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LONG-TERM CARE FINANCING AND THE LONG-TERM CARE WORKFORCE CRISIS: CAUSES AND SOLUTIONS

Prepared for:

CITIZENS FOR LONG TERM CARE

BY

PARAPROFESSIONAL HEALTHCARE INSTITUTE

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INSIDE PANEL #1:

Representatives from the following organizations participated in the discussions that helped define this paper's "common ground". As the guiding forces behind the development of this paper they actively support and affirm its conclusions.

- AARP
- Alzheimer's Association
- American Association of Homes and Services for the Aging
- American Health Care Association
- American Network of Community Options and Resources
- The Arc of the United States
- Greater New York Hospital Association
- MetLife Insurance
- National Association for Home Care
- National Committee to Preserve Social Security and Medicare
- Service Employees International Union

Citizens For Long Term Care is a nonprofit coalition of long term care providers, consumer and patient advocates, insurers, workers and advocates for people with disabilities who seek to inform and educate policymakers about the need for long term care financing reform.

This report was commissioned by Citizens For Long Term Care from the Paraprofessional Healthcare Institute (PHI) of the South Bronx, New York, and written by PHI's president, Steven L. Dawson. PHI is a nonprofit health care employment and policy organization whose mission is to create both quality direct-care jobs and quality care within our nation's long-term care system. PHI also staffs the *National Clearinghouse on the Direct Care Workforce* at www.directcareclearinghouse.org

LETTER FROM THE CHAIRMAN

The release of this paper marks the third time that the very disparate leadership organizations involved in Citizens For Long Term Care have developed a paper that sets out "common ground" on an important long term care financing issue. Citizens, since its founding, has been, and continues to remain devoted to the cause of long term care financing reform. This paper is a departure from the previous two in that it deals not only with advancing the issue of financing reform, but also focuses on how the current financing system affects the current and future shortage of paraprofessional caregivers. We undertook this project because it is the first and most obvious consequence of how our flawed financing system affects the quality of care available to people in need.

This paper clearly shows that how long term care is financed has a direct impact on the number and quality of people engaged in the long term care workforce. The inability of providers to hire, train and retain paraprofessional workers in an industry that is highly dependent on these workers to deliver safe, thoughtful, and respectful care does not portend well for the future deliver of quality long term care. We must develop a financing system that enhances the ability of providers to hire and invest in a developing long term care workforce if we expect long term care providers to deliver quality care. The correlation between financing reform and solving the workforce crisis is clearly established in this paper.

I believe establishing the link between current long term care financing policies and the current and future "care gap" is the first step in making policymakers understand the need for long term care financing reform. Unless we develop a stable workforce that can be adequately compensated for the important care they give, systemic quality care will remain an illusory goal.

We hope in the future to further examine the impact of financing policy on quality care. This first effort unequivocally shows the need for a new national commitment to long term care financing reform in order to avert a growing workforce crisis. We encourage readers of this paper to join Citizens For Long Term Care in pushing for the development of a national dialogue on long term care financing reform. Without it we will not achieve a stable, experienced workforce committed to delivering outstanding care.

Sincerely,

Hon. David Durenberger, (United State Senate, MN, 1978-1995)
Chairman

INSIDE PANEL #2

In our publication "Defining Common Ground" (CLTC, 2000), Citizens For Long-Term Care articulated the core relationship within long-term care between our current financing system and the resulting quality of jobs and quality of care. We noted the widening gap between long-term care *demand* and direct-care worker *supply*. Therefore, this companion publication examines in greater depth the direct-care worker crisis.

Citizens For Long Term Care (CLTC) recognizes that an effective long-term care system relies upon a full complement of staff—ranging from general practitioner and specialist physicians, through registered and licensed practical nurses and paraprofessional aides and personal care attendants, as well as administrators and other program-based workers. All of these positions are essential to long-term care, and nearly all report troubling rates of vacancies and turnover.

For the purpose of the following analysis, CLTC focuses particularly on *paraprofessional* workers—home health aides, certified nurse aides, personal care attendants, and direct support professionals. We focus on paraprofessionals since they are so critical to long-term care consumers, yet historically they have received very little public policy attention. However, in this paper we do place these "front-line" workers within the context of the broader long-term care workforce, in particular comparing how the high rates of paraprofessional vacancies and turnover are similar to, yet different from, those also confronting professional nursing staff.

CLTC acknowledges the critical role that *professionals* play in the assessment, design, and delivery of long-term services and supports. We recognize also that the economic and career rewards for professionals working within the long-term care system are currently not at par with those working within our nation's acute care system. Yet, for America's most vulnerable people—those who are elderly, chronically ill, and people with disabilities—the work of the professional is equally critical in both settings. Therefore, CLTC intends to address in a later document the common ground role that long-term care financing reform must play in attracting and rewarding professional staff.

LONG-TERM CARE FINANCING AND THE LONG-TERM CARE WORKFORCE CRISIS: CAUSES AND SOLUTIONS

~ Executive Summary ~

INTRODUCTION

Nearly four million long-term care consumers rely in part or exclusively on paid caregivers. Nationwide, these "direct-care workers" include at least 2 million aides, personal assistance workers and direct support professionals, plus more than 500,000 nurses, who day and night provide support to those living in their homes, assisted living facilities, group homes and nursing facilities.

These front-line staff are the hands, voice, and face of long-term care; the human relationship between the consumer and his or her direct-care worker is at the very core of long-term care. Unfortunately, our nation's long-term care financing system is not designed around this essential relationship between the consumer and caregiver. Instead, policy makers have created a fragmented funding system, resulting too often in a direct-care workforce that is poorly paid, insufficiently trained, undervalued, and inadequately supported.

Although the financing system is only part of the cause, and thus only part of the solution, to the long-term care workforce crisis, Citizens For Long Term Care is deeply concerned about the interrelationship between our current financing system, the quality of direct-care jobs, and the resulting decline in long-term care availability. Since government sources of financing total approximately 62 percent of all long-term care dollars spent, this paper calls upon public policy makers to re-examine how the United States finances and structures long-term care services and support.

The Workforce Crisis

Long-term care jobs are so physically and emotionally challenging, and yet so poorly compensated, that nursing home providers and home care agencies across the country have recently documented unprecedented rates of vacancies and turn-over among direct-care staff—in turn impacting consumers by delaying access to care services. Similarly high rates of vacancies and turnover are depleting the ranks of our professional nursing staff as well. No wonder that our loved ones across the country ask with rising concern, "Who will care for us?"

Within an increasingly competitive labor market, direct-care jobs have become relatively unattractive. In 2000, the median wage of home care workers was $8.23 per hour, while the median wage of personal care workers was $7.50 per hour. Yet in comparison, many entry-level jobs offer a relatively attractive employment alternative, providing far safer, less physically and emotionally demanding work—and at higher pay: for example, the median U.S. wage for a file clerk was $8.99 per hour, while a receptionist was $9.63 per hour.

The typical direct-care job keeps many women working, and yet impoverished. The U.S. General Accounting Office (GAO) has documented that the median income of all nursing home direct-care staff was *$13,287 per year*, while the median income for all home-based direct-care staff was *just $12,265 per year*. Furthermore, health care personnel in general are losing health care coverage more quickly than other workers: today, according to a recent article in the American Journal of Public Health, "1.36 million health care workers provide care that they and their children cannot expect to receive."

Of even greater concern, however, is the future: Exacerbated by profound demographic changes, a "care gap" is emerging between the number of those requiring assistance and those available to provide that assistance. According to the U.S. Bureau of Labor Statistics, by 2010 *more than 780,000 additional aides must be found* to fill long-term care direct-staff positions, an increase of 39 percent over the year 2000. However, during the same ten-year period, the "traditional" source of such new long-term care workers—women aged 25 to 44 participating in the civilian workforce—is projected to grow by just 1.25 percent, an increase of *only 400,000 workers*.

Negative Impact on Consumers, Providers, and Workers

High rates of staff vacancies and turnover harm all three key stakeholders within the long-term care system: *consumers* (and their families), *providers*, and *workers*:

Impact on Consumers: Health care researchers have long noted the connection between the quality of direct-care jobs and the quality of services and support. A recent report to the Commonwealth Fund found that inadequate staffing, a lack of individualized care, and high nurse-aide turnover are key causes of malnutrition and dehydration affecting an estimated one-third of our nation's nursing home residents. Home care aides who "work short" (too few staff to serve a particular number of individuals) are able to offer only "drive-by home care" as they rush from one home to another.

Impact on Providers: Staff vacancies and high turnover have a significant impact on health-care employers. Long-term care services are by nature labor-intensive, and thus high turnover and vacancies can cause significant instability—both operationally and financially—for long-term care providers.

Impact on Workers: Spiraling vacancies and turnover can trigger a downward cycle of deteriorating job quality. With fewer co-workers to share the load, direct-care workers are less able to provide the level of service they know their clients require and deserve, which makes the job less personally satisfying.

The Absence of National Policy

In the absence of a thoughtful national policy, long-term care in the U.S. will remain a rickety structure of disparate finance sources, creating segregated funding "silos" containing an even more disparate array of program "silos within silos"—nursing home services funded distinctly from in-home services, which in turn are funded separately from personal assistance services, assisted-living, and residential-care services. Thus, our long-term care financing consists of a patchwork of programs that is unable to adapt to the needs of consumers, workers, or providers. Furthermore, segregated financing streams spur "cost shifting" between funders, encouraging federal and state programs to compete with each other to *avoid* paying for services.

To address the direct-care crisis, a *national* strategy—integrating both federal and state policy into a comprehensive system of long-term support and services—is essential. Both private and public insurance programs must be re-designed—increasing resources and consumer choice, while ensuring protections for both consumers and direct-care staff. Only a system designed around the relationship between the long-term care client and his or her worker will ensure both quality jobs for direct-care workers, and quality of service for long-term care consumers.

SUMMARY OF RECOMMENDATIONS

As demand for long-term support and services increases inexorably during the next decade—and the supply of traditional caregivers fails to keep pace—our nation must reform the way we finance long-term care in order to create decent jobs and in turn ensure access to affordable, quality care. In addition to financing care adequately, we must both make direct-care jobs more attractive and broaden the supply of workers:

Recommendation #1: Develop a National Commitment to Long-Term Care Financing

Citizens For Long Term Care has called for a national insurance commitment to long-term care financing based on a public-private financing model. This model would combine a social insurance benefit (provided as cash, and based on level of functional disability) with private long-term care insurance tax incentives, and reforms in both Medicaid and Medicare programs.

In CLTC's proposal, recipients could use a cash benefit as they needed, including for hiring family caregivers. These benefits would "follow the consumer" through the entire spectrum of long-term care services and supports, allowing him or her to move more freely and to maintain a consistent level of financial support, independent of setting.

CLTC recognizes that—although a new financing system based on a cash benefit, with appropriate safeguards to protect against fraud and abuse, could better serve both long-term care consumers and direct-care workers—a cash payment benefit may not be the best solution for all consumers. Furthermore, CLTC believes that protections for *both* consumers and workers must be built into any new system of finance.

Recommendation #2: Make Direct-Care Jobs Competitively Attractive

In order for direct-care employment to compete successfully within a tightening labor market—for either traditional or non-traditional direct-care recruits—the *quality of jobs must be substantially improved*. Therefore, Citizens For Long Term Care recommends that long-term care finance reform follow seven essential elements of a quality job:

A. **"Self-sufficient wages," health insurance, and other benefits:** The long-range goal for direct-care wages should be set toward "family self sufficiency," achieved incrementally, and adjusted for inflation Within five years, by 2007, all publicly and privately financed direct-care workers should earn a self-sufficiency income at least equal to that of a wage earner within a two-wage family of four. In addition, any new finance systems should allocate sufficient resources to providers so that they can pay health insurance to their own workers and their families, as well as vacation pay, sick pay, paid holidays, retirement benefits, and paid family medical leave.

B. **Balanced and safe workloads that offer full-time employment, but do not overwork employees:** For those seeking full-time employment, reimbursement should be structured so that paraprofessional jobs can offer a minimum of 35 hours per week without overuse of off-hour shifts. In facility-based care, inadequate numbers of staff can frequently require overtime shifts and can also lead to unsafe care. Overtime should be discouraged, and staffing levels should be increased and adequately funded.

C. **More appropriate training standards**: Providing care to vulnerable clients requires at times more formal and accredited training than 75 hours of instruction. Training credentials should be "portable," particularly for home health paraprofessionals, thus allowing flexibility when re-locating to another state. Paraprofessional entry-level and "continuous" training should be updated and expanded to reflect current care needs, clinical realities, and adult life-long learning techniques. However, within all recommendations on training, CLTC recognizes the right of self-directed consumers to educate their own personal assistance workers as they see fit.

D. **Job re-design, opportunity for advancement, and management "culture" re-design:** Paraprofessionals require a job design that recognizes their skills as well as their special knowledge of the client. Paraprofessionals should be made a central member of the care team—which is one essential element of changing the "culture" of the long-term care workplace. This in turn requires higher levels of effective supervision—including job-coaching and other approaches that emphasize problem-solving over disciplinary actions. Furthermore, potential workers must have access to career pathways to develop themselves and, over time, receive higher levels of compensation for higher levels of experience, skills, and responsibilities.

E. Employee supports: Employers should be encouraged to help stabilize the lives of their staff, for example, by helping to identify resources for affordable housing, child care assistance, and transportation benefits. Assisting in arranging for employee supports—often available by partnering with nonprofit and community-based organizations—can be undertaken in a "case management" like approach as a human resources responsibility. Such an individual-by-individual system of support recognizes both the multiple challenges of low-income workers' lives and the difficulties of their everyday, on-the-job responsibilities.

F. Improved use of technology: New and existing forms of technology—for example, monitoring devices and hand-held computers—can extend and expand the capacity of direct-care workers, without sacrificing the "high touch" nature of long-term care services. These devices can save steps, promote higher levels of accuracy (for example, in charting), and free direct-care workers to spend more time with consumers. Effective use of such assistive technology should be further explored and funded.

G. Full payment for accountability systems: Finally, whether using public or private financing, accountability for appropriate use of funds is essential when delivering long-term care services and support. Expenditures for quality assurance mechanisms and accountability systems must continue to be met. Therefore, the full costs of accounting for appropriate use of these funds—particularly clear accounting for expenditures on direct-care staff and including the cost of time required for filling out paperwork on-site—must be accommodated within any new financing system.

Recommendation #3: Broaden the Supply

To rely for new caregivers solely on young women entering the workforce, our "traditional caregivers," would be to ignore the emerging demographic realities of the American workforce. Therefore, Citizens For Long Term Care recommends that reform of our finance system should also follow five paths to increased supply:

A. Encourage younger individuals into direct-care. To retain a higher percentage of younger workers will require, among other factors, re-design of preparation, education, and supervision structures in order to provide greater and more consistent support. For outreach to younger workers, education programs in high schools and community colleges should be expanded to introduce students to the benefits of long-term care service.

B. Encourage older workers. To recruit and retain a higher percentage of older workers will require greater job-design flexibility—built around the capacities of older workers—increased staffing levels (to ensure more than one worker is available for lifting and transfer for those residents who require greater assistance), and increased availability of assistive mechanisms to aid in transfer.

C. **Encourage men to enter direct-care occupations**. Just as is true for attracting and retaining women into our long-term care system, competitive pay and benefits will be required to attract male workers away from other job options. Furthermore, the "work culture" of direct-care employment must be broadened in order to make males feel welcomed into the long-term care industry.

D. **Encourage those currently receiving public assistance.** Although some states have used Temporary Assistance to Needy Families (TANF) funds for successful "welfare-to-health care" employment programs, other states have directed welfare recipients and the unemployed *away* from long-term care employment. Therefore, public initiatives to encourage welfare-to-health care programs should be linked to efforts that re-structure direct-care jobs into self-sufficient, high-quality employment.

E. **Explore expanded immigration.** Significantly expanding the pool of direct-care workers through increased immigration should be carefully explored. However, the quality of direct-care employment must be substantially improved for all workers, including immigrants, before looking to new immigration programs. All those who work in direct-care positions should receive competitive wages and benefits and should be afforded opportunities for training and advancement.

   Immigration programs for health care professionals and paraprofessionals should include the same workers protections provided to citizen employees. Visas should provide a "path-to-permanence" and sponsorship portability allowing foreign-born workers to change employers while maintaining status. Special direct-care training programs for "New Americans" should be supported, ensuring greater cultural competence, and offering additional benefits such as English as a Second Language. In addition, U.S. immigration policy must avoid depleting the already thin ranks of trained health care workers within poorer nations.

   Finally, granting employment status to undocumented residents already living within the United States would likely expand access of those workers into formal direct-care work, and thus should be aggressively encouraged. Working with refugee populations entering the country under U.S. State Department supervision—many already having significant health care experience in their countries of origin—may be another important source of direct-care workers.

All five paths to increased supply will require close cooperation with our nation's education and training systems. For example, special direct-care scholarships should be designed, along with tuition reimbursements and loan forgiveness programs, for those who complete a specified length of service as direct-care staff.

CONCLUSION

Addressing the direct-care staffing crisis is not only a matter of public policy, it is also a matter of practical implementation. Each of the three key stakeholders in long-term care—providers, consumers, and workers—must consider new models of service delivery, and work cooperatively with one another to re-structure direct-care employment.

The frightening severity of the emerging Care Gap must not immobilize, but rather galvanize this nation into immediate action. To create true and lasting finance reform will in particular require leadership from federal political leaders, as well as from national leaders representing consumers, providers and workers. At stake are not only our loved ones, but also ourselves—the current and future consumers of long-term care services and support.

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~ Guiding Principles ~

Citizens For Long Term Care believes that the following principles must guide our nation's efforts to reform long-term care financing and address the emerging workforce crisis:

- The right of consumers to safe, responsive, quality supports is paramount to all else within the long-term care system.
- To improve the competitiveness of direct-care employment, the financing system must reimburse providers to allow them to implement the recommendations for making direct-care jobs competitively attractive and for broadening the supply of workers, as outlined above.
- Public financing programs should review their reimbursement structures and regulations, in order to maximize direct-care worker recruitment and retention. Such review should include input and guidance from consumers, providers and workers, and result in greater stability across the nation's system of long-term care.
- All financing sources should encourage parity of compensation across the various direct-care sectors, services and payers—ensuring, for example, that community-based workers earn comparable wages to workers who perform similar duties in other care settings. Those financing sources should also encourage portability of training and experience certificates across the long-term care sector.
- Where immediate implementation of CLTC's recommendations might prove too costly, long-term targets should be established and pursued, and demonstration programs testing their efficacy should be encouraged.
- Long-term care financing reform should balance both the rights of consumers in selecting and educating direct-care staff and the rights of workers to be respected, appropriately trained, and adequately supported.
- The right of workers to form and join their own union or association must be respected.

LONG-TERM CARE FINANCING AND THE LONG-TERM CARE WORKFORCE CRISIS: CAUSES AND SOLUTIONS

INTRODUCTION

Across the United States, nearly 13 million elderly, chronically ill, and people with disabilities require support and assistance—some to be transferred from bed to toilet and then to chair or wheel chair, some to be helped with personal care or meal preparation. Others individuals need help to prepare themselves for work or school, or to be accompanied to shopping or a social activity.[1]

The needs of people with disabilities range broadly, from help with just one "instrumental activity of daily living"[2] while living in the community, to total dependency on others while living in a long-term care facility. Although the majority in need of long-term care support are elderly, more than two-fifths—five million Americans—are under 65 years of age, including increasing numbers of younger persons with physical and mental disabilities (U.S. General Accounting Office, 2001a).

Most who require long-term services and supports for this crucial assistance rely on their family members, friends, and neighbors. Yet others, nearly four million individuals, rely in part or exclusively on paid workers for more formal sources of long-term support and assistance (Agency for Healthcare Research and Quality, 2001). Nationwide, these "direct-care workers" include at least two million aides, personal assistance workers, and direct support professionals—and more than 500,000 nurses—who each day provide support to those living in their homes, assisted living, group homes, and nursing facilities.

These front-line staff are the hands, voice, and face of long-term care. They are, simply stated, irreplaceable: Their hands cannot be substituted by a machine, nor their voices by a telephone, nor their faces by a computer monitor. Requiring thoughtful observation and skillful response, the human relationship between the consumer and his or her direct-care worker is at the very core of long-term care (Stone and Wiener, 2001).

The Role of Financing

Unfortunately, our nation's partial attempts at financing long-term care are not designed around this essential relationship between the consumer and caregiver. Rather, policy makers have created a bewildering cross-hatch of state, federal, and privately funded programs and services. This fragmented system contributes to a direct-care workforce that is too often poorly paid, insufficiently trained, undervalued, and inadequately supported.

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[1] Nearly one in five Americans—54 million people—report some level of disability, defined as having difficulty in performing functional tasks or daily living activities, or as having a learning or developmental disability (General Accounting Office, 2001a).

[2] "Instrumental Activities of Daily Living, IADLs, are tasks necessary for independent community living, including shopping, light housework, telephoning, money management, and meal preparation. IADLs are sometimes used to measure a person's need for assistance as a result of mental or cognitive disabilities" (Tilly, Goldenson and Kasten, 2001).

Citizens For Long Term Care is deeply concerned about the interrelationship between our current financing system, the quality of direct-care jobs, and the resulting decline in long-term care availability—and believes that it is critically important that the U.S. examine how we finance and structure long-term care services and support.

For long-term care financing is inextricably tied to the direct-care worker crisis: Government sources of financing total approximately 62 percent of all long-term care dollars spent, with Medicaid the largest funder and Medicare the second largest. Several provider-sponsored studies suggest that government payments often do not fully cover the provider's costs for supplying the staff, medication, food, bedding, and all the other items essential to the care and support of the long-term care consumer (American Health Care Association, 2001).

Providers must aggressively implement cost containment strategies to help balance the cost of care against the reimbursement they receive for providing that care. Since long-term care is a labor-intensive service, paid staff represent the core expense in long-term care. In order to ensure that consumers receive the care, support and services they require (including food, medicines, clean linens, and adequate shelter), it is often the needs of our paid caregivers—their wages, training, education, and advancement—that suffer most when reimbursement is not adequate to cover costs.

However, a recent study of nursing home expenditures and quality in three states, published by the U.S. General Accounting Office (GAO), suggests that the interrelationship between financing and staffing levels is complex. The GAO study found that, although the level of spending varied, the average share devoted to resident care was relatively the same, and that as spending per-resident-day increased, the proportion of spending devoted to nursing care tended to decline (U.S. General Accounting Office, 2002). Therefore, the financing system is only part of the cause, and thus only part of the solution, to the long-term care workforce crisis—for certainly there are striking examples of nursing homes and home care agencies that attract, reward, empower, and retain workers at current levels of reimbursement

A Profound Shift in Demographics

The nation is only beginning to experience the full scope of the workforce crisis, for the long-term care industry is now competing with other employers for entry-level workers. "Traditional" care workers—particularly women between the ages of 25 and 44—are being lured into non-health jobs offering better pay and safer working conditions. The consequence has been unprecedented levels of direct-care staffing vacancies and turnover.

Indeed, long-term care jobs are so physically and emotionally challenging, and yet so poorly compensated, that many front-line staff have simply stopped reporting for

direct-care work[3]: Nursing home providers and home care agencies across the country have recently documented historically high rates of vacancies and turn-over among direct-care staff (National Association for Home Care, 2000; American Health Care Association, 2002), which can impact consumers by delaying access to care services.

Of even greater concern, however, is the future: Exacerbated by profound demographic changes, a "care gap" is emerging between the number of those requiring long-term care assistance and those available to provide that assistance. By the year 2010, *more than 780,000 additional aides must be found* to fill long-term care direct-staff positions, an increase of 39 percent over the year 2000. However, during the same ten-year period, the "traditional" source of such new long-term care workers—women aged 25 to 44 participating in the civilian workforce—is projected to grow by just 1.25 percent, an increase of *only 400,000 workers*. (Hecker, U.S. Bureau of Labor Statistics, 2001). Increasingly, our loved ones across the country are asking with rising concern, "Who will care for us?" (Stone and Weiner, 2001).

Citizens For Long Term Care believes that the exceptionally tight labor market experienced by long-term care providers this past year is just a foretaste of what long-term care consumers can expect as the decade unfolds: a widening gap between the supply and demand for direct-care workers. Unless our nation fundamentally re-examines how we finance and structure long-term services and support, we will knowingly place both our loved ones and ourselves at the mercy of a massive demographic shift within the U.S.—far more people living with disabilities requiring assistance; too few younger workers willing and able to provide that assistance; and a marketplace within which long-term care providers increasingly cannot compete for the workers they need.

Therefore, our primary hope for this paper is to articulate the direct connection between financial reform of long-term care and the direct-care workforce crisis.

PART I: DIRECT-CARE PARAPROFESSIONALS

Long-term care paraprofessionals provide health care services, personal care, housekeeping, and home management tasks across a variety of programs and settings: private homes, group homes, adult day care programs, assisted living facilities, and nursing homes.

These direct-care workers assist individuals of all ages who are frail, have chronic illnesses, or live with a physical, cognitive or mental disability: Although the total number of individuals requiring long-term care now approaches 13 million, more than two-fifths are non-elderly (younger than 65 years), of whom approximately 500,000 are children (U.S. General Accounting Office, 2001a). In general, improved trauma care and

[3] A 1999 survey in North Carolina found that less than half of the 180,000 North Carolinians certified as nursing assistants in the last decade were still employed in nursing homes or other long term care settings. Many had found more stable employment outside of health care: those still working as nursing aides were *more* likely to be working two or more jobs than those working outside of health care (Konrad, 1999).

medical technologies are extending the lives of those with life-threatening or debilitating illnesses or conditions, thus both expanding and changing the composition of the long-term care population (Tilly, Goldenson and Kasten, 2001).

Most individuals requiring assistance primarily receive support and services from their family, friends, and neighbors. Nonetheless, each day direct-care workers provide paid support and services to at least four million consumers (Agency for Healthcare Research and Quality, 2001).[4]

The formal work relationship between the consumer and the worker also varies. In some cases, the worker is hired directly by the consumer, and functions explicitly at his or her direction. In others, the paraprofessional is employed by an agency or facility, which in turn directs and is responsible for that worker. When the paraprofessional is delivering some form of health service—changing a dressing or assisting with medications—he or she acts under the licensed supervision of a registered nurse.

The three main categories of paraprofessionals recognized by the U. S. Bureau of Labor Statistics (BLS) are:

- **Home Health Aides:** "Provide routine, personal healthcare, such as bathing, dressing or grooming, to elderly, convalescent, or disabled persons in the home of consumers or in a residential facility."

- **Nursing Aides, Orderlies, and Attendants:** "Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move consumers, or change linens."

- **Personal and Home Care Aides: "**Perform a variety of tasks at places of residence. Duties include keeping house and advising families having problems with such things as nutrition, cleanliness, and household utilities."

In 2000, these three categories together accounted for approximately two million workers within long-term care settings (U.S. Bureau of Labor Statistics, 2000).[5] The U.S. General Accounting Office (GAO) reported that these jobs increased at a rate of 40 percent during the decade of 1988 through 1998, compared to just 19 percent for the total labor market (U.S. General Accounting Office, 2001b).

Unfortunately, these three categories combined do not fully capture all types of direct-care workers, and in general significantly underestimate the direct-care workforce. For example, in 2000 the BLS counted 414,000 personal care workers nationwide, yet the

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[4] The AHRQ analysis excludes consumers who require assistance for heavy housecleaning only, and thus is a conservative estimate.

[5] The definition of "nursing aides, orderlies, and attendants" includes some workers in acute care settings. Of this category, the General Accounting Office determined approximately 400,000 nurse aides worked in hospital settings. Subtracting 400,000 from the 2.4 million in all three categories results in approximately two million long-term care aides.

State of California alone reports employing 202,000 personal care workers in its In Home Supportive Services program (California Department of Social Services, 2001). Furthermore, one study estimates that a full-time equivalent of 750,000 paid workers serve people with developmental disabilities (Larson, Lakin & Hewitt, in press). In addition, beneath the formal sector described by the Bureau of Labor Statistics lies a "gray-market" workforce of paid caregivers who are hired directly by consumers, but whose income is not reported. The size of this unreported workforce is widely acknowledged to be significant, but remains unquantifiable.

Women represent approximately 90 percent of direct-care workers, compared to the entire U.S. workforce, of which approximately 47 percent are women. Direct-care paraprofessionals are also disproportionately women of color: One-third are African-American and approximately 15 percent are either Hispanic or other workers of color. For nursing home workers, the mean age is 37; for home care workers, the mean age is 41 (U.S. General Accounting Office, 2001b).

More than 20 percent of long-term care workers do not have a high school education. One quarter of home health aides and nearly one-third of all nursing home workers are unmarried living with children—this compared to the entire U.S. workforce, in which only 11 percent are unmarried living with children.

The rate of unionization among direct-care staff is less than 10 percent nationwide, compared to a national unionization rate of 13.5 percent among all U.S. wage and salary workers. Recently, the two largest unions in the United States—the Service Employees International Union (SEIU) and the American Federation of State, County and Municipal Employees (AFSCME)—have targeted direct-care staff for organizing drives.

Training requirements are quite varied for paraprofessionals. In general, certification requirements are quite low, and in some cases, non-existent. Federal law requires Medicare-funded certified nurse aides and home health aides to receive 75 hours of training, and/or pass a certification exam and skills test, followed by 12 hours each year of in-service education. Many states do, however, require additional hours of training. Federal law does not require *any* minimum training standards for personal care workers, although again, several states require their own minimum entry-level requirements.

Finally, direct-care jobs are simply not competitive within today's labor markets. Wages for direct-care workers are very low, even when compared with other low-wage, entry-level jobs. Health care and other benefits are relatively rare—a powerful disincentive to a workforce disproportionately made up of single women raising young children.

Comparison to the Nursing Professions

Although paraprofessionals are the primary concern of this paper, nurse professionals play a major role in the coordination and delivery of long-term care services and supports. As means of comparison, and to underscore that the staffing crisis is also deeply affecting professionals, we include here a brief description of the nursing workforce within long-term care.

The nursing professions within long-term care primarily include Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). RNs typically receive between two and four years of schooling, while training programs for LPNs are typically 12 to 18 months. The U.S. Bureau of Labor Statistics (BLS) estimated in 1999 that nursing homes employed 150,000 RNs and 208,000 LPNs, and that the home care industry employed 108,000 RNs and 43,000 LPNs—totaling 509,000 nursing professionals within the long-term care system.

The typical RN and LPN is also female—approximately 92 percent in 2000—but unlike paraprofessionals, 88 percent of nurses are white (Kimball and O'Neil, 2002). In comparison to paraprofessionals, full-time RNs typically earn a livable income: In 1980, annual RN salaries averaged $17,398, rising to $46,782 in 2000. However, during those 20 years, "real" earnings adjusted for inflation increased only 34 percent: A full-time RN in 2000 earned the equivalent of only $23,369 in 1980 dollars (U.S. Department of Health and Human Services, 2000).

As emphasized in *Health Care's Human Crisis: The American Nursing Shortage*, recently published by The Robert Wood Johnson Foundation: "The current nursing shortage is quantitatively and qualitatively different from past shortages" (Kimball and O'Neil, 2002). The greatest concern expressed by industry leaders and policy makers is the aging of the nursing workforce: In 1980, less than half of all RNs were over age 40, while in 2000 more than two thirds of all RNs were 40 or older; by 2010, the GAO projects that 40 percent of all nurses will be older than 50 years of age. Furthermore, fewer individuals are entering the nursing professions: Nursing school enrollment has declined 6.6 percent *each year* for the past six years; in 2000, less than 75,000 passed the national RN licensing exam compared to more than 97,000 in 1996 (U.S. General Accounting Office, 2001c).

PART II: DIRECT-CARE VACANCIES AND TURN-OVER RATES

Across the nation, state agencies, providers, and consumers have reported an inability to retain direct-care staff, resulting in alarming rates of vacancies:

- In a national survey collected in the spring of 2002, 37 states reported that paraprofessional recruitment and retention remained a major workforce issue, despite the recent softening of the economy (North Carolina Department of Health and Human Services, 2002).

  The national survey also reported that, within the past three years, more than half the states have passed either direct-care training or other types of job-related initiatives and that more than two-thirds have passed wage or benefit enhancement legislation. Current to the spring of 2002, new legislation was pending in 18 states, ranging from loan forgiveness programs, to staffing ratios, to elimination of mandatory overtime.

- The American Health Care Association (AHCA) reported that vacancy rates of certified nursing aides (CNAs) within a representative national sample totaling nearly 7000 nursing home facilities averaged 11.7 percent, and that annual turnover rates averaged 76.1 percent (American Health Care Association, 2002).

  More than half of the nursing home facilities responding to that June, 2001 survey stated that it was harder to recruit CNAs than it had been the year before (American Health Care Association, 2002).

- In 2001, the GAO noted, "*Retention of nurse aides is a significant problem for many providers, with some studies reporting annual turnover rates for aides working in nursing homes approaching 100 percent*." (U.S. General Accounting Office, 2001b)

- In a 2001 article in *Seniors Housing & Care Journal*, the authors surveyed ten studies of annual turnover rates among CNAs in nursing homes over the past 20 years, finding turnover rates ranging from 38 percent to 143 percent (Decker, Dollard and Kraditor, 2001).

- The GAO also reported vacancy rates for professional nurses in all settings ranging from 13 percent in Nevada to 20 in California (U.S. General Accounting Office, 2001c).

- The AARP Foundation Litigation Group has sued the State of Arizona for failing to provide Medicaid reimbursement rates adequate to attract a direct-care workforce for personal care services.

- Plaintiffs with developmental disabilities and their providers have sued the states of California and Pennsylvania, alleging that low wages paid to direct-care workers in home and community-based settings (particularly when compared to workers in state-operated facilities) fail to attract adequate staff and thus create barriers to full access of home and community-based services.

- In California, more than 80 percent of all low-wage workers in the health care industry left their jobs within three years, most to move out of the industry entirely (California Employment Development Department, 2001).

- A 2001 report by the Intragovernmental Council on Long-Term Care in Pennsylvania reported that 13 percent of providers were experiencing a vacancy rate of 20 percent or greater (Polisher Institute, 2001a)

High rates of staff vacancies and turnover harm all three key stakeholders within the long-term care system: *consumers* (and their families), *providers*, and *workers*. Although these three stakeholders do not always agree on long-term care policies, leaders of all three have publicly stated their common concern that vacancies and turnover are now one of the gravest challenges facing the future of direct-care.

Impact on Consumers

Health care researchers have long noted the connection between the quantity and quality of direct-care jobs and the quality of services, support, and care received by clients (Institute of Medicine, 1986; Kilpatrick and Roper, 2002). A recent report to the Commonwealth Fund found that inadequate staffing, a lack of individualized care, and high nurse-aide turnover are key causes of malnutrition and dehydration, affecting an estimated one-third of our nation's nursing home residents (Burger, Kayser-Jones and Bell, 2000).

Vacancy Rates

High rates of staff vacancy in nursing homes can mean that remaining staff must serve relatively more people, potentially compromising quality of care. Home care aides who "work short" (too few staff to serve a particular number of individuals) are able to offer only "drive-by home care" as they rush from one apartment across town to another. In areas of severe vacancy rates, clients may simply be turned away for lack of available direct-care workers (National Association for Home Care, 2000).[6]

In nursing homes, understaffed facilities may fail to provide essential bathing, toileting, feeding, and hydration. In April of 2002, the Centers for Medicare and Medicaid Services (CMS) released a report to Congress, prepared by Abt Associates, titled *Appropriateness of Nurse Staffing Ratios in Nursing Homes* (Abt Associates, 2001). In this report, the authors surveyed 5,000 nursing homes in ten states to determine "critical staffing thresholds, below which quality of care delivered to nursing home residents could be compromised."[7]

The report found that *more than half* of all nursing homes studied, 52 percent, failed to meet targeted research thresholds, and that *nearly all* homes studied, 97 percent, failed to meet at least one of the three research thresholds. Staffing at levels below these thresholds was found to result in long waits for service and inconsistent implementation of care—even when staff were working at high productivity levels.

According to the report, specific problems that can result from staffing below these thresholds include: dehydration, malnutrition, pressure sores, more hospitalizations, and other definable measures of poor quality care. The report also concluded that over 40 percent of all nursing homes would need to increase nurse aide staffing *by 50 percent or more* to reach the minimum research thresholds associated with their resident population. The study also recognized the limitations of its data, and recommended additional analysis and research.

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[6] In February of 2000, the National Association for Home Care testified to the U.S. House Committee on Education and the Workforce Subcommittee on Oversight and Investigations: "*In all geographic regions of this country, there is an ongoing inability to hire staff to provide the most fundamental care needed. The crisis for home care used to be lack of adequate business opportunities. Now agencies have to turn away requests for service for lack of competent, appropriately trained staff.*"

[7] These thresholds are: Nursing Assistants (paraprofessionals): 2.4 to 2.8 hours per resident day; Licensed Practical Nurses: 1.15 to 1.3 hours per resident per day; and Registered Nurses: .55 to .75 hours per resident per day.

Turnover Rates

High rates of turnover mean a constant replacement of new staff, which in turn disrupts the care setting and precludes the development of relationships that are centrally important to both the client and the worker. Furthermore, turnover results in a correspondingly high percentage of inexperienced direct-care staff, and concomitantly, relatively fewer senior staff are thus available as mentors. Since each long-term care client is an individual with particular needs and preferences, new staff members are understandably slow to understand each individual's particular needs, and can remove from those individuals a sense of dignity and control over themselves and their environment.

Most importantly, formal paid assistance does not function in isolation. It must be placed in context within the larger reality of family and volunteer care. Thus, particularly for a consumer who might be easily disoriented or frightened, high-quality assistance requires a smooth interface between the formal system of paid staff and family caregivers—an interlacing of schedules and information that changes from day to day. This continuity is impossible to achieve if the formal system is constantly disrupted by staff vacancies and turnover.

Impact on Providers

Staff vacancies and high turnover have a significant impact on health-care employers. Long-term care services are by nature labor intensive, and thus high turnover and vacancies can cause significant instability—both operationally and financially—for long-term care providers.

In particular, churning of staff and heated competition for workers force providers to divert precious financial and managerial resources toward additional advertising, hiring incentives, training, and orientation activities. Then, when workers leave, employers must also pay separation and termination costs. Those costs to replace staff can also be quite high: One extensive study determined that the cost of replacing a single direct-care worker was $2,341 (Johnston, 1998).

Furthermore, to ensure adequate coverage, many facility-based providers must hire replacement staff from temporary-employment agencies, at hourly costs of up to 200 percent more than that of regular employees. This is particularly true of nursing home facilities during second shift (3pm to 11pm) and weekends. Finally, and most importantly, high rates of vacancies, turnover, and temporary staff can frustrate the ability of long-term care providers to achieve their core mission: the provision of safe and high-quality services to their clients.

Impact on Workers

Spiraling vacancies and turnover can trigger a downward cycle of deteriorating job quality. With fewer co-workers to share the load, direct-care workers are less able to

provide the level of service they know their clients require and deserve, which makes the job less personally satisfying. Home care workers are forced to spend less time *with* clients and more time traveling *between* clients (often unpaid); nursing home workers are at times required to work overtime and double shifts. High turnover and vacancies leave new workers with less instruction and fewer mentors for on-the-job learning, less time for training, and less professional support from supervisors who are themselves over-stretched.

The impact of these conditions on direct-care workers can also include higher rates of injuries: Nationally, nursing home aides already experience 18.2 injuries per 100 workers—more than 200,000 injuries per year—far greater than coal mining (6.2 injuries per 100 workers), construction (10.6 per 100), and warehousing/trucking (13.8 per 100) (Service Employees International Union, 1997).

The result is a truly alarming spiral of instability: a growing exodus of experienced direct-care staff, leaving behind a workplace that is increasingly less attractive to potential new staff.

PART III: DYNAMICS OF THE DIRECT-CARE CRISIS

Why did vacancies among direct-care staff increase in the past few years? One key factor among several is that long-term care employers function within several *labor* markets. For example, they compete vigorously against other organizations for top leadership and for financial and clinical expertise. To attract and retain high-quality leadership and expertise, they must offer competitively attractive career opportunities.

One of those labor markets is the paraprofessional labor market. Unfortunately—with a seemingly endless supply of low-income individuals (usually women, and disproportionately women of color) willing to work in direct-care positions—long-term care policy makers were able to ignore the reality of that labor market for much of the past 30 years. Now, however, fundamental changes in both the U.S. economy and demographics have seized the attention of policy makers at both the federal and state levels (Paraprofessional Healthcare Institute, 2001b).

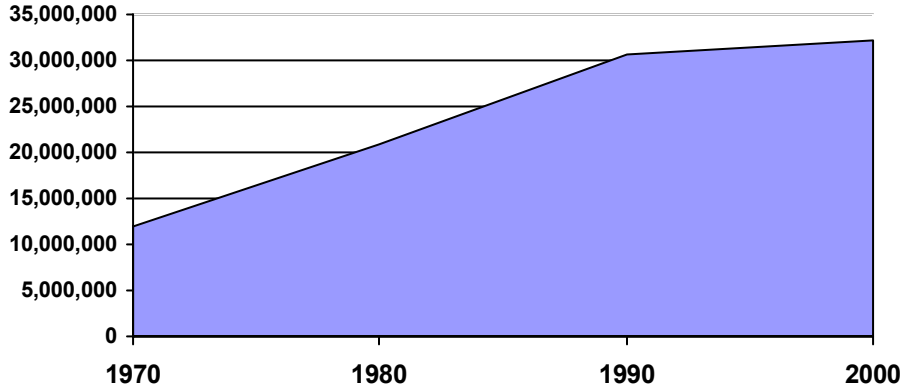
Like any other market, a labor market is governed by *supply* and *demand*, with *price* adjusting the tension between the two. In the paraprofessional labor market, most of the past 30 years have witnessed increasingly large numbers of potential workers (high supply) who, because of low skills and other employment barriers, had relatively few job opportunities other than entry-level health care jobs (low demand). High supply and low demand together meant that long-term care financing sources could constrain costs by presuming direct-care staff would be willing to work for relatively poor pay and few benefits (low price).

Suddenly, however, near the end of the 1990s, the dynamics of the paraprofessional labor market changed. One obvious cause was our nation's high-employment economy,

providing low-income women many more job opportunities to choose among—thus *demand* for these workers throughout the economy increased.

Less obvious, however, is that a significant shift had occurred within the U.S. population that dramatically changed the *relative supply* of paraprofessional labor. During the decade of the 1990s, growth in the "traditional" source of entry-level direct-care workers—women in the civilian workforce between the ages of 25 and 44—had begun to slow dramatically. This slow growth was significantly different from the prior two decades, during which this cohort of female workers had more than doubled in size:

Chart #1: Women Aged 25-44 in the Civilian Workforce, 1970 - 2000



Percent Increase:	74.0%	47.2%	4.4%

Source: 1970 figure is calculated from U.S. Bureau of Labor Statistics
All other data for 1980-2000 are from Howard N Fullerton, Jr. and Mitra Toosi, "Labor Force Projections to 2010: Steady Growth and Changing Composition," *Monthly Labor Review*, November 2001, Table 8, "Civilian Labor Force by Sex, Age, Race, and Hispanic Origin, 1980, 1990, 2000 and projected 2010,"

Two interacting factors caused the dramatic expansion of this cohort during the 1970s and 1980s: an increasing number of women from the Baby Boom generation coming of adult age, and the increasing rate of women within this age 25 to 44 cohort participating in the workforce (48.0 percent in 1970, rising to 75 percent in 1990). Now, however, the Baby Boom workforce is passing through this age range, soon to leave a smaller, Post-Baby Boom workforce to follow. Moreover, the rate of increasing participation of women in the workforce has slowed considerably, from 75 percent in 1990 to just 77 percent for 2000 (Fullerton, 1999).

Therefore, as we entered into the new decade beginning in 2000, the nation's full employment economy (*high demand*) met with a dramatically slower growth in the source of traditional entry-level paraprofessional workers (*tightening supply*). The results were higher rates of vacancies and turnover, as long-term care employers and consumers competed amongst each other and against other industries for relatively few new workers.

The decades-old presumption—of an endless supply of low-income women willing to support, feed, bathe, and assist direct-care consumers—was suddenly no longer valid.

PART IV: THE EMERGING "CARE GAP"

Looking to the future: *The need for long-term care services and supports will rise dramatically during the next 20 years, likely translating to an increase in demand for paid staff, while the supply of traditional caregivers will be unable to keep pace.* These diverging forces of consumer demand and labor supply will create a widening "care gap" that must be addressed as an integral part of long-term care financing reform.

Need for Services Will Increase

Between now and 2020, *both* the "65 and older" and the "85 and older" populations will increase by more than 50 percent (U.S. Census Bureau, 2000).[8] Yet the *prevalence* of disability among the elderly has been dropping—cumulatively nearly 25 percent from 1982 through 1999—and will likely continue to decline (Manton and Gu, 2001). This combination, an expanding elderly population with decreasing rates of disability, will counteract each other—to what extent will depend upon the degree to which disability rates continue to fall.

However, it is essential to note that the reported fall in disability rates among the elderly is attributable primarily to a decrease in those requiring assistance for Instrumental Activities of Daily Living (IADLs)[9], while the percent of those requiring assistance for Activities of Daily Living (ADLs)[10]—associated with a higher level of disability, and thus a higher level of person-to-person assistance—has stayed constant. Indeed, during the 10-year period from 1984 through 1994, when overall rates of disability among the elderly were dropping 1.5 percent annually, among all elderly with disabilities the percent receiving help with three to six ADLs (a very high rate of disability), increased from 35.4 percent to 42.9 percent (Agency for Healthcare Research and Quality, 2001).

Therefore, to focus solely on the dropping prevalence of disability among the elderly, without examining the increasing acuity of those still requiring assistance, may lead to false comfort. Although it is impossible to predict how these three trends—an expanding elderly population, decreasing rates of disability, and increasing acuity—will interact over the next two decades, a fourth trend raises additional concerns about the

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[8] After 2020, the elderly population will likely expand even *more* quickly, with those 65 and older increasing an additional 31 percent, and those 85 and older increasing an additional 32 percent, during the ten-year period 2020 through 2030.

[9] "Instrumental Activities of Daily Living, IADLs, are tasks necessary for independent community living, including shopping, light housework, telephoning, money management, and meal preparation. IADLs are sometimes used to measure a person's need for assistance as a result of mental or cognitive disabilities" (Tilly, Goldenson and Kasten, 2001).

[10] "Activities of Daily Living, ADLs, are activities necessary to carry out basic human functions, such as bathing, dressing, eating, getting around inside the home, toileting, and transferring from a bed to a chair" (Tilly, Goldenson and Kasten, 2001).

growing need for paid long-term care services: the increased use of formal caregivers to supplement family caregivers. In 1982, only 26 percent of elderly Americans requiring human assistance relied all or in part upon paid caregivers, while in 1994, that figure had risen to 36 percent (Feder, Komisar and Niefield, 2001).

Furthermore, long-term care services and support are not only required for the elderly; as we have noted, two-fifths of long-term care consumers are younger than 65 years of age. Unlike the elderly, the prevalence of disability among the non-elderly has increased: The percentage of those 18 to 64 requiring personal assistance rose from 2.0 to 2.5 percent from 1990 to 1994, and those aged 5 through 17 requiring personal assistance rose from .3 to .5 percent during the same time period (Kaye, et. al., 1996).[11]

Although the growth *rate* of the non-elderly population during the next two decades is relatively small compared to the elderly, the sheer *size* of the non-elderly population is far larger, and thus—if combined with a continued increase in use of personal assistance—may be an additional determinant in driving the need for long-term care services.

Need Will Likely Translate to Demand

Clearly, the combined need for long-term care services among both the elderly and non-elderly will continue to climb. However, given that the vast majority of formal long-term care services are paid by public tax dollars, how that "need" will translate into "effective demand" for direct-care staff will remain a matter of political will versus budgetary constraints.

Having weighed these trends, the Bureau of Labor Statistics now projects that by the end of the decade in 2010, direct-care jobs in long-term care will require *780,000 net new paraprofessional positions*—an increase in demand for paid caregivers of *39 percent*.[12] Using conservative estimates for those leaving paraprofessional work during that same period, the BLS further predicts that the total number of new job openings (growth plus replacements) will require *1,048,000 new paraprofessional long-term care workers* in the coming decade.

While total employment in the U.S. workforce is projected to grow by just 15.2 percent from 2000 to 2010, the demand for home health aides will increase by 47 percent, and personal care aides by 62 percent (Hecker, 2001). Registered nurses, in both long-term care and acute care positions, are projected to have the third largest increase in demand for net number of new jobs over the coming decade, at 561,000 new positions.

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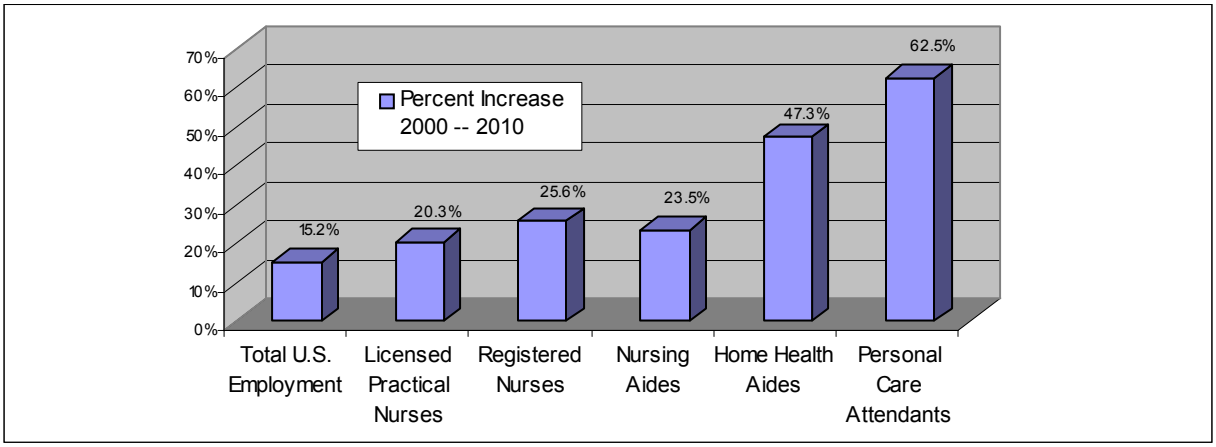
[11] Unfortunately, trends in acuity among the non-elderly disabled are not available.

[12] The category of "nursing aides, orderlies, and attendants" includes both long-term care and acute (hospital-based) care workers. The GAO estimates that approximately 72 percent of this category work in long-term care settings, while the remaining 28 percent work in hospital settings. Therefore, for purposes of these employment projections, we assume a similar distribution between long-term care and acute care positions.

Chart #2: U.S. Employment Growth Projections: 2000 – 2010



Source: Daniel E. Hecker, US Bureau of Labor Statistics, *Monthly Labor Review*, November 2001

In fact, personal care attendants rank 8th among all occupations in terms of the fastest percent in job growth projected between 2000 and 2010 (*first* among non-computer related occupations), while home health aides rank 15th in projected job growth (*fifth* among non-computer related occupations).

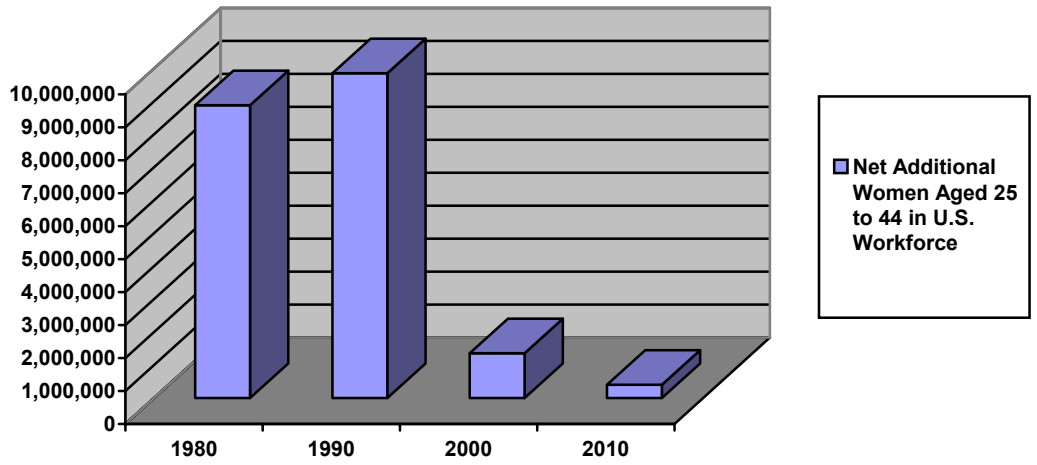
Despite the current economic recession, predictions of job growth for health care appear to be holding true: While the rest of the U.S. economy lost a net of 1.12 million jobs in the past 12-month period (August, 2002 compared to August, 2001), the health care industry *added 289,000 jobs*—one of the very few industries with steady employment growth in the nation (U.S. Bureau of Labor Statistics, 2002).

Yet Traditional Labor Supply Will Not Keep Pace

Where will long-term care consumers and providers find more than one million paraprofessionals over the next ten years? Unfortunately, during the decade of 2000 to 2010, the traditional flow of new workers to long-term care will slow dramatically, contributing *only 400,000 net new workers throughout the coming decade* (see Chart #3, below).

Chart #3: Women Aged 25-44 in the Civilian Workforce

1970-2000, and projected to 2010



Source: 1970 figure is calculated from U.S. Bureau of Labor Statistics
All other data for 1980-2010 are from Howard N Fullerton, Jr. and Mitra Toosi, "Labor Force Projections to 2010: Steady Growth and Changing Composition,"
Monthly Labor Review, November 2001, Table 8,
"Civilian Labor Force by Sex, Age, Race, and
Hispanic Origin, 1980, 1990, 2000 and projected 2010,"

Thus over the next ten years, even if the *entire* additional net population of 400,000 women aged 25 to 44 entering the civilian workforce chose long-term care paraprofessional employment, consumers and providers would still need to find *600,000 more workers* to fill the paraprofessional positions resulting from job growth and replacement of exiting workers.

PART V: DIRECT-CARE JOBS THAT CANNOT COMPETE

Within this newly competitive labor market of the past few years, paraprofessional jobs became increasingly unattractive. Close examination reveals just how unattractive: In 2000 (the most recent national data available), the median wage of home care workers was $8.23 per hour; the median wage of personal care workers was $7.50 per hour. (BLS, 2002).

Typically, direct-care employers draw from a labor market that competes with other relatively low-wage, entry-level jobs. However, even within this part of the job market, many positions today offer a relatively attractive employment alternative, providing far safer, less physically and emotionally demanding work—and at higher pay (Paraprofessional Healthcare Institute, 2001a):

Chart #4: Median Wages of Workers in U.S. — 2000

Job Category	2000 Median Hourly Wage
Receptionists	$9.63
Packaging and Filling Machine Operators and Tenders	$9.45
File Clerks	$8.99
Nursing Aides, Orderlies, and Attendants	*$8.89*
Home Health Aides	*$8.23*
Personal & Home Care Aides	*$7.50*

Source: National median hourly wages from data from National Occupational Employment and Wage Estimates for 2000 as published by the US Bureau of Labor Statistics.

Clearly, direct-care jobs are simply not competitive within today's labor markets. Yet beneath this fact lies a more troubling reality: The typical direct-care job keeps many women working, and yet impoverished. In fact, the May, 2001 GAO testimony to the U.S. Senate documented that the median income of all nursing home direct-care staff was *$13,287 per year*, while the median income for all home-based direct-care staff was *just $12,265 per year*.[13]

Furthermore, a recent analysis of the Current Population Survey revealed that "health care personnel are losing health insurance coverage more rapidly than are other workers," with the percentage of uninsured health workers making less than $25,000 per year increasing from 13.4 percent in 1988 to 19.1 percent in 1998. In all, "1.36 million health care workers provide care that they and their children cannot expect to receive." (Case, Himmmelstein and Woolhandler, 2002).

In addition, the GAO report documented that nurse aides working in home health agencies and nursing homes are *twice as likely* to receive public benefits than workers in other job categories—a "hidden subsidy" that tax payers unknowingly provide to long-term care employers. More specifically:

[13] The annualized median income of a direct care worker—assuming 40 hours per week, 52 weeks per year—would total $16,100. However, significant numbers of direct-care workers, particularly those working in home-based settings, are unable to piece together regular 40-hour work weeks due to the part-time structure of much of the long-term care industry.

- Φ Approximately 11 percent of all workers in the U.S. have family incomes below the poverty line. Yet 18 percent of all nursing home aides and 19 percent of all home care aides each night return home to families who are living in poverty;

- Φ Approximately 46 percent—nearly one out of every two—nursing home and home care aides live below 200 percent of poverty;

- Φ Approximately 16 percent of all workers in the United States have no health insurance. In comparison, one-third of aides in home care and one-fourth of aides in nursing homes are uninsured;

- Φ Approximately 4 percent of all workers in the U.S. are dependent on Medicaid coverage. However, nearly 10 percent of all nursing home aides and more than 11 percent of all home health care aides rely on Medicaid to provide health insurance; and

- Φ Nearly 5.5 percent of all workers in the U.S. rely on food stamps to help feed themselves and their families. Yet more than 13 percent of all nursing home aides and nearly 15 percent of all home health care aides receive food stamps.

…All this, for a job that consistently has ranked third (behind truck drivers and laborers) as having the *largest number of work-related injuries and illnesses* resulting in time away from work. In the year 1999 alone, more than 75,000 nurse aides reported injuries and illnesses that resulted in lost work days (U.S. Bureau of Labor Statistics, 2001).

The nursing home industry is the first industry to step forward to work with OSHA to develop and implement industry specific ergonomic guidelines to reduce injuries, but the costs of implementing these guidelines (i.e., costs of equipment and training) are, according to the industry, difficult to fund at current financing levels.

A range of focus groups of direct-care workers note that women who remain in long-term care do so not because of, but despite, the quality of their jobs. They report to work because they are rewarded by the very human experience of providing support and services to those who require daily assistance (Kopiec, 2000; Polisher Institute, 2001b).

Comparison to the Nursing Professions

The dynamics of the labor market for nursing professionals are in many ways parallel to that of paraprofessionals—the professions draw upon the same demographic pool (women between the ages of 25 to 44) for entry-level staff, and thus similarly face a relatively shrinking supply of potential workers. In fact, the unemployment rate for RNs declined from 1.5 percent in 1997 to 1.0 percent in 2000 (U.S. General Accounting Office, 2001c).

Furthermore, to an even greater extent than for females within the low-wage labor market, the past several decades created a wide range of employment options for professional women, forcing the nursing professions to compete with opportunities in

law, finance, science, and business. The result is a "nursing crisis" of unparalleled proportions: The Robert Wood Johnson Foundation's *Health Care's Human Crisis: The American Nursing Shortage* lists 16 major national studies published about nursing "shortages" just within the past two years (Kimball and O'Neil, 2002).

Unfortunately, many nurses describe the quality of their jobs as declining: Recent surveys determined that 51 percent of RNs were more dissatisfied with their direct-care jobs than they had been two years before, and half had thought about leaving their jobs within the past two years. More than half would not recommend nursing as a career, and 23 percent would "actively discourage someone close to them" from entering nursing (Nursing Executive Center, 2000; American Nurses Association, 2001).

According to the same surveys, among those expressing dissatisfaction with their job, 18 percent cited low wages, while 56 percent noted stress and the physical demands of their work. A primary concern noted by unionized nurses within understaffed agencies and facilities has been the need to work with too few support staff, and increasingly, to perform mandatory overtime service.

What particularly distinguishes the professional labor market from the paraprofessional labor market is the "time lag to entry" caused by higher educational requirements for nurses. While the "training barrier" for paraprofessionals is quite low—at most four weeks—the barrier for nurses is relatively high, ranging from at least one year for LPNs to between two and four years for RNs.[14]

Therefore, for the nursing professions, even if the relative competitiveness of jobs were to improve today, attracting new workers into those positions would require that new candidates first apply for, enter, and then graduate from a one- to four-year degree program. This lag time explains, in part, why reports of high nursing vacancy rates are persisting despite increased unemployment rates—and is of particular concern in the face of declining rates of nursing school admissions.

PART VI: LONG-TERM CARE FINANCING AND THE STAFFING CRISIS

In its founding publication, "Defining Common Ground," Citizens For Long Term Care emphasized how this country's fractured system of long-term care financing has led directly to inadequate and inconsistent services for consumers:

- Currently, private long-term care insurance accounts for approximately 7 percent of long-term services and support.

[14] Thus high rates of vacancies for aides and other paraprofessionals can, at least in theory, be addressed quickly: If jobs become relatively attractive within the paraprofessional labor market (either because direct-care jobs improve dramatically, or competing job options suddenly shrink), then new workers can be trained quickly and vacancies will drop within a short period of time. In fact, some providers in northern New England, for example, have recently reported improvement in paraprofessional recruitment (although, not necessarily *retention*) due to a combination of relatively small increases in wages and a relatively higher rate of area unemployment.

- Public financing of long-term care, to the extent it is available at all, is restricted primarily to Medicaid—accounting for 45 percent of all long-term care spending—yet Medicaid typically requires recipients to be impoverished before being able to access long-term care benefits.
- Although the majority of citizens erroneously believe that Medicare will pay for long-term services for the elderly (AARP, 2001), Medicare in fact accounts for only 16 percent of long-term care spending.[15]
- U.S. residents finance 27 percent of all long-term care services "out-of-pocket."

This disparate array of funding sources not only threatens quality of care, it also constricts the long-term care system's ability to address the emerging direct-care staffing crisis. Indeed, the two problems are fundamentally interrelated. In particular, Medicaid financing—which not only underfunds the true costs of care, but also varies considerably from state to state—causes significant disparities, both across geographic regions and among differing groups of long-term care consumers.

Ironically, without adequate financing of long-term care and dramatic improvement in the quality of direct-care jobs, we will face direct-care staffing disruptions in *both* good and bad times: During times of economic expansion, which we experienced at the beginning of 2001, direct-care workers proved exceptionally scarce, lured to more attractive employment. Then, at the end of 2001, when the economy did indeed stagnate, vacancies only lessened somewhat (North Carolina Department of Health and Human Services, 2002)—while at the same time, tax revenues plummeted in most states, threatening severe cutbacks in Medicaid funding and in turn jeopardizing efforts to improve reimbursement for staffing in long-term care.

In addition, cuts over the past several years in Medicare reimbursements, although a smaller proportion of financing for long-term care, also deeply impacted staffing within both nursing homes and home care agencies. One study by the School of Public Health at the University of North Carolina at Chapel Hill determined a direct association between lower Medicare reimbursement rates, lower levels of staffing and higher rates of deficiencies within our nation's skilled nursing facilities (Kilpatrick and Roper, 2002).

Financing Flaws Lead to Systemic Failure

Funded primarily through "third-party" insurers, our long-term care system, like the rest of health care, is not a conventionally financed industry. Of the nearly $127 billion spent on non-hospital-based long-term care in 1999, approximately 60 percent was

[15] Medicare's coverage of nursing home care is restricted to a patient's need for skilled service subsequent to a hospital discharge, and is time-limited. Medicare restricts coverage of home health services to those consumers who are homebound and who can demonstrate a need for skilled care services. While it may cover qualifying patients for an unlimited period of time, it does not cover personal care services needed, for a short or long term, in the absence of an accompanying skilled care need. Therefore, in the strictest sense, Medicare does not truly pay for long-term care services.

funded through public tax dollars—with the vast majority of those dollars derived from Medicaid programs that vary significantly from state to state, and on average significantly underfunds the true costs of care.[16] Private insurers currently cover approximately 7 percent of long-term care expenses (Burwell, 2000). Furthermore, our current system is one that offers limited support and services, primarily to those who either have no resources, or who have been forced to "spend down" their savings in order to qualify for support.

Most importantly, consumers do not seek specific services so much as they seek satisfaction for their long-term care needs. Third-party payers are several steps removed from a direct understanding of those needs. Both consumers and employers might be willing to pay more to compete effectively for direct-care workers, but first they must convince third-party payers to increase reimbursement rates accordingly.

Unfortunately, the "need" for increased reimbursements to pay for more services and/or higher-quality services, as defined by long-term care consumers, is almost always greater than the amount that government agencies are willing to pay ("effective demand"). Public agencies, shouldering the majority of the bill for long-term care, must apportion tax dollars to an array of public needs—with health care being only one public need among many, and long-term care being only a portion of total health care costs.

Exacerbating this dynamic are the variations in the payment system due to the current system's reliance upon states to set Medicaid payments[17] to fund long-term care services: States have significantly different tax bases, and thus significantly different abilities—even should the political will exist—to increase payments for long-term care services.

To balance these political choices, public payers implement cost-containment measures that constrict the amount of money providers can spend per client, per episode, or per visit. Since direct-care labor typically accounts for the majority of costs in long-term care, these cost containment measures to a large degree frame—and sometimes even specify—the amount of dollars available for wages, benefits, and hours of work.

Federal Reimbursement

At the federal level, cost containment measures, such as capitated budgets and prospective payment formulas, base their financial analysis on *historic* costs of care, defining a "basket" of expenses that the public insurer determines is necessary and sufficient to provide a certain type or amount of care.[18]

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[16] According to one recent study, nursing homes reimbursed by Medicaid lose, on average, more than $9 per patient per day (BDO Seidman, 2001).

[17] The cost of Medicaid is shared by states and the federal government, with at least 50 percent paid for by Federal tax dollars. However, funding levels and design of services are determined primarily by each state.

[18] For example, a certified home health agency will receive from Medicare a set amount of dollars for an "episode" of care to provide nursing and rehabilitative services to a person discharged from the hospital following surgery for a fractured hip. The episode can range from a few weeks to 60 days, during which

Although these types of reimbursement systems are called "prospective payments" (because they determine in advance a set amount of dollars for each health event), the basis upon which they are set are in fact *retrospective*: Formulae are based on historic costs—including historic labor costs, often from several years earlier—and thus the reimbursement rate allows providers little flexibility to respond to rapid changes in market forces.

Such an approach to reimbursements may function adequately in times of high unemployment and thus low demand for labor, when providers can "bargain" for workers at the lowest price possible. Yet when budget constraints collide with heightened labor competition, the reimbursement system responds too slowly, if at all, and publicly funded consumers and long-term care agency providers find themselves unable to offer competitively attractive employment for direct-care workers. As we enter into a time of massive demographic shifts that limit the supply of labor, these payments systems must be re-evaluated and adjusted to reflect the actual and future costs of attracting and retaining direct-care workers in an increasingly competitive marketplace.

State Reimbursement Policies

Because Medicaid pays such a significant portion of the long-term care bill, and because states are responsible for establishing Medicaid payment levels, state governments have found themselves more closely impacted by the direct-care crisis. Faced with increasing stakeholder concerns about inadequate service caused by high vacancy and turnover rates, 36 states have passed legislation to directly increase paraprofessional wages or benefits (North Carolina Department of Health and Human Services, 2002). Some states, including Michigan, New York and Massachusetts, have used "wage pass-through" mechanisms[19] for many years. Most all other "pass through" states, however, have implemented legislation only within the past three years.

The various wage initiatives have varied from state to state. For example, several of the county-based home care authorities in California—with the strong support of both labor and consumer groups—have specified wage floors, with set increases targeted for future years. Most other pass-through states have allocated additional monies to their long-term care reimbursement rates—typically Medicaid funds—usually requiring that those additional funds be dedicated exclusively for direct-care wages and/or benefits.

While the intent of these efforts has seemed quite simple—that is, to make direct-care jobs competitively more attractive in the labor market, and thus address the high

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the individual receives physical therapy, occupational therapy, nursing and possibly home care aide services. All services are provided as visits, which can begin several times a week for a week or two and then taper, as the individual becomes more functional and independent.

[19] A "wage pass through" is typically an additional dollar amount, added to long-term care providers' reimbursement rate by state government during a particular budget period, that is targeted specifically to raise wages and/or benefits for direct-care workers.

rates of vacancies—implementation has been frustratingly complex, and efficacy has been unclear. Challenges have included:

- **Accountability**: Ensuring that monies truly "pass through" the provider into the hands of workers is not an easy task. This has proven problematic not only from the workers' perspective, whose expectations for a wage increase may not be met as promised, but also from the providers'. Formulae for wage pass-throughs have often proved confusing and even contradictory, and accounting for these special funds becomes one more reporting requirement for employers.

- **Continuity**: Most wage enhancement legislation is only enacted for the period of the legislative budget, in essence becoming only a wage "bonus" that must be renewed each legislative session in order to create a truly new wage floor.

- **Parity**: Many wage enhancement initiatives have been directed only to one category of direct-care worker—nursing home staff, for example—thus causing or further exacerbating wage disequilibria among similar workers within different parts of a state's long-term care system.

- **Distribution**: While the primary source of wage enhancement dollars has been Medicaid, many long-term providers receive funding from a mixture of funding sources. Therefore, even within a single part of the long-term care system, additional funds may not be spread equally among direct-care workers.[20]

Finally, two important factors also shape the efficacy of wage enhancement initiatives:

- **The size of the wage increase that actually gets to the direct-care worker's paycheck**: Many states have only increased wages by 50 cents or less per hour; such a small increase may have little or no impact on improving recruitment and retention rates—particularly if this constitutes only a bonus for the year and not a new wage floor.

- **Whether the wage enhancement is enacted in isolation**: While increasing wages and benefits is essential to improving the competitiveness of direct-care jobs, per hour compensation is not the only factor. Other factors, such as the quality of management support, appropriate training, and the structure of the job itself (e.g., part-time home care jobs that result in only part-time pay) are equally important. Thus, no matter what the size wage increase, additional pay for a worker who frequently feels undervalued—by supervisors, co-workers or clients—may do little to keep that worker from leaving long-term care.

[20] For example, two home care agencies of the same size in a single state might each receive a mix of payment streams from Medicare, Medicaid, other state programs and private pay; however, the first might rely heavily on Medicaid dollars, yet the second might only serve a small number of Medicaid cases. If the state's wage enhancement is funded by Medicaid and distributed to agencies proportionate to Medicaid use, workers in the first agency will receive a relatively large share of pass-through funds, while workers in the second agency may enjoy little or no wage increase.

Indeed, only three states have evaluated the impact of enacting wage pass-through legislation on paraprofessional turnover rates, finding only modest results: *Michigan* found, in 13 years of providing wage pass-through funds, that wages earned by certified nurse assistants increased by 61 percent while turnover rates for that position decreased by 21 percent during the same time period. In *Kansas*, one year after implementing their program, the annualized turnover rates for all positions eligible for wage pass-through funds decreased slightly to 101 percent. The Kansas program funded less than half of the increase in wages identified as needed by the providers (North Carolina Department of Health and Human Services, 2002). Finally, a survey of *Massachusetts* nursing homes found that the wage pass-through contributed to an overall increase of 8.7 percent in CNA wages. In combination with a broad package of interventions enacted by the legislature, Massachusetts nursing homes reported improved stabilization in their vacancy and turnover rates after several years of escalating difficulties (Massachusetts Extended Care Federation, 2001).[21]

Medicaid is the primary source of funding at the state level, and thus state policy makers and stakeholders have little choice but to continue to attempt to manipulate Medicaid reimbursements should they wish to increase wages and benefits among direct-care workers. Hence, despite a limited track record, a large number of states have implemented some form of "wage enhancement" initiatives.

The Absence of National Policy

In the absence of a thoughtful national policy, long-term care in the U.S. will remain a rickety structure of disparate finance sources, creating segregated funding "silos" containing an even more disparate array of program "silos within silos"—nursing home services funded distinctly from in-home services, which in turn are funded separately from personal assistance services, assisted-living, and residential-care services.

Thus, our long-term care financing consists of a patchwork of programs that is unable to adapt to the needs of consumers, workers or providers. This disaggregated system of vertical structures fails to recognize that long-term care clients often move laterally back and forth, shifting from one part of long-term care to another. Similarly, many workers move *across* long-term care settings—when not blocked by incompatible education or credentialing requirements—since job responsibilities are similar within the settings.

Furthermore, segregated financing streams spur "cost shifting" between funders, encouraging federal and state programs to compete with each other to *avoid* paying for services. For example, during the Balanced Budget Act of 1997, the U.S. Congress re-

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[21] For a baseline evaluation of one central element of this broad set of interventions, see Eaton, et. al. *Extended Care Career Ladder Initiative (ECCLI): Baseline Evaluation Report of a Massachusetts Nursing Home Initiative.* Kennedy School of Government Working Paper # RWP01-035, July 2001. http://ksgnotes1.harvard.edu/Research/wpaper.nsf/rwp/RWP01-035?OpenDocument

wrote requirements for Medicare (funded only at the federal level) to discourage extended home care visits—as a result, Medicaid (funded in part by states) was forced to pick up at least some of the shifted costs.

In addition, great inconsistencies exist between states in both their ability and willingness to provide long-term care services—and even within some states differences exist between rural and urban long-term care services—making access to long-term care support and assistance an accident of geography rather than an equitable right of long-term care consumers.

Finally, and perhaps most importantly: isolated funding silos, gaps between state and federal programs, and often sudden changes within funding programs all combine to create enormous *instability* within long-term care—destabilizing consumers, workers and providers alike. For example, a historic reversal in Medicare reimbursements within the Balanced Budget Act cut funding for home care services *by 45 percent* in less than three years, resulting in more than *one third* of all Medicare certified home care agencies either closing or merging across the country. Similarly, the same Balanced Budget Act abruptly changed reimbursement incentives for nursing home services, at least in part contributing to *five of the ten largest nursing home chains* selecting Chapter 11 bankruptcy protection in 2000 and 2001.

The result of such instability is a "system" designed neither around the client nor the direct-care worker. As can be seen from the experience of states that have tried to address the direct-care crisis through wage enhancement legislation, this ill-designed cross-hatch of funding streams and program silos makes even targeted efforts to improve the quality of direct-care jobs frustratingly difficult (Stone and Wiener, 2001).

To address the direct-care crisis, a *national* strategy—integrating both federal and state policy into a comprehensive system of long-term support and services—is essential. Only a system designed around the relationship between the long-term care client and his or her worker will ensure both quality jobs for direct-care workers and quality of service for long-term care consumers.

The recommendations detailed below are examples of how long-term care financing must address the needs of consumers, workers, and providers. Both private and public insurance programs must be re-designed—increasing resources and consumer choice, while ensuring protections for both consumers and direct-care staff.

PART VII: RECOMMENDATIONS

As demand for long-term support and services increases inexorably during the next decade and beyond—and the supply of traditional caregivers fails to keep pace—our nation must reform the way we finance long-term care in order to create decent jobs and in turn ensure access to affordable, quality care. In addition to financing care adequately, we must also make direct-care jobs more attractive and at the same time broaden the

supply of those workers. Otherwise our nation's long-term care system will prove unable to keep pace with the demographic deluge of 77 million "Baby Boomers."

Recommendation #1: Develop a National Commitment to Long Term Care Financing

In the papers, *Defining Common Ground: Long Term Care Financing Reform in 2002* and *Long Term Care Financing Reform: An Integral Part of the Social Security and Medicare Reform Debates*, Citizens For Long Term Care called for a national insurance commitment to long-term care financing based on a public-private financing model. This model would combine a social insurance benefit (provided as cash, and based on level of functional disability) with private long-term care insurance tax incentives, and reforms in both Medicaid and Medicare programs. CLTC believes such a model would greatly improve upon the inconsistencies inherent in our current jury-rigged system of financing.

Specifically, Citizens For Long Term Care member organizations agree upon the following set of basic principles that would shape the development of an ideal long term care system:

Independence

Services should promote individual dignity, maximize independence and self-sufficiency, be provided in the least restrictive setting possible, and reflect the overwhelming preference of individuals to remain at home.

Choice

People should be able to choose from a full range of home, community-based, and facility-based health and social services so they can get the types of services that will meet their individual needs and preferences.

Role of Families

The central role families play in planning for and providing long term care should be recognized and supported.

Access

People of all ages and income levels should have access to long term care services and supports.

Eligibility

Eligibility for services should be based on functional criteria and social needs that take into account cognitive, physical, and behavioral limitations and the need for support, supervision, or training.

Financing

Costs should be spread broadly and progressively, so that out-of-pocket costs are affordable. This goal may involve tax policy, Social Security, Medicare, Medicaid, private health insurance and pensions, social services, and housing policies. Both public and private financing mechanisms should be strengthened toward this goal.

Accountability

Systems for assuring the quality of care should be built into all long term care programs. These systems should assure quality and value based on outcomes and consumer protections enforced through appropriate government regulations.

Standards

The highest standards of professionalism and quality are essential for caregivers and systems. This must be supported by thorough training, appropriate supervision, and fair compensation.

Coordination

Systems should coordinate services for people with multiple needs which change over time, providing a seamless continuum of care.

Efficiency

Incentives and controls in public and private programs must maximize quality and control costs.

In CLTC's proposal for long-term care financing, recipients could use a cash benefit as they needed, including for hiring family caregivers. These benefits would "follow the consumer" through the entire spectrum of long-term care services and supports, allowing him or her to move more freely and to maintain a consistent level of financial support, independent of setting.

However, CLTC recognizes that, although a new financing system based on a cash benefit—with appropriate safeguards to protect against fraud and abuse—could better serve both long-term care consumers and direct-care workers, a cash payment benefit may not be the best solution for all consumers. Furthermore, CLTC believes that protections for *both* consumers and workers must be built into the system.

For example, one successful consumer-directed model, built through the combined efforts of both consumers and workers, is the "public authority" home care system in California, which currently serves more than 275,000 consumers and employs more than 200,000 direct-care workers, many of whom are family members of the clients they serve. This model gives consumers the freedom to hire and fire their direct-care worker, but designates a public authority as the official "employer of record"—creating a mechanism through which workers can organize to improve their wages and working conditions and receive support services (Heinritz-Canterbury, 2002).

Finally, CLTC strongly believes that financing reform alone will not solve the direct-care staffing crisis. The following policy and practice reforms are equally important, both to broaden the supply of workers, and to make caregiving positions more attractive within an increasingly competitive labor market.

Recommendation #2: Make Direct-Care Jobs Competitively Attractive

In order for direct-care employment to compete successfully within a tightening labor market—for either traditional or non-traditional direct-care recruits—the *quality of jobs must be substantially improved*. [22] Therefore, Citizens For Long Term Care recommends that long-term care finance reform follow seven essential elements of a quality job:

H. "Self-sufficient wages," health insurance, and other benefits: The long-range goal for direct-care wages should be set toward "family self sufficiency," achieved incrementally, and adjusted for inflation[23]: Within five years, by 2007, all publicly and privately financed direct-care workers should earn a self-sufficiency income at least equal to that of a wage earner within a two-wage family of four.[24]

In addition, any new finance systems should allocate sufficient resources to providers so that they can pay health insurance to their own workers and their families, as well as vacation pay, sick pay, paid holidays, retirement benefits, and paid family medical leave. Such benefit packages should be flexible, since older workers entering the direct-care employment have different benefit needs than younger workers who are caring for children.

I. Balanced and safe workloads that offer full-time employment, but do not overwork employees: A large portion of the long-term care industry, community-based services in particular, is structured on the presumption of part-time work. For those seeking full-time employment, reimbursement

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[22] Dr. Susan C. Eaton, Assistant Professor of Public Policy at the John F. Kennedy School of Government, Harvard University, makes this case for nursing home workers and consumers in *Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs.* Keystone Research Center High Road Industry Series, No. 1. Harrisburg, Pennsylvania: Keystone Research Center, April 1997.

[23] The State of Wyoming just determined that a competitive wage for long-term care workers supported by public funding should be increased by more than $3.25 per hour, rising to a target of $10.23 per hour (Wyoming Department of Health, 2002).

[24] A self-sufficient wage varies with family size and from region to region, and sets a target that is significantly higher than the current typical direct-care wage level. For example, in the District of Columbia, for a family of two adults and two children, each adult would require earning approximately $12.50/hour, while a self-sufficient wage for a single mother with one child would be approximately $16/hour. Self sufficiency is defined as the income required for a family to meet its basic needs—food, clothing, housing, and health insurance—without public or private assistance. This standard was developed by Wider Opportunities for Women as part of its *State Organizing Project for Family Economic Self-Sufficiency.*

should be structured so that paraprofessional jobs can offer a minimum of 35 hours per week without overuse of off-hour shifts.

In facility-based care, inadequate numbers of staff can frequently require overtime shifts and can also lead to unsafe care. Overtime should be discouraged, and staffing levels should be increased and adequately funded.

J. More appropriate training standards: Providing care to vulnerable people requires at times more formal and accredited training than 75 hours of instruction (which is the current federal minimum standard for certified nurse aides). Training credentials should be "portable," particularly for home health paraprofessionals, thus allowing flexibility when re-locating to another state or agency. Paraprofessional entry-level and "continuous" training should be updated and expanded to reflect current care needs, clinical realities, and adult life-long learning techniques—particularly to cultivate problem-solving, interpersonal, and communication skills, as well as specific skills related to caring for clients with cognitive and mental impairments.[25]

However, within all recommendations on training, Citizens For Long Term Care recognizes the right of self-directed consumers to educate their own personal assistance workers as they see fit.

K. Job re-design, opportunity for advancement, and management "culture" re-design: Paraprofessionals require a job design that recognizes their skills as well as their special knowledge of the client. One approach is to ensure that paraprofessionals are made a central member of the care team—which is one essential element of changing the "culture" of the long-term care workplace from a *culture of turnover* to a *culture of retention*. This in turn requires higher levels of effective supervision—including job-coaching and other approaches that emphasize problem-solving over disciplinary actions.

Furthermore, to retain dedicated staff within the long-term care health system, potential workers must have access to career pathways to develop themselves and, over time, receive higher levels of compensation for higher levels of experience, skills, and responsibilities. At least ten states have initiated career ladder programs to improve recruitment and retention (North Carolina Division of Facility Services, 2001).

L. Employee supports: Many direct-care jobs are filled by individuals who have relatively few financial assets to rely upon—particularly when something goes wrong either at work or at home. Therefore, employers should be encouraged to help stabilize the lives of their staff, for example, by helping to identify resources for affordable housing, child care assistance, and transportation benefits. By helping employees identify these resources, an

[25] See Abt Associates' *Appropriateness of Nurse Staffing Ratios in Nursing Homes, Phase II Final Report,* Chapter 7, for a full discussion of paraprofessional training issues.

employer can significantly improve the stability, and thus the retention, of its direct-care workforce.

Assisting in arranging for employee supports—often available by partnering with nonprofit and community-based organizations—can be undertaken in a "case management" like approach as a human resources responsibility. Such an individual-by-individual system of employee management and support recognizes both the multiple challenges of low-income workers' lives and the difficulties of their everyday, on-the-job responsibilities.[26]

M. **Improved use of technology:** New and existing forms of technology (for example, monitoring devices and hand-held computers) can extend and expand the capacity of direct-care workers, without sacrificing the "high touch" nature of long-term care services. These devices can save steps, promote higher levels of accuracy (for example, in charting), and free direct-care workers to spend more time with consumers. Effective use of such assistive technology should be further explored and funded.

N. **Full payment for accountability systems:** Finally, whether using public or private financing, accountability for appropriate use of funds is essential when delivering long-term care services and support. Clearly, controls are required to ensure that resources are used by providers as intended. Expenditures for quality assurance mechanisms and accountability systems must continue to be met. Therefore, the full costs of accounting for appropriate use of these funds, particularly clear accounting for expenditures on direct-care staff and including the cost of time required for filling out paperwork on-site, must be accommodated in any new financing system.

Recommendation #3: Broaden the Supply

To rely for new caregivers solely on young women entering the workforce, our "traditional caregivers," would be to ignore the emerging demographic realities. Therefore, Citizens For Long Term Care recommends that reform of our finance system should also follow five paths to increased supply:

F. **Encourage younger individuals into direct-care.** Direct-care employment requires significant maturity, particularly for community-based jobs where the worker provides support and assistance as a guest in the consumer's home, typically with little or no supervision. To retain a higher percentage of younger workers will require, among other factors, re-design of preparation, education, and supervision structures in order to provide greater and more consistent support. For outreach to younger workers, education programs in

[26] For an in-depth description of a range of creative employer support activities, see *Finding and Keeping Direct Care Staff: Employer of Choice Strategy Guide for Catholic-Sponsored Long-Term Care and Home Care Providers.* Catholic Health Association (2002).

high schools and community colleges should be expanded to introduce students to the benefits of long-term care service.

G. Encourage older workers. Much of direct-care employment is "hands on" assistance, often requiring the lifting and transfer of clients, some of whom may be resistant or combative. To recruit and retain a higher percentage of older workers will require greater job-design flexibility—built around the capacities of older workers—increased staffing levels (to ensure more than one worker is available for lifting and transfer for those residents who require greater assistance), and increased availability of assistive mechanisms to aid in transfer.

H. Encourage men to enter direct-care occupations. Just as is true for attracting and retaining women into our long-term care system, competitive pay and benefits will be required to attract male workers away from other job options. Furthermore, the "work culture" of direct-care employment must be broadened in order to make males feel welcomed into the long-term care industry. This can only be achieved if training and education services are strengthened, with "cultural competence" embracing the needs of both male and female recruits.

I. Encourage those currently receiving public assistance. Although some states, such as New York, Pennsylvania and Massachusetts, have used Temporary Assistance to Needy Families (TANF) funds for successful "welfare-to-health care" employment programs, other states have directed welfare recipients and the unemployed *away* from long-term care employment. Therefore, public initiatives to encourage welfare-to-health care programs should be linked to parallel efforts that re-structure direct-care jobs into self-sufficient, high-quality employment.

J. Explore expanded immigration. Significantly expanding the pool of direct-care workers through increased immigration should be carefully explored. However, the quality of direct-care employment must be substantially improved for all workers, including immigrants, before looking to new immigration programs. All those who work in direct-care positions should receive competitive wages and benefits and should be afforded opportunities for training and advancement.

Immigration programs for health care professionals and paraprofessionals should include the same workers protections provided to citizen employees. Visas should provide a "path-to-permanence" and sponsorship portability allowing foreign-born workers to change employers while maintaining status. Special direct-care training programs for "New Americans" should be supported, ensuring greater cultural competence, and offering additional benefits such as English as a Second Language. In addition, U.S. immigration policy must avoid depleting the already thin ranks of trained health care workers within poorer nations.

Finally, granting employment status to undocumented residents already living within the United States would likely expand access of those workers into formal

direct-care work, and thus should be aggressively encouraged. Working with refugee populations entering the country under U.S. State Department supervision—many already having significant health care experience in their countries of origin—may be another important source of direct-care workers.

All five paths to increased supply will require close cooperation with our nation's education and training systems. For example, special direct-care scholarships should be designed, along with tuition reimbursements and loan forgiveness programs, for those who complete a specified length of service as direct-care staff.

Guiding Principles

Citizens For Long Term Care's "Principles of Reform," noted earlier, described a set of basic principles that would shape the development of an ideal long term care system. From these principles, CLTC sought to be more specific, developing "Eight Pillars of Financing Reform" that would help guide the national dialogue on long-term care financing reform:

- Every American must be assured access to needed long term care services.
- A wholly new, stand-alone, comprehensive financing system for long term care is neither practical nor likely at this time and hence long term care financing reform should be initiated on existing structures.
- The social commitment to long term care must be in the form of a public/private system built on the principles of social insurance and private insurance.
- Eligibility for the social insurance benefit should be based on functional limitations as an entitlement benefit.
- Private and public policies should be developed to educate and encourage individuals and families to plan for the financing of care prior to the onset of disability.
- Professionals, paraprofessionals, and direct support professionals are critical to quality care and must be recognized and valued by the system.
- Public assistance must be maintained and improved to provide a full range of services and supports to those who are not otherwise covered.
- The financing system must support choices across the continuum of care and help maximize personal independence, self determination, dignity, and fulfillment.

Building upon these eight principles, Citizens For Long Term Care believes the following additional principles must guide our nation's efforts to reform long-term care financing and address the emerging workforce crisis:

- The right of consumers to safe, responsive, quality support is paramount to all else within the long-term care system.

- To improve the competitiveness of direct-care employment, the financing system must reimburse providers to allow them to implement the recommendations for making direct-care jobs competitively attractive and for broadening the supply of workers, as outlined above.

- Public financing programs should review their reimbursement structures and regulations, in order to maximize direct-care worker recruitment and retention. Such review should include input and guidance from consumers, providers, and workers, and result in greater stability across the nation's system of long-term care.

- All financing sources should encourage parity of compensation across the various direct-care sectors, services and payers—ensuring, for example, that community-based workers earn comparable wages to workers who perform similar duties in other care settings. Those financing sources should also encourage portability of training and experience certificates across the long-term care sector.

- Where immediate implementation of CLTC's recommendations might prove too costly, long-term targets should be established and pursued, and demonstration programs testing their efficacy should be encouraged.

- Long-term care financing reform should balance both the rights of consumers in selecting and educating direct-care staff and the rights of workers to be respected, appropriately trained and adequately supported.

- The right of workers to form and join their own union or association must be respected.

Importantly, addressing the direct-care staffing crisis is not only a matter of public policy, it is also a matter of practical implementation. Each of the three key stakeholders in long-term care—providers, consumers, and workers—must consider new models of service delivery, and work cooperatively with one another to re-structure direct-care employment.

The frightening severity of the emerging Care Gap must not immobilize, but rather galvanize this nation into immediate action. To create true and lasting finance reform will in particular require leadership from federal political leaders, as well as from national leaders representing consumers, providers and workers. At stake are not only our loved ones, but also ourselves—the current and future consumers of long-term care services and support.

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