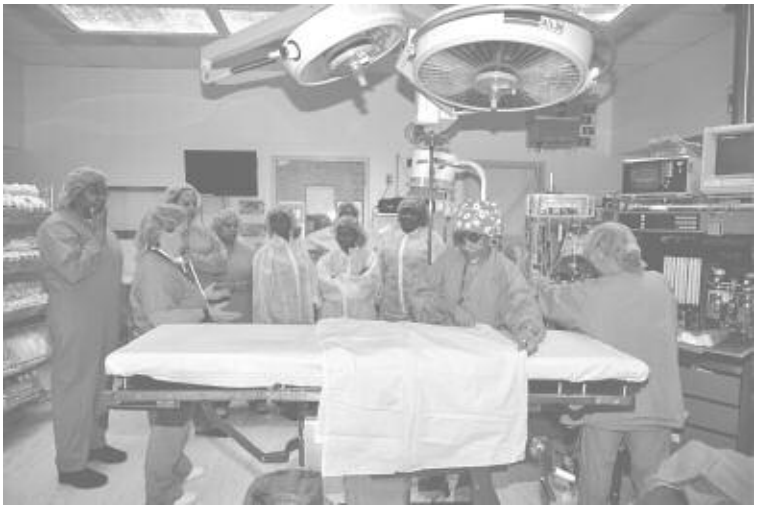
Local 1199C: Philadelphia-area employees enrolled in the Practical Nursing course completed the program at higher-than-average rates; 37 out of 45 participating nurse aides at one of the nursing facilities completed it (Goldberger 2005).

Platforms for Workforce Development: Change the Workplace

A clear lesson is emerging from diverse efforts to upgrade the entry-level health care workforce: to build platforms for workforce development, change must occur at the company level, not just for individual workers. Such platforms comprise rules, practices, and behavioral norms that support investments in improving the skills of, and advancement opportunities for, lower-skilled workers.

At the simplest level, an employer who wishes to utilize an employee's new skills and knowledge to improve care should reexamine the organization and management of the workplace. The job descriptions, expectations, and rewards for entry-level workers and their supervisors will change because the nature and scale of staff education rarely fit within the traditional structures of health care enterprises. This is especially the case for long-term care facilities, where nurse aides typically have little or no formal training beyond 12 hours per year of required "in-service" sessions (often limited to safety procedures). Such employers may have a single staff educator who has myriad other clinical and administrative duties. Moreover, career ladders, partnerships with community colleges, and new instruction or assessment technologies place new demands on organizational capacities for these employers.

For health care employers, the task of erecting platforms to support on-the-job learning is both cultural and strategic. First of all, it means addressing the norms of what is expected of people who work for a given hospital, nursing home, or other health care provider. Moreover, as the Center for Adult and Experiential Learning notes, a "comprehensive approach" to employee education recognizes "the important strategic role of employee learning and development in supporting organizational change goals and in providing opportunities for employees to maximize their potential." In this view, learning is "fully integrated into the environment and endorsed as a factor in all activities, including individual performance and advancement, retaining and recruiting staff, implementing new management structures, preparing for new facilities and equipment, improving processes, and cutting costs" (Adler et al. 2004). CAEL, which surveys health care employment practices, also found that comprehensive approaches to workforce development make an organization an "employer of choice," valued by workers as well as others, including patients.



Creating Supervisory and Coaching Capacity

Staff capacity to support learning-friendly practices is a critical component of a platform for workforce development. In Boston, Partners in Career and Workforce Development supports workplace change by recognizing certain managers and supervisors as "Workforce Champions." They recruit entry-level workers to the program, provide pre-employment internships, and hire participants. Employers recognize the champions for their efforts to coach and mentor staff and assist those preparing for school with skills in balancing work, family, and studies (Tolpin interview 2005).

At nursing homes and hospitals assisted by WorkSource Partners, entry-level workers are prepared for taking educational steps through carefully structured coaching and career planning. WorkSource provides a template for incorporating these services into the everyday operations of health care workplaces. The template includes outreach to and prescreening of candidates, one-on-one sessions between coaches and candidates to develop career advancement plans, and ongoing coaching to assist with academic needs, life issues, and attendance monitoring (Green and Griffen 2004, Goldberger 2005).

At Johns Hopkins Medical Systems and other hospitals affiliated with the Baltimore Alliance for Health Careers, career coaches help workers create career plans and understand the range of education and training alternatives that their employers offer. The coaches also serve as troubleshooters, case managers, and mediators, connecting with supervisors to resolve problems (Cromwell 2005).

Technological Supports

Technology can be another vital component of the organizational platform. Distance learning, computerized assessment and instructional programs, and other innovations have helped increase the capacity of hospitals and nursing facilities to upgrade incumbent workers and advance lower-skilled recruits. This has been particularly valuable in workplaces that are units of geographically far-flung organizations, as is the case with some nursing home chains. The Evangelical Lutheran Good Samaritan Society, a long-term care provider headquartered in South Dakota, developed its Distance Learning Network to transmit courses to 24,000 staff in 25 states through satellite broadcasting and an in-house studio (Adler et al. 2004). Several hundred learning events are available at a given time, including academic courses, workplace-focused skill instruction, and management courses.

The Distance Learning Network is integral to the society's Growing Our Own program, which prepares CNAs through apprenticeship programs and educates internal candidates for Associate's degree and Registered Nursing status. Students take general education and prerequisite courses online or through the network, while performing clinical lab requirements at their nursing facilities. Use of the network doubled from 2002 to 2003, from over 12,000 to nearly 24,000 users a year.

School At Work. One of the most ambitious applications of technology is School At Work/Building a Career in Healthcare, developed by a private company, Catalyst Learning, in cooperation with Anne Arundel Community College in Maryland. This program prepares entry-level workers for medical programs at community and technical colleges. It combines Internet-based courses, live television broadcasts with an instructor, and classroom-based pedagogy. It includes both basic skills training (math, reading, writing, computer use) and academic and occupational topics, such as anatomy and medical terminology. Typical School At Work students are employed in such areas as admissions, dietary, environmental service, housekeeping, or nursing assistance.

The development of the program was assisted by grants from the U.S. Department of Labor's High Growth Job Training Initiative. Over the course of the grants, participating hospitals have increased their share of funding for curricula, satellite and DVD equipment, and a site coach to facilitate implementation. The coach is usually a hospital staff educator or human resources employee but in some cases a consultant or community college staffer (Gilstrap interview 2005).

Kentucky Employability Certificates/WorkKeys. Kentucky has enabled health care employers to build their capacities for assessing worker skills and training needs and advancing workers. Kentucky Employability Certificates can be granted on the basis of WorkKeys, a computerized skills assessment tool. State workforce officials, in cooperation with Owensboro Community and Technical College, introduced Owensboro Medical Health Systems of Kentucky to WorkKeys, which is offered by ACT, a national testing and educational technology provider.

Hospital managers found that WorkKeys met their needs for an assessment tool better than other tests that were more narrowly focused on manufacturing. Moreover, its scoring system was easier for managers and directors to use. The hospital developed a combination of assessment and targeted instruction in cooperation with Kentucky's Department of Adult Education and Literacy and the community college. Seeded by the department's Alliance Grants, the program enabled the hospital to create a 24-hour, computerized laboratory for self-paced study and testing. Employees initially focus on attaining certification in three areas measured in the WorkKeys assessment: applied mathematics, reading for information, and locating information. Those completing the tests receive a stipend of $250.

Owensboro Medical Health Systems has reported very good results. Employees feel more valued and supported for their educational efforts, according to the hospital's human resource director. Participation has been wide-ranging, from professionals, including RNs and physical therapists, to maintenance and food service workers. In four years, about 800 staff members have completed the assessment. Managers report that workers in lower-skill categories see their scores as "a sign that they should enter college for even greater career advancement," and the hospital has correspondingly increased its investment in tuition assistance (ACT WorkKeys Case Studies 2004, Cox interview 2005).

The virtue of this application of WorkKeys is not simply having a computerized assessment tool but its application in concert with a portable recognition of skill attainment. The assessment and state certification based on the test enable lower-skilled employees to demonstrate skills and apply for higher-level positions without first attaining degrees or technical credentials. The hospital's human resource director noted a variety of accomplishments: a

long-time groundskeeper who received a high math score was recruited to be a pharmacy technician; food and nutrition service workers parlayed new skills into jobs as business office assistants. Other workers moved to higher clinical rungs in the hospital.

Results: Workforce Platforms

Johns Hopkins Medical Systems: Preliminary studies have linked career coaching to a 21 percent improvement in employee retention (Cromwell 2005).

Owensboro Medical Health Systems: Turnover fell 32 percent, which managers attribute in part to computer-based assessment and instruction (Cox interview 2005).

Superstructures: Building a Support System for Workforce Development

The fourth dimension of workforce development in health care is the creation of "superstructures"— programs and practices that enhance the capacity of communities, regions, states, or the nation to advance lower-skilled workers. Health care is one of a number of sectors that have been the focus of large-scale workforce projects. While sectoral employment initiatives vary widely in their focus, scale, and strategies, they share an emphasis on systems reform that aims to: benefit a wider group of workers than those employed by a single firm; better integrate human services, economic development, and education and training; and organize employers to create common training standards and advancement opportunities (Dawson and Clark 1995, Elliot and King 1999, Giloth 2000).

Efforts to reform adult education and community college services on a large scale (e.g., so that non-credit coursework flows more seamlessly into credit-bearing and credential-earning programs) are an example of systems changes to support worker-friendly education. Other kinds of superstructures are programs to build sustainable financing for health care workforce intermediaries. Examples of this are the Bay Area Workforce Funding Collaborative and Boston's SkillWorks. Both pool public and philanthropic funds from a number of sources to support partnerships in health care.

As noted, employers need to make worker education and training the norm—part of the expected way of doing things—in order for investments in entry-level workers to take hold and yield long-term benefits to workers and employers. This is no less true for the workforce system as a whole. A critical dimension of building capacity at the system level lies in raising standards and expectations for investments in lower-skilled health care workers. This can be done by entering the policy arena through lobbying, community organizing, or other means. It can also be accomplished by establishing a business or nonprofit agency that serves as a regional model of good training, advancement, and compensation practices or by creating broad, sectoral partnerships that identify regional workforce problems in health care and organize public/private solutions to them.

Cooperative Home Care Associates and the Tacoma/Pierce County Health Services Career Council are two examples of the integration of these various approaches.

Cooperative Home Care Associates/ Paraprofessional Healthcare Institute: Advocating Systems Change

Based in the Bronx, New York, Cooperative Home Care Associates is a worker-owned enterprise dedicated to advancing low-wage, minority workers in home care, one of the nation's lowest-paying, but increasingly essential, health care fields. CHCA's founders believed that the home care industry could be changed by "aggressively intervening as an employer" (Clark and Dawson 1995). To that end, the company strives to be a model employer by providing more hours and higher wages that the industry norm; at the same time, it develops, applies, and disseminates good practices in screening, training, coaching, and upgrading home care workers.

Through the Paraprofessional Healthcare Institute, its research and policy arm, CHCA has also collaborated with other employers, unions, legislators, and patient advocates to raise reimbursement rates for home care workers and to support initiatives, including Massachusetts' ECCLI program, for linking better home-based and long-term care to better jobs for direct care workers.

CHCA has expanded its cooperative model in two ways:

- *Growth:* CHCA became the preferred contractor for a large home health care organization, Visiting Nurse Service of New York, by recruiting and employing over 500 aides and building a reputation for high-quality care

in the New York Metropolitan Area. Other contractors have followed suit, raising expectations for wages, work hours, and other standards for their subcontractors.

- *Replication:* The Paraprofessional Healthcare Institute has seeded home care cooperatives in Philadelphia, New Hampshire, and other regions.

Tacoma/Pierce County Health Services Career Council: Coalition-Builder for Change

Operating through the public education and training system, Washington State's Workforce Training and Education Coordination Board established a system of regional "skills panels" to address skill and worker shortages in health care and other rapidly growing industries. The board also provided seed funds to local Workforce Investment Boards to target key growth sectors and create employer-driven teams that identify workforce challenges and opportunities. Taking advantage of this system-level initiative is Tacoma/Pierce County's Health Services Career Council.

The impetus for the Health Services Career Council came from the region's Workforce Development Council, which had previously begun its own process of labor market analysis and planning. The WDC mobilized nine of the region's largest health care employers, as well as two- and four-year colleges, with a dual aim: ensuring that the supply of health care workers meets the industry's needs, and providing access and training to health care jobs for county residents.

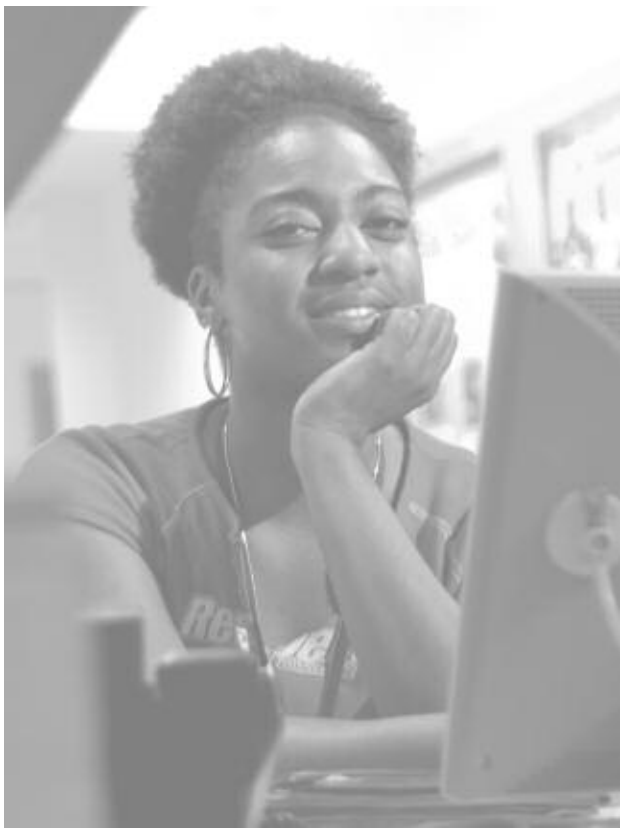
This broad coalition enabled a number of employers and educators to collaborate and plan strategically to solve workforce problems. It also identified strong leaders, including representatives from industry (e.g., from Good Samaritan Community Healthcare and Franciscan Health System) and education (e.g., Tacoma Community College's dean of workforce education). Health Services Career Council members also mobilized resources, through contributions and in-kind services from individual partners and through federal and state grants totaling almost $15 million. These efforts have helped the council to lower attrition rates in college LPN programs by enlisting retention counselors, support services, and tutoring services. Council members have also addressed faculty shortages in key health care disciplines, instituted distance learning, and stationed career counselors at participating hospitals (Nguyen interview 2005).

Employer partners attest to the benefits of collaborating in this process, including an increased supply of health care professionals (from both the ranks of incumbents and outside candidates, such as high school graduates, choosing to enter the field) and improved retention of employees.

Results: Systems-level Superstructures

Cooperative Home Care Associates: As a model business enterprise, CHCA has influenced the policies of other home care providers that are licensed partners with the Visiting Nurse Service of New York. Among its benchmark practices are guaranteeing full-time hours for aides, offering geographic-based assignment for services, reducing the travel time between cases, and strengthening the relationship among aides, supervising nurses, and patients (Inserra 2000).

Tacoma's Health Services Career Council: Colleges participating in the council have used retention counselors and other supports to help increase graduation rates in LPN programs, with completion rising from 53 percent to 90 percent (Nguyen interview 2005).



PART IV. Lessons for Advancing the Entry-level Workforce in Health Care

The four dimensions of JFF's framework for developing the entry-level workforce in health care suggest a variety of areas for practitioners and investors to focus their efforts to improve the quality of both health care work and health care delivery.

Lessons for Workforce Development Practitioners

The lessons for practitioners seeking to support the development of the entry-level workforce concern first of all two primary partners in such initiative: employers and educators. Large-scale, sustainable change will require cultural and structural changes on the part of both of these stakeholders. For employers, these changes will affect how jobs are structured and defined, as well as human resource policies that make workplaces learning-friendly. For educational institutions, they concern the way both developmental and occupational learning are conducted, making them accessible to workers and relevant to employers.

In addition, several areas appear critical to getting and maintaining the engagement of all partners in the development of the entry-level workforce. These include:

- Demonstrations of progress, through documenting activities and outcomes;
- Maintenance of confidentiality for both workers and employers; and
- The designation of one workforce service provider to be a conduit or "single point of contact" for employers.

Enlist and maintain employer commitment at multiple levels and times.

Few—if any—workforce development initiatives in health care succeed without the leadership of two key constituencies: high-level executives and lower-level managers and supervisors.

In the best cases, executives establish expectations and norms about the climate and direction of the workplace (Eaton 2001). This is particularly important in health care, where hierarchies can act as barriers to improving the jobs and supporting the advancement of entry-level staff. Executive leadership is also essential for investing resources in training and education, setting human resource policies, and encouraging middle managers and supervisors to implement them.

Yet executive commitment is far from sufficient. The field is littered with projects that began with strong support at the top but foundered due to inertia or even resistance by the supervisors of entry-level employees (Flynn 2005, Wilson et al. 2002). Enlisting supervisors is particularly critical because of their gateway function in encouraging staff development, recommending individuals for training, and allowing release time. Those who supervise clinical workers are often pressed to make hard choices about balancing long-term employee development with immediate needs for patient care. Thus, effective programs have demonstrated potential payoffs in terms of worker performance, morale, and satisfaction, while involving managers closely in program development and operations.

The Extended Care Career Ladders Initiative in Massachusetts has supplemented worker instruction with training for supervisors and managers. Other initiatives have tied manager performance evaluations and rewards directly to development of staff in their charge. Boston's Health Care Research and Training Institute learned the value of advising supervisors months before impending training; this eased the recruitment and enrollment process, while fostering greater trust and cooperation.

Also vital for the progress of the Health Care Research and Training Institute were multiple introductions or program "roll outs" to individual departments, using varied forms of communication (written and visual, individual and group-based). Restating the message helped to enlist and maintain managerial support, while informing new staff in cases of supervisory turnover. Leaders at Baltimore hospitals that engaged in a similar, multi-employer effort stressed the importance of top managerial participation in events such as trainee "graduations" to demonstrate the value of workforce investment to supervisors.

Finally, it is essential that managers at all levels understand the lengthy investments of time and effort necessary to advance individual workers while building the capacity of firms to support them. Evaluators for the Massachusetts-based program enabling expansion of the Health Care Research and Training Institute to seven sites noted that "it is critical not to oversell what training programs can accomplish in the short run" (Flynn 2005). (The institute subsequently grew to encompass eleven health care partners

through its participation in Boston's SkillWorks initiative.) This is especially true in health care, where entry-level workers face unusually steep advancement hurdles.

Enlist educational partners who respond to the needs of lower-skilled workers.

Enabling less-skilled workers to gain access to college-level health care credentials is made harder by institutions' competing missions (academic, developmental, vocational), as well as a lack of understanding or capacity to serve individuals with full-time or multiple jobs, families, and difficult lives. Yet some postsecondary institutions have succeeded in making education worker-friendly and the workplace learner-friendly. These include the Community College of Denver, with its part-time, worksite LPN program; Kentucky's Owensboro Community and Technical College, which assisted Medical Health Systems with adoption of a computer-based assessment tool; and Cabrillo College, a key partner in the Santa Cruz County Health Careers Partnership. Schools like these have deliberately made instruction in ESOL, pre-college health courses, or the attainment of Certified Nursing Assistant credentials a step toward further advancement rather than an end point.

Executive or senior leadership is critical for education partners as well as for employers. At Cabrillo College, for example, the dean for career education championed the Health Careers Partnership and the school's wider career ladders program, committing faculty and staff to program development, management, and instruction. The commitment of the president of Owensboro Community and Technical College to workforce and adult education was viewed as essential to the launch and use of Kentucky Employability Certificates in the medical sector (Chisman and Spangenberg 2005).

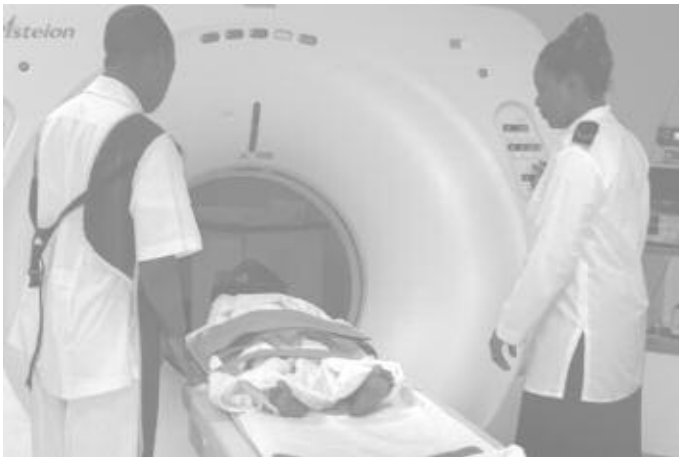
As important as executive leadership is a college's ability to marshal comprehensive supports (Liebowitz and Taylor 2004). These supports include skills and academic assessments, financial assistance, counseling, referrals, and other services that aid in retaining working students. But colleges also need the capacity to seek out and maintain partnerships with providers, such as community-based organizations, for help with child care, transportation, substance abuse, and other needs (Alssid et al. 2002). Some colleges blend these approaches, developing "integrated student support centers" that address both academic and personal challenges (KnowledgeWorks 2003).

Build in data collection from the start.

Assessments of progress (and mid-course corrections) are best served when participants create systems for collecting data and evaluation are part of an initiative's start-up plans. Practitioners of education and training need to demonstrate both short- and long-term benefits to all major stakeholders: workers, in the form of job retention, advancement, and family-supporting incomes; employers, through reduced turnover and vacancies, increased worker skill and motivation, and lower costs; and patients, through better care and health outcomes.

Progress in the field also depends upon documented progress in implementing training and adapting it to address barriers of individual skill, organizational operations, and partner commitment, as well as progress on "systems-level" issues, such as professional accreditation requirements and the supply of faculty. As one criteria for an "exemplary" health care provider, the Council for Adult and Experiential Learning cites the use of data collection and analysis to monitor progress in training and related areas and to pursue continuous improvement (Adler et al. 2004).

A notable documentation effort is Aspen Foundation's Business Value Assessment group, comprising both training programs and business clients engaged in sectoral employment initiatives, including Boston's Partners HealthCare, Tucson Medical Center, and Home Care Associates of Philadelphia. These partners have defined and collected "return on investment" data to assess how well programs meet employer needs. The framework



developed by the BVA group reflects employers' desire to know how well programs improve retention, productivity, and product quality, as well as to know about employees' "soft skills"—information not captured by typical data systems. BVA questionnaires, indicators, and other means of assessment also help gauge employers' costs of participating in workforce development (Blair 2005).

Maintain confidentiality for both workers and employers.

Clear rules about confidentiality protect workers and build and maintain their trust in a program and in providers. Assessments of workers' skills and aptitudes, as well as counseling about career development, place individuals in a vulnerable position. Workers may fear that their test scores, if low, could put their jobs at risk. Those insecure about their level of literacy or proficiency in spoken English can be especially protective of their privacy. Others expressing interest in movement to jobs in new departments or organizations may wish to keep such information from their supervisors. These concerns may be magnified when supervisors, rather than external professionals, assume the role of career coaches. And sessions with outside trainers, counselors, or other workforce staff may prompt critical discussion of sensitive workplace and organization-wide issues.

Discretion is no less important when competing employers collaborate in multi-partner training initiatives. Workforce providers must understand each employer's workforce challenges and the organizational context underlying them. This requires candid information sharing on both worker performance and corporate practices. Organizers of the Health Care Research and Training Institute maintain confidentiality within participating organizations, follow ground rules that allow brainstorming at joint meetings, and reserve decisions on internal matters for individual sessions (Jamaica Plain Neighborhood Development Corporation 2002).

Create a single point of contact for service providers.

Programs that recruit pre-employment candidates from the community illustrate an important organizational lesson: the value of maintaining a single point of contact for community-based organizations seeking to place candidates into health care workplaces with career path programs. At Boston's Health Care Research and Training Institute and Partners in Career and Workforce Development, one CBO serves each participating hospital and interacts with other workforce development providers in the participating neighborhoods. This structure streamlines recruitment and referral and helps to broker and coordinate vendor services more effectively.

Lessons for Investors

If commitment by executives and managers is essential to the daily operation of workforce projects in health care, it is equally critical for investors wishing to support such efforts over the long term. The programs studied by JFF reveal that such commitment must be patient, deep, and broad, fostering the growth of capacity in both workplaces and in the network of workforce development providers.

Reliable, multi-year funding streams are essential.

The scale and accomplishments noted in this report did not occur overnight. In some cases, employer partners and their counterparts in workforce development spent years getting to know and trust one another, setting ground rules for collaboration, addressing confidentiality concerns, and moving from broad goals or targets to specific training activities. A recurring issue has been the accommodation of differing human resource systems and, in the case of employers and workforce providers, distinct funding cycles, management styles, and terminology. Equally important to effective partnerships has been mutual can-

dor and recognition of differing as well as overlapping interests: workers (and sometimes organized labor) and managers; community-based organizations advocating for neighborhood residents and employers focused on incumbent training; multiple employers targeting a finite group of skilled candidates; and career ladder champions and professional or accreditation boards concerned about scope of practice.

Nor is the task of building learning-friendly workplaces and worker-friendly education cheap. The bottom line includes startup costs for creating working partnerships, the time required to shake out program activities, vendor relationships, and curricula, and many other expenses in the implementation and operational phases. Common to every significant initiative is a period of adaptation to barriers, experience, and changing conditions. Also common is the time required to get top and mid-level managers committed and ensure buy in from supervisory staff. Partners and investors need to budget for the staff time of communication, including time for establishing systems of communication among partners and ensuring the coordination of divisions within a workplace or within a community college or other training entities.

Projects that begin with significant, multi-year funding commitments—rather than being tied to one-year grants or legislative calendars—are better prepared to navigate such challenges. This also allows time for workforce intermediaries to develop a track record and demonstrate a return on investment to employers, while maintaining relationships with employers and their staff (Flynn 2005). It thus makes for a smoother transition to sustainable, long-term investments by the employers themselves.

Remediation may require additional investment, as could the need to address low self-confidence and fear of failure.

Less-educated workers in health care face a steep learning curve in order to advance. A common experience in workforce development efforts, whether in hospital partnerships, nursing home interventions, or college-based projects, has been unexpectedly low skill levels among entry-level workers. Meeting training goals has been complicated by low academic skills, including English proficiency, literacy, math, and study skills. This has been of particular importance when the objective is moving less-skilled staff toward the acquisition of college credentials, such as an LPN, allied health, or technician credential. Deep remediation needs have also forced practitioners to reach across "silos" (e.g., those separating workforce development from adult education) and consider new ways to blend curricula, instructional methods, and funding streams. Remediation concerns also have placed a premium on career coaching and other practices that identify educational barriers.

The very real barriers, both educational and personal, faced by entry-level workers have led some practitioners and investors to scale back their expectations of advancement, or even to believe that only a few low-skill workers can rise to licensed or credentialed positions. Granted, the road is long and not for everyone, yet evidence from the projects described here and elsewhere in the field shows that—with enough effort and support—many entry-level health care workers defy pessimistic forecasts. Career ladder and grow-your-own-workforce projects, by themselves, are unlikely to satisfy the demand for Registered Nurses, pharmacists, and other health professionals, but they have demonstrated the potential to make a significant contribution to doing so.

The most promising projects have addressed workers' barriers of skill, confidence, and knowledge of careers with a dual focus on instruction and career support. Until recently, most workforce development efforts—both in community organizations and within workplaces—focused narrowly on instruction, at the expense of practices that supported worker advancement and retention. Missing were "navigational aids," including coaching, career path diagrams, job shadowing, and mentoring. Among the lessons touted by the Health Care Research and Training Institute is that these aids—in concert with training—offer greater impact for the entry-level workforce and their employers than does training alone (Jamaica Plain Neighborhood Development Corporation 2002).

Invest in building the workforce development capacity of employers and of workforce intermediaries.

The most effective initiatives have multiplied the capacity of both sides of the labor market—employers and job seekers—to develop the workforce. To achieve sustainable change, investors in workforce development need to foster organizations and systems change. On the employer side, the long-term care intervention exemplified by the Extended Care Career Ladders Initiative has shown the importance of a staff development coordinator or similar person to program success (Wilson et al. 2002). The coordinator both champions investments in entry-level staff and provides a trusted conduit of information between more senior management and entry-level and frontline staff.

Smaller health care providers—in particular, nursing homes and home health agencies—typically lack the expertise or resources that enable large hospitals, for example, to provide comprehensive human resources services. With less specialized staffing structures, one person—often an administrator or nursing director—may wear multiple hats, including human resources. Moreover, even major health systems are not in the business of workforce development. For this reason, agile organizations attuned to both sides of the labor market (e.g., WorkSource Partners, the Paraprofessional Healthcare Institute, the Tacoma Workforce Development Council) are invaluable assets for small and large health care providers alike.

Yet the capacity of these workforce intermediaries is limited as well. Greater investment is required in expanding their services and replicating their models. At the same time, employers are wisely looking ahead to enhancing their in-house capacities. One such partnership, whose members have worked extensively with WorkSource Partners, opted to "move to a more sustainable model where career planning was done in-house," while retaining WorkSource as consultants if special needs or interests arose (Nemeth 2005). Grantees in the Casey Foundation's Better Jobs, Better Care demonstration underscored the importance of strengthening the leadership and management skills of frontline nurse-supervisors in long-term care facilities, calling them the lynchpin in making lasting change in the direct care work environment (Institute for the Future of Aging Services 2005).

Invest in data collection to determine the return on investments.

To make an effective business case for development of the entry-level workforce, health care employers need hard data, based on rigorous methods, for measuring costs, benefits, and outcomes. Such data is lacking in the field of health care workforce development, although efforts such as Aspen's Business Value Assessment, noted above, are a promising start. The absence of convincing data inhibits the spread of promising practices throughout the field, as well as within health care enterprises.

Investors can make an important contribution by providing needed resources to support systematic data collection, analysis, and reporting. Such resources could include technical assistance as well as direct funding. In addition, data collection should be made a condition for receiving grant support for workforce development in health care.

Achieving large scale is possible.

Most workforce development activities in health care are small in scale. Hospitals and other health care employers maintain staff education capacities to teach entry-level and more advanced workers about legal requirements, safety issues, and the like. Community-based organizations and larger national nonprofits maintain programs to train Certified Nursing Assistants, sometimes in cooperation with workforce boards. This is important, necessary work, and it goes on largely under the radar nationwide. However, almost all of the larger, more experimental programs JFF identified are islands, with little connection to similar ones in other institutions or regions. Focused, long-term investments in the skills and education of the entry-level workforce remain the exception, not the rule. And when such investments occur, they are more likely to be in a single hospital or nursing home, for example, than in citywide or regional consortia.

That said, the examples listed here, and dozens of others, speak to the emergence of complex, multi-partner demonstrations that are mature enough to have shown results and evolved—adding partners, shedding others; adapting to changing labor markets, funding streams, and operational challenges; and even taking small programs and practices to a significantly larger scale. Even more important, initiatives that operate across workplaces are becoming more common. In Massachusetts, the Extended Care Career Ladder Initiative has expanded over five years to encompass one in four of the state's nursing homes and over 10 percent of its home health agencies. Over half of Boston's major teaching and research hospitals are involved in extensive career ladder initiatives for incumbent workers and new recruits from the community. Over time, demonstrated return on investment has helped convince employers to maintain and even increase their commitment. The hospitals in the Health Care Research and Training Institute have increased their contributions toward funding from about 10 percent of program costs to at least 40 percent.

Such achievements attract employers to partnerships, and they also prompt other organizations to adopt good practices. The success of Tacoma's Health Careers skill panel, and its decision to locate Workforce Development Council career specialists on site in partner hospitals, helped lead to the model's adoption by the Seattle/King County's Workforce Development Council. Architects of the Baltimore Alliance for Careers in Health Care looked to St. Paul's East Metro Health Careers Institute, as well as to Boston's Health Care Research and Training Institute, for models of organization and practice.

These instances suggest directions for funders seeking to bring high-leverage practices and effective model to scale. One is to continue the "mapping" begun here of identifying health care employers and partnerships in several regions that have demonstrated scaleable practices and touting them as exemplary models to the field. Building on this, investors could benchmark individual models and their components and help other employers and educators to adapt them to their own organizations. Finally, as learning-friendly workplaces and worker-friendly education practices emerge, their experiences should be documented, analyzed, and widely disseminated throughout the health care and workforce development systems.

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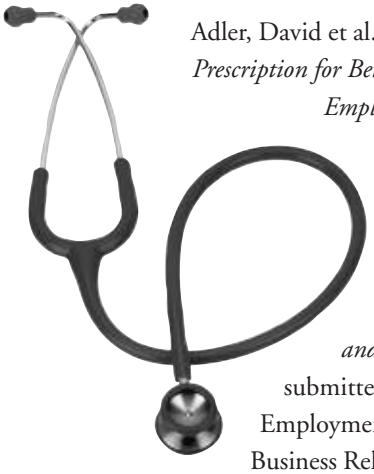

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Interviews

The following individuals were interviewed by Laura Dowd and Randall Wilson between August and December 2005.

Tony Bohn, Human Resource Director, Baptist Hospital East, Louisville, KY

Joan Braconi, Director, Shirley Ware Education Center, Service Employees International Union, Local 250, Oakland, CA

Pamela Cox, Human Resources Director, Owensboro Medical Health System, Owensboro, KY

Barbara Edward, Education Specialist, Johns Hopkins Medical Institute, Baltimore, MD

Cindy Fiorella, Dean of Community, Workforce, and Economic Development, Owensboro Community and Technical College, Owensboro, KY

Brian Foley, Special Assistant to the President, Medical Education Center, Northern Virginia Community College, Springfield, VA

Peggy Frost, Assistant Director for Administration, Shirley Ware Education Center, SEIU Local 250, Oakland CA

Carol Gilstrap, School At Work Project Manager, Catalyst Learning, Louisville, KY

Hugh Hall, Chair, Workforce Development Committee, Rhode Island Health Care Association, Providence, RI

Parminder Jassal, Senior Associate, FutureWorks (formerly Project Director, Kentuckiana Healthcare Workforce Initiative), Belmont, MA

Deborah Knight-Kerr, Director of Community and Education Projects, Johns Hopkins Health System, Baltimore, MD

Lisa Morten, Director of Employment, Franciscan Health Care, Tacoma WA

Linda Nguyen, Planning and Development Manager, Tacoma-Pierce County Workforce Development Council, Tacoma, WA

Vincensa Petrilli, Assistant Director, Shirley Ware Education Center, Service Employees International Union, Local 250, Oakland CA

Cindy Price, Assistant Director, Human Resources, Jewish Hospital, Louisville KY

Debrah Rayman, Director of Workforce Development, Norton Health Care, Louisville, KY

Flo Richmond, Special Assistant to the President, Northern Virginia Community College, Medical Education Campus, Springfield, VA

Christine Rohmann, Human Resource Director, Kindred Healthcare, Louisville, KY

Mary Rosenthal, former Executive Director, East Metro Health Careers Institute, St. Paul, MN

Jack Salvadore, System Director of Organizational Development, Christus Health, Irving, TX

Marjorie Smelstor, Chief Acceleration Officer, Truman Medical Centers, Kansas City, MO

Jodi Smith, Director, Human Resources, Multi Health Care System, Tacoma, WA

Madeleine Thompson, Policy Analyst/Legislative Liaison for Washington State Workforce Training and Education Coordinating Board, Olympia, WA

Harriet Tolpin, Workforce Development Consultant, Partners in Careers and Workforce Development, Boston, MA

Laura Weidner, Executive Director, Continuing and Professional Programs, School of Continuing and Professional Studies, Ann Arundel Community College, Arnold, MD

APPENDIX
Projects and Organizations Cited

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Bay Area Workforce Funding Collaborative, San Francisco, CA
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Cooperative Home Care Associates, Paraprofessional Health Care Institute, New York, NY
www.paraprofessional.org

Council for Adult and Experiential Learning, Nursing Career Lattice apprenticeships, South Dakota, Maryland, Washington, Chicago, IL, Houston, TX
www.cael.org

East Metro Health Careers Institute, St. Paul, MN
www.vhahf.org/vhahf/communitywidecareerladders.pdf

Evangelical Lutheran Good Samaritan Society, Sioux Falls, SD
www.careerlattice.org

Extended Care Career Ladders Initiative, Massachusetts
www.commcorp.org/programs/eccli

Flint Healthcare Employment Opportunities, Flint, MI
www.flintstrive.com/healthcare.htm

Genesis HealthCare, Heritage Hall East, Agawam, MA
www.worksourcepartners.com/new/uploadDocs/Heritage.pdf

InterCare Alliance, Worcester, MA
www.worksourcepartners.com/new/uploadDocs/eccli-Intercare.pdf

Kentucky Employability Certificates/Work Keys, Owensboro Community and Technical College, Owensboro Medical Health Systems of Kentucky
www.act.org/workkeys/case/owensboro.html

Partners in Careers and Workforce Development, Boston, MA
www.partners.org/pcwd

Project SEARCH, Cincinnati Children's Hospital and the Great Oaks Institute, Cincinnati, OH
www.cincinnatichildrens.org/svc/alpha/p/search

Robert Wood Johnson Foundation, Better Jobs, Better Care, Princeton, NJ
www.bjbc.org

Santa Cruz Health Careers Partnership, Santa Cruz County, CA
www.cabrillo.edu

School At Work/Building a Career in Healthcare, Catalyst Learning, (Louisville, KY) Anne Arundel Community College, MD
www.schoolatwork.com

SkillWorks: Partners for a Productive Workforce, Boston, MA
www.skill-works.org

Tacoma/Pierce County Health Services Career Council, Tacoma, WA
www.workforcecollege.com

Training and Upgrading Fund of District 1199C (American Federation of State, County and Municipal Employees), Philadelphia, PA
www.1199ctraining.org

U.S. Center for Medicare and Medicaid Services, Systems Change Grants for Community Living, Washington, DC
www.cms.hhs.gov/realchoice

U.S. Department of Labor High Growth Training Initiative, Washington, DC
www.doleta.gov/BRG/JobTrainInitiative

WorkSource Partners, Boston, MA
www.worksourcepartners.com

Building the Workforce of the Future in Health Care

A capable, diverse health care workforce is critical to the health of all Americans. Increasingly, the most distinctive activities to create this workforce of the future are emerging through large, multi-sector partnerships, backed by public or private funders. JFF participates in such partnerships and supports initiatives that address two needs simultaneously:

- *Quality Care:* To meet the demand for high-quality health care, employers—hospitals, nursing homes, primary care centers, home care providers—depend upon a well-trained workforce at all levels, as well as a reliable "pipeline" of workers to fill vacancies and address shortages in critical jobs.
- *Opportunity for Advancement:* Health care offers potentially significant advancement opportunities for entry-level workers, including those providing direct care. These opportunities will continue for the foreseeable future, given the high demand for quality services, the difficulty of "exporting" many health care jobs, and the changing demographics in the workforce and the general population.

Jobs to Careers: Promoting Work-Based Learning for Quality Care seeks to change the way that health care employers train, advance, and reward frontline workers, contributing to improvements in care and service delivery. This four-year demonstration will fund up to 16 partnerships; a health care employer and an educational institution must be part of each partnership, which can also include unions, Workforce Investment Boards, and community agencies. JFF is the National Program Office for *Jobs to Careers*, an initiative of the Robert Wood Johnson Foundation, in collaboration with the Hitachi Foundation.

Investing in Workforce Intermediaries, launched by the Annie E. Casey, Ford, and Rockefeller foundations, is seeding a national support infrastructure for workforce partnerships. The funders have invested in five cities and one state: Austin, Baltimore, Boston, New York, Pennsylvania, and the San Francisco Bay Area. Partnerships in the project sites are improving access to good jobs in health care, improving the quality of these jobs, and helping employers and communities to create good jobs.

SkillWorks: Partners for a Productive Workforce, an *Investing in Workforce Intermediaries* site, is investing $13 million over five years in advocacy for the public policies and systemic infrastructure needed to support quality programming leading to long-term economic benefits for low-income, unemployed, and underemployed individuals in the Boston area. *SkillWorks,* a public/private funders collaborative, supports several intermediaries focused on health care.

Selected JFF Resources

Community Health Worker Advancement: A Research Summary (2006)

Creating Careers, Improving Care (2006)

Invisible No Longer: Advancing the Entry-level Workforce in Health Care (2006)

From the Entry Level to Licensed Practical Nurse: Four Case Studies of Career Ladders in Health Care (2005)

Creating Pathways to Advancement: A Manual for Project Developers (2004)

More information on *Building the Workforce of the Future in Health Care* is available on the JFF Web site, where all publications are available for downloading: www.jff.org

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