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# Long-Term Care Workforce Shortages: *Impact on Families*

POLICY BRIEF NO. 3

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COMMISSIONED FOR

**Who Will Provide Care?**  
*Emerging Issues for State Policymakers*

FUNDED BY

*The Robert Wood Johnson Foundation*

OCTOBER 2001

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FAMILY CAREGIVER ALLIANCE®  
National Center on Caregiving

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Robyn I. Stone, Dr.P.H.

## INTRODUCTION

The paraprofessional long-term care (LTC) workforce—nursing assistants (NAs), home health and home care aides, personal care workers and personal care attendants—forms the centerpiece of the formal LTC system. After family caregivers, these frontline workers provide a large share of the hands-on care, supervision and emotional support to millions of elderly and younger people with chronic illness and disabilities. They work across the service continuum including the nursing home, assisted living and other residential care settings, adult day care and private homes. Low wages and benefits along with hard working conditions, heavy workloads and a job that has been stigmatized by society make recruitment and retention of workers difficult, even when

unemployment rates are high. While concerns about the availability of this workforce have ebbed and flowed over the past two decades (see Crown et al. 1992; Bayer et al., 1993; Atchley, 1996; Wilner and Wyatt, 1998), many policymakers, providers, consumers and researchers currently use the term “crisis” to describe the problems with attracting and retaining workers. Finding a qualified, committed NA or home care aide has become a second-order priority; recruiting “warm bodies” to provide the frontline care has become the primary goal for many nursing homes, residential care providers, home care

agencies, community-based care organizations and families.

The media has begun to document the crisis status of this labor shortage, underscoring the potentially negative consequences for quality of care and quality of life. Policymakers at the federal and state levels are also beginning to acknowledge this problem. Officials from 42 states responding to a 1999 national survey of LTC workforce issues identified recruitment

and retention of frontline workers as a major priority; 30 states reported engaging in a workforce initiative (North Carolina Division of Facility Services [NCDFS], 1999).

Difficulty in recruiting nursing and home health aides is likely to worsen over time as the number of people needing LTC

increases relative to the population age 20-64, which makes up most of the workforce (The Lewin Group, 1999). Between 1998 and 2008, analysts project an increased need for 325,000 NA and 433,000 personal care and home health aide jobs (Bureau of Labor and Statistics [BLS], 1999), but little evidence that there will be enough people to fill them. Reflecting the growing emphasis on and preference for provision of LTC at home or in alternative residential settings rather than institutions, total employment in nursing homes is projected to grow less quickly than in home and community-based settings. A sharp economic downturn could end the

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current worker shortage, but the long-run demographic imbalance between the demand for and supply of workers can only worsen over time.

The purpose of this Policy Brief is to describe the nature and scope of the short- and long-term frontline workforce shortage, to highlight the issues particularly germane to state policymakers and to discuss the implications for family caregivers. After a profile of the frontline LTC worker, the problem is summarized, emphasizing the need to address both the immediate worker-shortage crisis and the more systemic problem of developing a qualified, committed, stable frontline workforce. The third section highlights the direct and indirect consequences of this problem for family caregiving. This Policy Brief concludes with a discussion of the role of state policy in addressing these concerns and a review of current state initiatives attempting to address the problem.

#### PROFILE OF FRONTLINE WORKERS

Most paid providers of LTC are paraprofessional workers. They deliver the largest share of the primarily low-tech personal care and assistance with managing daily life. NAs held about 750,000 jobs in nursing homes in 1998. Home health and personal care aides held about 746,000 jobs in 1998 (BLS, 1999). However, many home care workers are hired privately and official federal statistics may not include them. According to a study of independent home care workers in California, for example, the state employs more than 200,000 workers through its In-Home Supportive Services (IHSS) program, 72,000 in Los Angeles County alone (Cousineau, 2000). In their national study of home care workers providing assistance to the Medicare population, Leon and Franco (1998)

found that 29 percent of the workers were self-employed.

As is true with informal caregivers, the majority of frontline LTC workers are women. According to 1998-2000 national data (Scanlon, 2001, Table 2), while half of all workers and about two-thirds of service workers are women, 91 percent of nursing home aides and 89 percent of home health care workers are female. Compared to the workforce in general, nursing home and home

health care aides are more likely to be non-white, unmarried and with children under age 18 at home. Most of these frontline workers are relatively disadvantaged economically (Scanlon, 2001, Table 3). Median family incomes for aides working in nursing homes

and home health care were lower than service workers in general (\$26,970 and \$25,908 respectively compared with \$30,769); they were also more likely to be living below 150 percent of the poverty level (31% and 35% respectively compared with 29%).

Paraprofessionals in nursing homes, home care and other LTC settings tend to make little more than the minimum wage (BLS, 1999). In 1998, median hourly wages for NAs working in nursing and personal care facilities were \$7.50; for those working in residential care, the rate was \$7.20 per hour, the same as for home health aides. The comparable estimate for personal and home care aides was between \$6.00 and \$7.00 depending on the job category. In the Benjamin et al. (2000) study of California's IHSS workers, the mean hourly wage for agency workers was \$6.22; and \$4.79 for the client-directed, independent provider.

Wages do vary widely across states as does the competitiveness of wages for LTC aides with those of other service jobs where they

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might find employment (Scanlon, 2001, Table 4). As a percentage of state per capita income, the mean annual earnings of a nurse aide in 1999 ranged from a high in Alaska (85%) to a low in the District of Columbia (48%) (Scanlon, 2001, Table 5).

Approximately 58 percent of nursing home aides and 47 percent of home health care aides have some type of health insurance coverage through their employers (Scanlon, 2001). It is not clear, however, whether the reported coverage applies only to full-time workers, whether dependent coverage is included and how much the employer actually contributes. If the employee’s share of the premium cost or the deductible is too high, workers generally opt out of the benefit (Wilner and Wyatt, 1998). A larger proportion of workers in nursing homes and home health agencies are enrolled in Medicaid than are service workers in general (9.9% and 11.1% respectively compared with 6.9%).

THE LONG-TERM CARE WORKER PROBLEM:  
DEFINITION AND MAGNITUDE

The severe shortage of NAs, home health and home care aides and other paraprofessional workers is central to current concern about the long-term care workforce. This crisis is a global problem, affecting also the European Union members and Japan whose relative elderly populations are much higher than in our country (Christopherson, 1997). Demographic, economic and policy trends suggest that without serious and sustained

intervention, the inadequate supply of frontline workers will remain a problem and even worsen over the next few decades.

The problem is not simply one of supply. The more fundamental, long-term dilemma is how to develop a committed, stable pool of frontline workers who are willing, able and prepared to provide quality care to people with LTC needs.

***The Current Problem***

Across the country, nursing homes, assisted living and other residential care providers, home health agencies, community-based home care and adult day care programs and individuals and their families all report significant difficulties in recruiting and retaining frontline workers. Nationally, data on turnover rates show wide variation.

- ♦ Estimates of turnover rates for NAs in nursing homes range from 45 percent to 105 percent. A 1998 survey of 12 for-profit nursing home chains found 94-percent turnover in nursing aide positions

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(American Health Care Association [AHCA], 2001).

- ♦ Estimates of home care worker turnover are lower, but anecdotal evidence points to great variation across agencies and among independent providers (MacAdam, 1993; Crown et al., 1995). A recent national study of home health agencies conducted by the Hospital and Healthcare

Compensation Service identified a 28 percent turnover rate among aides in 2000, up from 19 percent in 1994 (cited in Scanlon, 2001).

Officials from 42 state Medicaid or aging offices reported significant recruitment and retention problems among their paraprofessional workforce (NCDFS, 1999) and selected state reports substantiate this concern. Massachusetts's nursing home administrators, for example, reported an 11 percent vacancy rate in frontline worker positions in 1999 (Frank and Dawson, 2000). In a 2000 study of the Pennsylvania frontline LTC workforce, three-fourths of nursing homes and more than half of all home health agencies reported staff shortages (Leon et al., 2001). In the fall of 2000 an estimated 94,150 persons were employed in frontline jobs across the 3,400 licensed providers serving Pennsylvania's disabled elderly and younger physically disabled populations; the survey identified an additional 11,300 open job positions. The Northeast region of the state had the highest vacancy rate and the Philadelphia metropolitan area the lowest (yet its 4,500 job openings accounted for 40% of all open positions in the state).

States and providers have also identified significant retention problems.

- ♦ California nursing homes report an overall employee turnover rate of 67.8 percent, with the annual NA turnover rate estimated to be even higher (Ruzek et al., 1999).
- ♦ New York nursing homes and home health agencies had an average NA turnover rate between 1997 and 1998 of 42 percent statewide, 21% for the New York City/Long Island area and 56% for the rest of the state (New York Association of Homes and Services for the Aging, 2000). Ohio nursing homes reported NA turnover

rates from 88 percent to 137 percent (likely underestimated) and home health aide turnover rates ranged from 40 percent to 76 percent (Straker and Atchley, 1999).

- ♦ North Carolina annual NA turnover rates reportedly exceed 100 percent; the comparable estimate in adult care homes is over 140 percent (NCDFS, 1999). Former NAs now employed in other sectors are earning more in a single position than before (many NAs have multiple jobs to help them make ends meet) (Konrad, 1999).

### ***The Long-Term Outlook***

The 21<sup>st</sup> century will experience an unprecedented increase in the size of the elderly population as the large baby boom generation ages. While most elderly people are not disabled, the likelihood of needing LTC increases with age. Assuming reasonable rates of economic growth, baby boomers are likely to have higher real incomes during their retirement years than today's retirees (Manchester, 1997). Those facing long-term care decisions may be more willing and able to purchase formal services than to rely solely on informal care. This trend, coupled with the aging of the population, will increase demand for formal LTC services over the next 30 years.

The future availability of informal caregivers is less predictable. On the one hand, the ratio of the population between ages 50 and 64 (the average caregiving range) to the population aged 85 and older likely will decrease from 11 to 1 in 1990 to 4 to 1 in 2050 (Robert Wood Johnson Foundation [RWJF], 1996). However, this estimate does not include the large number of elderly spouses, particularly wives, and the increasing number of adult children, both above 65 and under 50, who may be available to care for their parents. The baby boom generation's parents are aging with

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a larger average pool of family members than the Depression-era generation had and than older people likely will have during the next 30 years (Stone, 2000). Due to an increase in delayed childbearing, more employed women are expected to be juggling parenting and elder care responsibilities. A recent survey of private geriatric care managers (Stone et al., 2001) suggests growth in the long-distance caregiving market, which could place more demands on the formal LTC system in the future.

The future availability of frontline workers is of serious concern. By 2010, as baby boomers approach old age and begin to require assistance, the pool of middle-aged women available to provide low-skilled basic services will be substantially smaller than it is today (Feldman, 1997).

- The pool of “traditional” caregivers (women between the ages of 25 and 54) is predicted to increase little during the next 30 years (7%).
- More importantly, the pool of potential “entry-level workers (women aged 25 to 44 in the civilian workforce) is projected to decline (by 1.4%) during the next six years (Paraprofessional Healthcare Institute [PHI], 2001).
- The educational level among minority women—those most likely to enter the paraprofessional workforce—is also improving dramatically (U.S. Bureau of the Census, 1998). These more educated women will be less willing to work in the same low-wage, low-benefit jobs as those who preceded them (Burbridge, 1993).

The official unemployment rate in the United States is at historic lows. With very low population and labor force growth, even a

“normal” business cycle recession will likely yield only a modest increase in the number of unemployed (Judy, 2000). Therefore, the unemployed do not offer a large untapped pool of potential frontline workers. Individuals transitioning from welfare to work are a potential source of labor, but many of these individuals have already been absorbed into the economy (Frank and Dawson, 2000). Those who remain on public assistance may have multiple physical, mental and lifestyle barriers to employment, particularly with respect to the type of caring, yet demanding work required of NAs and home care aides.

Many policymakers and providers in the U.S., as well as in Western Europe and Japan, view immigrants as a potential pool of workers. Reliance on a major influx of immigrants to solve the labor shortage may have significant negative consequences for our society and the global

economy:

- Increased costs to states and localities for health care, educational and housing needs associated with immigrant families.
- Competition for jobs with the low-wage domestic workforce should a major downturn in the economy occur.
- Diminishment of the worker pool in the country of origin, placing strain on that nation’s economy.

Finally, seeking immigration as a solution does nothing to address the issue of how to create a quality job for frontline workers.

The long-term outlook for the paraprofessional labor market, therefore, does not look promising, and developing a qualified, committed workforce—a more fundamental issue—has not even been considered. The lack of a well-trained, well-qualified workforce for long-term care—professional and paraprofessional—is a graver

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problem than financing and delivery problems (Stone, 2000). It is more than just hiring “warm bodies”. There are few financial or cultural incentives to obtain training or to pursue careers in the care of older adults with chronic illness and disabilities.

### ***Implications for Family Caregiving***

High rates of staff vacancies and turnover have negative effects on family caregivers—both directly and indirectly. First, the inability to recruit and retain home care workers places more pressure on family caregivers to provide care and creates anxiety for those who are trying to arrange for formal care. Anecdotal evidence suggests that families with loved ones in nursing homes and assisted living are augmenting the care provided in facilities because of the worker shortage. The projected decrease in the informal caregiver pool, along with the dearth of formal providers, could create a care crisis for people with disabilities across the age span.

Turnover is expensive for providers. Several studies suggest that staff turnover and vacancy costs within health care industries—recruitment, training, increased management expenses and lost productivity—range from \$1400 to \$3900 per direct care worker (Zahrt, 1992; Pillemer, 1996). Since Medicaid reimbursement rates are not being increased to address these expenses, such costs are likely to be passed on to individual consumers and their families.

Labor shortages and high turnover rates also have potentially negative consequences for consumers. Anecdotes and qualitative studies suggest that the inability to attract and retain frontline workers may translate into major disruptions in the continuity of care, the

receipt of poorer quality and/or unsafe care, and perhaps reduced access to care (Wunderlich et al., 1996). Because of the important role that workers play in meeting the most basic needs of LTC users and the close personal relationships that are frequently established between the aide and the care recipient, the reduced availability and frequent churning of such personnel may ultimately affect the physical and mental functioning of the client. Several studies have observed that inadequate staffing levels, an inevitable byproduct of a worker shortage, are associated with poorer nutrition (Kayser-Jones and Schell, 1997) and preventable hospitalizations (Kramer et al., 2000) among nursing home residents. Reduced quality of and access to care will have negative consequences for family caregivers too, placing more physical and emotional burden on them.

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Labor shortages and high turnover also affect NAs, home care aides and other workers who enter and remain in these jobs.

- ♦ Workers in understaffed environments may experience higher levels of stress and frustration, potentially leading to poorer quality of care.
- ♦ They may experience higher rates of injury (SEIU, 1999).
- ♦ In nursing homes, they have responsibility for far too many residents and cannot dedicate adequate time to any one individual.
- ♦ In home care, short staffing may limit personal interaction between aides and their clients and heighten tensions between workers and family members. Aides making shorter and less frequent visits also must cut back on the time devoted to caregiving tasks.

THE ROLE OF STATE POLICY

Because states play a major role in LTC policy, the successful recruitment, retention and maintenance of a committed, prepared frontline workforce is an important state responsibility. States influence employer and employee decisions through reimbursement, regulation and program design.

### ***Reimbursement Policy***

Medicaid accounted for almost 38 percent of total expenditures on LTC in 1995; 17 percent was state funds (Stone, 2000). Consequently, Medicaid reimbursement policy plays a substantial role in determining provider wages, benefits and training opportunities. Providers' flexibility in setting wages and benefits is limited by this third-party payer constraint (Atchley, 1996). If payment rates fail to keep up with the "true" cost of providing services, organizations have less flexibility to offer competitive wages and benefits and to provide ongoing training for frontline caregivers. In their review of workforce policy in Massachusetts, for example, Frank and Dawson (2000) argued that Medicaid reimbursement has played a significant role in keeping wages and benefits artificially below the levels necessary to attract and retain quality staff within the Commonwealth's highly competitive labor market.

The State Supplemental Payment (SSP) to the federal Supplement Security Income (SSI) benefit is one reimbursement source that has not received much attention as a factor influencing recruitment and retention of workers. SSI is a cash benefit program for low-income elderly or disabled individuals; states may supplement this benefit. Most low-income individuals living in residential care settings, particularly board and care, rely on their SSI benefits to cover room and board. A number of states also use SSP funds to augment these payments to facilities. Several residential care providers have indicated that low SSP reimbursement keeps them from

offering the wages necessary to attract direct care workers in this tight labor market.

### ***Regulatory Policy***

Regulatory policy in LTC focuses primarily on protecting the consumer and does not explicitly recognize the needs or concerns of frontline workers. Many states, for example, have minimum nursing home staffing requirements that providers find difficult to meet during severe worker shortage periods. The employed workers face unintended negative consequences; they may become demoralized due to increased inspections and deficiencies. The combination of federal and state regulations do not provide the flexibility for workers to respond creatively to the labor force shortages and may even penalize providers for trying to afford their workers more authority and autonomy.

Regulations address the need for training but not the range of education and on-going support paraprofessionals need to assume increasingly complicated and complex responsibilities. Approximately one-third of the states have regulations mandating hours of training above the federally required 75 hours for NA certification (PHI/National Consumer Coalition for Nursing Home Reform [NCNHR], 2000). California, Maine and Oregon are at the high end (requiring 150 to 180 hours). At least 10 states are exploring strategies to improve training of frontline workers in all LTC settings, with California and Oklahoma focusing special attention on dementia care. Nine states have accessed civil monetary penalty funds from nursing home enforcement activities to strengthen their worker training programs.

One major issue for developing the residential care frontline workforce is how much states are willing to moderate their nurse practice acts to allow certain tasks to be delegated to aides, such as administering medication, caring for wounds, and changing catheters (Kane, 1997). Oregon, Kansas, Texas,

Minnesota, New Jersey and New York have included nurse delegation provisions, but the latitude and interpretation of the provisions vary tremendously. This issue gets to the heart of the debate about worker and consumer autonomy. The assisted living philosophy asserts that residents should live in a homelike environment, able to make choices about their care, including decisions that may put them “at risk”. Workers, similarly, should be empowered to make decisions about the care provided. Opponents of nurse delegation, particularly state boards of nursing, argue that aides do not have the skills (and cannot be educated) to engage in such activities as medication management; allowing workers more responsibility and autonomy would jeopardize patient safety. Proponents argue that with the appropriate education and proper supports, nurse delegation would provide more intrinsic rewards for workers, strengthening retention and perhaps expanding the pool of individuals attracted to these jobs.

### ***Program Design***

States have discretion in developing home and community-based service programs financed through Medicaid waivers, the personal care state plan option or state-only funds. Many states have consumer-directed programs that allow beneficiaries to hire and fire their workers. At least 35 states allow family members to be paid as a home or personal care provider. (See the Policy Brief, “Paying Families to Provide Care: Policy Considerations for States,” by Larry Polivka.) The flexibility built into these programs has helped expand the potential pool of workers in these states. Researchers studying the IHHS program in California, for example, found that one-fifth of the paid family providers were new to caregiving; that is, they were not providing informal care prior to participation in the IHHS program (Benjamin et al., 2000). This finding suggests that with modest financial incentives family members not predisposed to informal caregiving might join the pool of formal care workers.

### ***Labor Policy***

Federal and state labor policies have an important role to play in expanding the pool of frontline LTC workers. The federal government invests more than \$8 billion to prepare primarily low-income and unemployed individuals for new and better jobs (PHI, 2000). Ironically, state and federal employment agencies indirectly prevent the LTC industry from participating in training support programs; they require program graduates to secure wages that exceed typical frontline worker salaries. While these policies are designed to protect the trainee from obtaining poverty-level jobs, they essentially preclude graduates from entering the paraprofessional LTC labor force.

In 2000 the federal Work Investment Act (WIA) established a flexible statewide framework for a national workforce preparation and employment system. WIA offers opportunities for experimentation with training initiatives in the LTC field. Funds can be used to help low-income adults become employable through “paid work experience” and on-the-job training. Given the newness of the program, however, the implications of WIA for the development of a frontline workforce remain to be seen.

### ***Welfare Policy***

The Temporary Assistance to Needy Families (TANF) program, created by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), replaced the cash welfare system with a new block grant program to states. TANF provides flexibility to states in developing job opportunities at the state and county level, including public job creation programs and offering wage subsidies in lieu of direct cash grants to welfare recipients.

Although the intent of PRWORA was to increase work opportunities for welfare

recipients, some provisions in the legislation may undermine this goal. Embedded within this law is a presumption, often referred to as “work first”, that discourages entry-level, skill-based training (PHI, 2000). States adhering to this philosophy encourage former welfare recipients to secure any job as quickly as possible. That conflicts with federal nursing home and home health aide requirements for skill-based training. Thus, it is difficult to expand the pool of qualified frontline workers with former welfare recipients. According to PHI (2000), policymakers have recently begun to recognize the problems with the “work first” philosophy, and new state regulations may encourage skill-based training for this population.

Recognizing that TANF participants with a five-year lifetime limit on benefits need employment prospects, the 1997 Balanced Budget Act (BBA) authorized the U.S. Department of Labor to create a \$3 billion Welfare-to-Work grant program for states and local communities. These grants assist long-term welfare recipients and certain low-income non-custodial parents in high-poverty areas to get jobs and succeed in the workforce. Job creation through wage subsidies is one activity permitted. The success rate with this population has been quite variable. Many former welfare recipients are not predisposed to this occupation and lack the basic lifestyle skills to assume the responsibilities of a frontline worker. Without proper training, ongoing mentoring and adequate supports (e.g., subsidized child care), this program is setting individuals up for failure.

#### STATE EFFORTS TO ADDRESS RECRUITMENT AND RETENTION

Several studies over the past several years have documented the range of state legislative and administrative workforce initiatives (NCDFS, 1999, 2000; PHI/NCNHR, 2000; General Accounting Office [GAO], 2001). The major categories of activities are identified and briefly described below.

### *Wage Pass-Throughs*

The most prevalent state initiative is the “wage-pass through” (WPT). With WPT, a state stipulates that some portion of a LTC reimbursement increase (typically Medicaid but may include Older Americans Act Funds, state appropriations, etc.) is to be used specifically to increase wages and/or benefits for frontline workers. Typically, WPTs have been implemented by designating either that some specified dollar amount per hour or client/resident day be used specifically for wages/benefits or that a certain percentage of a reimbursement increase be used for wages/benefits.

WPT initiatives are not new. Massachusetts, for example, passed WPT legislation in the early and late 1980s to address episodic labor shortages (Feldman, 1994); the fiscal year (FY) 2002 budget proposal of its Senate Ways and Means Committee supports a \$40 million WPT and \$3 million more to increase homemaker wage rates in the state. As of September 2000, 26 states had some form of WPT, wage supplement, or related program to supplement wages or benefits (GAO, 2001). Little data exist, however, about the direct influence of this mechanism on recruitment or retention in LTC settings. Historical data from Michigan show an overall drop in aide turnover rates between 1990 and 1998, which the state attributes, at least in part, to WPT implementation (as reported by the NCDFS 2000 survey). No evaluations have examined the short or long-term effects of the WPT strategy and differences in outcomes based on variations in the methodology.

Some policymakers and providers are skeptical about the potential of WPTs to address long-term recruitment and retention problems. The strategy is used primarily during tight labor markets, offering only temporary relief. The increases are minimal, creating undue expectations that may further demoralize workers and exacerbate

worker/management tensions (American Association of Homes and Services for the Aging [AAHSA], 2000). Financially strapped providers in a number of states (e.g., Wyoming, Minnesota) did not accept WPTs due to concern about the employer's share of fringe benefits tied to increased wages.

State officials have reported being satisfied with their accountability procedures to monitor the WPTs' use (NCDFS, 2000). A recent *Sacramento Bee* article, however, highlighted the failure of many California nursing homes to pass increases directly on to frontline workers, underscoring the difficulty in tracking the effectiveness of this mechanism. Advocates and workers in Virginia and Minnesota have also expressed concerns about the lack of formal procedures to ensure that increased reimbursement goes directly to workers (Wilner, personal communication).

### ***Other Financial Incentives and Worker Supports***

States use other mechanisms to increase reimbursement rates and encourage quality of care.

- ♦ Rhode Island has passed legislation that ties nursing home and home care reimbursement rates to increased performance by both providers and staff and provides higher reimbursement rates for workers on the night or weekend shifts.
- ♦ California offers monetary rewards to nursing homes that provide exemplary care to the highest number of Medicaid residents as well as financial grants to stimulate innovative programs.

While these initiatives may be well intended, successful implementation depends on the extent to which outcomes such as degree of care continuity, client and worker satisfaction, and "exemplary" care can be defined and measured in specific facilities.

A number of states also offer specific subsidies for transportation and child care costs associated with getting to and remaining on the job. States also can offer housing assistance vouchers or lower interest loans such as teachers receive in some parts of the country.

### ***Health Insurance Coverage***

Several states have or are exploring programs to expand health insurance coverage (PHI/NCCNHR, 2000).

- ♦ New York's Health Care Reform Act of 2000 authorizes the establishment of a state-funded health insurance initiative specifically targeted to uninsured home care workers. It applies to workers in the New York City/ Long Island area only, a decision attributed to that area's strong unionization (NYAHS, 2000). The New York Association of Homes and Services for the Aging (NYAHS), the state association for non-profit LTC providers, has recommended that all workers in home care, nursing homes and residential care settings across the state be covered.
- ♦ Hawaii and Vermont have strong safety-net programs for all low-income workers to obtain health insurance and prescription drug coverage.
- ♦ New York, Minnesota and Washington have health insurance initiatives that assist small employers—including LTC providers across the continuum—in gaining access to coverage for themselves and their employees.
- ♦ Several states (e.g., Wisconsin, Rhode Island) are experimenting with Medicaid expansions and enhanced State Children's Health Insurance Programs (SCHIP) to increase low-income worker coverage.

To date there are no estimates of how many frontline LTC workers have benefited from these initiatives.

### ***Career Ladders***

In the early 1990s, the New York City Human Resources Administration supported a study to test the effectiveness of a new home care position—the field support liaison (FSL), an individual hired from the home care worker ranks and trained to visit attendant workers to identify problems and to provide peer support in the community. A case-control evaluation found that agencies employing FSLs reduced home care attendant turnover by 10 percent over a two-year period compared with those not using FSLs (Feldman, 1994). Because of lack of city and state funding this demonstration never became an operational program. As part of a comprehensive, multi-year workforce strategy, the Massachusetts legislature created a \$5 million Extended Care Career Ladder Initiative in FY 2001 to support the development and implementation of career ladder programs using innovative caregiving and workplace practices; an expansion of the program with increased funding (\$6.5 million in FY 2002) has been proposed. Grantee nursing homes must partner with workforce development organizations and other LTC providers (home health agencies, assisted living providers, vocational rehabilitation providers) and must provide paid release time (at least 50%) for work training and project participation. The Commonwealth Corporation for Business, Work and Learning is currently evaluating this demonstration.

### ***Training***

States have developed training initiatives for LTC workers over the past two decades. For example:

- ♦ In the mid-1980s New York state awarded \$2 million in grants to 39 organizations to develop basic home care training programs, some specifically on Alzheimer's and related dementias. By 1993, however, the budget was just \$578,000, raising the question of sustainability (NYAHSA, 2000).
- ♦ As part of its Nursing Home Quality Initiative in FY 2001, the Massachusetts legislature appropriated \$1.1 million for

training, including adult basic education and job supports, and another \$1 million for a scholarship program for NAs to get certification training. Its Senate Ways and Means Committee's FY 2002 budget proposal increases the NA scholarship appropriation to \$2 million and expands the scope to enable cross training for workers in other settings such as home care and residential care.

- ♦ In 2000, California appropriated \$25 million (\$15 million from WIA funds and \$10 million from state general revenues) for its Caregiver Training Initiative, designed to improve recruitment and retention of entry-level staff across the continuum. As of February 2001, regional partnerships of providers, public agencies, labor organizations and public education organizations had received 12 grants.
- ♦ North Carolina is funding a pilot project in 10 sites across the LTC continuum to test the effects of several new training programs (NCFDS, 2000). The state will provide financial incentives to encourage aides to complete the training and will evaluate the effects of this subsidized program on aide retention. North Carolina also intends to develop a statewide mentoring program for NAs and home care workers, and the state's General Assembly appropriated \$500,000 for the State Board of Community Colleges to develop on-site Internet training in nursing homes and other innovative programs to help increase recruitment and retention.

### ***Developing New Worker Pools***

States also are looking for alternative sources of workers. States have experimented with attracting high school students into the field through programs established by the School to Work Opportunities Act of 1994. For example:

- ♦ Wisconsin received funds to create a Youth Apprenticeship Program for NAs in nursing homes and assisted living.

- ♦ Several Colorado public high schools created a specific NA training curriculum through it's the School-to-Career Pathway program.

In 1997, the Borough of Manhattan Community College (BMCC) in New York City developed a direct care worker training demonstration. Nineteen Hispanic students completed a six-month program of bilingual vocational training to become paraprofessionals in the field of mental retardation and developmental disabilities (Melendenz and Suarez, 2001). Evaluators found that 80 percent of the students completed the program, and 63 percent were placed in jobs. They attribute the effort's initial success to a strict selection of students who had had prior orientation and counseling, the availability of support services and the active participation of and connection to employers and the industry.

Many states (e.g., New Jersey, New Mexico, Florida, Arkansas) are considering former welfare recipients as candidates to broaden the pool of potential aides (NCDFS, 1999). New York has used some of its Welfare-to-Work grants to develop training programs for former welfare recipients and to encourage placement in a range of LTC settings. A member survey of the New York Association of Homes and Services for the Aging (2000) found mixed results: turnover rates were no higher for former welfare recipients than for other workers, but some providers expressed concern about not being able to screen out inappropriate candidates adequately and wasting training and administrative costs.

### ***Building a Positive Image***

In 1999, the Wisconsin Bureau of Aging and Long-Term Care Resources created the Community Links Workforce Project, providing grant funds to 32 counties to support local LTC workforce initiatives. Kenosha County's Division on Aging and Long-Term Care Staffing Task Force

launched a campaign in Fall 1999 to improve the image of work in this field (KCDAS, 2001). A community outreach specialist, a social marketing consultant and a community advisory committee collaborated on the development of the campaign strategy, logo and slogan, and dissemination plan. Strategies included postcards, posters, payroll slip and church bulletin inserts, and radio and television ads. Findings from a descriptive evaluation suggest that the campaign may have contributed to increased retention rates and improved attitudes of employees across a range of LTC settings. It was less effective in increasing the number of new applicants or reducing turnover among newer employees, although it did result in more inquiries and enrollees for the local technical college's NA classes. The campaign organizers are now exploring the possibility of a statewide replication of this initiative.

### **CONCLUSION**

This Policy Brief underscores the short- and long-term problems related to the recruitment, retention and training of the frontline LTC workforce. It has focused on the implications of this workforce crisis for workers, providers and consumers, including family caregivers, as providers and purchasers of care for their loved ones.

State policymakers play a major role in ensuring that we have a stable, committed workforce of qualified individuals to meet the needs of people with disabilities across the age spectrum. This brief has outlined the major policy levers and provided examples of current state initiatives to address these issues. States must recognize, however, that developing and sustaining a quality pool of formal caregivers requires a long-term financial commitment and the support of partnerships among the various stakeholders including providers, consumers and their families, labor representatives and public education institutions as well as the various agencies within state government. They must

explore ways to use their policy levers to create job-related supports such as good supervision, mentoring and peer support programs for frontline workers, particularly those who are new to the field. States also must invest in applied research and evaluation to assess the success and failure of various interventions and to provide incentives that reward good practice.

Family Caregiver Alliance acknowledges the valuable contribution to this Policy Brief of the following expert reviewers: Honorable *Mark C. Montigny*, Massachusetts State Senate, and *Mary Ann Wilner, Ph.D.*, Director of Health Policy, The Paraprofessional Health Care Institute.

Support for this Policy Brief was provided by a grant from the **Robert Wood Johnson Foundation**.

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