

PEOPLING LONG-TERM CARE: ASSURING AN ADEQUATE LONG-TERM CARE WORKFORCE FOR MINNESOTA



Faculty Workgroup on Peopling Long-Term Care

Sponsored by:
Minnesota Chair in Long-term Care and Aging
& Center on Aging

UNIVERSITY OF MINNESOTA

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PREFACE

This report represents a new endeavor. As the holder of the Chair on Long-term Care and Aging, I was urged to mobilize the resources of the University to examine pertinent problems that affect the field of long-term care. It was believed (and we concur) that the University can bring a different perspective, hopefully one that is disinterested (but not uninterested). Our goal was to examine problems and frame ideas at a more general level, while still contributing something practical. We saw our audience as being both inside the University (for recommendations about education and research) and outside it. This year we focused on issues around staffing, a topic that has been widely recognized as a major problem.

This report was a university-wide effort convened under the auspices of the Chair in Long-term Care and Aging and the Center on Aging. The goal was to reflect the insights of an interdisciplinary workgroup of faculty from various schools and departments, who looked at the topic from varied perspectives. The list of the participating faculty is on page ii.

In order to maintain a disinterested perspective we deliberately did not invite representatives of any constituency to participate in the committee. Rather, we tried to meet with as many technical experts and representatives of stakeholder groups as possible. (Persons and organizations consulted are listed on page iii.) In each case we asked a few guiding questions but allowed the conversations to take their own path. In several cases, the interactions continued as new material was shared.

The work was conducted in full knowledge that we were not plowing virgin soil. Virtually every organization we spoke with had issued (or was about to issue) its own white paper on the topic. The state has established a task force to examine a broad array of long-term care issues, including staffing. Specific elements of the recent Minnesota legislation addressed this issue directly.

The overall structure of the operation relied on the hard work of two staff members. Jake Priester and Annette Totten had the difficult task of drafting sections and presenting them to the committee at monthly meetings. The direction and feedback from the committee was used to prepare revisions. The penultimate draft was reviewed by each workgroup member, who was then asked if he or she was prepared to endorse it. The list below indicates which members chose to endorse the report. At the same time a copy was sent to each person with whom we consulted for their review and comment. No endorsement was sought from any of these participants.

The report contains a number of recommendations that address various aspects of the staffing problem. As we worked on this report it became evident that it was impossible to conceptualize the problem and implement solutions in the time allotted. Therefore, one of our major recommendations calls for the creation of a statewide commission that will continue the work and the dialogue begun here. We certainly hope that the University can be a part of such an ongoing effort. The work that went into this report has succeeded in mobilizing a substantial faculty presence and interest in this topic.

Robert L. Kane, MD

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This report was written by Jake Priester and Annette Totten, with significant contributions from Christine Mueller, James Reinardy, Kathleen Krichbaum, Lois Cutler, Steven Miles, and Robert Kane.

ACKNOWLEDGMENT

Members of the faculty workgroup and the project staff would like to thank these resource people for the assistance they provided to this project. Many took time to meet with us personally and review a draft of the report. The people listed, and the organizations they represent, do not necessarily approve, disapprove, or endorse this report: the faculty workgroup assumes full responsibility for its content.

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We also thank Sheryl Papp and Marilyn Eells for their administrative assistance and Mary Beth Nierengarten for her editorial assistance. Finally, the project staff offers special recognition to Christine Mueller, a member of the faculty workgroup, for her active efforts on behalf of the project and report.

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SUMMARY WITH RECOMMENDATIONS

Staffing shortages in long-term care (LTC) affect the cost, quality, and availability of care. Although shortages of LTC workers are a recurring phenomenon, the current shortage, driven in part by fundamental shifts in the labor market, the aging of the population, and other social and demographic changes, is unlikely to be resolved either quickly or easily.

Recruiting and retaining LTC workers are distinct yet closely linked issues. The fundamental issue underlying the recruitment problem is an imbalance between supply and demand; the fundamental issue underlying the retention problem is high turnover. A variety of social and economic factors will further constrict the supply of workers while the dramatic increase in the number of elderly Minnesotans will increase demand for LTC services. Turnover rates are higher in LTC than in most other industries. The average annual rate of turnover for nursing assistants (NAs) in nursing homes is nearly 100 percent. Such high turnover rates are costly, impair continuity of care, and may reduce the quality of care.

The looming workforce crisis in LTC provides an opportunity to more critically examine the possible causes of the current problem. Despite its urgency, the crisis may also present an opportunity for major changes in long-term care. It may provide incentives for taking steps that have been difficult for policy makers and the long-term care sector to take. Assuring adequate staffing across long-term care settings in Minnesota will require both short-term actions to alleviate the immediate crisis and long-term strategies that address its roots.

Framework for Solutions

Since public programs will likely remain the major payor of LTC, public policy will continue its fundamental role in shaping the LTC sector. Significant improvement in worker recruitment and retention requires a mechanism that can coalesce stakeholders, promote a comprehensive approach, build and maintain momentum, and provide a direct conduit to public policy changes. Therefore, we recommend that the Minnesota Legislature establish a broadly representative, statewide, long-term care workforce commission with the responsibility to oversee the development, implementation, and evaluation of a comprehensive plan for improving worker recruitment and retention in long-term care. The public policy changes

initiated by this commission should be supplemented with private sector initiatives. Additional research is needed to support changes in both the public and private sectors.

Improving the Workplace

Recruiting and retaining nursing personnel is a serious challenge for long-term care. A variety of strategies are needed to help assure an adequate and qualified LTC workforce. Increased compensation by itself is not enough: the work itself must be made more rewarding. A rewarding and satisfying workplace is needed to attract and retain committed long-term care workers. The LTC workplace can be improved by 1) changing the organizational culture, 2) changing the organization and delivery of nursing care, 3) creating new work roles, 4) improving leadership and supervision, and 5) creating a supportive physical environment.

- ◆ Changing an organization's culture involves redefining the workers' roles or redesigning the system. Granting frontline staff more autonomy, empowering them with information, and involving them more directly in decisions about care can reduce staff turnover. Smaller units of care within a system can become the basis for more sustained personal relationships between caregivers and clients and permit more stable staff assignments.
 - ◆ Changing the organization and delivery of nursing care involves adjusting the number of long-term care workers (based more squarely on the needs of the clients), providing a more satisfying work environment for them, and increasing the efficiency and effectiveness of how care is delivered.
 - ◆ Strategies to change work roles include new types of workers and more career advancements opportunities. One new work role is the "universal worker" concept, which allows all caregivers the ability, flexibility, and responsibility to respond to residents' needs. Another is the "single task employee," a minimally-trained worker permitted to perform specific, nonmedical tasks to support nursing staff. Career matrices enable staff to take on added responsibilities within a job category (e.g., Nursing Assistant Level I to Nursing Assistant Level II to Senior Nursing Assistant). Developing meaningful career matrices may require that more credit be given for skills acquired through experience.
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- ◆ A rewarding and satisfying workplace requires effective leadership and supervision. Directors of nursing (DONs) hold key leadership positions, but are often inadequately prepared for their demanding jobs. Schools of nursing and the LTC sector need to promote the professional development and education of DONs.
- ◆ The physical environment can support and empower workers; it can also be a detriment. A more supportive workplace environment can often be achieved through space reallocation, policy changes, and simple modifications of the physical plant.

Technologies

Several existing and emerging technologies are intertwined with the organization of LTC work and the number and types of workers needed, including:

- ◆ Information technologies could streamline charting and record keeping, transfer information among workers, reduce errors, and document residents' progress. Reductions in paperwork would free staff for other tasks. Automated alerts and computerized protocols could facilitate decisions and tasks for all levels of workers.
- ◆ Information can demonstrate the impact of care. Given that most elders decline with time, workers are often understandably disheartened. Using data to demonstrate how care slowed this decline may foster a sense of accomplishment among workers and a greater appreciation of LTC work by outsiders.
- ◆ Telemedicine and communications technologies may allow both training and consultations that would not be otherwise possible. This can expand a workers' circle of colleagues and allow professional development that is often hampered by the worker shortage.
- ◆ Monitoring, robotics and assistive technologies may reduce the number of workers needed to ensure clients' safety or allow them to stay in their own home by allowing them to complete tasks independently or by increasing the amount of care family members can provide. Advancements in lifts and ergonomics may also reduce the number of workers needed as well as reduce injuries.

Along with the specific impact each technology may

have on LTC, the general association of LTC with technology may itself increase the prestige of this historically low-tech field.

Temporary Workers

While the use of temporary employees from pools or agencies remains a small percentage of the total payroll for nursing homes, the significant increase of temporary workers in recent years has raised concerns about the impact on providers' finances as well as on the continuity and quality of care.

Very little is known about the employment patterns and motivations of temporary workers. Most in the field contend that workers choose temporary work because of higher pay and more flexibility. Pools may also allow people to continue to work in the field as their situation changes and allow permanent workers to supplement their income. Workers, particularly nursing assistants, often alternate between temporary and permanent work.

The use of temporary staff varies significantly among LTC providers. Several facilities have instituted programs to reduce or eliminate the use of pools, including internal pools, nontraditional scheduling, and creative incentives to recruit and retain permanent employees.

Whether a temporary employee is more expensive to a LTC provider cannot be answered by a strict comparison of rates since the costs of recruitment and training may offset the higher rate, particularly when turnover is high. Legislation recently enacted in Minnesota caps the rates a temporary employment agency can charge LTC providers. Proponents of capping rates argue that temporary workers lower the quality of care by inhibiting long-term caregiver/client relationships. However, capping temporary worker rates may have negative effects on worker availability if temporary employment agencies have in fact kept individuals in the field who would otherwise have left.

Recruiting New Americans

Potential sources of new LTC workers, beyond the traditional pool of women aged 25-54, include students, older workers, and retirees. Relatives of nursing home residents are an overlooked but potentially promising group since they resemble the people who are most inclined to be long-term nursing assistants in their motivation, values, and experience with caregiving.

Immigrants and foreign workers are also frequently identified as potential sources of new workers for LTC. With targeted recruitment and retention efforts, Minnesota's rapidly growing immigrant population (the so-called "New Americans") can become an even more important source of labor for frontline LTC workers. However, for New Americans to succeed, they will have to overcome a variety of cultural and language barriers and, equally important, the institutions and agencies that comprise the LTC system will have to exhibit a higher level of sensitivity to cultural differences. Recruiting workers from other countries, either permanently or temporarily, is difficult because of restrictive visa classifications, is unlikely to significantly impact the worker shortage, and may have risks that outweigh the potential rewards.

The Role of Long-Term Care Providers

Nursing homes may both contribute to the workforce problem and be victims due to circumstances beyond their control. Some factors affecting recruitment and retention are internal to and under the control of the organization itself. The argument for looking at nursing home behavior rests largely with the observation that sometimes nursing homes within a few miles of each other have radically different staffing experiences.

Our Vision for the Future

We believe adopting the recommendations of this report will help assure that in the future, all long-term care settings will be better places to work and to live. All elements of working conditions, including compensation, training, physical space, supervision, worker's roles and responsibilities, must be changed, reflecting our belief that there is no single solution to workforce issues in long-term care. These changes will benefit nursing personnel and people who require care. Over time, these changes will also slowly transform the image of LTC work, building the public support that will allow long-term care providers to recruit and retain high quality workers.

Recommendations

Recommendation on Establishing a Long-term Care Workforce Commission

1. The Minnesota Legislature should establish a statewide long-term care workforce commission to oversee the development, implementation, and evaluation of a comprehensive approach to the workforce crisis in LTC. The commission should include representatives from across Minnesota of all major stakeholders, including the LTC sector (nursing homes, assisted living, home care), nursing personnel (RNs, LPNs, NAs), unions, consumers, higher education, and relevant state and local government agencies.

The commission's primary responsibility should be to prepare a set of legislative initiatives for the Commissioner of Human Service that are designed to improve the recruitment and retention of nursing personnel in long-term care settings throughout Minnesota. Additional responsibilities will include providing direction for implementing, monitoring, and evaluating policy initiatives. The commission should also monitor progress of the other recommendations in this report.

The following are among the legislative initiatives that the commission should submit to the Commissioner:

- ◆ Centralize in a single agency or department the collection, analysis, and dissemination of relevant data on long-term care nursing personnel in Minnesota. Criteria for new data collection should be based on filling existing gaps in our understanding of workforce issues in long-term care, should not duplicate existing data and information systems, and should use existing data collection infrastructure
- ◆ Add to the state's LTC "wage pass through" program to increase worker compensation
- ◆ Assure health care coverage for nursing personnel working in long-term care by, for example, developing and implementing strategies to:
 - allow LTC employees in Minnesota to participate in the state employee health plan; and
 - maximize enrollment of eligible LTC workers and their dependents in existing state programs such as MinnesotaCare, CHIP, and MCHA.

Recommendations on Improving the Workplace

2. Foundations should be encouraged to sponsor grant initiatives to support long-term care facilities' efforts to increase the involvement of nursing assistants in care decisions, include them in care conferences, and use them as "experts" in relation to the residents in their care.
3. The long-term care sector should continue to explore ways to increase frontline workers' involvement in decision-making and care planning.
4. The long-term care sector, in partnership with research institutions, should develop, implement, expand, and evaluate alternate systems of delivering care that empower staff, residents, and families to make decisions regarding how and by whom care is delivered in long-term care facilities.
5. The following are ways to improve the organization of the delivery of nursing services in LTC:
 - ◆ The long-term care sector should expand and further integrate Gerontologic Advanced Practice Nurses into long-term care facilities, focusing on staff development, quality improvement, and the use of research-based clinical protocols to ensure quality nursing care
 - ◆ The long-term care sector and the Minnesota Departments of Health and Human Services

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- should provide incentives to nursing facilities for innovations in the use of acuity-based staffing systems, variations of nursing practice models, and creative use of staff (e.g., RNs as case-managers)
- ◆ The Minnesota Directors of Nursing Administration/LTC (MN-DONA/LTC) should use the criteria from the American Nurses Credentialing Center (ANCC) Magnet Nursing Services Recognition Program as benchmarks for the quality of nursing services in long-term care facilities. They should develop education programs for members that will assist them in meeting the Magnet criteria
6. The State Departments of Health and Human Services should support demonstration projects to evaluate the use of universal and single task workers in long-term care facilities.
 7. The LTC sector should spearhead the implementation of career matrices for frontline workers that offer progressive responsibilities, training, and compensation. The matrices could include the following:
 - ◆ Formal pathways for advancement within the NA job classification (e.g., NA Level I, NA Level II, Senior NA)
 - ◆ Specialty training for NAs (e.g., geriatric nursing assistant specialist)
 - ◆ The assignment of duties commensurate with training
 8. The LTC workforce commission should submit to the Commissioner of Human Services legislative initiatives to provide more financial assistance for students choosing nursing careers in LTC by, for example:
 - ◆ Increasing the state's loan forgiveness program for LPN and RN nursing students who agree to practice nursing in a LTC setting; or
 - ◆ Establishing a LTC career scholarship program for high school or college students who work or volunteer in LTC settings
 9. Schools of nursing and other education institutions should modify education requirements to expand career mobility for nursing personnel in LTC by:
 - ◆ Encouraging more opportunities to use demonstrated competence to substitute for formal education in LPN and RN programs
 - ◆ Promoting accelerated LPN education for people with a related Associate Degree or demonstrated experience
 - ◆ Developing new career ladders, and encouraging the use of existing ones (i.e., NA to LPN to RN career paths), which shorten the time and cost for progressing up the ladder, provide credit for work experience, and expand the use of competency testing
 - ◆ Offering more evening and night classes and web-based education courses to meet the needs of prospective students
 - ◆ Making NA and LPN preparation and experience a means to enter a variety of careers (e.g., Occupational Therapy Assistant, Physical Therapy Assistant, Social Work, Administration), and not just to professional nursing
 10. Schools of nursing, in cooperation with the LTC sector, should encourage the development of expertise among and increase the prestige of Directors of Nursing (DONs) in LTC by:
 - ◆ Establishing (virtual or real) support groups for DONs that foster communication, networking, and professional development
 - ◆ Increasing educational opportunities in leadership and management for DONs
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In addition, the LTC sector should:

- ◆ Provide DONs with sabbaticals or fellowships to pursue interest or work with experts
- ◆ Provide incentives (to individuals or their employers) for DONs to complete certification/added credential programs

Recommendations for Technology

11. Long-term care providers and consumers should support the development of new technologies by expressing interest in the products, volunteering to test prototypes, and participating in planning and design efforts. Researchers and management specialists should evaluate the technologies' safety and effectiveness and analyze their cost and feasibility.
12. For technologies already on the market, but not yet widely adopted, policy and research should promote their adoption, expansion, and applications in long-term care.
13. Given the potential of technology to improve both care and worker recruitment and retention:
 - ◆ A small grant program should be developed for long-term care providers for specific technology-based projects sponsored by either state funds or a private foundation. The application process should be competitive with successful projects used as models for other providers.
 - ◆ The curricula for all levels of nursing personnel should include sufficient training in the use of current and anticipated technologies.
14. To complement policy changes, researchers should promote the use of technology as part of the response to long-term care workforce issues by:
 - ◆ Conducting and disseminating case studies of successful implementation of various technologies in long-term care
 - ◆ Including in any grant program an evaluation component to determine the effectiveness of various technologies in long-term care and promoting those with the greatest potential for improving care as well as working conditions

Recommendations for Temporary Workers

15. The Department of Human Services should require, as a condition for licensure, long-term care providers in Minnesota to collect and make public certain management information such as:
 - ◆ Usage of temporary labor pools
 - ◆ Turnover rates for nursing personnel
 - ◆ Stability of nursing personnel
16. To use temporary labor pools more efficiently, long-term care provider associations should develop policies and best practices for managing temporary workers. These include:
 - ◆ Developing contracts with pools to assure consistent prices and performance standards;
 - ◆ Developing personnel policies concerning the orientation, supervision, and resolution of problems with pool employees; and
 - ◆ Reducing the use of temporary workers by creating internal pools, developing flexible scheduling, and establishing incentives for employee attendance.
17. The University of Minnesota and other members of the research community should conduct and promote research on the impact of legislation that places caps on temporary agency rates, including:
 - ◆ Monitoring the temporary labor sector (i.e., how many temporary workers discontinue work in long-term care);

- ◆ Following a sample of nursing homes that rely heavily on temporary workers;
- ◆ Studying the employment patterns of a sample of pool workers after the legislation is implemented; and
- ◆ Evaluating the legislation's effect on the quality of care and quality of life of the recipients of care.

Recommendations on Recruiting Immigrants and Foreign Workers

18. The LTC workforce commission should submit to the Commissioner of Human Services legislative initiatives to expand LTC training and employment opportunities for New Americans in Minnesota. The commission should develop strategies for the state, counties, and other local government units to increase public funding and for obtaining, to the extent possible, more federal money for LTC workforce training and development. Priority should be given to expanding LTC worksite-based English as a Second Language (ESL) programs, subsidizing early in-facility training and mentoring of New Americans, and other activities designed to help immigrants overcome cultural and language barriers to successful employment in LTC.
19. Long-term care employers, individually and collectively, should step up their efforts to expand employment opportunities for New Americans in Minnesota by:
 - ◆ Developing new and adding to existing recruitment, training, and retention initiatives directed at New Americans before devoting resources to recruiting foreign workers;
 - ◆ Establishing new and enhancing existing partnerships with employment agencies, public and private human service organizations, and education institutions to recruit, train, and place New American workers;
 - ◆ Increasing the use of student and worker assessment tools to assure New Americans are directed to the most appropriate training programs and to determine graduates' job-readiness; and
 - ◆ Supporting a diverse workforce by becoming more sensitive to cultural issues, both in their workforce and in organizational practice.

Recommendations for Additional Research

20. The University of Minnesota and other members of the research community should conduct and promote additional research on workforce issues in LTC. Priority issues include:
 - ◆ Developing a comprehensive portrait of LTC nursing personnel in Minnesota, including basic demographic information, educational levels, racial and ethnic diversity, and their distribution across geographic areas and LTC settings;
 - ◆ Examining the wage elasticity for NAs and RNs in LTC;
 - ◆ Examining the relationship between LTC worker satisfaction and retention and the quality of care and quality of life for recipients of care;
 - ◆ Examining reasons why NAs leave their line of work and what it would take to keep them on the job (and for those who leave, what it would take to get them to return);
 - ◆ Examining strategies that foster greater accountability and responsibility of RNs for the care of residents;
 - ◆ Developing and testing staffing systems and innovative staffing models in LTC facilities including a) development of acuity-based staffing systems which effectively identify and differentiate care needs according to nursing skill mix, b) identification of quality indicators that are strongly
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related to staffing, c) identification of nursing practice models that promote positive resident, staff and organizational outcomes;

- ◆ Evaluating permanent assignments and other strategies to promote continuity of care;
 - ◆ Evaluating the impact on worker recruitment and retention of Minnesota's "wage pass through" program to increase worker compensation;
 - ◆ Studying the effectiveness of communication strategies to improve staff satisfaction and retention; and
 - ◆ Determining whether investing in better training, career paths, higher wages, or improved benefits is cost-effective for LTC employers.
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INTRODUCTION

WANTED: Someone to care for frail older persons who require assistance with their most basic functions, including the handling of bodily wastes. Some heavy lifting involved. Clients may be unable to show gratitude for the care received, and sometimes may even be physically and verbally abusive. Active government oversight involved. Pay is minimal. Prestige is low.

Shortages of health care workers are a recurring problem. Regardless of their underlying causes, these shortages typically abate with policy and programmatic changes in the health care system and changes in the overall economy. The current workforce crisis in the long-term care (LTC) sector portends to be different. It is a multidimensional problem demanding a multidimensional solution. Compared to previous shortages, the current crisis of an inadequate supply of workers and high turnover rates is driven in part by fundamental shifts in the labor market and the aging of the population, as well as other social and demographic changes. Combined, these changes will further constrict the supply of, and vastly increase the demand for, long-term care workers. The current workforce crisis is unlikely to be resolved either quickly or easily.

As suggested in the above opening job advertisement, it is hardly surprising that we face a shortage of long-term care staff. Indeed, some may marvel that we have been able to sustain the industry this long. At a time of prosperity, when jobs, even service jobs that require little formal training, are plentiful, finding and keeping an adequate staff is daunting. The search for solutions may require more than exploring new incentives; it may demand re-examining the way we provide this type of care.

The workforce crisis affects all segments of long-term care (albeit not uniformly), from nursing homes to assisted living facilities to home health care. Moreover, shortages exist among all levels of staff, from frontline workers such as nursing assistants (NA), to nurses, to directors of nursing and other managers. And it is nationwide; nearly all states report problems recruiting and retaining long-term care workers, many have commissioned reports on the issue, and some have taken action (Leon 2001; North Carolina Division of Facility Services 1999).

Staffing shortages affect long-term care costs, quality, and access. They are believed to be financially costly to the LTC sector, particularly because of the high cost of replacing workers. Difficulties in recruiting and retaining workers in the very labor-intensive LTC sector threaten the

quality and availability of services, because care may become rushed, delayed, or forgone entirely. Long-term care is high-touch, manpower-dependent, and historically low-tech. Without adequate staffing, the quality of life may diminish for the recipients of long-term care, and the quality of the care they receive may decline¹ (Wunderlich 2001). Some needs may not be met at all if labor shortages prompt LTC providers to cut back on services or close off admissions.

Context

Although recruitment and retention difficulties have long plagued the LTC sector, the current problem is worse because of the convergence of three far-reaching phenomena with different timelines: 1) fluctuations in the economic cycle, 2) long-term demographic trends, and 3) the changing role of women in the workplace. Even if economic conditions deteriorate and unemployment increases, the challenges of recruiting and retaining LTC workers are likely to persist because of the broader and deeper social and demographic factors.

Economic Cycle

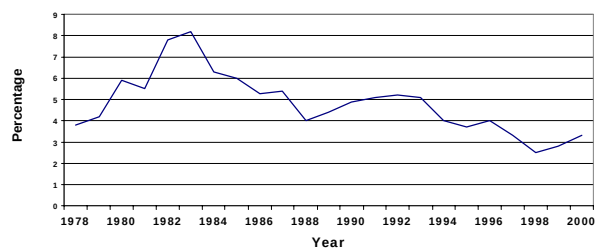
◆ **Changes in unemployment rate.** Wages, benefits, and alternative sources of employment and income are among the factors affecting the supply of labor in long-term care (Feldman 1994). Paraprofessional jobs in long-term care have traditionally been vulnerable to competition from similar low-wage, low-benefit, and low-skill positions in other industries. Typically, a low unemployment rate intensifies the competition for such workers by expanding the range of alternative sources of employment.

The unemployment rate rises and falls in response to changes in the nation's overall economy. Although fluctuating over the past two decades between 2.8 and 8.2 percent in Minnesota (and about two percentage points higher nationwide), the clear trend has been toward a lower unemployment rate (Figure 1). A sustained low unemployment rate will exacerbate the LTC sector's

¹ In long-term care, the distinction is often made between *quality of care practices* (e.g., bathing, feeding) and their related outcomes (e.g., pressure sores, urinary tract infections) and the care processes and environmental factors that affect care recipients' *quality of life*, including their "dignity; individuality; autonomy/choice; sense of privacy; enjoyment; meaningful activity; relationships; sense of security/order; comfort; spiritual well-being; and functional competence" (Health Care Financing Administration 2000).

persistent difficulty in recruiting and retaining nursing personnel, particularly frontline paraprofessionals.

Figure 1
Unemployment Rate, Minnesota 1978-2000

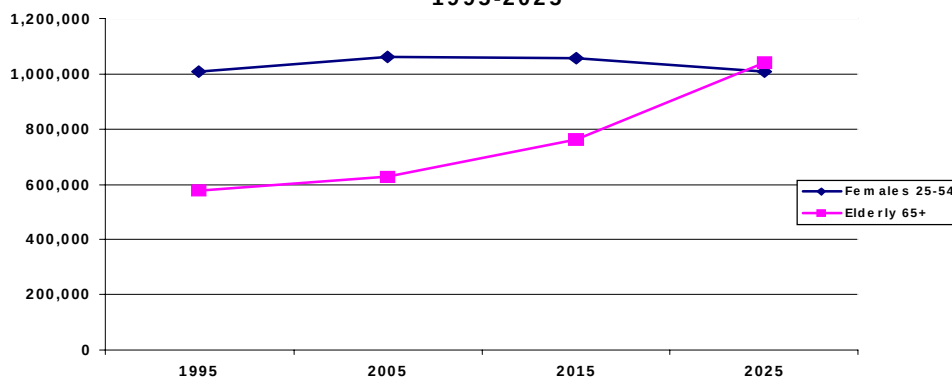


Source: www.mnworkforcecenter.org/lmi/laus/minn.htm

Demographic Trends

◆ **Aging of population.** The aging of the baby boom generation will have an unprecedented impact on the population's age distribution. Between 2000 and 2020, the proportion of the nation's population 65 years of age or older and 80 years of age and older will increase by 33 percent and 14 percent, respectively. Increases for both age cohorts in Minnesota will be even greater. The increase in the number of people who are at least 80 years old is particularly noteworthy since it is these oldest members of our society who will most likely need LTC services. No matter how healthy elderly persons in the future will be compared with earlier generations, their sheer numbers are almost certain to increase the demand for LTC.

Figure 2
Number of Elderly and Women Aged 25-54 in Minnesota, 1995-2025



Source: Minnesota Planning, 1998

◆ **Decreasing ratio of workers to retirees.** The aging of the population will reduce the number of people in the working age cohorts (ages 20 to 65) relative to the number of people over age 65. In Minnesota, the ratio

of these two age cohorts will peak in 2005 at 4.78 and then decline rapidly to 2.93 in the year 2025 (McMurry 1998). The ratio of women aged 25 to 54, the traditional labor source for nursing personnel, to people over age 65 will also decline. In fact, the elderly population will exceed this traditional labor pool in Minnesota in 2025 (Figure 2).²

◆ **Aging of workforce in long-term care.** An increase in the average age of nursing personnel in long-term care may have workforce implications since some older workers are not able to perform some of the more physically demanding tasks, such as lifting or bathing nursing home residents. Also, older workers are more prone to on-the-job injury, particularly back injuries, which are the most common injuries among NAs (Wunderlich, Sloan, and Davis 1996).

Women's Role in the Workforce

◆ **Expanded opportunities for women in the workplace.** One consequence of the women's movement and other complex social changes in recent decades is the dramatically altered role of women in the labor market. More women than ever are working and their range of opportunities in the workplace has expanded vastly (Andersen 1983). Even though the majority of women continue to work in jobs where most

of the other workers are women, many have taken advantage of new opportunities and entered fields formerly closed to them (e.g., law, medicine) (Glaser 2001). As a result, the traditional pool of applicants for nursing education programs and nursing positions is shrinking.

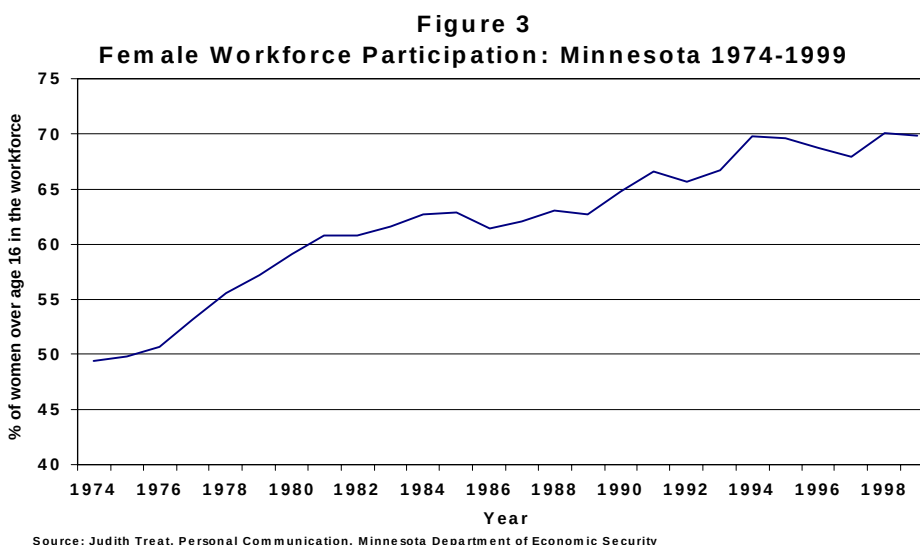
Opportunities for women have expanded within health care as well. The number of female physicians has significantly increased as more women interested in health careers choose to become physicians rather than nurses (e.g., the 2000-2001 medical school class at the University of Minnesota had a

² This figure was inspired by a similar figure prepared for Massachusetts in (Frank 2000).

female majority). Finally, even for nurses, career options have expanded, including more positions in advanced practice nursing and new jobs in utilization review, health plan administration, and other nonclinical positions.

Despite these changes, the nursing workforce in LTC remains overwhelmingly female. Over 93 percent of NAs in LTC are women (Wilner 1998). As recently as 2000, 94.6 percent of the entire RN population was female, and although men are entering the nursing profession more frequently, most of them gravitate to the more technologically-dependent nursing positions in hospitals (Division of Nursing 2001).

market for NAs is more responsive than the market for nurses to changes in the economic cycle. Education requirements also sharply divide the nursing workforce from the paraprofessional workforce. Paraprofessional nursing positions typically require only 75 hours of training (often without a high school diploma). In contrast, the minimum training required for licensed practical nurses (LPN) is a 12-month practical nursing program and the minimum RN education program is two years. Since paraprofessionals can work almost immediately, whereas the education pipeline delays nurses' entry into the workforce, the market for paraprofessionals can respond more quickly to short-term economic changes.



Regulatory Framework

An additional contextual issue for the workforce crisis in LTC is the complex public financing and regulation of LTC services and providers. Together, Medicare and Medicaid pay for the vast majority of LTC and will continue to play a dominant role in this arena. For example, in 1999, Medical Assistance paid nearly 65 percent of the approximately \$1.63 billion that was spent on

nursing home in Minnesota and Medicare paid for an additional 7 percent.³ Both programs strictly regulate LTC services, facilities, and the provision of care. Payment rates under Medicare and Medicaid are based on complex formulas set by federal and state laws. This regulatory framework affects both the nature of the recruitment and retention problem faced by LTC and limits the range of potential solutions. Many strategies to redress worker shortages in less regulated industries are not available to LTC employers. They cannot, for example, significantly increase compensation levels since their revenues are largely determined by government reimbursement. The locus for solutions will be different as well: improving the recruitment and retention of nursing personnel in LTC will require a mix of private and public policy changes.

◆ Greater participation of women in the workforce.

The percentage of working-age women participating in the workforce has steadily increased over the past few decades. For several years, Minnesota has led the nation in the percentage of women in the workforce. About 70 percent of all women over age 16 now participate in the workforce in Minnesota. This rate, about 10 percent below the historical workforce participation rate for men, has reached a plateau since 1994 and is unlikely to rise appreciably (Figure 3).

The interaction of these three broad phenomena underscores the differences in the labor markets for nurses and nursing assistants. For example, because of differences in worker demographics and career goals, the

³ <http://www.dhs.state.mn.us/agingint/Services/nhfacts.htm>

Despite many studies and proposed solutions, the LTC workforce shortage persists. It is difficult to solve in part because key information is still not available. Not enough is known, for example, about why people choose careers in LTC as nursing personnel and what motivates them to stay. This is particularly true for paraprofessionals. Policy makers thus remain largely in the dark about what inducements might be necessary to inspire nonworkers to enter the long-term care labor force or entice those who enter to stay (Callahan 2001). The workforce shortage is also difficult to solve because many of the proposed solutions cannot be implemented “given the constraints of American society” (Callahan 2001). For example, significantly increasing the pay for paraprofessional caregivers probably would attract many more workers into LTC, but we (as taxpayers and thus as primary funders for LTC) have been reluctant to raise wages far enough to impact recruitment.

Recruiting and retaining an adequate and qualified workforce in LTC requires both short-term actions to alleviate the immediate crisis, as well as long-term strategies that address the social and demographic roots of the problem. Any short-term “solution” that aims to make LTC nursing jobs more attractive (e.g., by providing more benefits) is unlikely to succeed in the long term. Comprehensive solutions must be developed with a clear understanding of the broader social and political context surrounding the workforce problem in LTC.

Proposed solutions will also need to consider projected changes in how long-term care services will be provided in the future. Reflecting a trend nationwide, Minnesota’s “over-reliance” on the institutional model of long-term care, with nursing homes functioning as “miniature hospitals” and regulated primarily to ensure residents’ safety (State of Minnesota Long-Term Care Task Force 2001), will likely be moderated with new and a wider range of options. These include more home care and other in-home services, new kinds of residential care in private homes (e.g., adult foster care) and in private apartments, and adult day care and other community-based services. The clear trend is toward rebalancing our LTC investment in institutional care with a renewed emphasis on home- and community-based services and moving from provider-directed care to consumer-directed care. The principles underlying this shift (more consumer choice and control, individual autonomy, privacy) may promote other innovations as well. Institutionally based LTC services will also change. For

example, some trends, such as earlier discharge from hospitals, point to increased acuity levels in nursing homes. Nursing homes are also being used more frequently for “short stays, as a transition between the hospital and home, and as an option when community services and the family’s efforts can no longer meet their needs” (Minnesota DHS Aging Initiative 2000). All of these changes will impact the demand for and supply of LTC workers, which will affect their number, needed skill sets, or both, but in as yet unforeseen and unpredictable ways.

Focus of Report

This report addresses recruitment and retention of nursing personnel across long-term care settings in Minnesota. We use the term “nursing personnel” to include 1) the frontline paraprofessional workers referred to as nursing assistants (often also called “aides”), 2) nurses (including licensed practical nurses and registered nurses), and 3) directors of nursing. Since most of the research on workforce issues in long-term care relates to nursing homes, this report will concentrate on that segment as well. However, to the extent possible, the report will also consider workforce issues in other long-term care settings.

Minnesota

Workforce Shortage

There are no comprehensive data to describe the nature and extent of the current shortage of nursing personnel in long-term care (GAO 2001). Nonetheless, experts agree that the nation is indeed facing a shortage of nurses and nursing assistants (Wunderlich 2001). Similar conclusions have been made for Minnesota, where a task force recently identified a “severe shortage” of nursing personnel in health care and long-term care (State of Minnesota Long-Term Care Task Force 2001). Minnesota’s workforce shortage extends far beyond these industries. In early 2001, statewide job vacancies, for example, outnumbered unemployed workers by a 2:1 margin. Among the factors signaling a tight labor market in Minnesota are:

- ◆ an unemployment rate around 3% since 1998, “representing a particularly low reserve pool of labor;”
- ◆ a steady decline over the past 20 years in the proportion of the population not working, indicating a decreasing pool of potential workers; and

- ◆ a workforce participation rate of 75.1% in 1998, the highest among all states (Minnesota Department of Economic Security 2000).

While none of these factors alone signals a labor shortage, in combination they indicate a significant imbalance between workforce supply and demand. This imbalance is particularly acute in health care and long-term care (Minnesota Department of Economic Security 2001). A study conducted in the 4th quarter of 2000 found the following:

- ◆ The 10 percent job vacancy rate for the “health care support” occupational group was the highest of all occupational groups in Minnesota and twice the job vacancy rate for all occupations.⁴ The job vacancy rate for “nursing aides, orderlies, and attendants” (one of the occupational classifications in the healthcare support group) was 18 percent, with a total number of vacancies statewide over 5,300. The estimated vacant full-time equivalent (FTE) positions in Minnesota’s nursing homes in 2000 were 477 RN positions, 599 LPN positions, and 1,839 NA positions (Long-Term Care Imperative 2001).
- ◆ Most positions in the health care support group were reported as being “always open,” meaning that employers are always recruiting and hiring new staff for these positions. A concentration of “always open” positions often indicates high turnover.
- ◆ Health care support was one of seven occupational groups with an above average “turnover adjusted demand” in Minnesota. This indicator compares job vacancy rates by measuring workforce demand caused by factors other than turnover, mainly the demand for new entries into the field.
- ◆ Combining these three indices, the Department of Economic Security (DES) concluded that in the fourth quarter of 2000, “the health care support occupational group shows evidence of the most severe shortage of workers”⁵ (Minnesota Department of Economic Security 2001).

Minnesota will likely continue to experience labor shortages across all industries. For Minnesota’s economy as a whole, the expected future supply of workers is unlikely to meet anticipated demand, expanding the gap between the number of new jobs and the number of workers to fill

them (Minnesota Department of Economic Security 2000). Problems will be particularly acute in selected segments of the economy, with labor shortages in health care support occupations remaining severe as the demand for such workers increases and competition intensifies among all low-skill, low-wage industries.

Uniqueness of Minnesota

Several features distinguish the recruitment and retention problem in LTC in Minnesota. First, Minnesota is one of only two states with a rate equalization requirement in long-term care (North Dakota is the other).⁶ This requirement was designed to prevent a two-tier system of nursing homes. Requiring nursing homes to charge private pay residents at the rate set for Medicaid further constricts their ability to increase workers’ compensation to improve recruitment and retention. Market forces or competition can do little to boost payment rates for nursing personnel; instead, there is virtually no flexibility or opportunity to change them without direct legislative action.

Second, Minnesota’s nursing home utilization rate has historically been high compared to other states; in 1996 the state ranked 43rd based on a mix of 5 utilization criterion (Ladd, Kane, and Kane 1999). The state had 77.5 nursing home beds per 1,000 population over age 65 in 1998, well above the national average of 52.7 beds and 5th highest among all states. In 1999, the percentage of persons age 65 and older who resided in nursing facilities was 6.8 in Minnesota, compared to only 4.3 percent nationwide. These figures reflect the fact that Minnesota has relied heavily on an institutional model of long-term care at least since Medicaid was passed in 1965 and federal funds became available for nursing home care (State of Minnesota Long-Term Care Task Force 2001).

The occupancy rates of Minnesota nursing homes are now declining. While there is still a demand for nursing home care, that demand is changing over time and the future configurations of care will likely be very different from today. The state must now work with a sector it has in essence developed with public funds. Changing a highly regulated sector dependent on public revenue is a formidable challenge. Recruiting and retaining workers within that sector is just one of the many challenges presented.

⁴ The “Healthcare Support” occupational group, as defined by the U.S. Department of Labor’s Standard Occupational Classification System, includes occupational classifications such as nursing aides, orderlies and attendants; home health aides; dental assistants; and pharmacy aides

⁵ The Twin Cities differed from Greater Minnesota on a number of issues: for example, the job vacancy rate for the healthcare support occupational group is higher in the Twin Cities (11 percent) than in Greater Minnesota (9 percent) but hiring cycle times are similar (most positions were “always open”). Also, the job vacancy rate for nursing aides, orderlies and attendants in the Twin Cities was 22 percent, compared to a rate of 14 percent in Greater Minnesota (Minnesota Department of Economic Security 2001)

⁶ Minn. Stat. Sec. 256B.431

Climate for Change

Despite and partly because of its urgency, the current workforce crisis in long-term care in Minnesota also presents unique opportunities.

◆ **Consensus on the problem.** Consensus is building on the broad outline of the problem and the need for concerted action. In the past few years, many long-term care provider organizations in Minnesota have established committees to study workforce shortages, how they impact their members, and issued a wide range of recommendations. Other organizations have held numerous forums and workshops throughout Minnesota on health care workforce shortages.⁷

◆ **Financial feasibility.** Minnesota's robust state economy, combined with record state budget surpluses for the past several years, provide the state with the financial wherewithal to put in place strategies to address the LTC workforce shortage that may not be affordable in leaner times. Unfortunately, rapid changes in the economy since early 2000 may shorten the state's window of opportunity.

◆ **Legislative and provider initiatives.** In January 2001, a bipartisan task force composed of Minnesota legislators and state agency commissioners issued a report outlining a vision for the future of long-term care in Minnesota and a set of recommendations for "reshaping" the state's long-term care system. According to the Task Force, central to any change is a substantial investment in recruitment and retention efforts to alleviate the "severe shortage" of workers in long-term care (State of Minnesota Long-Term Care Task Force 2001). Many of the recommendations by the Task Force were included in legislation passed in the 2001 legislative session.⁸ This Task Force built on the collaborative effort of Minnesota's two LTC provider associations (Care Providers of Minnesota and Minnesota Health & Hospital Alliance), which had earlier articulated their shared vision for the future of long-term care in Minnesota. The effort's guiding document, *Principles for Change*, called for changes to make caregiving in LTC a more "honored and respected profession."

◆ **Other ongoing initiatives.** A variety of innovative strategies to improve the selection and preparation of entry-level employees for careers in the health care industry are already underway in Minnesota. For example, the Healthcare Education-Industry Partnership (HEIP), sponsored by the Minnesota State University System, is actively engaged in multiple recruitment and training activities designed "to guide education and training of a high quality healthcare workforce in a rapidly changing industry."⁹ Other initiatives in the state more narrowly target specific populations for careers in LTC. The International Institute of Minnesota (IIM), for instance, has offered a nursing assistant training program for refugees and recent immigrants since 1990. Activities such as these can serve as models for expanded recruitment and retention efforts throughout Minnesota.

Nursing Personnel

Nursing Assistants

Nursing assistants provide personal and nursing care to patients in nursing homes, assisted living facilities, private homes, and community health organizations. They provide a range of patient care services, from simple personal care and housekeeping tasks to nursing and nursing-related services. Nursing assistants represent between 70 and 90 percent of nursing staff in residential facilities and provide the vast majority of care (Wunderlich 2001). They also have much more direct contact with the residents (clients) than other nursing personnel, functioning, in the words of one researcher, as the "eyes and ears" of the system (Stone 2001). An estimated eight out of every ten hours of formal (i.e., paid) care received by patients in long-term care facilities is provided by a nursing assistant (Frank 2000).

Despite NAs' central care-giving role, these positions are entry-level jobs requiring a minimum of training. Federal regulations require NAs who work in nursing homes that participate in Medicare or Medicaid to be certified and listed on the state's Nursing Assistant Registry. Certification can be obtained by completing an approved nursing assistant training program and a "competency evaluation" of written and hands-on testing within four months of the start of employment.¹⁰ Training programs for NAs either focus

⁷ These organizations include the Minnesota Hospitals and Homes Partnership (MHHP), Minnesota Colleagues in Caring Collaborative, Minnesota Nurses Association, Care Providers, and the Minnesota Home Care Association (MHCA)

⁸ S.F. 4, 2001 1st Special Session (Articles 4 – 8)

⁹ http://www.tip.mnscu.edu/healthcare_facts.htm

¹⁰ Alternatively the NA can opt out of the training requirement and pass the competency test prior to employment. Minnesota's test-only option is designed to allow nursing assistants who are returning to the occupation to be re-listed on the state's Nursing Assistant Registry without taking the required training and thus to be working sooner. Minn. Stat. Sec. 144A.61, Subd. 3a

only on nursing assistance or combine nursing assistance with home health care. Both programs are a minimum of 75 hours.¹¹ Minnesota is not among the nearly 20 states that have raised the training requirement above the Federal minimum.

Home Health Aides

Home health aides help elderly, disabled, and ill persons live in their own homes instead of in a health facility. Although there can be substantial overlap of duties, in general, home *health* aides provide health related services, such as administering oral medications under physician's orders and RN supervision, whereas home *care* aides provide mainly housekeeping and routine personal care services. Both types of aides generally work on their own, with occasional supervision. Most are employed by home health agencies, visiting nurse associations, nursing and personal care facilities, or temporary help firms. A growing minority of aides are self-employed, with no agency affiliation or supervision and accepts clients, sets fees, and arranges work schedules on their own. Federal law sets a minimum of 75 hours of classroom and practical training supervised by a registered nurse (parallel to the requirement for NA training). Minnesota does not have licensing or registration requirements for home health and home care aides. However, a home health or home care aide can obtain a Class C, or individual paraprofessional license, which allows the licensee to perform home health aide, home care aide, and home management tasks as an independent home health care provider.¹²

Licensed Practical Nurses

Licensed practical nurses (LPNs) provide practical or vocational nursing care under the direction or supervision of a registered nurse or physician. They provide routine bedside care, adapting nursing care methods and procedures as needed to meet changing patients needs, and may help develop patient care plans and supervise nursing assistants. Training for LPNs is typically a 12-month program at a community college or vocational school. To practice in Minnesota, an LPN must be licensed by the state's Board of Nursing.

Registered Nurses

Registered nurses (RNs) provide professional nursing care to patients. They assess patient health problems and needs, develop and implement nursing care plans, maintain medical records, assist patients in complying with prescribed medical regimen, and supervise LPNs and nursing assistants. Registered nurses in LTC facilities devote most of their time to administrative and supervisory tasks. Registered nurses can be licensed in Minnesota following a two-year associate degree program or a four-year baccalaureate program.¹³ About 30 percent of RNs in LTC settings have a baccalaureate degree, compared to 34 percent of all active RNs in the state.¹⁴ Regardless of their education program or where they intend to work, all candidates for RN licensure take the same examination. Licensing by the Board of Nursing is a prerequisite to practicing as an RN in Minnesota.

Directors of Nursing

By federal regulations, directors of nursing (DON) in nursing homes must be RNs. In nursing homes, DONs are often graduates of diploma or associate degree programs and rarely have advanced preparation in geriatrics (Wunderlich 2001). Minnesota requires that DONs in nursing homes have (an unspecified amount of) administrative and management training in addition to appropriate clinical training before or within the first 12 months after appointment as Director of Nursing Services.¹⁵ Staffing issues are a primary responsibility of DONs. Table 1 summarizes training and licensing requirements for nursing personnel in Minnesota.

The demographics of the different types of nursing personnel differ. For example, the majority of NAs in nursing homes are between the ages of 25 to 44, with a mean age of 36. In contrast, nearly a majority of home health aides are between the ages of 45 and 65, with a mean age of 47 (close to the mean age of RNs in nursing homes [45]). Nursing assistants are disproportionately people-of-color, comprising about 43 percent of NAs in nursing homes compared to 26 percent of all workers (GAO 2001). Registered nurses, in comparison, are disproportionately Caucasian: 86.6 percent of all RNs in 2000 compared with 71.8 percent of the total U.S. population (Division of Nursing 2001).

¹¹ 42 CFR Sec. 483.152. In comparison, a cosmetology license in Minnesota requires at least 1,550 hours of training; manicurists must receive at least 350 hours of training. Minn. Rules, Ch. 2644.0510; 2644.530.

¹² Minn. Rules, Ch. 4668.0100.

¹³ Some RNs completed their educational requirements in a 3-year diploma program. While these programs no longer exist in Minnesota, a small number continue operation in several states.

¹⁴ Minnesota Nurses Association, Long-term Care Taskforce *Focus on Long-term Care Nursing: A survey of MNA members working in long-term care*. July 2000. Unpublished report.

¹⁵ Minn. Rules, Ch. 4658.

Organization of Report

In the next chapter, we delineate the dimensions of the problems of recruiting and retaining nursing personnel in long-term care. In the subsequent chapters, we examine several proposals for resolving these problems. As one researcher has observed, “the successful recruitment, retention, and maintenance of a committed, prepared, long-term care workforce across a range of settings is dependent upon a variety of interactive factors that occur at different levels,” including social, organizational, environmental, and

technological factors (Stone 2001). We explore some of these factors, concentrating on those we believe hold the most promise for improving worker recruitment and retention. These include improving the working conditions in long-term care, employing new technologies, optimizing the use of temporary workers pools, and expanding the labor pool by targeting recruitment and retention efforts to recent immigrants. For each section, we offer policy recommendations and suggestions for additional research.

TABLE 1
Training and licensing requirements for LTC nursing staff in Minnesota

Position	Training	Licensing	Legal definition	Applicable laws and regulations
Nursing assistant	At least 75 hours of classroom and laboratory instruction required by Federal regulations. 42 CFR Sec. 483.152. No additional state requirements. No continuing education requirements.	No license required. Nursing assistants (NA) employed by "certified" LTC providers must register with the state's Nursing Assistant Registry. To be placed on Registry, NA must: (1) Successfully complete NA training and the "competency evaluation program" within 4 months of employment; OR (2) Successfully complete the "competency evaluation program" prior to employment. NA will be considered "active" on state's registry list by working at least 8 hours in previous 24-month period.	"Nursing assistant" means an individual providing [at the direction of a nurse] nursing or nursing-related services that do not require the specialized knowledge and skill of a nurse." Minn. Stat. Sec 148.171, Subd. 12. "Nursing assistant" means a nursing home employee who is assigned by the director of nursing services to provide or assist in the provision of nursing or nursing-related services under the supervision of a nurse." Rules, Ch. 4658.0010, Subpart 8.	Minn. Stat. Sec 148.171. Minn. Stat. Sec. 144A.61 Minn. Rules, Ch. 4658.
Home health aide/Home care aide	At least 75 hours of classroom and laboratory instruction to perform home health aide tasks. At least 24 hours of classroom and laboratory instruction to perform home care aide tasks. No continuing education requirements.	No license required if employed by home health agency. Class C, or individual paraprofessional license, allows the licensee to perform home health aide, home care aide, and home management tasks as an independent home health care provider.	"Home health aide" and "home care aide" are not defined in Minnesota laws or regulations. "Home health aide tasks" are defined in Minn. Rules, Sec. 4668.0100, Subpart 1. "Home care aide tasks" are defined in Minn. Rules, Sec. 4668.0110, Subpart 1.	Minn. Rules, Ch. 4668.

Table 1 Continued

Position	Training	Licensing	Legal definition	Applicable laws and regulations
Nurse	LPN (licensed practical nurse) ➤ 1 year vocational-technical training An LPN shall participate in the ratio of at least one contact hour of acceptable continuing education for each two months of registration.	License required to practice practical nursing Practical nursing license must be renewed every 2 years.	LPN "means an individual licensed by the [Minnesota board of nursing] to practice practical nursing." Minn. Stat. Sec 148.171, Subd. 8.	Minn. Stat. Sec 148.171 to 148.285. Minn. Rules, Ch. 4658
	RN (registered nurse) ➤ 2-year associate degree program; ➤ 3-year, hospital-based diploma program; or ➤ 4-year bachelor of science nursing program An RN shall participate in the ratio of at least one contact hour of acceptable continuing education for each month of registration.	License required to practice professional nursing. Professional nursing license must be renewed every 2 years.	RN "means an individual licensed by the [Minnesota board of nursing] to practice professional nursing." Minn. Stat. Sec 148.171, Subd. 20.	Minn. Stat. Sec 148.171 to 148.285. Minn. Rules, Ch. 4658
	APRN (Advanced practice nurse) ➤ 2-year masters degree program in nursing Continuing education requirements same as for RN.	License required to practice professional nursing. No additional licensure requirements. Professional nursing license must be renewed every 2 years.	APRN "means an individual licensed as an RN by the [Minnesota board of nursing] and certified by a national nurse certification organization to practice as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner." Minn. Stat. Sec 148.171, Subd. 3.	Minn. Stat. Sec 148.171 to 148.285
Director of Nursing	(For nursing homes) a DON must have training in rehabilitation nursing, gerontology, nursing service administration, management, supervision, and psychiatric or geriatric nursing before or within the first 12 months after appointment as director of nursing services. Minn. Rules, Ch. 4658 Continuing education requirements same as for RN.	License required to practice professional nursing. No additional licensure requirements. Professional nursing license must be renewed every 2 years.	Not defined in Minnesota laws or regulations.	Minn. Rules, Ch. 4658

References

- Andersen, M.L. 1983. *Thinking About Women: Sociological Perspectives on Sex and Gender*. 4th ed. Newark, DE: Allyn and Bacon.
- Callahan, J.J., Jr. 2001. Policy perspectives on workforce issues and older people. *Generations* 25 (1):12-16
- Division of Nursing. 2001. The Registered Nurse Population: National Sample Survey of Registered Nurses - March 2000. Washington, DC: Division of Nursing, Bureau of Health Professions, HRSA, DHHS.
- Feldman, P.H. 1994. Labor Market Issues in Home Care. In *Home-Based Care for a New Century*, edited by D. M. Fox and C. Raphael. Williston, VT: Blackwell Publishers.
- Frank, B., and S.L. Dawson. 2000. Health Care Workforce Issues in Massachusetts. Boston: Massachusetts Health Policy Forum.
- GAO. 2001. Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern. Washington, D.C.
- Glater, J.D. 2001. Women are close to being majority of law students. *New York Times*, March 26, 2001, A1.
- Health Care Financing Administration. 2000. Appropriateness of Minimum Staffing Ratios in Nursing Homes: Report to Congress. Baltimore, MD.
- Ladd, R.C., R.L. Kane, and R.A. Kane. 1999. State LTC Profiles Report, 1996. Minneapolis: University of Minnesota.
- Leon, J., J. Marainen, and J. Marcotte. 2001. Pennsylvania's Frontline Workers In Long Term Care: The Provider Organization Perspective. Jenkintown, PA: Pennsylvania Intra-Governmental Council on Long Term Care.
- Long-Term Care Imperative. 2001. *Data from Fall 2000 Survey* [Power Point slide show]. Care Providers and MAHA 2001 [cited April 2001].
- McMurry, M. 1998. Faces of the Future. St. Paul, MN: Minnesota Planning, State Demographic Center.
- Minnesota Department of Economic Security. 2000. Workforce Shortage? A Fact Book of Labor Shortage Indicators. St. Paul, MN: Minnesota Department of Economic Security.
- Minnesota Department of Economic Security. 2001. Help Wanted: 2001 State of Minnesota Job Vacancy Survey. St. Paul, MN: Minnesota Department of Economic Security.
- Minnesota DHS Aging Initiative. 2000. Policy Considerations for Nursing Facilities: A Report to the Minnesota Legislature. St. Paul, MN: Minnesota Department of Human Services.
- North Carolina Division of Facility Services. 1999. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. Raleigh, NC.
- State of Minnesota Long-Term Care Task Force. 2001. Reshaping Long-Term Care in Minnesota. St. Paul, MN: Minnesota Long-Term Care Task Force.
- Stone, R.I. 2001. Research on frontline workers in long-term care. *Generations* 25 (1):49-57.
- Wilner, M.A., and W. A. 1998. Paraprofessionals on the Front Lines: Improving their Jobs, Improving the Quality of Long-term Care. Washington, DC: AARP.
- Wunderlich, G.S., and P.O. Kohler, eds. 2001. *Improving the Quality of Long-Term Care*. Washington, D.C.: National Academy Press (Institute of Medicine).
- Wunderlich, G.S., F.A. Sloan, and C.K. Davis, eds. 1996. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington, D.C.: National Academy Press (Institute of Medicine).
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DIMENSIONS OF THE PROBLEM

Recruitment and retention are distinct yet closely linked issues whose origins, effects, and solutions are sometimes hard to differentiate. Some factors important to recruitment may be important to retention as well. Low wages and limited benefits, for instance, impede employers' efforts to attract new workers as well as to keep existing employees. Similarly, some of the factors that lead workers to stay with their employer likely entered into their decision to seek and accept the job in the first place. Overall, however, recruitment problems are more closely linked to factors external to an employer or industry, such as the local unemployment rate and the size of the pool of potential workers. Retention problems, on the other hand, are more closely linked to the culture of an organization and the way in which it conducts its business (Leon 2001). To better understand the causes and dimensions of the recruitment and retention problems facing the LTC sector, and to craft corrective strategies, it is important to separate, to the extent possible, the two types of problems.

To delineate the dimensions of the personnel problem facing LTC, we first examine the fundamental issue underlying recruitment (i.e., an imbalance between supply and demand) and then the fundamental issue underlying retention (i.e., high turnover rates). We also explore worker compensation, since low wages and benefits are a key component of the dimension of the problem and increased compensation is probably the most straightforward and frequently-proposed strategy for improving recruitment and retention. We conclude that higher wages and better benefits are necessary but not sufficient to resolve the workforce shortage. We close this background section to the report with a recommendation to establish a statewide long-term care workforce commission, which we believe is essential to developing and carrying forward the needed comprehensive reform strategies.

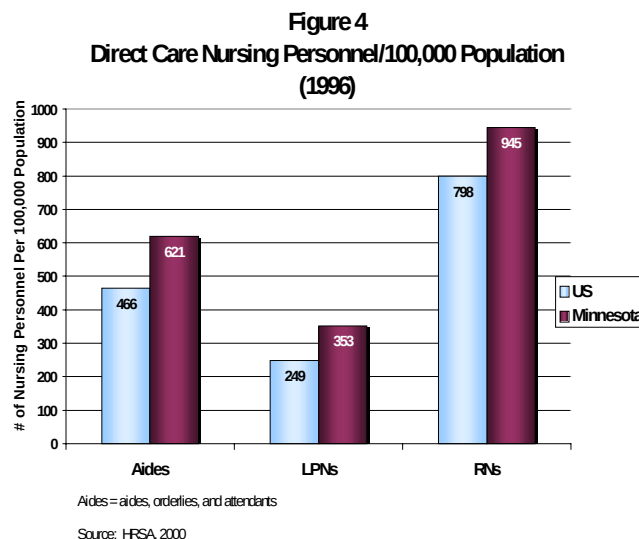
Supply-Demand Imbalance

Current Supply of Nursing Personnel

Only a few sources of data exist on the number of nursing personnel working in long-term care, and of these data, comparison is difficult because of definitional and methodological issues. Accurate data on nursing assistants, an extremely fluid workforce, are notoriously difficult to obtain.

In November 2000, the federal Health Resources and Services Administration (HRSA) issued a first edition of health workforce profiles for each state. The profiles permit useful rankings of states across a variety of indices, but since they are based on only national data they may not include potentially more accurate and timely data collected by individual states. According to the HRSA profiles, Minnesota ranks among the top states across a variety of health care and long-term care workforce supply measures. Among the specific findings are the following (unless otherwise noted, all figures are for 1998):

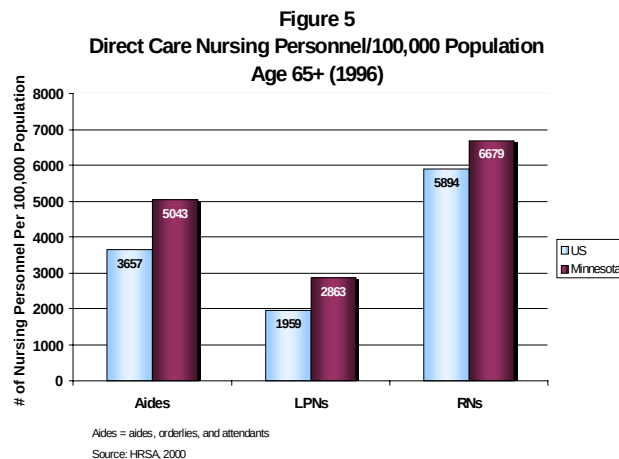
- ◆ The national ratio for direct care nursing staff was 1,513 per 100,000 population, including 798 RNs,¹ 249 LPNs, and 466 "aides, orderlies, and attendants." Minnesota's ratios in comparison were 1,919 direct care nursing staff per 100,000 population, including 945 RNs² (12th highest among the states), 353 LPNs (8th highest), and 621 aides, orderlies, and attendants (12th highest) (See Figure 4).



- ◆ The national ratios for direct care nursing staff per 100,000 population age 65+ were 5,894 RNs, 1,959 LPNs, and 3,657 aides, orderlies, and attendants (total 11,511 per 100,000). Minnesota's ratios were 6,679 RNs, 2,863 LPNs, and 5,043 aides, orderlies, and attendants (total 14,576 per 100,000 population age 65+) (See Figure 5).

¹ Figures for RNs are for 1996.

² Figures for RNs are for 1996.



- ◆ Of Minnesota's entire health service workforce, 23 percent were employed in "nursing and personal care facilities," higher than the national average of 16.6 percent.
- ◆ Minnesota employed 1.22 workers per nursing and personal care facility bed, substantially higher than the national average of 1.02 worker per bed.
- ◆ Of Minnesota's health service workers, 4.5 percent were employed in home health care, compared to the national average of 6 percent (Bureau of Health Professions 2000).

Minnesota had 59,639 licensed RNs in 2000.³ Nearly 84 percent, or approximately 47,000, of all licensed RNs were employed in nursing positions.⁴ Of these, about 11 percent, or 5,170, were employed in long-term care and 6 percent (2,820) were employed in home health care (Table 2).

Table 2 Registered Nurses (RNs) in Minnesota, 2000		
Total # of RNs		59,639
84% work in nursing positions		47,000
Of Whom:	11% work in LTC	5,170
	6% work in Home Health	2,820
Sources: (Office of Rural Health & Primary Care 2001b)		

Also in 2000, as shown in Table 3, Minnesota had 22,342 licensed LPNs, of whom 86 percent, or approximately 19,000, were employed in nursing positions. Of these, 35 percent, or 6,650, were employed on long-term care and

another 6 percent (1,140) were employed in home health care (Office of Rural Health & Primary Care 2001a).

Table 3 Licensed Practical Nurses (LPNs) in Minnesota, 2000		
Total # of LPNs		22,342
86% work in nursing positions		19,000
Of Whom:	35% work in LTC	6,650
	6% work in Home Health	1,140
Sources: (Office of Rural Health & Primary Care 2001a)		

Minnesota does not have an accurate count of the number of nursing assistants working in long-term care. Minnesota's Nursing Assistant Registry lists about 100,000 NAs, of whom approximately 45,000 are considered "active," which is defined as having worked at least one 8-hour shift in the previous 24 months. Thus, less than half the people who at one time worked as nursing assistants in Minnesota are still employed as NAs. However, given the minimal work requirement and the high turnover rate, it is likely that a large but unknown percentage of "active" NAs are, in fact, not currently working as nursing assistants. Other features of the Registry further undermine its usefulness as a database for measuring NA employment in Minnesota. Only NAs working for Medicaid and/or Medicare certified facilities must be listed on the registry. Thus, the Registry may or may not include on its active list NAs who are in private-pay arrangements as caregivers to individuals. Second, the NAs themselves are responsible for registering and notifying the Registry of any changes in employment; however, according to the Registry's director, many fail to do so.⁵ The HRSA's state health workforce profile reports 11,460 home health aides and 29,350 nursing "aides, orderlies, and attendants" working in Minnesota in 1998; however, a breakdown by health care sector is not available (Bureau of Health Professions 2000).

Future Supply of Nursing Personnel

Workforce Growth Rate

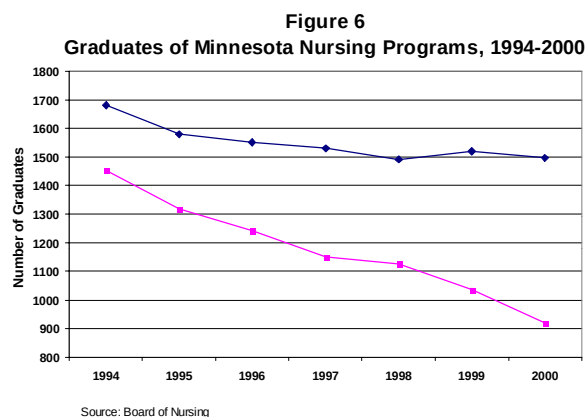
The rate of growth of both the RN and LPN workforce in Minnesota decreased during the 1990s from the previous decade (Minnesota Colleagues in Caring 2000). This trend is likely to persist if the number of new entrants to nursing

³ The state's two primary sources of information on nurses are the Board of Nursing, which licenses nurses to practice in Minnesota, and the Department of Health's Office of Rural Health and Primary Care (ORHP). The ORHP created the Health Services Personnel Database (HSPD) at the Minnesota Department of Health in 1993. The HSPD includes about 110,000 Minnesota medical professionals (including RNs and LPNs). The HSPD questionnaire is sent to medical professionals when they renew their licenses or registration. Although responses are not required to renew licensure or registration, response rates vary between 60% and 90%, depending on the position surveyed.

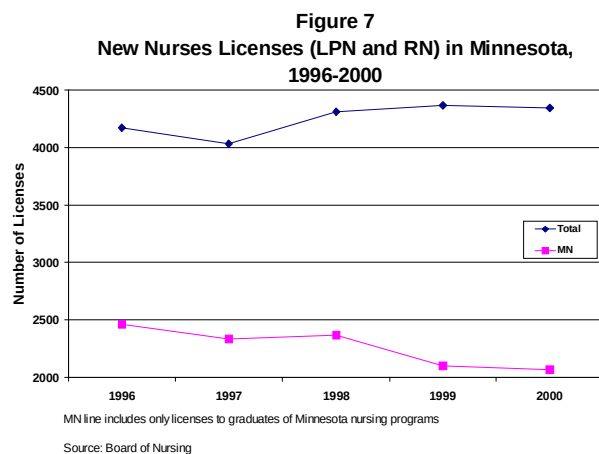
⁴ This translates to 955.4 RNs per 100,000 population in 2000, very close to the 1996 figure of 945 RN per 100,000 population estimated by HRSA.

⁵ Deena Dunkel, personal communication 2/8/2001.

continues to decline. Nationwide, enrollment in both practical (LPN) and professional (RN) nursing programs is declining. Enrollment in BSN programs, for example, fell by 4.6 percent in 1999, dropping for the 5th year in a row. Mirroring enrollment figures, the number of graduates from Minnesota's nursing programs peaked in 1994, and has declined steadily since then. Between 1994 and 2000, the number of graduates from RN programs in Minnesota seeking licensure in the state dropped by 11 percent, from 1,680 to 1,496, compared to a 36 percent drop in the number of graduates from LPN programs, from 1,453 to 918 (Figure 6).



Despite the decline in the number of graduates from Minnesota-based nursing programs, the total number of nursing licenses issued (either through testing or interstate endorsement of nurses already licensed in other states) has increased over the past few years, from 4,171 in 1996 (2,822 RN licenses and 1,349 LPN licenses) to 4,349 in 2000 (3,292 RN and 1,057 LPN) (Figure 7).

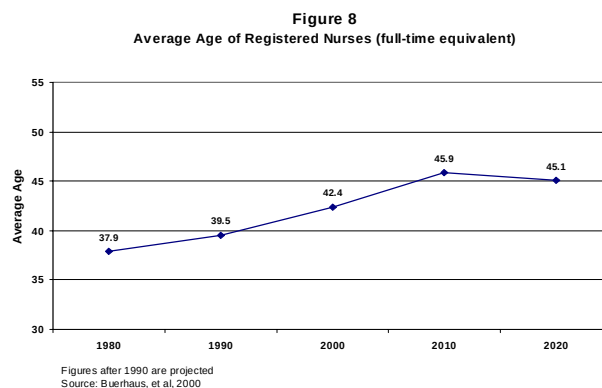


The growth in new licenses reflects the continued

attractiveness of Minnesota's health care system as a place of employment for nurses from other states.

Aging of Nursing Workforce

The reduced number of new entrants into nursing has contributed to the aging of the nursing labor force. The average age of working RNs nationwide, for instance, increased by 5 years between 1983 and 2000, from age 37.4 to 42.4 (Figure 8).



Unless the trend of decreased interest in nursing as a career and the corresponding decline in enrollment in nursing training programs is reversed, within the next 10 years, the average age of RNs is projected to increase another 3 years to 45.4 years, with more than 40 percent of the RN workforce expected to be older than 50 years (Buerhaus 2000). Since RNs in nursing homes are on average older than RNs in hospitals (e.g., 45 years vs. 40.8 years in 1996) the average age of RNs in nursing homes will likely be even higher.

The RN workforce in Minnesota is older than the national RN workforce (average age in Minnesota is 45.3, compared to a national average of 42.4 in 2000) (Table 4). Minnesota's RN workforce in long-term care is older than the state's overall RN workforce. A larger proportion of Minnesota's RNs aged 55 or older work in LTC; in fact, 25 percent of all RNs in long-term care in Minnesota are over age 55 (Office of Rural Health & Primary Care 2001b). The average age of Minnesota's LPN workforce, in contrast, has remained steady since 1994 at 44 years, with the average age of LPNs in LTC slightly lower (Office of Rural Health & Primary Care 2001a). Along with the concern over replacing the increasing number of nurses who will retire in the next few decades, an aging workforce has other personnel implications. Nursing personnel who are older

may have a reduced capacity to perform certain tasks, such as lifting and transferring patients (Wunderlich, Sloan, and Davis 1996). Therefore, as the nursing workforce ages, more workers may be needed to perform these functions.

Table 4 Average Age of Registered Nurses (RNs), 2000	
Nationwide, all RNs	42.4
Minnesota, all RNs	45.3
Nationwide, RNs in long-term care	45.0*
*1996 Data Source: (Buerhaus 2000; Office of Rural Health & Primary Care 2001b)	

Supply Projections

The total number of RNs per capita nationwide is projected to increase more slowly over the next few years, peak around the year 2007, and then decline steadily as many current RNs retire (Buerhaus 2000). By the year 2020, the total number of RNs nationwide will be about the same as in the year 2000, although the nation's total population is projected to increase by 50 million.⁶ Even if, for example, the number of students entering nursing significantly increases in the next few years, the impact on RN supply would be nominal since "the size of the RN workforce during the next 20 years is largely determined by the size of the cohorts that have already entered the labor market" (Buerhaus 2000).

Projections of the future supply of nursing personnel in Minnesota are not available. However, a supply model to project the number of health care workers indicates that in the West North Central region (which includes Minnesota) the number of FTE RNs per 100,000 population will increase from 873 in 2000 to 951 in 2010 and then decline to 926 in the year 2020 (Decker and Dollard 2001). The number of nursing assistants nationwide is projected to increase 36 percent between 1998 and 2008, while the number of such workers in home care is projected to increase 58 percent in the same period (GAO 2001).

Future Demand for Long-Term Care

Demographic Projections

The aging of the population and the resulting surge in demand for LTC has been endlessly reported. Despite

their familiarity, however, the projections remain daunting. According to the state's Project 2030, the older population (65 years and older) will be the fastest growing age group in the state between 2000 and 2030. Within this group, different age cohorts will experience different rates of growth. For instance, between 2000 and 2030, the number of Minnesotans between ages 65 and 84 will increase significantly. Then, between 2030 and 2050, the state will experience dramatic growth in the "very old" age group (those over 85) as the last baby boomers turn 85. Following is a list of specific projections:

- ◆ The population of persons 65 years or older will almost double between 2000 and 2030, from 592,332 to 1,173,339. The nonelderly population will decline in numbers during this period.
- ◆ In 2030, older people will constitute 23% of the total state population, up from 12.7% of the population in 2000.
- ◆ In 2030, over one-half of the total population of persons 65 years and older will be between ages 65 and 74. By 2050, less than one-half of this population will be between 65 and 74.
- ◆ Also by 2050, the population of persons 85 years and older will represent 22% of Minnesota's elderly population, up from 12% in 2030 (Minnesota Department of Human Services 2000)

The changing profile of Minnesotans over age 65 will affect the demand for long-term care. The Department of Human Services projects that even "with the [anticipated] decline in disability rates, the number of older persons with some functional limitations in activities of daily living (ADLs) will double over the next 40 years" (Minnesota Department of Human Services 2000). Future demand for formal LTC (i.e., paid) is also linked to the availability of informal caregivers. While the proportion of married couples aged 65 years and older will be relatively stable, the proportion of Minnesota's elderly living alone (and thus without a spouse or caregiver) will more than double over the next 40 years. Further, the number of adult children available to care for their parents will be at an all-time low (Minnesota Department of Human Services 2000). The sheer volume of people reaching age 65 in the next few decades, however, will overwhelm any of these other socio-demographic trends affecting future demand for LTC.

⁶ http://www.npg.org/facts/us_pop_projections.htm

Workforce Demand Projections

Between 1991 and 2020, the demand for RNs in nursing homes is projected to increase 66 percent, with the increased demand for LPNs and nursing aides projected at 71 and 69 percent, respectively. In comparison, the demand for nursing staff in all health care settings is projected to increase 54 percent for RNs and 62 percent for both LPNs and nursing aides. A more than 260 percent increase in need is projected in home health for each of these three categories of workers (Decker and Dollard 2001).

Projections of future “demand” (or “need”) for LTC personnel must be viewed with caution. The forces driving up the level of demand will encounter equally powerful forces seeking to constrain costs by attempting to restrict increases in demand. It is not clear how this battle will play out, leaving even more uncertain the future size and make-up of the workforce that will, in fact, be needed to meet the “effective demand” (i.e., the level of services that payers are willing to fund) (Dawson 2001). It is clear, however, that effective demand will almost certainly be less than the “needs,” “desires,” or “expectations” of the recipients of long-term care. The “effective demand” for LTC, and thus for nursing personnel, will be driven by changeable and unforeseeable political and financial, as well as by more predictable health-related considerations (Dawson 2001). It is also clear that if present trends continue unchanged, the future workforce will be woefully inadequate to meet demand, regardless of how “demand” is measured.

Turnover

High turnover is the fundamental issue underlying the retention problem in long-term care. All industries experience turnover among their workers. Whereas turnover rates for the overall economy average an estimated 13 to 18 percent a year, health care and other service industries report average annual turnover rates of 20 percent. The historically high turnover rate among nurses is more than double the rates reported for professionals of comparable education and gender (Price and Mueller 1981). Nursing assistant turnover in long-term care has been exceptionally high. National data indicate the average annual nursing home turnover rate for nursing aides is nearly 100 percent (Wilner 1998; American Health Care Association 1999).

Turnover rates among nursing staff in Minnesota's nursing facilities in 2000 were measured at 33 percent for RNs, 31 percent for LPNs, and 62 percent for NAs, which are slightly lower for each category of worker than in 1999 (Table 5). Also, for each category of worker the turnover rates were highest in the Twin Cities metro area, nearly 41 percent for RNs, for example, compared to only 23 percent in the southwest region of the state (Long-Term Care Imperative 2001).

Table 5 Staff Turnover in Minnesota Nursing Facilities, 2000	
Registered Nurses (RN)	33%
Licensed Practical Nurses (LPN)	31%
Nursing Assistants (NA)	62%
Source: (Long-Term Care Imperative 2001)	

Generally, higher nursing job levels are associated with lower turnover rates. Nationwide, the turnover rate among RNs in all health care settings is consistently lower than the rate for LPNs, whose rate, in turn, is consistently lower than the turnover rate among nursing assistants (Tai 1998). Turnover is significantly higher among nursing personnel with less tenure (Tai 1998). This finding holds for paraprofessionals in LTC as well. About 50 percent of paraprofessional staff in nursing homes leave in just over seven months (Salmon 1999) and many of them leave within the first 90 days, often because they are emotionally and technically unprepared to meet the demands of the job (Van Kleunen 2000). As a result, some nursing assistant positions may turn over several times in one year.

Reliability of Turnover Rates

Although the focus of much attention, turnover rates by themselves present neither a comprehensive nor an accurate picture of the retention problem. As already noted, reported turnover rates for nursing personnel in LTC vary widely. This variation is explained in part by the lack of a consensus definition. A common but by no means universal measure for turnover is to divide the number of workers who terminate employment by the total number of workers employed on average during the year (Salmon 1999). Reported turnover rates may exclude some workers; for example, some researchers do not count

workers who leave involuntarily (e.g., dismissal, layoff, or forced retirement). Turnover rates also typically do not include part-time workers, a significant weakness since a substantial number of nursing personnel work part-time. In Minnesota, 59 percent of all RNs and LPNs work less than 40 hours a week and nearly one-third of RNs and one-quarter of LPNs work less than 30 hours a week (Office of Rural Health & Primary Care 2001a, 2001b).

The greatest drawback, however, is that the relatively short tenure of many NAs magnifies the high turnover rate. Focusing only on turnover may therefore exaggerate the retention problem. Accordingly, some additional measures are used to provide a more accurate picture. A few studies calculate “stability rates,” which is defined as the number of workers employed one year or more divided by the total number of workers employed on average during the year. Length of service of workers who remain employed is another measure to illustrate staff stability (Remsburg 1999). Currently, statewide data on stability rates and length of service of nursing personnel in LTC in Minnesota are not available.

Impact of Turnover

The adverse effects to the employer of turnover include financial costs (such as direct costs of recruiting and hiring and indirect costs of worker orientation and decreased productivity) as well as reduced morale and group cohesiveness among the workers who stay (Cavanagh 1989). Turnover costs are estimated to be around \$3,400 to \$4,000 per nursing assistant (Leon 2001; Straker and Atchley 1999). High turnover also impairs continuity of care and may reduce quality of care (Spector 1991; Munroe 1990). Turnover can also breed more turnover as the workload for remaining staff is increased, often forcing them to “work short” and thus reducing the time they have to interact with their clients, which is frequently cited by the workers themselves as the most rewarding aspect of their job. In contrast, direct contact over an extended period of time builds trusting relationships between caregivers and clients and enables nursing personnel to more fully understand their clients, know their idiosyncrasies, and notice subtle changes in their behavior or health status.

Turnover may have some positive effects as well. For example, turnover should help weed out workers who are wrong for the job. Employee mobility may also compel organizations to become more flexible and adaptable to

change. Thus, health care facilities that employ and promote staff from outside may facilitate the introduction of new practices and standards of care (Cavanagh 1989). The extent to which this applies to LTC providers is unclear, however. Other researchers suggest personnel turnover may have positive effects on nursing home resident outcomes (Halbur 1986). The reported positive effects of turnover, however, are more likely if the turnover rate is low, and it is not clear at what rate the adverse effects will tip the balance so that the negative consequences outweigh the positive. Alternatively, a high turnover rate among a small percentage of employees is likely to have relatively fewer (nonfinancial) adverse consequences than a lower rate across all employees. The financial costs of quick turnover is high, however, since the employer is unlikely to recover the investment in recruiting and training workers who leave shortly after being hired.

Demographic Profile of “Stayers” and “Leavers”

Studies of nursing personnel identify a number of characteristics associated with turnover. A literature review found that increased age, longer tenure, racial or ethnic minority, and higher job status were the “consistently significant socio-demographic factors” which predictably decreased the likelihood of turnover of nurses across health care settings (Tai 1998). A similar review of turnover studies among paraprofessionals concluded that compared to people who leave, nursing assistants who stay are older women with longer tenure, more likely to be African American or another racial or ethnic minority, come from lower income families, and often endure great hardship in their personal lives. Those who stayed received the highest pay, received better health benefits or pension benefits, cared for fewer residents, and were more likely to have permanent assignments or infrequent changes in resident assignments. Having input into resident care plans also increased the length of service of NAs (Salmon 1999).

Worker Compensation

Paraprofessional positions in LTC have long been low-wage, low-benefit jobs. The median hourly wage for full-time nursing and home health aide jobs in Minnesota is about \$9.79, lower than the median hourly wage (\$10.00) for all job vacancies, and far lower than the median hourly wage of \$15.73 (1999 dollars) for all jobs⁷ (Minnesota Department of Economic Security 2001). Full-time

⁷ www.bea.doc.gov/bea/regional/spi/action.cfm

employment at an hourly wage of \$9.79 (\$20,363 annually) is slightly higher than the Federal poverty level for a family of four (\$17,050) but only about 60 percent of a "livable wage" (National Priorities Project 1998). Nationwide, one in three NAs in nursing homes earned less than \$10,000 per year and 36 percent reported family incomes below \$20,000 (GAO 2001). About 14 percent of NAs working in long-term care receive food stamps and 10 percent participate in Medicaid.

The wages for frontline LTC workers are on a par with the wages of other unskilled jobs that do not require more experience but are far less stressful and difficult.⁸ Comparable pay for comparatively more difficult jobs can exacerbate recruitment problems. Likewise, the fact that paraprofessionals' wages generally do not increase appreciably with job tenure (on average, the highest paid frontline LTC workers receive an hourly wage only 25 percent over the starting, post-probationary, wage rate) intensifies retention problems (Leon 2001).

Paraprofessional jobs in LTC are also not competitive with regard to benefits. Nursing assistants in LTC are less likely to have employer-provided health insurance or pension coverage than workers in general (GAO 2001). Even when employers offer benefits, worker participation rates in these benefit programs are not known. There are few data on the cost of employee benefits to the employee. Studies suggest that while more employers are offering these benefits, employee contribution requirements are rising as well (Salmon 1999). A survey of LTC providers in Pennsylvania, for example, reported that only 31 percent contributed to the cost of family health care coverage for frontline workers (Leon 2001). Since the average cost of family coverage is over \$600 per month, or about 34 percent of the full-time NA's gross income, it may be too expensive for such employees. Even when employers contribute to the premium cost, the out-of-pocket costs may be prohibitive. For instance, one large LTC employer in Minnesota pays 60% of the cost of health insurance coverage, yet less than one-third of its employees participate in this benefit.⁹

Compounding the problem, wages and benefits for nursing personnel in long-term care have traditionally been lower than for those in acute-care settings. Full-time RNs in nursing homes, for example, earned on average 19.7

percent less than RNs in hospitals in 1996 (Wunderlich 2001 p. 213).¹⁰ The wages for nursing assistants are about 21 percent lower in nursing homes than in hospitals; in contrast, wages for LPNs were roughly equal in both settings (Wunderlich 2001 p. 213).

Important as wages and benefits are, studies are mixed on the relationship of compensation to recruitment and retention. Some studies show the lack of benefits hinders recruitment and retention, whereas others link higher benefits with job satisfaction and length of services. Still other studies find no impact of the availability of benefits on recruitment or retention of frontline workers or on job vacancy levels (Leon 2001; Caudill M. 1991; Grau L. 1991). Studies show similarly mixed findings regarding the impact of wages on turnover among nurses (Tai 1998; Cavanagh 1989). Moreover, the price elasticity of wages is not clear; thus, the extent to which increased compensation will resolve workforce shortages in LTC is uncertain.

Nursing assistants consistently cite pay as the most negative aspect of their job and a number of studies find that the majority of paraprofessionals who leave their LTC jobs cite low pay or poor benefits as a reason (Health Care Financing Administration 2000; Grieshaber 1995; Helmer 1993). Other studies, however, show no difference in hourly wages between "stayers" and "leavers." Finally, an initial review of state "wage pass through" initiatives¹¹ (so far the most common public policy response to workforce shortages in LTC) concluded that there is as yet little hard data "to substantiate whether or not the wage pass through has had any definitive and positive impact on [frontline worker] recruitment or retention" (North Carolina Division of Facility Services 2000). With appropriate accountability procedures, such initiatives can assure that at least a portion of reimbursement increases are in fact used to increase wages.

Despite these ambiguous findings, higher wages would likely attract and retain more workers in long-term care. A recent study which found the median annual wage for nursing assistants in North Carolina who had left LTC for other work was 27 percent higher than the median wage for NAs who continued to work in LTC (\$14,425 compared to \$11,358), concluded that NAs who left "seemed to fare better in the workforce, largely by moving away from work in long-term care" (Konrad 2000). Since all of these NAs

⁸ For example, the median hourly wage in 2000 in Minnesota for retail positions was \$7.50 and \$8.80 for "building, grounds cleaning, and maintenance" (Minnesota Department of Economic Security 2001).

⁹ The proportions of those who decline the benefit because they have alternative coverage or because the cost is too high (or for other reasons) are not known.

¹⁰ The multi-year contracts signed by hospital-based nurses in Minnesota in June 2001 will exacerbate this differential.

¹¹ "Pass throughs" are reimbursement increases to LTC providers in which all or some specified portion of the increase is earmarked exclusively for worker salaries and/or benefits (North Carolina Division of Facility Services 1999). As of 2000, 26 states had established some form of a wage pass through for NAs in long-term care.

were at one time interested enough in the job to get certified, higher wages may well have kept more of them from leaving.

The myriad studies on LTC worker compensation lead to two conclusions. First, on balance, the weight of the evidence provides some support for the intuitive notion that increased compensation will improve LTC providers' ability to attract and then retain workers (Leon 2001). Second, although increased wages and better benefits are without a doubt a necessary part of the solution, they are not by themselves sufficient to solve the recruitment and retention problems; they are clearly not the panacea, as some would believe.

Long-Term Care Workforce Commission

The remainder of this report examines more closely and offers recommendations on selected aspects of the workforce shortage. Whenever possible, this report is based on published data. However, much of the available literature is anecdotal, describing "best practices." Analysts who have reviewed the relatively small number of relevant studies on paraprofessionals agree that this literature cannot be said to offer any conclusive evidence regarding the effect of most types of provider interventions on the recruitment or retention of such workers in long-term care (Leon 2001; Stone 2001). Due to the paucity of data on some key elements, our analysis also relies heavily on the numerous interviews we conducted with stakeholders throughout Minnesota's long-term care sector. Their observations and insights help provide a more robust picture of the current workforce shortage.

We direct our recommendations — similarly informed by a literature review, supplemented by our discussions with Minnesota stakeholders — to policy makers (within both the public and private sectors), educational institutions, and the research community. We introduce here our principal recommendation, calling for the establishment of a long-term care workforce commission in Minnesota, which we believe is necessary for the development and implementation of a comprehensive, integrated, and sustained response to the workforce shortage and is the linchpin for carrying forward our public policy recommendations.

Barring a radical shift, public programs will remain the majority payor of LTC; thus, public policy will continue its

fundamental role in shaping the LTC sector, including the recruitment and retention of the workforce. Private initiatives led by the LTC sector independently or in conjunction with allied organizations (e.g., educational institutions) are essential but unlikely, by themselves, to ameliorate the workforce crisis. The impetus for significant improvement must come from the public sector.

Furthermore, as we noted above, numerous LTC organizations in Minnesota have already studied the problem and issued white papers, and a substantial number of LTC providers have taken steps to try to improve worker recruitment and retention. Overall, however, little headway has been made. Missing is a mechanism that can coalesce stakeholders around a common vision, facilitate the development of an array of short-term and long-term strategies that cut across all LTC settings, build and sustain momentum, and provide a direct conduit to public policy changes. What is needed is an accountable group charged with the responsibility to oversee the development, implementation, and evaluation of a comprehensive plan for resolving the workforce crisis in Minnesota. This group must be able to consider the problem in an ongoing capacity, taking into account economic, social, and demographic changes, include those we cannot foresee today.

Accordingly, we recommend that the legislature establish a statewide, broadly representative long-term care workforce commission whose primary responsibility will be to propose legislative initiatives for improving worker recruitment and retention in long-term care. We also recommend several essential elements of the commission's legislative proposal, based on our analysis of the current situation. A priority task is to centralize data collection, analysis, and dissemination. Information on the supply of LTC workers in Minnesota is now scattered among different state agencies, as is information on the future supply and on current and future demand for LTC services. Timely data are needed to fill existing information gaps, assist in designing and targeting corrective efforts, as well as to align education, workforce development, and other social and economic policies with the state's long-term care policy goals. For longer-term planning and evaluation, policy makers will need a coordinated system of data collection and analysis that documents current conditions, forecasts future supply and demand, provides data to consumers and other stakeholders, and assists in the monitoring of current and evolving conditions (Frank 2000).

Based on our conclusions regarding worker compensation, we recommend the LTC workforce commission develop legislative proposals that would add to Minnesota's "wage pass through" to increase the wages of LTC nursing personnel. The wage pass through should be sufficiently flexible to permit LTC employers to effectively use it to solve their specific workplace issues (e.g., adding staff or incentives to work shifts that are less attractive). We also recommend the commission explore ways for the state to assure health care coverage to such workers. By serving a basic human need, health care coverage is the most important of all benefits employers typically provide to their employees. If Minnesota has been unwilling or unable to set reimbursement levels high enough to permit LTC employers to provide affordable health care coverage to their employees, the state (as the putative employer¹²) should explore alternatives. We thus recommend that the

LTC workforce commission develop legislative proposals to allow LTC nursing personnel to participate in the state employee health plan and to maximize enrollment of such workers and their dependents in existing state health care programs.¹³ Such steps would advance the state's recent aggressive efforts to expand coverage for uninsured populations.

The public sector changes initiated by the proposed commission will need to be supplemented with developments in the private sector, including changes within the long-term care sector, but also, for example, modifications in the education and training of LTC workers. Additional research on a variety of issues will be needed to support the development and implementation of the most appropriate, effective, and efficient strategies for workforce reform.

Recommendation on Establishing a Long-term Care Workforce Commission

1. The Minnesota Legislature should establish a statewide long-term care workforce commission to oversee the development, implementation, and evaluation of a comprehensive approach to the workforce crisis in LTC. The commission should include representatives from across Minnesota of all major stakeholders, including the LTC sector (nursing homes, assisted living, home care), nursing personnel (RNs, LPNs, NAs), unions, consumers, higher education, and relevant state and local government agencies.

The commission's primary responsibility should be to prepare a set of legislative initiatives for the Commissioner of Human Service that are designed to improve the recruitment and retention of nursing personnel in long-term care settings throughout Minnesota. Additional responsibilities will include providing direction for implementing, monitoring, and evaluating policy initiatives. The commission should also monitor progress of the other recommendations in this report.

The following are among the legislative initiatives that the commission should submit to the Commissioner:

- ◆ Centralize in a single agency or department the collection, analysis, and dissemination of relevant data on long-term care nursing personnel in Minnesota. Criteria for new data collection should be based on filling existing gaps in our understanding of workforce issues in long-term care, should not duplicate existing data and information systems, and should use existing data collection infrastructure
- ◆ Add to the state's LTC "wage pass through" program to increase worker compensation
- ◆ Assure health care coverage for nursing personnel working in long-term care by, for example, developing and implementing strategies to:
 - allow LTC employees in Minnesota to participate in the state employee health plan; and
 - maximize enrollment of eligible LTC workers and their dependents in existing state programs such as MinnesotaCare, CHIP, and MCHA.

¹² LTC nursing personnel can reasonably be considered quasi-public employees since LTC is predominantly publicly financed.

¹³ We believe the benefits of providing public health care coverage to these employees would outweigh any potential negative impact on the private insurance market in Minnesota.

References

- American Health Care Association. 1999. Facts and Trends: The Nursing Facility Sourcebook, 1999. Washington, D.C.: American Health Care Association.
- Buerhaus, P.I., D.O. Staiger, and D.I. Auerbach. 2000. Implications of an aging Registered Nurse workforce. *JAMA* 283 (22):2948-2954.
- Bureau of Health Professions. 2000. HRSA State Health Workforce Profile - Minnesota. Rockville, MD: National Center for Health Workforce Information & Analysis, Health Resources and Services Administration, USDHHS.
- Caudill, M., and M. Patrick. 1991. Turnover among nursing assistants: Why they leave and why they stay. *Journal of Long Term Care Administration* 19:29-32.
- Cavanagh, S.J. 1989. Nursing turnover: Literature review and methodological critique. *Journal of Advanced Nursing* 14:587-596.
- Dawson, S.L., and R. Surpin. 2001. Direct-care healthcare workers: You get what you pay for. *Generations* 25 (1):23-28.
- Decker, F., and J. Dollard. 2001. Staffing of Nursing Services in Long Term Care: Present Issues and Prospects for the Future. Washington, DC: American Health Care Association.
- Frank, B., and S.L. Dawson. 2000. Health Care Workforce Issues in Massachusetts. Boston: Massachusetts Health Policy Forum.
- GAO. 2001. Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern. Washington, D.C.
- Grau, L., B. Chandler, et al. 1991. Institutional loyalty and job satisfaction among nurse aides in nursing homes. *Journal of Aging and Health* 3:47-65.
- Grieshaber, L.D., P. Parker, and J. Deering. 1995. Job satisfaction of nursing assistants in long-term care. *Health Care Supervisor* 13 (4):18-28.
- Halbur, B.T., and N. Fears. 1986. Nursing personnel turnover rates turned over: Potential positive effects on resident outcomes in nursing homes. *Gerontologist* 26 (1):70-76.
- Health Care Financing Administration. 2000. Appropriateness of Minimum Staffing Ratios in Nursing Homes: Report to Congress. Baltimore, MD.
- Helmer, F.T., S.F. Olson, and R.I. Heim. 1993. Strategies for nurse aide job satisfaction. *Journal of Long Term Care Administration* 21 (2):10-14.
- Konrad, T.R. 2001. *Where have all the nurse aides gone?* North Carolina Institute on Aging 2000 [cited March 30 2001]. Available from <http://facility-services.state.nc.us/aides.pdf>.
- Leon, J., J. Marainen, and J. Marcotte. 2001. Pennsylvania's Frontline Workers In Long Term Care: The Provider Organization Perspective. Jenkintown, PA: Pennsylvania Intra-Governmental Council on Long Term Care.
- Long-Term Care Imperative. 2001. *Data from Fall 2000 Survey* [Power Point slide show]. Care Providers and MAHA 2001 [cited April 2001].
- Minnesota Colleagues in Caring. 2001. *Minnesota Colleagues in Caring Collaborative*. Minnesota Colleagues in Caring 2000 [cited March 26 2001]. Available from www.tip.mnscu.edu/powerpoint/Health%20care%20presentation%202/index.htm.
- Minnesota Department of Economic Security. 2001. Help Wanted: 2001 State of Minnesota Job Vacancy Survey. St. Paul, MN: Minnesota Department of Economic Security.
- Minnesota Department of Human Services. 2000. Project 2030 Report: Minnesota Department of Human Services.
- Munroe, D.J. 1990. The influence of registered nursing staffing on the acuity of nursing home care. *Research in Nursing and Health* 13 (4):263-270.
- National Priorities Project. 2001. *Fact Book: Working Harder, Earning Less*. National Priorities Project 1998 [cited May 5 2001]. Available from <http://www.natprior.org/grassrootsfactbook/jobgrowth/pdf/mn.pdf>.
- North Carolina Division of Facility Services. 1999. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. Raleigh, NC.
- North Carolina Division of Facility Services. 2000. Results of a Follow-up Survey to States on Wage Supplements for Medicaid and Other Public Funding to Address Aide Recruitment and Retention in Long-Term Care Settings. Raleigh, NC.
- Office of Rural Health & Primary Care. 2001a. Licensed Practical Nurse Workforce Profile. St. Paul, MN: Minnesota Department of Health.
- Office of Rural Health & Primary Care. 2001b. Registered Nurse Workforce Profile. St. Paul, MN: Minnesota Department of Health.
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- Price, J.L., and C.W. Mueller. 1981. *Professional Turnover: The Case for Nurses*. Ames, Iowa: Iowa State University Press.
- Remsburg, R.E., K.A. Armacost, and R.G. Bennett. 1999. Improving nursing assistant turnover and stability rates in a long-term care facility. *Geriatric Nursing* 20 (4):203-208.
- Salmon, J.R., C. Crews, et al. 1999. Nurse Aide Turnover: Literature Review of Research, Policy and Practice. Tampa, Florida: Florida Policy Exchange Center on Aging, University of South Florida.
- Spector, W.D., and H.A. Takada. 1991. Characteristics of nursing homes that affect resident outcomes. *Journal of Aging and Health* 3 (4):427-454.
- Stone, R.I. 2001. Research on frontline workers in long-term care. *Generations* 25 (1):49-57.
- Straker, J., and R. Atchley. 1999. Recruiting and Retaining Frontline Workers in Long Term Care: Usual Organizational Practices in Ohio: Scripps Gerontology Center, Miami University.
- Tai, T.W.C., S.I. Bame, and R.C. D. 1998. Review of nursing turnover research, 1977-1996. *Social Science and Medicine* 47 (12):1905-1924.
- Van Kleunen, A., and M.A. Wilner. 2000. Who will care for Mother, tomorrow? *Journal of Aging and Social Policy* 11 (2/3):115-126.
- Wilner, M.A., and W. A. 1998. Paraprofessionals on the Front Lines: Improving their Jobs, Improving the Quality of Long-term Care. Washington, DC: AARP.
- Wunderlich, G.S., and P.O. Kohler, eds. 2001. *Improving the Quality of Long-Term Care*. Washington, D.C.: National Academy Press (Institute of Medicine).
- Wunderlich, G.S., F.A. Sloan, and C.K. Davis, eds. 1996. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington, D.C.: National Academy Press (Institute of Medicine).
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IMPROVING THE WORKPLACE

Recruiting and retaining long-term care workers requires a rewarding and satisfying workplace. For nursing assistants (NAs) and licensed nurses (RNs and LPNs), long-term care can be hard and frustrating work. Without a context in which to place their efforts, NAs may see only the Sisyphean struggle to keep up with unachievable demands for care. Inadequately trained, the NAs may fail to appreciate why they are asked to do what they do or what difference it is expected to make. Without some means of appreciating the impact of their efforts, they can readily become discouraged. Add to this the realities of the nature of the services required, which include taking care of the basic bodily needs of clients and often dealing with cognitively-impaired clients who can be unappreciative as well as abusive, and it is hardly surprising that this is not a sought after career path. Indeed, the commitment and dedication of many of those who do this work should be recognized and built upon as the bedrock for designing a better and more rewarding system.

The situation for nurses is only slightly better. Many devote the bulk of their time to administrative and managerial tasks rather than to the clinical care for which they are trained. They must contend with mountains of mandatory paperwork to document clients' status and to generate payment. Those catapulted into leadership positions as directors of nursing must assume huge responsibilities for which few are trained or prepared. They are literally thrown into the heat of battle. They must organize and oversee complicated plans of care provided primarily by meagerly trained staffs. They are responsible for scheduling to assure that staffing standards are met and assuring that the quality of the care provided is sufficient to prevent adverse events that can affect their own licensure status.

This picture is not the basis for a recruitment poster, but it is harshly real. The work does, however, have rewards: the relationships that develop between client and caregiver can be meaningful to both parties. Despite the stereotypes, LTC clients can benefit enormously from personal attention and good clinical care. They represent some of the neediest patients in nursing, and for some nurses, serving this group is satisfying just for this reason.

In addressing questions of staff recruitment and retention, it is helpful to ask how the work itself can be redesigned to make it easier and more satisfying. Although

inequities in wages between LTC nursing positions and comparable jobs in other health care settings and industries must be addressed, it is not possible to rely solely on increased compensation as a means of attracting and retraining a committed staff. The work itself must be made more rewarding.

Making the work more rewarding involves critically examining the roles and skill mix of nursing staff as well as implementing strategies to organize and deliver care safely, effectively, and creatively. The overarching goal should be to meet the needs of the recipients of care (e.g., residents or patients) and to effectively use the knowledge and skills of all nursing personnel to meet those needs (Mueller 1998). The care needs of residents or patients influence a number of factors associated with the organization and delivery of care. In hospitals, characteristics of patients shown to be a major determinant of the features of patient care units include 1) the relative predictability of achieving the desired outcome (uncertainty), 2) fluctuations in the patient condition (instability), and 3) variations in the types of health problems presented (variability) (Leatt 1982). Patients in a coronary care unit may show little variability but high levels of uncertainty and instability, whereas patients on a general medical-surgical unit would be highly variable but could have relatively low uncertainty and instability. Groups of LTC residents can also vary on these dimensions (i.e., although most would be expected to get worse, the variability in their trajectory would be high).

Strategies to improve the work place for nursing staff in long-term care can be categorized into six topical areas: 1) changing the organizational culture, 2) changing how nursing care is organized and delivered, 3) creating new work roles and staffing patterns, 4) improving leadership and supervision, 5) creating a supportive physical environment, and 6) using technology to support the work of nursing staff. These areas are not mutually exclusive, rather a combination of two or more will likely lead to success in recruiting and retaining nursing staff. In this chapter, we discuss and examine the first five topics using evidence from the literature, and explore their implications for recruiting and retaining nursing personnel in long-term care.¹

¹ Technology is discussed in the following chapter.

Changing the Organizational Culture

The term, organizational culture, refers to “a pattern of basic assumptions—invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems” (Schein 1985). Thus defined, organizational culture includes the presenting problem and the response(s) to it in the form of the system organized to respond to the problem, as well as the individual patterns of behavior among members of the organization. In LTC facilities, the problem is defined as safely and effectively delivering care to people who need long-term assistance with activities of daily living and monitoring medical and (even more often) chronic health concerns. The system in LTC is typically highly structured in terms of bureaucratic, centralized directives for the completion of numerous tasks in eight-hour blocks of time by caregivers, the majority of whom are minimally skilled. The patterns of behavior that have evolved are perpetuated in large part because the caregivers at the point of service have limited ability to make a suggestion about changing that pattern, let alone authority to do so. To alter this “culture,” at least one of these three features would need to be changed: the problem, the system, or the patterns of behavior of the members.

Nursing homes are highly centralized organizations. They mirror the medical model of organization used throughout today's health care system, particularly in hospitals. This system evolved to cure people with illnesses and diseases and to provide facilities where treatment could be delivered and within which close supervision of the recovering patient could occur. The idea grew out of the logic of centralizing resources for efficiency. Hospitals, organized as treatment facilities, persist as the model for health care today, using a hierarchical, bureaucratic organizational structure that centralizes power and authority for decision-making from the top.

This model has also driven the evolution of LTC facilities as well as the roles and responsibilities of nursing personnel in LTC and the organization of nursing care. Staffing patterns and the associated skill mix for nursing facilities, home care, and assisted living facilities have also been quite traditional: unlicensed nursing staff provide the great majority of personal care to residents, and licensed nursing

staff administer medications and treatments and coordinate the residents' care. The current shortage of professional staff and the strict regulatory oversight reinforce top-down authority. Indeed, in most LTC facilities, there is no formal mechanism for those involved in the direct and daily care of residents to have any decision-making input into the policies, procedures, protocols, routines, and organization related to how care is provided.

However, the reality of decision-making in LTC facilities is often quite different. Given the shortage of supervisory staff and the pressure for them to attend to paperwork, hands-on supervision is often minimal, and those who actually give the care make many decisions, often without adequate consideration of relevant factors. It seems sensible to recognize this reality and to establish a deliberate system of decentralized decision making, whereby caregivers closest to residents are empowered to make decisions and take action (within their scope of practice). Such a step could build on the unique perspectives of frontline workers, who provide the majority of care and thus see first hand how the resident is feeling and responding to care.

Changing an organization's culture to one that recognizes positive achievements and is committed to decentralized decision-making is an important step that is more easily proposed than implemented. The regulatory climate makes it difficult, if not dangerous, to innovate, lest such innovations threaten the dominant orthodoxy and invite even closer regulatory inspection. Additional factors that make changing the culture difficult have to do with human nature; that is, once a person figures out how to solve a specific problem, he or she tends to incorporate that solution into the daily routine. It takes tremendous energy to try something new and see if it works, especially if faced with multiple tasks that need to be accomplished in a short time, if many of those tasks are repetitive, and if there are other equally taxing problems to be addressed when the work day is done.

The two chief ways to affect cultural change within LTC at the point of service are to redefine the role of the nursing assistant or redesign the system in which the NA operates. Either of these strategies can improve job performance and/or job satisfaction of NAs and thus reduce turnover and improve retention. Studies on job performance of NAs in nursing homes and in LTC demonstrate that task repetition, low pay, poor supervision, and lack of autonomy

reduce performance and job satisfaction (Banaszak-Holl 1996; Buelow, Winburn, and Hutcherson 1999; Cohen-Mansfield 1997; Cotton and Tuttle 1986; McDonald 1994; McGillis-Hall and O'Brien-Pallas 2000; Mesriow, Klopp, and Olson 1998; Stryker 1982). Using job performance as a proxy for patterns of behavior shows that altering any of these contributing factors can alter the culture of the organization.

Redefining the Role of Nursing Assistants

Several options to redefine the role of the NA have been shown to reduce turnover. These include increasing their involvement in care decisions, using them as consultants in care, and employing intensive efforts to increase their knowledge about elders and care issues. In a report on the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to nursing homes, researchers found increased job satisfaction among NAs who were given a chance to form close relationships with patients, provided an opportunity to contribute to care decisions, able to use their own judgment about care in consultation with other professionals, and respected in their own choices in assignments. Other studies demonstrate reduced turnover among NAs simply by involving them in care conferences or staff meetings during which care plans are revised or care decisions are made (Bowers and Becker 1992; Brannon, Cohn, and Smyer 1990, Spring; Tellis-Nayak and Tellis-Nayak 1989; Yeatts 2000; Smyer, Brannon, and Cohn 1992; Schnelle et al. 1993). Still other strategies involve NAs in care planning and decisionmaking and as consultants to more highly-educated staff (Krichbaum, Pearson, and Hanscom 2000; Ryden 2000; Chappell and Novak 1992).

In a test of a specific educational model to improve the level of staff performance, Burgio and Scilley found that an effective staff-training model included knowledge assessment, in-service competency assessment, and in vivo (while working) competency assessment as a follow-up to formal classes (Burgio and Scilley 1994). This model, coupled with better supervision (i.e., more active performance monitoring and feedback), resulted in significant improvements in staff retention rates.

Changing the System

Changing the system for care delivery can also increase job satisfaction and thereby improve retention of NAs.

Alternative models include the Eden Alternative model, the Swedish House model, clusters (or communities) of care, and the Lazarus Project. In the Eden model, designers list 10 principles that underlie the beliefs and values of the model, including the belief that the nursing home is first a home and that companionship is essential for residents to ward off feelings of loneliness, helplessness, and boredom (Thomas and Stermer 1999). Although this model focuses on the resident, its central tenet is that the "maximum possible decision-making authority [should reside] in the hands of those closest to the residents" (Renick and Ransom 2001). Preliminary studies indicate this model increases job satisfaction among NAs (Renick and Ransom 2001).

Large institutions like nursing homes may create an unnecessary sense of depersonalization that adversely affects both residents and staff. Even large physical structures can be transformed into smaller, more autonomous service units. These smaller units, or "clusters of care," can become the basis for more sustained personal relationships between caregivers and residents. Staff assignments in smaller care settings can be more stable, fostering bonding and allowing caregivers to more readily appreciate when their clients' condition changes.

The Swedish House model groups small numbers of residents into clusters or "houses" in which one caregiver lives alongside the residents and provides them with all necessary care. The NAs receive additional education about caring for elders. The idea, piloted in Sweden, was shown to initially improve quality of life for residents and increase autonomy and job satisfaction for NAs. Similar clustering of residents with like problems has been replicated in many facilities; a prime example is in Special Care Units for residents with dementia. The effects on staff retention are mixed, but many staff report increased satisfaction with the specialized knowledge of caring for these residents that accompanies placement on such units.

In another model, the Lazarus Project applies its governing democratic philosophy by empowering both those who work and those who live in the nursing home. The idea is that people who coexist in this environment should share in decisions about how the system should work. Staff have been satisfied with this arrangement and a decreased turnover rate was indicated (Kari and Michels 1991).

These examples illustrate the power inherent in changing the system to allow for more autonomy among frontline staff, empowering them with information, and involving them more directly in decisions about care. However, such a step would also make apparent current shortcomings in the training and understanding of personnel and could lead to better structures to help nursing personnel place their care in its proper context. In some cases, the use of guidelines or pathways based on evidenced-based interventions could facilitate the handling of more routine procedures. In other instances, greater access to consultation may be required. Structured information systems that provide a context and structure for observing and recording salient events in the clients' behavior and condition make it more likely that staff would recognize changes in their status and take action more quickly. Such a structured system could also provide a context for caregivers to better appreciate health and behavior changes that occur over time. Indeed, if these systems could be coupled with some points of comparison about what the clinical course might look like in absence of the care being provided, the staff might gain perspective about just how much difference their care was actually making.²

Changing the Delivery of Nursing Care

Changing the delivery of nursing care involves adjusting the number and skill mix of nursing personnel, using such personnel effectively, and improving the environment for professional nursing practice.

Adjusting the Number and Skill Mix of Nursing Personnel

The residents' needs should determine the number of staff as well as the skill level, education, and experience of the staff. A systematic way to identify the care needs of residents is needed so that decisions can be made about the appropriate amount and qualifications of staff to meet those needs. Patient classification (or case-mix) systems, which attempt to measure the amount and skill level of care needed by patients, have been used primarily in acute care hospitals. In LTC, case-mix classifications use the amount of nursing care needed by residents to determine the payment level in nursing homes. In Minnesota, the case-mix system is also used by directors of nursing as a guide to determine the nursing hours required per resident.

The Minnesota case-mix system is not useful, however, for determining the amount of time a resident needs from licensed staff versus unlicensed personnel. Moreover, Minnesota's staffing regulations, which specify only a minimum of two hours of nursing care per resident per day, provide little guidance since the average case mix for a nursing facility may require more (or less) than two hours of care.

The federal requirements for licensed staffing in nursing homes are also of little assistance on this issue. According to these requirements, a licensed nurse must be on duty 7 days a week, 24-hours a day and for 8 of those hours the licensed nurse must be a registered nurse. Although these requirements are widely viewed as woefully inadequate, many nursing homes throughout the country staff at this minimum level (Health Care Financing Administration 2000). An expert panel that recommended new minimum nurse staffing standards for nursing facilities recognized that safe and appropriate staffing requires consideration of the case-mix or acuity level of the resident in addition to simple staff-to-resident ratios (Harrington 1996).

Few tools are available, however, to help directors of nursing determine how many licensed staff are needed. One potential tool is the Resource Utilization Group-III (RUG-III) case-mix classification system, designed for Medicare payment and used in some states for Medicaid payment as well. It specifies the nursing time, by skill level, associated with each of the 44 RUG-III case-mix groups. A study of the RUG-III case-mix system for making staffing decisions in nursing homes suggested that the RUG-III nursing time may not be adequate to meet the needs of nursing home residents (Mueller 2000). However, the study found that the minimum data set (MDS), which is the source document for the RUG-III case-mix system, can identify residents' clinical needs and serve as a valid component of a staffing methodology for LTC facilities.

More sophisticated systems are needed that can quantify the care needs of residents and link those needs to the appropriate number and type of staff. Software vendors have not yet designed such systems because of the lack of market for them. A requirement that nursing homes need to demonstrate how they base their staffing on residents' acuity or care needs of would likely be an incentive for designing such systems.

² We discuss these information technologies in greater detail in the technology chapter below.

Relating Staffing to Quality Indicators

Another way to help determine the appropriate number and type of nursing staff is to relate staffing to indicators of quality. For nursing facilities, these indicators could include the MDS quality indicators or changes in residents' functioning over time. Facilities receive monthly reports on the prevalence and incidence rates of the 24 MDS quality indicators. It is then up to the facility to analyze and investigate the scope and root cause of indicators that may be below a desired threshold and to take appropriate action. The investigation should analyze the relationship between the quality indicators and staffing indicators (e.g., RN/LPN/NA hours per resident day; use of pool staff). Although the data are readily available, this type of investigation is not commonly conducted by LTC facilities.

Criteria for accreditation by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and for designation as a Magnet Nursing Organization through the American Nurses Credentialing Center (ANCC) both require a system that bases daily nurse staffing on the comprehensive needs of residents (American Nurses Credentialing Center 2001). The ANCC Magnet Nursing Services Recognition Program, for example, requires analysis of staffing data and clinical and human resources data (American Nurses Credentialing Center 2001). The JCAHO is currently testing standards and performance indicators to assess the effectiveness of staffing in health care organizations. This new approach does not depend on staffing ratios; rather, it uses an evidence-based model that relies on the application of sets of clinical (e.g., adverse drug events, injuries to residents, and infections) and human resources (e.g., staff satisfaction, staff vacancy rates, and staff turnover rates) indicators to screen for potential staffing issues. Since the Centers for Medicare & Medicaid Services (CMS)³ collects staffing data from LTC facilities as well as MDS quality indicator data, it too has the potential to evaluate the relationship between nursing staffing and quality care indicators in nursing facilities.

Effective Use of Nursing Personnel

The three dominant models for organizing and delivering nursing care are functional nursing, team nursing, and primary nursing. The models vary in the number and type of staff used and on methods for distributing and coordinating the workload. Nursing homes typically use the functional delivery model in which a set of tasks (as opposed to residents) is assigned to nursing personnel.

Team models of care, which are widely used in acute-care settings, assign responsibility for the care of a group of patients to a team that usually includes both professional and nonprofessional staff. The team leader distributes the work among team members, such as responsibility for the total care of selected patients, specific tasks, or a combination of the two.

The third model, primary nursing, was first described and implemented at the University of Minnesota Hospital by Marie Manthey and colleagues in the 1960s. This Minnesota invention was developed in response to the then prevalent functional and team models. Primary nursing assigns 24-hour accountability for care of a caseload of patients to a primary (RN) nurse who is assisted by other nursing personnel (Manthey 1980). The model is widely favored by nurses, although systematic evaluations of its benefits with respect to patient outcomes and costs are inconclusive (Daeffler 1975; Felton 1975; Gardner 1991; McPhail et al. 1990; Sellick, Russell, and Beckmann 1983). Among the most widely cited advantages are increased accountability, continuity of care, improved communication, and increased professionalism.

According to the few reports in the literature about the use of primary nursing in nursing homes, the concept was modified for LTC in two ways. Sometimes facilities applied the concept to NAs by giving them permanent case assignments in contrast to the usual pattern of rotating assignments on a daily, weekly, or monthly basis. In one of the more controlled studies, cognitively-impaired residents showed improvement in their behavior and affect. Nursing assistants on the experimental units reported that they felt more responsible, felt closer to the residents, and were able to spend more social time with them (Teresi et al. 1993). Anecdotal reports also suggest permanent assignments reduce absenteeism and turnover among NAs. The second modification blended primary and team nursing into a modular model that more accurately reflects the usual staff mix in nursing homes. In this modification, a group of staff members, led by a licensed nurse, assumes permanent or prolonged responsibility and accountability for a group of residents (Anderson and Hughes 1993; Patterson 1987). Results have been similar to those achieved with an unmodified primary nursing model.

³ Formerly the Health Care Financing Administration (HCFA).

Improving the Environment for Professional Nursing Practice

In the early 1980s, during another national nursing shortage, researchers noted a small number of hospitals had little difficulty attracting and retaining registered nurses. These hospitals, referred to as 'magnet' hospitals, were distinguished by sustained professional nursing practice, flat organizational structures, decisionmaking at the unit level, creative scheduling to minimize shift rotation and week-end work, strong nurse leaders, and investments in the education and development of nurses (McClure et al. 1983). Subsequent comparisons of magnet and non-magnet hospitals show clear relationships with better patient outcomes as measured by mortality (Aiken 1994, 1997). The organizational attributes of magnet hospitals are thought to enable nurses to use their knowledge and expertise more fully so that they can provide high-quality patient care (Havens and Aiken 1999). Magnet hospitals tend to have higher nurse-to-patient ratios, but the costs of the extra nurses were offset by significantly shorter lengths of stay and lower use of ICU days (Aiken, Havens, and Sloane 2000).

The Nursing Work Index-Revised measures the organizational attributes reported by such magnet hospitals (Kramer and Hafner 1989; Aiken 2000). These attributes are associated with nursing organizations that attract and retain nurses because of maintaining a professional practice environment.⁴ Continuity and collaboration are the attributes most relevant to LTC workforce issues.

Continuity

Continuity refers to the consistency in care providers and the care provided to residents. Strategies to promote continuity include assigning nursing staff regularly to the same unit, assigning residents to paraprofessional and licensed personnel on a permanent basis or at least a prolonged period of time, and involving these staff in developing and evaluating the plans of care. As previously discussed, permanent resident assignments for NAs are associated with positive resident and organizational outcomes. The limited available evidence suggests that systematically involving direct care nursing staff in developing and evaluating care plans, and ensuring that such staff care for the same residents on a regular basis, leads to good resident outcomes and staff satisfaction with their job and work setting. High turnover, on the other hand,

interrupts continuity of care and is associated with poorer resident outcomes (Wunderlich, Sloan, and Davis 1996).

Continuity is also relevant to the role of RNs, and a number of studies have examined creative and innovative strategies to facilitate continuity of care for residents by registered nurses. Skima described the Partners-in-Care Model in which RNs serve as team leader for a consistent group of residents (Skima 1999). They are responsible for working with the multidisciplinary team, residents, and families on planning, evaluation, discharge planning, and coordination of care. Positive outcomes were reported in regards to infection rates, resident and family satisfaction, discharge of residents to lesser levels of care, individualized resident care, and staff retention. Similarly, Smith described the use of RNs as case-managers in which each RN assumed responsibility for a consistent group of residents, coordinated the assessment and care planning process for the residents, and interacted regularly with the resident and family (Smith 1991). Using RNs as case managers in a nursing facility has led to a significant change in the number, specificity, and measurability of problems documented in the residents' care plans. Satisfaction among the licensed staff regarding the role of the case manager was high. Haff and colleagues found that the staff, family, and residents rated the overall quality of care as good to excellent when RNs functioned in the role of a primary nurse and assumed 24-hour accountability and responsibility for a consistent group of residents (Haff et al. 1988).

Collaboration

Collaboration is the extent to which nursing and other staff work together to identify and meet residents' needs. The evidence for the benefits of involving all nursing staff in decision-making about the residents is building. Lack of involvement of NAs, for example, reduces their job satisfaction (Waxman, Caner, and Berkenstock 1984; Kruzich 1995). Coworker teamwork was found to be one of five aspects of nurses' jobs in special care units that leads to greater job satisfaction (Karner et al. 1998). Anecdotal and documented evidence also indicate that collaboration between nursing staff and gerontological nurse practitioners (GNPs) contributes to better resident outcomes and satisfaction of nursing staff. Wellspring Innovative Solutions, for instance, uses GNPs in their nursing homes to train nursing staff in how to apply clinical guidelines. Wellspring facilities also empower all staff,

⁴ The previously-mentioned ANCC Magnet Nursing Services Recognition Program, employs criteria based on these organizational attributes to determine if a nursing organization or a hospital or LTC facility meets magnet status. Currently, 33 hospital-based nursing organizations and one long-term care nursing organization have received Magnet status from the ANCC

including nursing assistants, to make decisions (such as care decisions based on clinical guidelines) that affect the quality of care (Reinhard and Stone 2001). In a large number of nursing facilities in Minnesota, particularly in the Twin Cities metropolitan area, GNPs provide primary care to residents and the nursing staff value the collegial support they receive from the GNPs (Kane and Huck 2000). Researchers also demonstrate reduced cost in acute and emergency care with the use of teams comprised of GNPs and MDs who care for residents in nursing facilities (Burl et al. 1998). These teams provided expert assessments and onsite visits to frail nursing home elders, which benefit the residents as well as help educate nursing staff about the assessment of frail residents.

New Work Roles

Universal and Single-Task Workers

Improving the workplace by changing the organizational culture of LTC facilities often entails redefining, expanding, or creating new work roles. For example, in many cases, the smaller service units, or clusters of care, discussed earlier in this chapter require or foster a different approach to staffing that is built around the universal worker concept. Although a standardized definition is lacking, the term “universal workers” usually refers to persons employed in a nursing facility who have the ability and qualifications to respond to many of the basic care needs of residents. Universal workers in LTC facilities typically minimize the role distinctions among staff. Thus, for example, a person hired as a housekeeper could also answer resident call lights, assist residents to the toilet, assist with resident meals, and so on. The main idea is that everyone employed in the facility has the ability, flexibility, and responsibility to respond to residents’ needs.

The universal worker approach is most successful when a facility’s staff supports the concept as a means to create a more family-like environment. In some instances, introducing this change may involve staff turnover, and hence it should not be undertaken lightly in the face of extant recruiting problems. However, its potential to improve the quality of life for both residents and staff should also be appreciated. Other potential barriers to the universal worker concept are staff training and education requirements. These requirements may prevent staff members who are not certified from providing services to the residents for which NAs are currently trained. The costs

of ensuring that all staff have the minimum 75 hours of training (required for NAs) may be prohibitive. Despite these concerns, the Minnesota Legislative Task Force on Long-Term Care proposed expanding the use of the universal worker concept, as have similar groups in other states.

An alternative strategy (implemented most broadly in Wisconsin) is to create a “single task worker,” a minimally-trained worker permitted to perform specific, nonmedical tasks to support nursing staff, primarily in the areas of feeding, transportation and mobility, or activities.⁵ Clearly, having some work activities performed by unlicensed and uncertified personnel would not threaten quality of care if those activities do not require specialized training or education. These activities were also identified in a survey conducted by Wisconsin Association of Homes and Services for the Aging (WASHA) as activities that could help NAs with their job. On the other hand, some NAs have voiced opposition to this type of worker precisely because it would remove the easier parts of their job.

Different concerns arise if the single-task worker performs tasks that do not comprise the easier parts of NAs’ jobs. Opposition then comes from professional nursing organizations and others out of fear that it could compromise resident safety and the quality of care since nursing facilities would be allowed to employ staff with less than 75 hours of training to carry out direct-care activities. There is also concern that single-task workers could replace a facility’s existing nursing staff. Proponents argue that single-task workers should only augment, and not replace, existing staff, be supervised by a licensed health professional, and only perform single tasks for which certification is currently not required.

No research-based evidence was found on the effectiveness and safety of universal or single-task workers and whether these types of workers contribute to the overall retention of nursing personnel. Even so, there is heated controversy about the use of these workers, with legislation proposed at both national and state levels in support and in opposition. Conventional wisdom suggests the need for some creative strategies for using unlicensed and uncertified personnel to safely and effectively meet residents’ needs. Demonstration projects that provide waivers to LTC providers to test the use of universal and single-task workers are warranted.

⁵ www.wahsa.org/isstask.htm

Some successful models have already experimented with broadening job descriptions of nursing home workers. For example, in organizations characterized as regenerative communities, care delivery was reorganized so that a small group of residents (5 to 7) are supported by care using a 'home nursing model' (Eaton 2000). Registered nurses visit residents as needed and each group of residents has a 'resident' aide, rather than a nurse aide, emphasizing that the assistance is to the resident rather than the nurse. Job descriptions are broadened and cross-training of workers enables housekeeping staff to assist residents or social service staff to serve meals to residents. The philosophy is based on resident-focused care, meaning that the role and responsibilities of all staff in the facility focus on the needs of the residents. This model is described as a new paradigm that reverses the assumption of inevitable resident decline and emphasizes dignity, choice, and growth for both residents and employees.

It is perhaps less the broadening of roles and responsibilities and more the philosophy supporting these practices that transform traditional organization practices for care of residents and the roles and responsibilities of staff. Nursing homes that have successfully implemented the principles of the Eden Alternative, for example, reported reductions in mortality, illness, and drug use (Thomas and Stermer 1999). A Catholic facility in Seattle, Washington reported higher job satisfaction among the resident aides, improvement in residents' functional capacities, decreased use of medications/dosages, and increase in resident activity levels and social interaction (Eaton 2000). While these initial findings are extremely promising, the evidence is limited and further research is clearly needed on both process and outcome measures associated with these regenerative models.

Career Paths

One long held premise to increase the supply of nursing staff, while simultaneously providing a mechanism to encourage personal growth among current staff, is to encourage career paths whereby NAs might aspire to more professional training. Ideally, career paths (or "career ladders") promote and recognize staff for additional experience, education, or training that enables them to take on added or expanded responsibilities. In theory, a career ladder could provide incentives for nursing staff to obtain additional education as follows: NA-LPN-RN (associate

degree) to RN (baccalaureate degree) to RN (masters degree). The reality of this approach is somewhat less than its theory. If NAs who worked in that role as students while pursuing higher education are excluded, relatively few NAs have successfully made the career move to LPN and even fewer to RN. The cost of implementing and maintaining such career ladders for nursing staff has not been documented, nor is there strong evidence to suggest such career ladders improve retention of unlicensed personnel.

An alternative, which may be more compatible with current realities, is to establish a matrix within the various levels of practice. Under this alternative, NAs could take on added responsibilities (with concomitantly more pay) by acquiring or demonstrating special skills. The additional skills and corresponding responsibilities for NAs often associated with a career matrix program include administering medications as a result of training and certification achieved through the Trained Medication Assistant program; preceptor responsibilities for newly hired staff; serving as the 'lead' nursing assistant for a nursing unit; and training and education to become a restorative aide. Some NA career matrix programs are based on additional training and length of service, but not necessarily having additional responsibilities.

The evidence to support career matrix programs for NAs in nursing homes is fairly strong. Nursing assistants consistently report their desire for more responsibility and advancement⁶ (Remsburg, Armacost, and Bennett 1999; Salmon et al. 1999; WAHSA 2000). The WAHSA survey included suggestions from NAs to create career matrix programs with expanded responsibilities such as preceptors, medication aides, unit clerks, data entry, restorative aide, and charge aide.

A serious commitment to developing meaningful career paths of either type will require a reexamination of nursing education. More credit will need to be given for skills acquired in atypical ways. Competence-based testing may have to predominate. Even then, many NAs may not develop the social maturity needed to assume the responsibilities of LPN and RN positions without specific education to instill leadership and build self-confidence. Staff development programs, mentoring programs, and tuition reimbursement programs will be needed to support advancement in these paths.

⁶ <http://members.aol.com/iowacga/recruitment.html>

Improving Leadership and Supervision

Creating a rewarding and satisfying workplace requires leaders in the organization who can effectively foster change as well as facilitate communication with staff, families, and residents. A key leader in long-term care facilities is the director of nursing (DON). The president and CEO of a chain of 50 facilities recently stated that "[t]here is no higher correlate to quality care than the stability and competency of the director of nursing. Directors of nursing will also determine to a great extent the stability of the staff" (Gold 2000). According to Vestal, "for directors of nursing, being a good clinician and manager of day-to-day clinical activities isn't enough anymore" (Vestal 1995). The role also requires knowledge of organization theory, finance, marketing and planning, personnel administration, staffing and scheduling, quality improvement, and gerontological nursing, as well as leadership, management, and supervisory skills (Mueller 1998; Ballard 1995; Vaughan-Wrobel and Tygart 1993).

Many DONs, however, are inadequately prepared for such demanding positions. The limited data on DONs in long-term care facilities indicates that less than one-third nationwide have a baccalaureate degree in nursing (Mueller 1998). A 1989 survey found that only 24% of DONs in Minnesota had a baccalaureate degree in nursing and 3% had a Masters degree (Krichbaum, Johnson, and Ryden 1992). Yet as early as 1984, a national project to promote the professional development and education of DONs in long-term care facilities had recommended that by 1992, directors of nursing have a masters degree in nursing with specialized preparation in administration (Lodge 1985).

There are very few education programs, either in continuing education or formal academic coursework, designed specifically for directors of nursing. Surveys find that almost half of DONs intended to pursue formal education, but needed a nontraditional education program, such as a distance learning, to be able to pursue their education (Mueller 1998; Arioan, Patsdaughter, and Wyszynski 2000). Although schools of nursing across the country have made their RN-BSN programs more

accessible for nurses without a degree, they have not developed graduate programs in long-term care nursing administration, primarily because of the lack of nursing faculty with expertise in long-term care nursing administration (a second reason is the lack of demand). The University of Minnesota School of Nursing is currently developing web-based continuing education courses for nurse leaders in LTC facilities with a future intent to offer these courses for academic credit. A website for nursing leadership and management in LTC also provides the opportunity for nurse leaders to participate in a listserv to share ideas and obtain support from other LTC nurse leader colleagues.⁷

Until recently, the LTC sector had not proactively promoted the professional development and education of nurse leaders in long-term care. The American Health Care Association (AHCA) has launched a multiyear initiative to support the achievement of the highest level of senior nurse leader management. This project articulates the management and leadership competencies that are essential for nurse leaders who work in various LTC settings. The AHCA will also produce a self-assessment tool for individual senior nurse leaders to assess and benchmark their professional progress, and will provide a "map" to guide their professional development throughout their career.⁸ The Minnesota Health and Housing Alliance (MHHA) has offered an annual year-long program for directors of nursing. Over the past six years the program has enrolled over 150 directors of nursing. However, no data are available on the impact of this program on reducing DON turnover or improving their effectiveness.

Deliberate efforts on the part of schools of nursing and the long-term care sector are needed to promote the professional development and education of current and future DONs and nurse managers in long-term care. In the mid-1980s, a national project funded by the Kellogg Foundation and administered through the American Nurses Foundation delineated recommendations to provide incentives and support mechanisms for DONs to pursue professional and educational development (Lodge 1987). These recommendations targeted nursing

⁷ <http://ltnurseleader.umn.edu/>

⁸ <http://www.ahca.org/quality/competency1.htm>

education programs, professional nursing organizations, LTC organizations and facilities, and consumer organizations interested in long-term care.⁹ These recommendations continue to be relevant and should be considered by Minnesota Schools of Nursing and the Minnesota long-term care sector.

Researchers at the University of Minnesota Carlson School of Management have shown that leadership in long-term care can significantly affect staff morale. In a study of over 100 nursing homes, which included surveys of staff at all levels, Sandra Potthoff and Douglas Olson showed that the homes where the leaders (primarily the administrators and directors of nursing) exhibited more focused vision, support of change and effective communication were associated with greater employee satisfaction among all levels of employees (professional nurses, nursing assistants, and managers). Although the extent of the relationships among specific components of leadership and employee satisfaction varied somewhat across the different types of employees, the evidence of strong leadership was associated with greater satisfaction for each type of employee. (Olson 2000). Employee satisfaction is, in turn, linked to employee turnover. Hence, it is reasonable to conclude that the leadership practices of a nursing home can substantially influence the level of employee retention.

Supportive Physical Environment

Environmental conditions affect the growth and development of a person and ultimately their quality of life. Although it is customary in a nursing home setting to be primarily concerned with the residents' quality of life, we should also be concerned with the quality of life of the staff. This section focuses on staff as a resource, how that staff interacts with their workplace environment, and the potential of that environment to influence job satisfaction, stress levels, and ultimately the level of job turnover.

In today's corporate world, it is accepted that change in all parts of the organization, including facilities management, is a matter of economic survival. Yet many long-term care providers have not sought to up-date either

their facility's physical features or organization to maximize staff efficiency and create a more pleasant work environment. In a well-functioning workplace, the physical environment, technology, work processes, management style, and organizational philosophy are in harmony. Together they create a system that supports cooperation, collaboration, creativity, and allegiance to the workplace (Becker and Steele 1995). Previously, we discussed the management and organizational structure that have the potential to improve the workplace by empowering staff through increased participation in decision making, better communications, and decentralizing organization resources (Kruzich 1995). Here we explore environmental features of the LTC workplace, which can be supportive of the employees, hinder employees from using their skills appropriately, or in some situations require the employees to work in unsafe conditions.

Ecology is about the interdependency of organisms and their environment. Lawton and Nahemow's Ecological Model (Lawton 1973) is based on the theory that behaviors are a function of the interaction of personal factors with the physical, psychological, and social dimensions of the environment. The workplace environment's "size, shape, layout, quality, furnishings, and equipment shape our work lives, at the same time as our behaviors, and values shape the nature of that designed environment, how it is used, and the meaning we attach to it" (Becker and Steele 1995). Workers frequently compensate for shortcomings in the workplace but at the cost of reduced effectiveness, efficiency, and reduced morale. On the other hand, a more supportive workplace environment can often be achieved through space reallocation, policy changes, and simple modifications of the physical environment.

Nursing personnel in LTC may not directly work in all areas of a facility but it is important to look at the entire workplace to gain a better understanding of the total work experience. This includes the staff lounge, corridors, employee entrance, management offices, outdoor areas, and the facility's lobby, as well as the residents' rooms, bathrooms, shower rooms, lounges, and dining rooms. Safety, air quality, ergonomics, noise levels, lighting, and

⁹ The recommendations specific to nursing education and the LTC sector are as follows:

For University Education in Nursing

1. Continue to plan for LTC nursing as a component in graduate education (including administration in LTC nursing) and integrate LTC into baccalaureate programs in nursing.
2. Encourage faculty sensitivity to the needs of nurse administrators in long-term care as well as to consumer needs in that area.
3. Assist nurses in LTC in moving through formal education pathways.

For LTC organizations and facility owners and administrators (individual and corporate)

1. Endorse and implement the "Statement of Roles, Responsibilities, and Qualifications for Nurse Administrators/Directors of Nursing in Long-term Care."
2. Plan funding requirements for ongoing scholarship aid; tuition support; educational leave for nurse administrators in LTC; libraries related to LTC nursing; incentives for and recognition of nurse administrators in LTC who advance through formal and informal education programs.
3. Plan collaboratively with nursing for a) implementation of the educational requirements for professional practice and administration of LTC nursing; b) employment of nurse clinical specialists to assist nurse administrators in LTC in the implementation of professional nursing care; and c) appropriate use of nursing assistants in that care (Lodge 1987).

signs all directly affect the work experience. Although written mission and value statements are common to most LTC organizations, and often express the goal of providing a high quality of life for the residents and encouraging them to be active participants in their care and their lives, these statements too frequently fail to reflect the operative values of an organization. Organizations also send strong messages about their values and expectations in the way in which they allocate space, as well as in their cleanliness, arrangement and type of furniture, control of noxious stimuli, and other features of their physical environment.

Characteristics of the workplace environment can be either congruent or incongruent with the facility's mission statement. For example, a mission statement proclaiming dignity and respect is a contradiction for both the staff and the residents if the shower rooms are dark, dank, and dismal places to work and bathe. A windowless and stifling staff lounge located in the far corner of the basement, or a facility in which only the main lobby and executive offices are air-conditioned, sends clear messages to the employees about their worth. Well-designed break areas for the staff, on the other hand, can have the potential to relieve tension and improve employees' morale.

Completing tasks safely and promptly has been identified as a factor in job satisfaction, yet a common complaint from NAs is that interruptions are a constant

frustration and prevent them from finishing a task. Approximately 85 percent of patient calls are for assistance because they are cold, hot, thirsty, or have to go to the bathroom. Simple modifications, such as wheelchair accessible clothes storage, choice of beverages in each room, adequate supply of toilet paper within reach, linen storage within the resident's room or in close proximity, can increase the residents' autonomy while decreasing interruptions for staff. Cell telephones are a technological marvel but their ring while an aide is toileting a resident is both disrespectful of the resident and an interruption for the employee. Here, too, modifying the environment may help; creating neighborhoods of residents that are in close proximity to each other, for example, may reduce the need for using a cell telephone to summon aides.

Frontline positions and other nursing jobs in LTC facilities can be improved by paying more attention to the workplace environment. The social and physical environments of employees should support them as workers and individuals, allow them to use their skills appropriately, and protect them from working under unsafe conditions. Further, as the demographics of the workforce change, becoming older, more ethnically diverse, more temporary workers, and with a multitude of life styles and values, long-term care facilities need assurance that their social and physical environments support all of their workers.

Recommendations on Improving the Workplace

2. Foundations should be encouraged to sponsor grant initiatives to support long-term care facilities' efforts to increase the involvement of nursing assistants in care decisions, include them in care conferences, and use them as "experts" in relation to the residents in their care.
 3. The long-term care sector should continue to explore ways to increase frontline workers' involvement in decision-making and care planning.
 4. The long-term care sector, in partnership with research institutions, should develop, implement, expand, and evaluate alternate systems of delivering care that empower staff, residents, and families to make decisions regarding how and by whom care is delivered in long-term care facilities.
 5. The following are ways to improve the organization of the delivery of nursing services in LTC:
 - ◆ The long-term care sector should expand and further integrate Gerontologic Advanced Practice Nurses into long-term care facilities, focusing on staff development, quality improvement, and the use of research-based clinical protocols to ensure quality nursing care
 - ◆ The long-term care sector and the Minnesota Departments of Health and Human Services should provide incentives to nursing facilities for innovations in the use of acuity-based staffing
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systems, variations of nursing practice models, and creative use of staff (e.g., RNs as case-managers)

- ◆ The Minnesota Directors of Nursing Administration/LTC (MN-DONA/LTC) should use the criteria from the American Nurses Credentialing Center (ANCC) Magnet Nursing Services Recognition Program as benchmarks for the quality of nursing services in long-term care facilities. They should develop education programs for members that will assist them in meeting the Magnet criteria
6. The State Departments of Health and Human Services should support demonstration projects to evaluate the use of universal and single task workers in long-term care facilities.
 7. The LTC sector should spearhead the implementation of career matrices for frontline workers that offer progressive responsibilities, training, and compensation. The matrices could include the following:
 - ◆ Formal pathways for advancement within the NA job classification (e.g., NA Level I, NA Level II, Senior NA)
 - ◆ Specialty training for NAs (e.g., geriatric nursing assistant specialist)
 - ◆ The assignment of duties commensurate with training
 8. The LTC workforce commission should submit to the Commissioner of Human Services legislative initiatives to provide more financial assistance for students choosing nursing careers in LTC by, for example:
 - ◆ Increasing the state's loan forgiveness program for LPN and RN nursing students who agree to practice nursing in a LTC setting; or
 - ◆ Establishing a LTC career scholarship program for high school or college students who work or volunteer in LTC settings
 9. Schools of nursing and other education institutions should modify education requirements to expand career mobility for nursing personnel in LTC by:
 - ◆ Encouraging more opportunities to use demonstrated competence to substitute for formal education in LPN and RN programs
 - ◆ Promoting accelerated LPN education for people with a related Associate Degree or demonstrated experience
 - ◆ Developing new career ladders, and encouraging the use of existing ones (i.e., NA to LPN to RN career paths), which shorten the time and cost for progressing up the ladder, provide credit for work experience, and expand the use of competency testing
 - ◆ Offering more evening and night classes and web-based education courses to meet the needs of prospective students
 - ◆ Making NA and LPN preparation and experience a means to enter a variety of careers (e.g., Occupational Therapy Assistant, Physical Therapy Assistant, Social Work, Administration), and not just to professional nursing
 10. Schools of nursing, in cooperation with the LTC sector, should encourage the development of expertise among and increase the prestige of Directors of Nursing (DONs) in LTC by:
 - ◆ Establishing (virtual or real) support groups for DONs that foster communication, networking, and professional development
 - ◆ Increasing educational opportunities in leadership and management for DONs
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In addition, the LTC sector should:

- ◆ Provide DONs with sabbaticals or fellowships to pursue interest or work with experts
- ◆ Provide incentives (to individuals or their employers) for DONs to complete certification/added credential programs

References

- Aiken, L.H., D.S. Havens, and D.M. Sloane. 2000. The magnet nursing services recognition program: A comparison of two groups of magnet hospitals. *American Journal of Nursing* 100:26-35.
- Aiken, L.H., and P. Patrician. 2000. Measuring organizational traits of hospitals: The revised nursing work index. *Nursing Research* 49 (3):146-152.
- Aiken, L.H., D.M. Sloane, and E.T. Lake. 1997. Satisfaction with inpatient acquired immunodeficiency syndrome care: A national comparison of dedicated and scattered-bed units. *Medical Care* 35 (9):948-962.
- Aiken, L.H., H.L. Smith, and E.T. Lake. 1994. Lower Medicare mortality among a set of hospitals known for good nursing care. *Medical Care* 32 (8):771-787.
- American Nurses Credentialing Center. 2001. *The Magnet Nursing Services Recognition Program for Excellence in Nursing Services, 2000-2001*. Atlanta: American Nurses Publishing.
- Anderson, C.L., and E. Hughes. 1993. Implementing modular nursing in a long-term care facility. *Journal of Nursing Administration* 23 (6):29-35.
- Arioan, J., C. Patsdaughter, and M. Wyszynski. 2000. DONs in long-term care facilities: contemporary roles, current credentials and educational needs. *Nursing Economics* 18 (3):149-156.
- Ballard, T. 1995. The need for well-prepared nurse administrators in long-term care. *Image: Journal of Nursing Scholarship* 27 (2):153-154.
- Banaszak-Holl, J., and M.A. Hines. 1996. Factors associated with nursing home staff turnover. *Gerontologist* 36 (4):512-517.
- Becker, F., and F. Steele. 1995. *Workplace by Design*. San Francisco, CA: Joeesy-Bass Publishers.
- Bowers, B., and M. Becker. 1992. Nurse's aides in nursing homes: The relationship between organization and quality. *Gerontologist* 32 (3):360-366.
- Brannon, D., M. Cohn, and M. Smyer. 1990. Caregiving as work: How nurse's aides rate it. *The Journal of Long-term Care Administration* 1 (Spring):10-14.
- Buelow, J.R., K. Winburn, and J. Hutcherson. 1999. Job satisfaction of home care assistants related to managerial practices. *Home Health Care Services Quarterly* 17 (4):59-71.
- Burgio, L.D., and K. Scilley. 1994. Caregiver performance in the nursing home: the use of staff training and management procedures. *Seminars in Speech and Language* 15 (4):313-322.
- Burl, J.B., A. Bonner, et al. 1998. Geriatric nurse practitioners in long-term care: Demonstration of effectiveness in managed care. *Journal of the American Geriatric Society* 46 (4):506-510.
- Chappell, N.L., and M. Novak. 1992. The role of support in alleviating stress among nursing assistants. *Gerontologist* 32 (3):351-359.
- Cohen-Mansfield, J. 1997. Turnover among nursing home staff. A review. *Nursing Management* 28 (5):59-62,64.
- Cotton, J., and J. Tuttle. 1986. Employee turnover: a meta-analysis and review with implications for research. *Academy of Management Review* 11 (1):55-70.
- Daeffler, R. 1975. Patients' perceptions of care under team and primary nursing. *Journal of Nursing Administration* 5 (2):20-26.
- Eaton, S. 2000. Beyond 'unloving care': Linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management* 11 (3):591-616.
- Felton, G. 1975. Increasing the quality of nursing care by introducing the concepts of primary care: A model project. *Nursing Research* 24 (1):24-32.
- Gardner, K. 1991. A summary of findings of a five-year comparison study of primary and team nursing. *Nursing Research* 40 (2):113-117.
- Guillard, S., R.M. Gallagher, and J. Ryan. 2000. Can long-term care survive the staffing crisis? *Provider* 26 (12):37-39.
- Haff, J., C. McGowan, et al. 1988. Evaluating primary nursing in long-term care: Provider and consumer opinions. *Journal of Nursing Quality Assurance* 2 (3):44-53.
- Harrington, C.A. 1996. Nursing Facility Quality, Staffing, and Economic Issues. In *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, edited by G. S. a. P. O. K. e. Wunderlich. Washington, D.C.: National Academy Press.
- Havens, D.S., and L.H. Aiken. 1999. Shaping systems to promote desired outcomes: The magnet hospital. *Journal of Nursing Administration* 29 (2):14-20.

- Health Care Financing Administration. 2000. Appropriateness of Minimum Staffing Ratios in Nursing Homes: Report to Congress. Baltimore, MD.
- Kane, R.L., and S. Huck. 2000. The implementation of the EverCare demonstration project. *Journal of American Geriatrics Society* 48 (2):218-223.
- Kari, N., and P. Michels. 1991. The Lazarus Project: the politics of empowerment. *American Journal of Occupational Therapy* 45 (8):719-725.
- Karner, T.X., R.J. Montgomery, et al. 1998. Increasing staff satisfaction: The impact of SCUs and family involvement. *Journal of Gerontological Nursing* 24 (2):39-44.
- Kramer, M., and L.P. Hafner. 1989. Shared values: Impact on staff nurse job satisfaction and perceived productivity. *Nursing Research* 38:172-177.
- Krichbaum, K.E., J. Johnson, and M. Ryden. 1992. Educating nurses in leadership and management. *Geriatric Nursing* 13 (3):170-174.
- Krichbaum, K.E., V. Pearson, and J. Hanscom. 2000. Better care in nursing homes: advanced practice nurses' strategies for improving staff use of protocols. *Clinical Nurse Specialist* 14 (1):40-46.
- Kruzich, J.M. 1995. Empowering organizational contexts: patterns and predictors of perceived decision-making influence among staff in nursing homes. *Gerontologist* 35 (2):201-216.
- Lawton, M.P., and L. Nahemow. 1973. Ecology and the Aging Process. In *Psychology of Adult Development and Aging*, edited by C. Eisdorfer and M. P. Lawton. Washington, D.C.: American Psychological Association.
- Leatt, P., and R. Schneck. 1982. Work environments in different types of nursing subunits. *Journal of Advanced Nursing* 7 (6):581-594.
- Lodge, M. 1985. Profession Education and Practice of Nurse Administrators/Directors of Nursing in Long-term Care(Phase I). Kansas City, MO: American Nurses Foundation.
- Lodge, M. 1987. Profession Education and Practice of Nurse Administrators/Directors of Nursing in Long-term Care: Executive Summary. Kansas City, MO: American Nurses Foundation.
- Manthey, M. 1980. *The Practice of Primary Nursing*. St. Louis: C.V. Mosby.
- McClure, M., M.A. Poulin, et al. 1983. *Magnet hospitals: Attraction and retention of professional nurses*. Kansas City, MO: American Nurses Association.
- McDonald, C.A. 1994. Recruitment, retention, and recognition of frontline workers in long-term care. *Generations* 18 (3):41-42.
- McGillis-Hall, L.M., and L. O'Brien-Pallas. 2000. Redesigning nursing work in long-term care environments. *Nursing Economics* 18 (2):79-87.
- McPhail, A., H. Pikula, et al. 1990. Primary nursing: a randomized crossover trial. *Western Journal of Nursing Research* 12 (2):188-97.
- Mesirow, K., A. Klopp, and L. Olson. 1998. Improving certified nurse aide retention. A long-term management challenge. *Journal of Nursing Administration* 28 (3):56-61.
- Mueller, C.A. 1998. LTC directors of nursing define educational needs. *Nursing Management* 29 (11):39-42.
- Mueller, C.A. 2000. The RUG-III case-mix classification system for long-term care facilities: Is it adequate for nurse staffing? *Journal of Nursing Administration* 30 (11):535-543.
- Olson, D. 2000. How do leadership practices influence nursing facility employee satisfaction? A multilevel structural equation model analysis of long term care quality leadership practices. Doctoral Dissertation, School of Public Health, University of Minnesota, Minneapolis, MN.
- Patterson, J. 1987. Maximizing RN potential in long-term care. *Geriatric Nursing* 8 (3):142-144.
- Reinhard, S., and R. Stone. 2001. Promoting Quality in Nursing Homes: The Wellspring Model: Institute for the Future of Aging Services, American Association of Homes and Services for the Aging.
- Remsburg, R.E., K.A. Armacost, and R.G. Bennett. 1999. Improving nursing assistant turnover and stability rates in a long-term care facility. *Geriatric Nursing* 20 (4):203-208.
- Renick, O., and S. Ransom. 2001. The search for Eden: An alternative path for nursing homes. *Long-term Care Interface* 2 (1):45-48.
- Ryden, M., M. Snyder, et al. 2000. Value-added outcomes: The use of advanced practice nurses in long-term care facilities. *Gerontologist* 40 (6):654-662.
- Salmon, J.R., C. Crews, et al. 1999. Nurse Aide Turnover: Literature Review of Research, Policy and Practice. Tampa, Florida: Florida
-

Policy Exchange Center on Aging, University of South Florida.

- Schein, E. 1985. Defining organizational culture. In *Organizational culture and leadership*. San Francisco: Jossey-Bass Publishers.
- Schnelle, J., M. McNees, et al. 1993. Managing nursing aides to promote quality care in the nursing home. In *Improving care in the nursing home: comprehensive reviews of clinical research*, edited by L. Rubenstein and D. Wieland. Newbury Park: Sage Publications.
- Sellick, K.J., S. Russell, and J.L. Beckmann. 1983. Primary nursing: an evaluation of its effects on patient perception of care and staff satisfaction. *International Journal of Nursing Studies* 20 (4):265-273.
- Skima, S. 1999. An innovative model for long-term care nursing delivery. *Research Nursing Registry: Sigma Theta Tau International*.
- Smith, J. 1991. Changing traditional nursing home roles to nursing care management. *Journal of Gerontological Nursing* 17 (5):32-39.
- Smyer, M., D. Brannon, and M. Cohn. 1992. Improving nursing home care through training and job redesign. *Gerontologist* 32 (3):327-333.
- Stryker, R. 1982. The effect of managerial interventions on high personnel turnover in nursing homes. *Journal of Long Term Care Administration* 10 (2):21-33.
- Tellis-Nayak, V., and M. Tellis-Nayak. 1989. Quality of care and the burden of two cultures: When the world of the nurse's aide enters the world of the nursing home. *Gerontologist* 29 (3):307-313.
- Teresi, J., D. Holmes, et al. 1993. A primary care nursing model in long-term care facilities: Evaluation of impact on affect, behavior, and socialization. *The Gerontologist* 33 (5):667-673.
- Thomas, W., and M. Stermer. 1999. Eden Alternative principles hold promise for the future of long-term care. *Balance* 3 (4):14-17.
- Vaughan-Wrobel, B., and M. Tygart. 1993. Management education needs of nurse administrators in long-term care. *Journal of Gerontological Nursing* 19 (3):33-38.
- Vestal, K. 1995. Reinventing the director of nursing. *Nursing Home* (March):18-19.
- Waxman, H.M., Carner, E.A., & Berkenstock, G. 1984. Job turnover and job satisfaction among nursing home aides. *Gerontologist* 24 (5):503-509.
- Wisconsin Association of Homes and Services for the Aging (WAHSA). *Enhancing Employment in Long Term Care: A Guide to Retention*. 2000 [cited January 3, 2001. Available from <http://www.wahsa.org/emppref.htm>.
- Wunderlich, G.S., F.A. Sloan, and C.K. Davis, eds. 1996. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington, D.C.: National Academy Press (Institute of Medicine).
- Yeatts, D., and R. Seward. 2000. Reducing turnover and improving health care in nursing homes: The potential effects of self-managed work teams. *Gerontologist* 40 (3):358-363.
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TECHNOLOGIES IN LONG-TERM CARE

Technological developments in long-term care are inevitable. The question is not if technology will transform long-term care, but why the adoption of technology has been comparatively slow in this sector. In many industries, the adoption of technology, the organization of work, and the characteristics of the workforce are intertwined. The use of technology in service fields, such as banking and acute health care, has radically altered the demand for labor, in terms of numbers and skills needed, and has led to the redesign of the work environment. As technologies are applied to long-term care, the impact on the recruitment and retention of workers is likely to be equally dramatic.

This chapter focuses on several types of technology that may play increasingly important roles in LTC and describes their workforce implications. Technology could alleviate a shortage by replacing workers or exacerbate a shortage by creating a demand for skilled workers that exceeds the supply. The goal is to predict how technologies might affect the current and projected shortage of licensed and paraprofessional nursing staff. Long-term care policy, practice, and research should promote the application of technologies, and the development of a workforce with the skills needed to function in a more high-tech environment, to the extent that it improves the quality of life and/or care for the frail elderly.

Technologies and Workforce Implications

Technologies have typically been adopted to improve efficiency or increase quality. In long-term care, new technologies may have an indirect effect on the workforce shortage by reducing the number of workers needed or changing the job requirements. They can also change the nature and attraction of the work. Minimizing aspects of work that are unappealing (injuries, paperwork) and enhancing the positive aspects of the work (demonstrating positive outcomes, allowing more time for preferred activities) are important secondary effects that have the potential to profoundly impact LTC staff recruitment and retention. Computerized records and information systems can eliminate redundant paperwork, provide needed information or reminders, and allow data to be presented in a way that lets workers see the impact of their efforts. Communication technologies can cut travel time by

reducing the number of in-person visits and allow remote supervision, consultation, and decision support. In effect, using information systems to facilitate care can make expert supervision and assistance available to each line worker, while providing oversight designed to minimize errors. Robotics and monitoring technologies may ultimately replace some types of workers by both providing care or delaying the need for hands-on care. Assistive technologies and advanced mobility aids may decrease the quantity of direct care needed and reduce the amount of heavy lifting that prohibits some people from engaging in this work and remains a major cause of injury.

Application of existing technologies and development of new technologies could radically alter all LTC settings by changing the nature of the work. This in turn might present a way to maximize the workforce available and improve working conditions. Key types of technologies are discussed below, with an emphasis on how they may specifically affect the long-term care workforce; however, the more general effect of increased technology itself could magnify the impact of any individual technologies. At a superficial level, association with technology in this society enhances prestige. Given the relatively low prestige associated with all levels of long-term care work, adoption of any technology may have the added benefit of increasing the appeal of the field.

Information Technologies

There is continuing interest in using information technology (IT) to produce better care and to do it more efficiently. Both systems designed to handle a single task such as charting and integrated systems created to handle multiple tasks (e.g., charting, billing, care planning) have the potential to change the tasks themselves and how tasks are organized in long-term care. Information systems can reduce paperwork, make clinical data more readily available when needed, prevent errors, and locate staff. These technologies can offer new insights into how clients are progressing and even alert caregivers when interventions are needed. Perhaps most importantly, information can be used to give frontline workers a concrete sense of what they are accomplishing and mitigate much of the hopelessness often associated with long-term care work.

One of the most vexing problems licensed nurses face in nursing homes and home care is the amount of paperwork required. A recent survey conducted by the Minnesota Nurses Association found that RNs in nursing homes spend an average of 3.4 hours per shift doing paperwork, much of which is duplicative (Minnesota Nurses Association 2000). With computerized information systems, data collected and entered for one purpose (e.g., compliance with regulations) can be used for multiple purposes (e.g., compliance with regulations as well as communication with other caregivers, monitoring of process, development of care plans and task lists). Today, the majority of nursing facilities collects and updates resident information using either handwritten or simple word-processing forms. Computerized information systems in which a care plan can be updated electronically and used to provide structured prompts or instructions to all levels of caregivers can save significant time in reduced paperwork. Although the initial investment for this type of technology may seem formidable, the long-term savings from transferring staff from paperwork to patient care far outweighed the cost of the technology in the experience of at least one facility (Wagner 2001).

Point of care technologies (POCs) are a promising approach to both simplifying data entry and providing information to all levels of caregivers, which is becoming more important, given the increased complexity of care (Oatway 2001). Small computers can be placed either at the point of care or carried by clinicians and used to record patient data and transmit it to a central information system. Preprogrammed to prompt the nursing staff to collect all needed information, POCs can also assist with implementing protocols and aid in decision-making at many levels. The information system can provide instructions to staff about what additional information to collect and what action to take in commonly encountered situations. Point of care technologies are especially useful in organizing routine tasks, where direction can be combined with monitoring. For example, hand-held bar code readers that allow NAs to record the status of residents (wet or dry) and remind them to take the residents to the toilet on a certain schedule have improved the management of urinary incontinence. The data recorded in these hand-held devices can then be downloaded at the end of every shift and a report automatically prepared. Each NA can immediately see her performance and how it compares to her colleagues and her own over time (Schnelle et al. 1989;

Schnelle 1990; Schnelle et al. 1998). Such an approach can help organize the tasks that make up LTC work and provide immediate feedback about both individual performance and the impact of care on the elderly resident or client.

Other time-consuming activities include locating people (e.g., staff, residents), and retrieving supplies, linens and medications. In one system a nurse is directly notified of the resident's name and room number via a phone when a resident activates a call light, with the option to also talk to the resident directly. With another application of this locator technology nurses wear badges detected by infrared sensors that transmit their location to the nurse's station. Similar technology can be used to locate equipment that is frequently moved around, such as lifts and wheelchairs.

Bar coding and databases to prevent medication errors and monitor compliance with medication orders and regulations are the most common use of information technology. Additionally, medication dispensing systems can eliminate the need for nurses to count narcotics and provide timely access to newly ordered and discretionary medications. Efficiently designed medication carts and the use of unit dose medication administration systems also contribute to efficiency, safety, and time savings for nurses.

Information Technologies as a Means to Demonstrate the Impact of Care

Information technology has the potential to transform how long-term care work is perceived by those in the field as well as by the general public. Faced with a seemingly endless set of demands from residents and clients that seems to grow worse every day, it is easy to understand why LTC workers become discouraged. Indeed, the very psychological concept of "learned helplessness" was coined to describe the situation where events seem to occur despite efforts to change them (Seligman 1976). Although this concept has been applied to the lives of nursing home residents whose ability to affect their daily routines is heavily compromised (Mercer and Kane 1979), it also applies to long-term care workers who see themselves unable to affect the course of the people they serve.

Most workers only see elderly residents or clients deteriorate despite their best efforts and care. Without information that allows a comparison of the outcomes of actual care with those expected if such care were not rendered, workers are unable to appreciate the difference

their care makes. Yet the same information that can be used to monitor an elder's status can also be used to provide feedback to nurses and nursing assistants on the effectiveness of their actions. Harnessing the power of information about clinical outcomes and quality of life could completely transform the way long-term care workers view themselves and their accomplishments.

Ever more clinical information is available as prospective payment policies have been implemented and data collection mandated as part of these policies. Federal regulations currently require all nursing homes to collect and transfer the minimum data set (MDS) electronically to the federal government. Home care agencies face similar requirements with the implementation of OASIS. In most cases, the data is collected and transmitted as required, but it is not analyzed or otherwise used by the provider. This is a missed opportunity to provide important information to direct care workers and to demonstrate the impact of their work. The MDS and OASIS can be used to trace changes over time in individual resident performance, such as ADL status.

Rates of problems with the various quality indicators derived from the MDS can also be used as management tools to alert nursing home staff to areas that may need more attention (Zimmerman et al. 1995; Karon and Zimmerman 1996) and to document improvement. Resident Assessment Protocols (RAPs), developed at the same time as the MDS, were designed to help nursing home staff identify and care for problems uncovered by the MDS. These treatment guidelines are available and could be incorporated into a robust information system that would document that the appropriate action was taken, and extrapolate the effect on the elder experiencing a problem.

Managing long-term care clients and tracking outcomes may require more comprehensive systems and more frequent data collection than the quarterly updates required by law. This does not mean, however, that the feedback system needs to be extremely complex. For example, a model information system developed decades ago relied on recording simple structured information keyed to each problem of a nursing home resident. In effect, each problem triggered a list of standardized observations that can be completed by minimally trained NAs. These observations were entered into a flow sheet that allowed early identification of deviations in residents' course. These changes became the basis for a notification system that

alerted caregivers to the potential need for an early intervention (Kane et al. 1976; Woolley et al. 1974; Pepper et al. 1972). Information technologies present the opportunity to merge systems such as this and the now standardized reporting to provide ongoing feedback to workers, administrators, and families. This would provide staff with the positive reinforcements they need and deserve, while cultivating a greater appreciation of long-term care work by others.

Barriers to Using Information Technologies in Long-Term Care

Although using technology to improve efficiency, monitor processes and outcomes, and provide feedback to workers have become the norm in many industries, it has been slow to be adopted in long-term care. Spending ranges from an average of 0.5 to 1.5 percent of the total operating budget in long-term care. By comparison, the acute health care sector spends 3 to 5 percent of its operating budget on information technology, while other industries, such as banking and brokerage, spend over 10 percent (Wagner 2001). Furthermore, very few nursing homes have computer terminals on nursing units and, as of 1998, 16% of nursing facilities did not have any computer system at all.

Despite the enormous potential of information technology to improve LTC and to give caregivers a greater sense of accomplishment, there has been great reluctance to invest in such systems. Most significant computerization efforts have been in financial accounting and billing (Lewis 2000) or in response to the demand that mandated the electronic delivery of information, like the MDS, to the federal government. Nursing homes and other LTC providers have never felt they had the capital to invest in developing this information infrastructure. There is no reason, however, to view this sort of capital in any different light than the capital needed for physical renovations.

In addition to the significant start-up cost, another barrier to the introduction of IT systems into nursing homes is staff proficiency and comfort in using computerized documentation systems. This is usually a relatively simple challenge that can be met by providing adequate training and ongoing technical support for the users of the system. In fact, many clinicians who did not receive computer training during their formal education, and paraprofessionals who may have limited education and

access to computers, welcome the opportunity to learn about a system. Problems are common only when training is inadequate and support insufficient.

The current staff shortages may motivate providers to overcome these barriers. Since IT has the potential to both increase the efficiency of current workers and the appeal of the work to future recruits, it is the technology that could have the greatest impact on the recruitment and retention of nursing staff.

Telemedicine and Remote Staff Support

Smaller, cheaper, and more powerful computers and telecommunications devices that make remote communications and data transfers possible have multiple potential applications for long-term care. Currently, the most common use of telemedicine is for specialty consultations. Using a combination of video and high-speed communication lines, a physician or other clinician can conduct an exam or interview, diagnose, and, in some instances, provide treatment remotely. For patients, this reduces travel time and increases access to medical care. Evaluations of telemedicine programs report that patients are overwhelmingly satisfied and willing to accept this mode of care (Mair and Whitten 2000). In nursing homes or assisted living arrangements, use of telemedicine reduces the time that residents need to travel and wait in unfamiliar environments and allows them increased access to specialists. The staff who would have accompanied patients on these visits have more time for other activities. Additionally, staff members benefit from increased interaction with experts with whom they would have been otherwise unlikely to communicate.

However, telemedicine, or more generally "telehealth," is likely to have the greatest impact in home care. Videophones and specialized monitoring units make it possible to collect information on vitals or medication compliance, and "visit" with home care patients remotely. This allows nursing personnel to reduce travel and increase the number of patients that can be cared for in a day. Systems exist that also allow the patient or a family member to contact an on-call nurse 24 hours a day to report a change or discuss symptoms. Even when hands-on care is needed, this technology could allow nurses or therapists to supervise unlicensed staff remotely and allow a caregiver in the home to get support or advice any time it is needed.

Another application of telehealth is to facilitate care team meetings. Everyone involved in an individual's care can be involved in a conference video call. Alternatively, electronic bulletin boards can be used to keep caregivers and family members up to date between "virtual" meetings. Similarly, remote communications can be used for staff meetings and training, allowing people at several sites to discuss a common issue, receive in-service training, or access skill-building workshops.

Communications technologies also have the potential to alter the level of independence exercised by nurses and paraprofessionals, while simultaneously increasing their connections with their colleagues (Hicks 2001). Remote supervision of unlicensed staff may reduce the number of independent decisions that must be made. Whereas this may be viewed as restrictive by some, knowing that professional support is available may make the work less stressful and open this field up to people who may need more back-up, such as students, new immigrants, and recent health professions graduates. Lower levels of professional staff may be allowed to do work that would normally be done by others, and RNs and advanced practice nurses would be able to diagnosis difficult cases and implement complex treatments. Using this technology for meetings and the exchange of ideas may also reduce isolation and allow workers to identify and communicate with others facing similar challenges. These electronic interactions could both increase the dissemination of good ideas and encourage workers to remain in the field.

Whatever its use, telemedicine requires physicians and nurses to be comfortable with the technology and have confidence in their abilities to diagnose and manage remotely. Additionally, all levels of providers must examine what they believe about what constitutes care and the need for face-to-face contact. A recent survey found that 80% percent of home care nurses felt it was possible to "touch" a patient without physically laying on hands; however, only 5 percent felt they could always provide quality care remotely (Remington 2000).

For benefits to be realized, however, telehealth needs to be cost-effective and video visits need to be reimbursed. Both falling prices for hardware and current rulings from HCFA suggest that this type of technology is becoming more affordable and desirable. Technical challenges such as machine delay and difficult interfaces also have to be addressed if telehealth is to be embraced by providers.

Robotics and Monitoring

Robotics and monitoring (or sensor) technology have changed many industries, including health care. For long-term care, both of these technologies are still primarily in the prototype stages. For example, HelpMate Robotics is developing a robotic caregiver that could extend the time disabled elders could remain in their homes by fetching and carrying, assisting with transfers and ambulation, preparing meals, cleaning, monitoring vital signs, and requesting emergency assistance when needed (Engelberger 1997). The goal is to avoid institutional care; however, robots could also supplement staff in nursing homes and assisted living facilities or reduce the need for home care visits.

Geopositioning technology can monitor the location of anyone equipped with a simple transmitter. Alternatively, institutions can be built with sensitive devices that alert staff when specific individuals go beyond established boundaries. A more traditional type of monitoring has been the installation of so-called “Grannycams,” video cameras that record the activities of residents and staff.

Several groups, such as the AwareHome project at Georgia Tech (“Home—phone for help!” 2000), are working to develop home-based systems that could do more than simply monitor the occupants’ status and activity. They can also manipulate appliances, adjust environmental controls, and initiate communication with the community (i.e., family, health care provider, and emergency services). These functions will reduce the need for human supervision to assure safety and could delay institutionalization by dramatically increasing the amount of time frail or demented elders could remain in their own homes. These combined monitoring/robotics technologies also have applications in nursing homes and assisted living facilities. In perhaps the most automated facility, an Oregon nursing facility has a system that monitors residents to collect data on vital signs and activities (i.e., heart rate, toileting frequency, sleep patterns) as well as residents’ location, thus reducing the need for staff to collect basic data and constantly observe residents (“Wired facilities for the elderly” 2001).

Many of these advanced monitoring/robotics systems are not yet ready for mass distribution, but they are close to becoming reality. In fact, ethical issues, more than technical constraints, may slow the dissemination of these systems. Advocates assert that monitoring can extend independence and reduce abuse, but detractors worry

about the loss of privacy. The ethical debate surrounding monitoring in LTC is just beginning and currently very few people are working to sort out the issues (Donahue 2001). If monitoring systems are going to be used, scholars and LTC providers must begin to discuss their ethical implications and formulate guidelines before the technology is fully diffused, as has been done with the advancement of technologies in other areas of health care (i.e., genetic testing, fetal cell treatments).

Assistive Technologies and Ergonomics

Assistive technologies include items that can compensate for physical and sensory deficits, from everyday items such as wheelchairs and hearing aides to elaborate prostheses and cutting-edge mobility devices. As these aids improve and more are developed, individuals, whether at home or in a nursing home, may be able to perform more self-care and activities of daily living without the assistance of another person. Each activity an elder is able to do independently reduces the tasks for direct care staff. Such a reduction could either reduce the number of workers needed, or it could allow staff time to be allocated to other activities, such as restorative therapy, facilitating activities, and continuing education or training.

The aging of LTC workforce will also increase the need for assistive devices. Many people who want to give physical care may simply not have the strength necessary or may be at great risk of injury without assistance from another person. Given the staff shortages and declining numbers of potential informal caregivers, assistance from more than one person may be a luxury that will be unavailable in the very near future. With assistive devices, informal caregivers may be able to continue for longer periods before turning to formal care. Improvements in ergonomics and the tools that nursing staff use to do their jobs could also have a direct impact on the ability to recruit and retain workers. Back injuries are common and force many nursing assistants and nurses to leave long-term care. Additionally, the physical nature of the work precludes some groups of people (e.g., those with prior injuries, young retirees) from ever entering the field. Technologies that could change the way people with mobility limitations are transferred could stem the loss of staff due to injuries and make the work accessible to others, thereby expanding the long-term care workforce.

Conclusions

Many different technologies are either currently available or on the horizon for long-term care. To take full advantage of their potential, LTC workers need increased exposure to technologies, training, and technical support. Nursing homes, assisted living facilities, and home care agencies may need to create new positions or designate existing employees as trainers/technicians. At the same time, training programs need to introduce future aides, nurses, and other health professionals to the information technology, communications systems, robotics, and assistive devices that are currently available as well as to the new innovations that will reach long-term care in the near future. Although LTC has been comparatively slow to adopt some technologies, the shortage of workers makes

both the increases in efficiency and prestige that can accompany technology essential to the continued functioning of many long-term care providers. Staff shortages may provide the motivation for many changes in long-term care, but the adoption of technology has an advantage over other solutions that seek simply to procure more workers (i.e., recruiting foreign workers, using temporary workers, or increasing enrollment in training programs) in that it has the potential to revolutionize both the organization of care and the general perception of the field. In an ideal future, technologically advanced long-term care providers will be able to use labor efficiently and attract high quality professional and paraprofessional workers.

Recommendations for Technology

11. Long-term care providers and consumers should support the development of new technologies by expressing interest in the products, volunteering to test prototypes, and participating in planning and design efforts. Researchers and management specialists should evaluate the technologies' safety and effectiveness and analyze their cost and feasibility
 12. For technologies already on the market, but not yet widely adopted, policy and research should promote their adoption, expansion, and applications in long-term care.
 13. Given the potential of technology to improve both care and worker recruitment and retention:
 - ◆ A small grant program should be developed for long-term care providers for specific technology-based projects sponsored by either state funds or a private foundation. The application process should be competitive with successful projects used as models for other providers.
 - ◆ The curricula for all levels of nursing personnel should include sufficient training in the use of current and anticipated technologies.
 14. To complement policy changes, researchers should promote the use of technology as part of the response to long-term care workforce issues by:
 - ◆ Conducting and disseminating case studies of successful implementation of various technologies in long-term care
 - ◆ Including in any grant program an evaluation component to determine the effectiveness of various technologies in long-term care and promoting those with the greatest potential for improving care as well as working conditions
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References

- Engelberger, Joseph F. 1997. A gauntlet thrown down for elder care. *The Industrial Robot* 24 (3):202-206.
- Hicks, Judith. 2001. Improving patient care and access through telehealth: a PPS success Story. *The Remington Report* 9 (2):30-32.
- Home—phone for help! 2000. *Poptronics* 1 (5):21-22.
- Kane, R. L., L. A. Jorgensen, B. Teteberg, and J. Kawahara. 1976. Is good nursing-home care feasible? *Journal of American Medical Association* 235:516-519.
- Karon, S.L. , and D.R. Zimmerman. 1996. Using indicators to structure quality improvement initiatives in long-term care. *Quality Management in Health Care* 4 (3):54-66.
- Lewis, Alan. 2000. Information systems in the era of prospective pay: generating a proper bill just part of the struggle. *The Remington Report* 8 (2):6-8.
- Mair, Frances, and Pamela Whitten. 2000. Systematic review of studies of patient satisfaction with telemedicine. *British Medical Journal* 320 (7248):1517-1520.
- Mercer, S., and R.A. Kane. 1979. Helplessness and hopelessness in the institutionalized elderly. *Health and Social Work* 4:90-116.
- Minnesota Nurses Association. 2000. Survey of Nursing Needs and Nurse in MN. St. Paul.
- Oatway, D. 2001. The point-of-care revolution. *Advance for Providers of Post-Acute Care* (May/June):77-79.
- Pepper, G.A., L.B. Jorgensen, R.L. Kane, and et al. 1972. Problem-Oriented Process: Nurse's Manual. Salt Lake City: University of Utah.
- Remington, Lisa, and Ann Frantz. 2000. Emerging technologies: The transition from "low-tech" personal touch to "high-tech" personal touch. *The Remington Report* 8 (2):24-26.
- Schnelle, J.F. 1990. Treatment of urinary incontinence in nursing home patients by prompted voiding. *Journal of the American Geriatrics Society* 38:356-360.
- Schnelle, J.F., P.A. Cruise, C.A. Alessi, N. Al-Samarrai, and J.G. Ouslander. 1998. Individualizing nighttime incontinence care in nursing home residents. *Nursing Research* 47:197-204.
- Schnelle, JF, B Traubhber, VA Sowell, Dr Newman, CO Petrilli, and M Ory. 1989. Prompted voiding treatment of urinary incontinence in nursing home patients: A behavior management approach for nursing home staff. *Journal of the American Geriatrics Society* 37:165-171.
- Seligman, M.E.P. 1976. *Learned Helplessness and Depression in Animals and Men*. Morristown, NJ: General Learning Press.
- Wagner, Lynn. 2001. From paperwork to patient care. *Provider* (March):23-24, 27.
- Wired facilities for the elderly. 2001. *New York Times*, April 5.
- Woolley, F.R., R. Warnick, R.L. Kane, and E.D. Dyer. 1974. *Problem-Oriented Nursing*. New York: Springer.
- Zimmerman, D.R., S.L. Karon, G. Arling, B.R. Clark, T. Collins, R. Ross, and F. Sainfort. 1995. Development and testing of nursing home quality indicators. *Health Care Financing Review* 16 (4):107-127.
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TEMPORARY WORKERS IN LONG-TERM CARE

“Pools” or “agencies” are terms for businesses that provide temporary workers. They may be small, local businesses or national companies. Although only a few of these agencies specialize in long-term care, more focus on health care staffing more broadly, and still others have multiple divisions that provide temporary workers in a variety of fields. Historically, temporary workers have helped businesses adapt to fluctuating workforce needs. They have also been used to “stretch” a company’s labor during expansion, cover vacations and illnesses, or add expertise for a specific project.

Trends in the overall economy have led to substantial growth in the temporary help industry. This type of employment grew at an annual rate of 11% per year between 1972 and 1995. Despite this growth, temporary employment still represents only 1.8% of the total employment in the U.S. (Segal and Gullivan 1997). The increase has been attributed to a variety of factors including general economic expansion, the increasingly common practice of using a temporary position to “try out” an employee or employer, or the desire by an employer to implement a two-tier pay scale (that is, to bring in workers at lower rates than would be allowed under existing contracts or practice).

In long-term care, the use of a pool worker may be planned, as in the case when a regular employee takes vacation, or unplanned, if an employee is sick, on leave, or resigns and a regular employee is not available to fill in. In hospitals, temporary workers, particularly nurses, have also been used to adjust for fluctuations in the census or the acuity of patients. In long-term care, the demand for labor is more predictable. Whereas “private duty” work or home care may resemble temporary work, in the case of temporary employment the nature of the work itself is temporary in the sense that the employer or patient will need care or assistance for a limited time. This chapter focuses on a particular use of temporary workers; namely, the use by a nursing home or other LTC provider of temporary nursing staff hired through a pool or agency to do work that would normally be done by its own employees.

In contrast to traditional uses of temporary employees, long-term care providers are now more often using pools as a regular source of staff when they are unable to recruit or retain their own workers. The increase in the use of pools in this way has led to concerns about the effects on

personnel costs (and ultimately the financial status of the provider) as well as the implications for the quality of care. Many nursing homes attribute recent financial difficulties to the additional expenses incurred for temporary workers above the planned personnel budgets for permanent workers. Additionally, the agencies have been accused of raising prices indiscriminately and actively recruiting permanent long-term care workers for their own clients. Advocates and families worry that, at best, temporary workers will be unfamiliar with residents’ needs and behaviors or that, at worst, temporary employment allows an abusive worker to evade detection.

Given these concerns, it is important to explore the use of temporary workers in long-term care in Minnesota. We will describe what is known about the use of pools in long-term care, discuss its advantages and disadvantages, link these to an estimation of the costs, and end with policy and research recommendations.

Temporary Workers and Workforce Issues

If data are lacking about the motivations, incentives, stresses, and employment patterns of permanent workers in long-term care, even less is known about temporary or pool employees. Whereas temporary nurses and nurse assistants are required to be either licensed or registered according to the same laws and regulations that apply to permanent staff, no government agency routinely collects information about temporary workers in LTC and no studies of these workers have been done to date; nor do the agencies that employ these workers routinely collect information on these employees. It is hard to extract information from the data these agencies do collect, given that one person may work for several agencies and that employees are often maintained on agencies’ rosters indefinitely. Even information about the temporary agencies themselves is hard to come by. The American Staffing Association (ASA), the trade association for temporary employment agencies in the U.S., collects general information on the size and number of agencies, but does not collect data that would allow examination of trends in a specific sector. For example, it is difficult to determine what percentage of agencies specialize in long-term care or whether the number of agencies placing nursing personnel in LTC has increased. In the ASA data, long-term care is

combined with other services industries that represent only 7 percent of all temporary employees (American Staffing Association 1998).

Discussions with long-term care provider associations, individual nursing homes, and temporary agencies provide some anecdotal insight into both providers' and temporary workers' motivations and behaviors. It is apparent from this informal data collection that the use of temporary employees produces a complex mix of management and public policy issues. These include the way facilities manage the use of temporary workers, the responsibilities of the agencies that provide these workers, and the government's role in regulating this industry.

Use of Pools by Long-Term Care Providers

The variation in the use of temporary workers across providers raises questions about how facility-level characteristics affect the use of pools. It is not unusual for two nursing homes in the same geographic area to have very different experiences. For example, in two nursing homes less than two miles apart in the Twin Cities metro area temporary labor is not used at all in one of the homes while such labor accounts for over one-third of the payroll at the other. Providers in urban areas are more likely to use temporary workers than facilities in rural areas where the workforce is more stable or where a nursing home may be a relatively large employer. Long-term care providers view their increasing reliance on pools differently. Some providers see this as a management failure, while others see it as an inevitable consequence of the tight labor market and their own inability to increase their income, which in turn limits their ability to increase wages.

Although the differences across facilities are important, there are some general trends in long-term care providers' relationships with agencies and the employment environment that seem to affect all nursing homes. Most nursing homes seem to do business with multiple pools and do not have contracts that set rates over a given period. This differs from many other industries that regularly use temporary workers. In those industries most employers request bids and establish contracts with selected temporary agencies. Also, many LTC facilities do not have explicit policies on the orientation and supervision of temporary workers, including how to handle problems with temporary employees.

Some nursing homes have reduced or eliminated their dependence on temporary workers by training and/or by rewarding the schedulers and managers who reduce pool use; by providing incentives for existing employees to work full-time, improve attendance, work overtime, and recruit their family members and friends; and by developing new recruitment and retention techniques, such as advertising in different media, or offering benefits ranging from frequent flier miles to coupons for gasoline. Another approach that has been used by some facilities is to create an "internal pool" by offering higher wages but no benefits to a few employees who then are given the flexibility to pick their shifts. These in-house temps work different days and different units based on need. The advantage to this approach is that the worker has some of the benefits of temporary work, but is familiar with the facility and accountable to its management. However, creating and maintaining an internal pool can be difficult. One disadvantage is that some positions may need to be set aside (i.e., not filled by permanent employees) to guarantee the in-house temps enough hours. Smaller facilities may not be able to support their own internal pool, and organizing a pool across several facilities has not been done to date and presents many organizational problems.

Temporary Workers

Why an individual would choose to work for a pool or agency rather than for an employer directly is more complex than it may initially appear. The most frequently cited reason is higher pay. In some industries, however, temporary workers are paid less than permanent employees. Adjusting for demographic factors and experience, the difference ranges from 2% to almost 30% less (Segal and Gullivan 1997). Long-term care work is an anomaly in the sense that the hourly rate received by temporary NAs, LPNs, and RNs is higher than the hourly wage (without benefits) of permanent employees. The average wage for a nursing assistant in the Twin Cities metro area is \$11.12 weighted for experience and tenure (\$9.79 for the entire state) (Care Providers of Minnesota, Minnesota Health & Housing Alliance 2000), whereas several agencies we contacted offered starting rates between \$11 and \$17 depending on experience and the shift to be worked. The rates for licensed staff are also higher (\$13.98 vs. \$22-28 for LPNs, respectively, and \$21.49 vs. \$22-45, for RNs, respectively).

It is frequently suggested that the higher pay, even without benefits, appeals to workers who have benefits from another source or to whom the immediate need for income outweighs potential future concerns that underlie the demand for health and life insurance or retirement benefits. Although figures about what percent of temporary nursing assistants and nurses have benefits in Minnesota are not available, some temporary agencies provide benefits that include health insurance, paid vacation, and even profit sharing.

Another reason (some suggest the primary reason) people may choose temporary work is flexibility and control. A temporary LTC worker can determine her or his own schedule, refuse an assignment, and easily increase or decrease hours as personal and family obligations change. Other possible reasons for choosing temporary work include the opportunity to work in a variety of settings, and more support or respect (several informants reported that working for agencies was preferable because the agencies treated their employees well).

How these perceived advantages of temporary work affect the employment patterns of workers appears to vary considerably between the licensed and unlicensed worker. Licensed practical nurses and RNs may take temporary assignments for a defined period, such as when they are in school, but many pursue temporary work because they like the variety, in addition to the higher pay, even if there is less job security. This group of nurses will often work for temporary agencies for extended periods.

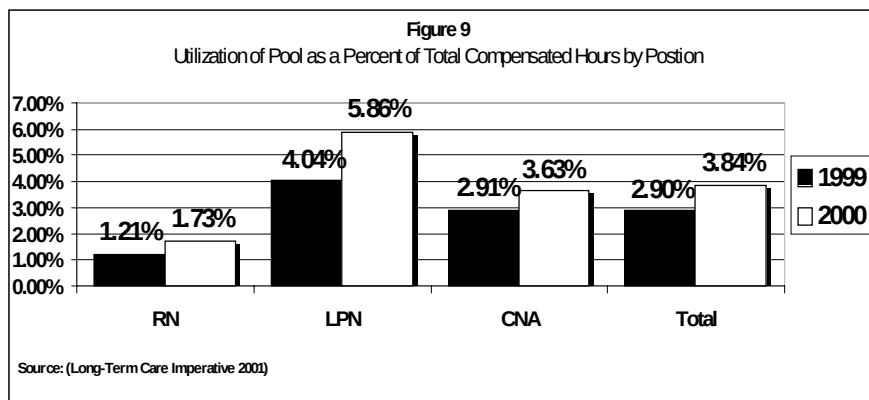
For nursing assistants, temporary work has been characterized as primarily short-term work. Although a core of unlicensed staff work as temporary employees for years, this appears to be a small group. Typically, a temporary worker alternates between temporary and permanent positions in response to a variety of economic and non-economic factors. Although difficult to verify empirically, staffing agencies described one scenario in which a person works for a pool for six weeks to three months, then accepts a regular position and remains for six months to one year and then cycles back to temporary work. This reflects the trend in temporary employment in which almost half of all temporary employees

are in permanent positions one year later (Segal and Gullivan 1997). In addition, some temporary workers hold full- or part-time permanent positions and use occasional pool work to supplement their income as needed.

Advantages and Disadvantages

The tight labor market and concerns that work shortages are now endemic to long-term care have focused attention on temporary employees. Discussions in the press or among policy makers, providers, and advocates overwhelmingly emphasize the detrimental effects of the growth in the use of pools by nursing homes. Positive experiences or situations where temporary workers were necessary are only rarely mentioned. Enumerating the advantages and disadvantages of using temporary workers from the providers' point of view can improve understanding of the issues and provide a context for workforce policy options.

Overall, use of nursing pools represents a relatively small percentage of the total nursing hours in Minnesota. In 1999, 1.38 million out of a total of 43.83 million nursing hours were from nursing pools (Wolfe 2001). Figure 9 shows the use of pools as the percent of total compensated hours for RNs, LPNs, and CNAs separately and the total for all nursing staff for 1999 and 2000. Although payments for pool staff is a relatively small percentage of total payroll (1.73% for RNs, 3.63% for CNAs, and 5.86% for LPNs), the increases in recent years have been large. From 1998 to 1999, the total number of hours of nursing pool staff increased 42% (Wolfe 2001) and increased 35.48% from 1999 to 2000 (Long-Term Care Imperative 2001). This rapid increase combined with the unequal use of pools across facilities prompts concerns about the detrimental impact on providers.



The concerns of providers are not limited to the bottom line, and although many nursing home administrators and advocates do not agree, some suggest there may be advantages to using temporary employees. The disadvantages and advantages cited in our discussions with facilities, advocates, regulators, and temporary agencies are summarized in the following list:

Disadvantages

- ▶ Less continuity with residents
- ▶ Unfamiliar with facility
- ▶ Reduced accountability to supervisors
- ▶ Easier to hide criminal, negligent, or abusive behavior or incompetence
- ▶ Negative impact on morale of permanent employees (who earn less and may work harder)
- ▶ Increased probability of permanent staff moving to pools
- ▶ Expensive—may contribute to providers' financial problems
- ▶ Agencies' ability to change prices at the last minute
- ▶ Restricts providers' ability to plan and project labor costs

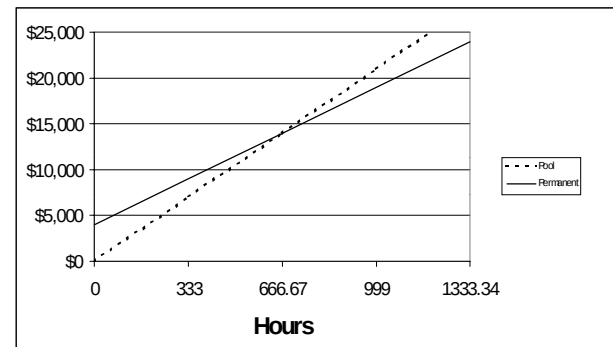
Advantages

- ▶ Attract and keep people in long-term care who might leave for family or other reasons
- ▶ Provides needed staff when permanent employees are not available to cover due to vacations, illness, or absences
- ▶ Reduced human resources and administrative costs
- ▶ Potential recruitment to permanent staff as a way for both sides to "test out" an employment situation
- ▶ Ability to refuse to accept a specific employee with no need to follow union and human resources procedures to terminate employment

Costs

Modeling the costs of the use of temporary nursing personnel can be done in several ways. The simplest approach compares the fixed costs of recruiting and hiring a permanent employee added to the hourly compensation (including wages and the cost of benefits) with the hourly rate paid to a temporary agency. This basic approach requires information on the initial costs involved in recruiting and training a new worker and the hourly rates for both types of employees. The following table and graph show that whether a temporary nursing assistant is more cost-effective than a permanent employee depends on how long the permanent employee remains with the facility.

Figure 10
Cost Comparison of a Pool and a Permanent Employee



Pool Worker		Permanent Employee		Point Equal		
Fixed Cost	Hourly Rate	Fixed Cost	Compensation per hour	Hours	Days (8 hours)	Weeks (5 days)
\$0	\$21	\$4000	\$15	667	83	16.6
\$0	\$21	\$3000	\$15	500	62.5	12.5
\$1000	\$21	\$3000	\$15	333	42	8.4

The graph above visually presents the tradeoff between permanent and temporary workers using the data from the first row of the table, showing the costs over time of the two types of employees. In the graph, the lines cross at 666.67 hours, which represents the point at which a temporary worker becomes more expensive than a permanent worker. The hourly rate paid to an agency for a nursing assistant and the compensation per hour for a permanent nursing assistant are based on financial information provided by a long-term care provider who operates several sites in the Twin Cities.

If there are no fixed costs for a pool worker, then using a temporary worker is cheaper initially, even if they are paid at a higher rate because all of the costs associated with hiring a new worker are avoided. These costs include a portion of the salaries of those involved in recruitment, interviewing, processing payroll, and training new employees. They also include the cost of physical exams, immunizations, and training materials provided by the facility to permanent workers. For this example, \$4,000 is used as an estimate of these costs. This amount is what has been used in models of the cost of NA turnover (Straker and Atchley 1999) and is in line with a 1992 estimate that of \$3,362 for replacing a home care worker (Zahrt 1992). The permanent employee is more cost-effective only after 667 hours or 83 shifts (16.6 weeks assuming 5 shifts per week). Another way to say this is that the permanent

employee costs less, but only if they stay at least 17 weeks. If the employment patterns are such that new employees remain less than four months, using temporary workers is less expensive despite their higher cost per hour.

This model depends on several assumptions, which can be changed to test different scenarios. The second row in the table illustrates that if fixed costs are reduced (from \$4,000 to \$3,000), the amount of time before a permanent worker becomes more cost effective than a temporary worker declines to 12.5 weeks. Also, the ability of the employer to reduce fixed costs if a pool worker is used may vary. In the first two examples, it is assumed that the fixed costs associated with the use of a pool employee are zero. This means that the employer is able to avoid these costs for some employees and not others. For items such as physicals that are specific to the employee, this seems reasonable. However, expenditures on human resource personnel and advertising may not be eliminated entirely, even when a pool worker is used. For this reason, a third example is given in the table in which the fixed costs for a pool worker are reduced, but are not zero.

As demonstrated by these examples, evaluating the effect of temporary workers in economic terms produces different answers depending on the assumptions about the costs of recruiting and training a worker and about how long a worker remains in a position. Discussions of costs frequently ignore these factors, comparing only the rate paid to an agency or pool and the wage paid a permanent employee.

Issues Other Than Cost

Although the difference in the wage paid to permanent employees and the fee paid to a temporary agency is the most frequently discussed issue, several other questions need to be addressed. An accurate comparison of temporary and permanent workers needs to include all of the advantages and disadvantages, such as reductions in morale, changes in quality of care, and the ability to maintain a person in the field. These items pose particular problems because they are difficult to measure, and not easily expressed in terms of actual dollars. Nevertheless, even more than comparisons of costs, these non-economic factors have inspired both management and policy initiatives to reduce the use of pools.

Most administrators and resident advocates feel that the use of temporary employees is always negative, typically because the loss of continuity inherent in the use of pool workers is believed to cause a decline in quality of care and quality of life for the recipients of care. The nature of long-term care requires personalized attention, and residents, or family members that serve as resident advocates, react negatively to changes in staff. Staff unfamiliar with resident status and routines are less able to notice important changes or comply with resident wishes. This reason alone is used to justify policies designed to eliminate or at least severely restrict the use of pools.

Policy and Management Initiatives

The Long-Term Care Reform passed in Minnesota in 2001 includes a requirement that temporary agencies be licensed and caps payments to pools at 150% of the average wage paid to permanent employees.¹ The licensing requirement is designed primarily to keep unscrupulous agencies out of the field and assure that the workers the agencies provide meet requirements for training, licensing, and background checks. The reasons offered for a rate cap include 1) the inability of agencies to pay significantly higher rates to temporary employees if their rates are lowered, and thereby eliminating one incentive for workers to leave permanent positions for temporary work; 2) the ability of nursing homes to better plan because of their knowledge of the rates in advance; 3) the inability of agencies to change prices; and 4) the inability of agencies to make a profit at the capped rate. Although driving the agencies out of business is not a stated goal of all of the Bill's supporters, several acknowledge this is one of their objectives. They assume that people currently working for the pools will stay in long-term care and accept work as permanent employees. Another argument for fee caps is that the state, as primary payer for nursing home services, should not be paying for agency costs and profits or encouraging a situation where workers are paid different rates for similar work.

At least three other states (MD, RI, and NH) have proposed caps on payments to temporary agencies for nursing staff for nursing homes and Minnesota is the second state to pass such legislation (MA passed legislation recently). In Minnesota, the temporary agencies did not oppose the licensing requirement, but understandably opposed the rate cap. Other opposition to the rate cap was based directly on concerns about the

¹ S.F. 4, 2001 1st Special Session (Minnesota). Article 7

supply of workers. Given the little we know about long-term care workers, opponents fear that eliminating these agencies could actually reduce the number of workers in long-term care. Workers who need more flexibility for a period or who want to test out employers may not be willing to become permanent workers. Additionally, permanent employees who use agency work to supplement their incomes may leave long-term care for occupations with higher wages.

The cap on rates paid to temporary agencies could also significantly impact nursing home management in other ways. If the pools were to stop providing long-term care workers, facilities relying on temporary workers for a significant portion of their staff may not be able to provide appropriate care and supervision. At issue is whether an immediate transition to no temporary workers is even possible and whether it is worse to have a temporary nurse or aide than to have no one to answer a call bell or provide a treatment. On the other hand, if a rate cap results in the withdrawal of the pools from the long-term care personnel market, this could force administrators to develop new approaches to staffing and serve as an incentive to improve human resources management. However, if the agencies continue to provide temporary workers at the capped rate, this may make temporary workers more attractive to some long-term care providers. Certain managers may find it cheaper to use pool staff than to recruit and retain their own employees. At this time, the positive and negative consequences of severely restricting or eliminating agencies are unknown, given the limited information available.

Since it is generally agreed that high use of temporary staff in long-term care is undesirable, limiting their use to

those situations in which vacations and absences cannot be covered internally seems to be an appropriate goal. To do this, nursing homes need to develop management approaches to both the financial and personnel challenges posed by temporary workers. Legislation capping the rates of temporary agencies may or may not reduce pool use and seems an extreme measure given that few alternatives have been pursued. Regardless, the rate cap is unlikely to solve all problems related to temporary workers. Approaches that hold employers accountable for the use of temporary staff and encourage better management of staff in general seem to be warranted. Examples could include contracting with reputable pools to provide personnel at set prices, making information about pool use publicly available, and providing reimbursement incentives that encourage management initiatives (e.g., creating internal pools, employee involvement in scheduling). Policies are needed to encourage changes in recruitment and retention strategies and innovation in staffing and organizational initiatives.

To evaluate the impact of these policy and management initiatives, data on the use of temporary employees should be collected and made generally available. This data would allow facilities to compare themselves to their peers. It would also allow potential and current residents and their advocates to assess a facility or provider. This would be one way to reward providers who have developed innovative approaches to staffing problems and encourage others to develop their own approaches. The information on pool use could be one of a few selected management indicators that could be used with clinical indicators to evaluate and monitor long-term care providers.

Recommendations for Temporary Workers

15. The Department of Human Services should require, as a condition for licensure, long-term care providers in Minnesota to collect and make public certain management information such as:
 - ◆ Usage of temporary labor pools;
 - ◆ Turnover rates for nursing personnel; and
 - ◆ Stability of nursing personnel.
 16. To use temporary labor pools more efficiently, long-term care provider associations should develop policies and best practices for managing temporary workers. These include:
 - ◆ Developing contracts with pools to assure consistent prices and performance standards;
-

- ◆ Developing personnel policies concerning the orientation, supervision, and resolution of problems with pool employees; and
 - ◆ Reducing the use of temporary workers by creating internal pools, developing flexible scheduling, and establishing incentives for employee attendance.
17. The University of Minnesota and other members of the research community should conduct and promote research on the impact of legislation that places caps on temporary agency rates, including:
- ◆ Monitoring the temporary labor sector (i.e., how many temporary workers discontinue work in long-term care);
 - ◆ Following a sample of nursing homes that rely heavily on temporary workers;
 - ◆ Studying the employment patterns of a sample of pool workers after the legislation is implemented; and
 - ◆ Evaluating the legislation's effect on the quality of care and quality of life of the recipients of care.
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References

- American Staffing Association. 2001. *Staffing firms employ individuals in broad range of occupations*. 1998 [cited February 2001]. Available from <http://www.staffingtoday.net/staffstats/factsheet03.htm>.
- Care Providers of Minnesota, and Minnesota Health & Housing Alliance. 2000. Minnesota Nursing Facility Compensation Report. Minneapolis.
- Long-Term Care Imperative. 2001. *Data from Fall 2000 Survey* [Power Point slide show]. Care Providers and MAHA 2001 [cited April 2001].
- Segal, L.M., and D.G. Gullivan. 1997. The growth of temporary services work. *Journal of Economic Perspectives* 11 (2):117-136.
- Straker, J., and R. Atchley. 1999. Recruiting and Retaining Frontline Workers in Long Term Care: Usual Organizational Practices in Ohio: Scripps Gerontology Center, Miami University.
- Wolfe, W. 2001. Coalition urges curbs on temp workers in nursing homes. *Star Tribune*, February 15, B1, B7.
- Zahrt, L.M. 1992. The cost of turnover in a home care agency. *Caring* 11 (4):60-66.
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RECRUITING IMMIGRANTS AND FOREIGN WORKERS

Immigrants and foreign workers are two populations frequently identified as potential sources of new workers for long-term care. Whereas some people regard the recruitment of foreign workers as essential for easing the workforce shortage, others view this strategy as a stopgap measure at best, which is not economical and fraught with moral uncertainties. These people contend that initial efforts should focus on recruiting immigrants already in this country. To highlight the different legal, economic, and practical issues, we distinguish three immigration-related strategies that have been proposed to expand the labor pool for LTC workers: 1) recruiting recent immigrants and refugees (i.e., the so-called “New Americans”¹) living in Minnesota, 2) recruiting foreign workers to come to the U.S. permanently, and 3) recruiting temporary foreign workers. After discussing these strategies, we concluded that efforts to recruit, train, and retain New Americans for positions in long-term care present win-win opportunities and should be expanded. On the other hand, recruiting workers from other countries, either permanently or temporarily, is difficult because of restrictive visa classifications, is unlikely to significantly impact the worker shortage, and may have risks that outweigh the potential rewards.

Recruiting New Americans

Immigrants who come to the U.S. for family reunification, a better life, or for humanitarian reasons have traditionally been a source of labor for low-skill, low-wage jobs. Historically, these workers have exhibited a greater willingness to work in jobs that many U.S. nationals are reluctant to take because of their low wages, difficult working conditions, and other perceived drawbacks. For many immigrants, such jobs provide an entry into the American workplace and become a stepping-stone to more lucrative and rewarding positions. The jobs also serve as an important source of income for relatives left behind.

Paraprofessional jobs in long-term care have been one of the common sources of employment for many recent immigrants in this state and elsewhere. With targeted recruitment and retention efforts, Minnesota’s rapidly growing immigrant and refugee population can become an even more important source of labor for frontline LTC workers. Leaders in organizations that serve these populations in Minnesota agree that, in general, New Americans have a higher reverence for the elderly and a

more robust ethic of caring for the elderly than is exhibited among the general U.S. population. In addition, New Americans generally are highly motivated to get jobs, bring a positive attitude toward work, and tend to view the position of nursing assistant as a career – not just a job.

However, recruiting, training, and retaining workers from different cultures for frontline positions in LTC also present a host of difficult challenges. The nature of the nursing assistant’s job, which is to provide assistance with eating, bathing, dressing, and otherwise attending to an individual’s most intimate and personal needs, can magnify any cultural differences between the caregiver and client. Religious beliefs can present particularly difficult barriers: for example, a Muslim woman may not be able to provide nursing care to an unrelated male. Similarly, language barriers between the immigrant worker and co-workers or supervisor (or between the immigrant worker and client) can jeopardize the worker’s on-the-job success and interfere with client care.

To be successful employees in LTC, Minnesota’s New Americans will have to overcome a variety of cultural and language barriers. Equally important, the institutions and agencies that comprise the long-term care system will have to exhibit a higher level of sensitivity to cultural differences, at the policy, practitioner, administrative, and consumer levels. This implies a LTC sector that values diversity, understands how its services are shaped by its own culture, is able to deal with the “dynamics of difference” that are part of cross-cultural interactions, and incorporates cultural knowledge into the delivery and receipt of services. Anecdotal evidence suggests that helping New Americans overcome cultural and language barriers, and enhancing the “cultural competence” of LTC organizations are worth the resources and effort needed. The (perceived) payoff comes from a more stable workforce and a more appealing environment for workers and clients alike. In this section (after a short discussion of New Americans in Minnesota), we first review the initiatives that enable New Americans to succeed as LTC employees and then those that foster cultural competency on behalf of employers and the LTC system itself.

New Americans in Minnesota

Between 1987 and 1998 a total of about 84,000 immigrants came to Minnesota, about 1% of all immigrants

¹ We use the term “New Americans” to refer to immigrants, refugees and other aliens who have come to the U.S. to establish permanent residency but have not yet become citizens. Other immigration terms are defined in the Glossary at the end of this chapter

to the U.S. (Ronnigen 2000). An estimated 6,000 to 8,000 new immigrants come to Minnesota each year.² As is true nationwide, family reunification remains the primary drive behind immigration patterns in Minnesota. The immigrant population in Minnesota, as in other states, is also becoming increasingly diverse. In contrast to the European-dominated immigration of the middle of the 20th century, large numbers of Minnesota's immigrants now come from Southeast Asian, Asian, Mexico and Central American countries, and (since 1990) Russia, other former Soviet republics, and Somalia and other African countries. However, the profile of immigrants in Minnesota differs in some dimensions from the immigrant population nationwide. Most notably, a higher proportion of immigrants coming to Minnesota are refugees; in 1998 (the latest year for which data are available) nearly one out of every four immigrants to Minnesota was a refugee, more than triple the national ratio. The State Demographic Center notes that the factors that draw immigrants to Minnesota – their liking of the place, combined with Minnesota's strong social services and active charitable sector and strong economy — will likely continue to draw refugees and other immigrants to Minnesota, although precise estimates of the number of future immigrants or their countries of origin are not available (Ronnigen 2000).

Overcoming Cultural and Language Barriers of New Americans

Recruitment

An initial step for recruiting New Americans for frontline LTC positions is to identify those individuals who are interested in caregiving and possess the characteristics needed to perform well as frontline caregivers.³ Targeted outreach efforts, such as partnerships among employers and public and private-worker placement, human services, and community organizations, can help the selection process. These community organizations, even if not specifically job-support programs, “are always looking for ways to empower their clients and encourage independence” by, for example, referring clients to appropriate job training programs and employers (Kahn 2000).

Partnerships with agencies and organizations serving and representing Minnesota's immigrant and refugee populations are particularly important for recruiting new workers. Formal employment agencies often do not have complete access to the target populations and these agencies are often intimidating to the New Americans. Interviews we conducted with a Somali Committee of Elders in the Twin Cities, for example, highlighted two important factors for recruiting among minority populations. First, working with informal associations is critical for disseminating information about jobs. These include neighborhood centers that serve the population, cafes, social organizations, and media programs, such as community radio/TV, that serve the specific ethnic group. These nontraditional venues are additional resources to the partnerships with employment programs that are run by the community agencies serving New Americans. Second, initial information about LTC positions, such as nursing assistants, must give potential recruits a clear notion of what this position entails. Potential recruits who are new to the U.S. are less inclined to seek out further information on work opportunities that are unclear to them.

Furthermore, since the LTC system in the U.S. is so different from LTC systems in other cultures, many New Americans will need some exposure to nursing homes or other long-term care settings to decide if this field is right for them. For example, as part of a screening process, potential employees can visit LTC facilities to see first-hand the major differences between the way their culture and the U.S. treat and care for the elderly. Some of the New Americans face major challenges in adapting to what they consider a process of “warehousing” elderly in the U.S. system of long-term care. These doubts and concerns about the U.S. system can be exacerbated if these New Americans find themselves isolated and under-appreciated for their work once they begin their jobs.

Training

Cultural and language barriers often hinder the ability of New Americans to succeed on the job as well as to complete existing training programs for LTC positions. Pretraining assessments can be used to evaluate the New

² Due to quirks in the INS's data collection system it is nearly impossible to obtain accurate counts of the state's annual or total immigrant population. For example, the INS asks immigrants at their port of entry to identify their final destination but does not track them to see where they ultimately settle. It is therefore not clear how many of the estimated 6,000-8,000 immigrants actually come to Minnesota each year. Further, while most immigrants come directly from their home country, an additional but unknown number come to Minnesota after first living in other U.S. states. INS data also do not capture this movement of immigrants between states (“secondary migration”).

³ The Health Education Industry Partnership (HEIP) initiative spearheaded by the Minnesota State University system (MnSCU) is developing an “employment inventory.” Such an assessment tool would facilitate recruitment by identifying and describing the skills, knowledge, and experience of the New American as well as reveal barriers that could interfere with initial or ongoing employee success. The inventory focuses on three success factors; work readiness, language/communication, and education. Each success factor category is segmented into developmental levels along a continuum. The inventory also identifies a set of “Wraparound Issues” that pose potential barriers. Ideally, the inventory will allow the employer to consider how job might be reconfigured to take advantage of the emerging worker's capacity. HEIP's proposed employment inventory is meant for all “emergent workers” — defined as workers who “because of language barriers or underdeveloped social and learning skills were not able to succeed in current programs.” http://www.tip.mnscu.edu/powerpoint/emergent_worker/Emergent%20Wrkr%2011-26.htm

American's proficiency in English, aptitude for completing a training program, and motivation for working in long-term care. Such individual assessments can help identify the particular language, skill, and cultural competency training the candidate needs and thus direct him or her to the most appropriate training. The required curriculum of current nursing assistant training programs can be supplemented with training in cross-cultural and communications skills to help New Americans overcome the potential cultural and language barriers they are likely to face on the job. Occupational English is a particularly important need for many New Americans. English as a Second Language (ESL) instruction focused on the terminology the worker is likely to encounter on the job can be integrated into NA training, for example, by pairing an instructor in Occupational English with a nursing instructor.

Although on-the-job training is appropriate for some health-care positions, training New Americans for personal care positions such as nursing assistant is typically done in technical colleges or in programs such as the International Institute of Minnesota's (IIM) "Nursing Assistant Training Program for New Americans."⁴ The IIM program is an eight- or eleven-week program (depending on the language proficiency of the student) of competency-based training in 56 personal care/safety-related skills, 22 of which are tested in the State certification examination. Culture issues enter into much of the curriculum and vary greatly depending on student background. An immigrant student, for example, may find it challenging to learn to make a bed (having grown up sleeping on a mat), but may initially be able to perform a more attentive job at bathing than another student.

Before their first day on the job, many New Americans will need a basic introduction to the American workplace as well as to American culture. Our concept of privacy, preoccupation with documentation and records, and the importance of being on time (and the concept of time in general) are examples of the many unfamiliar yet vitally important features of American life (and work) the New American will need to understand and appreciate. Expectations regarding appearance and behavior may need to be introduced and then reinforced continuously, particularly for people from cultures vastly different from ours. Other issues include cultural differences about death and dying, the role of the elderly in society, and how to approach elderly persons with dementia. Many New American trainees have a cultural bias in favor of doing

things "for" the elderly, and find it difficult to learn our culture's emphasis on independence and personal control. The workplace's emphasis on a fast work-pace is also a challenge to many of them, particularly to refugees who have spent years in refugee camps with little to do with their time.⁵

Retention

After completing training, pre-employment assessments of the New American's attitude, aptitude, and ability to communicate and follow instructions can determine their job readiness and identify additional support, if any, needed on the job. The transition from student to worker is particularly difficult. New Americans may require more supervision when first hired and require more support and encouragement since they are learning how to perform the duties of a job as well as how to live and work in a new culture. Although New Americans are trained to work at the best standards of care, they often find themselves in situations where they are forced to cut corners, to "unlearn" what they have been taught. For example, the time allotted to do everything necessary to get ten residents off to breakfast is sometimes simply not enough. Yet new LTC employees work in a regulated culture that cannot admit that standards of care are compromised. Weighted judgments about what corners to cut are extremely difficult for a person who does not understand the culture.

Support for transitioning from training to the job can be provided by linking the New American with a mentor, such as a co-worker of the same culture. Although many LTC facilities claim to provide mentors or preceptors, these personnel frequently are too busy to perform such roles. Another option to smooth the transition is to provide a longer, more in-depth orientation period for New Americans who need to learn language and cultural differences and who may find it difficult to get the feedback necessary to improve their performance or even to understand what they are being asked to do. Unfortunately, current staffing shortages may not allow for this. A final option for facilitating orientation and acclimation to the job is for an external organization to provide on-the-job support. The IIM, for example, provides such support services for their graduates for up to three months after placement. The organization's staff function as the new worker's advocate, helping with employment-related questions and concerns and providing support and advice to smooth the transition from the classroom to the workplace and address the most

⁴ The International Institute of Minnesota (IIM) is a social service agency affiliated with the Immigration and Refugee Services of America and the United Way.

⁵ IIM staff, personal communication, 1/31/2001.

commonly experienced problems preventing new graduates from succeeding on the job.

Overcoming these cultural and language barriers takes time, clearly more than the typical training and orientation period. Ongoing on-the-job support for the New American worker may be needed to help them become proficient in workplace English and acculturated to the workplace. And, as previously noted, expectations for on-the-job behavior need to be frequently reinforced.

Based on its program's 10-year history and over 500 graduates, IIM is convinced that an enhanced training program that covers the standard curriculum, addresses cultural and language barriers, and provides "wrap around" services (e.g., child care, transportation) can provide New Americans and refugees the skills, competencies, and support needed to succeed as nursing assistants. Almost 98 percent of those who enter this program complete it and pass state certification. A recent review of the job retention rate at six months for graduates of the program revealed that about 90 percent were still employed as nursing assistants. Of these, about 80 percent remain on their jobs after 12 months (longer term data are not available).⁶ No separate data exists on turnover rates or worker longevity for immigrant long-term care employees in Minnesota.

For New Americans to succeed on the job, both the worker and the employer will need to make adjustments. The New American worker will need to understand and adapt to the employer's expectations regarding on-the-job behavior, the performance of tasks, and the discharge of responsibilities. In turn, the employer needs to understand how to work with foreign-born workers, to be more aware of cultural differences, and to make some adjustments to the New American worker's needs and expectations. For example, people from many other cultures consider time differently than people in the U.S. and may initially have trouble maintaining a fast pace, or keeping to a rigid schedule. They may view rushing a nursing home resident through the meal as disrespectful to the resident rather than as essential to keeping to the nursing home's set schedule.

It is not clear whether the needed adjustments are transitory or permanent. Some of the employers' responses to the specific needs of New American workers may in fact address issues that have been cited as barriers to recruiting and retaining paraprofessional staff in general. Although

rushing a nursing home resident through a meal may be particularly uncomfortable for a New American worker, rigid adherence to a set schedule is also a standard complaint of LTC staff. Implementing a schedule that allows for more flexibility may make the jobs more appealing to all (current and potential) employees. Furthermore, unless long-term care employers make changes that respond to both the familiar barriers to recruiting and retaining nursing personnel (such as low compensation, task-oriented repetitive work, lack of advancement opportunities) and the special needs of New American workers, these workers, too, may become dissatisfied with their jobs and leave.

Foreign trained health care professionals who emigrate to the U.S. face many of the same cultural and language barriers as other New Americans who seek to enter the LTC workforce. But they encounter additional barriers as well. Most notable, foreign trained health care professionals may not be able to become certified or licensed as a health care practitioner in Minnesota — because of the heavy reliance on training and education requirements — even if they have the necessary competencies and experience. Even highly trained professionals (e.g., physicians) may not meet the licensing requirements for lower level positions (e.g., physician assistant) without obtaining additional training. In addition, a lack of familiarity with the American LTC system on the part of the foreign trained health care worker, combined with an overly rigid approach of LTC employers in matching job requirements with candidates' training and experience, may result in missed opportunities to creatively use the foreign trained workers' unique skills and competencies.⁷

Cultural Competence and the Long-Term Care Employer

Helping New American workers overcome cultural and language barriers is one side of the coin. Nursing homes, home health-care agencies, and other long-term care organizations interested in hiring and retaining New Americans also must have the capacity to welcome and support a diverse workforce. This requires that personnel, such as supervisors and frontline staff, value diversity and that the organization itself, in its policies and practices, be committed to valuing the diverse potential of each of its employees. A more culturally diverse population in need of LTC will further command a more culturally competent LTC industry. The challenge to LTC agencies and facilities is to become culturally competent, both in personnel and in organizational practice.

⁶ IIM staff, personal communication, 1/31/2001

⁷ D. Fresco, Minnesota Council of Churches. Personal communication 7/9/2001. This workgroup did not study this sub-population of New Americans in greater detail

Cultural Competence

Although there is no standardized definition of “cultural competence” in the literature, the concept generally refers to the ability to think, feel, and act in ways that appreciate and build upon ethnic, cultural, and linguistic diversity (Lynch 1998). When applied to health and human services, the notion most often refers to the knowledge, attitudes, skills, and procedures that allow individuals or systems to render services across cultural lines efficiently and effectively. By hiring and training New Americans, agencies and facilities will help address Minnesota’s long-term care workforce needs. They also will be taking a major step, by developing staff diversity, in building a culturally competent system of care to meet the needs of an increasingly diverse consumer population. However, this can only happen if the LTC sector has the capacity to welcome, train, and include employees in a cross-cultural workplace.

Cultural competency, both personal and organizational, is often characterized as a continuum that encompasses several stages (Administration on Aging 2001; Cross 1989). The continuum’s extreme negative end is represented by attitudes and policies that are antagonistic toward different cultures. Less negative, but nevertheless harmful, is the notion that class and cultural differences do not exist. Organizations and persons grow in competence as they leave behind the idea of “color blindness,” acknowledge differences, develop appreciation and respect for them, and, through self assessment, adopt strategies that are inclusive of differences. A culturally competent front-line supervisor, for example, understands her own culture as well as how different communication styles influence interactions among staff, and between staff and supervisor. She uses her grasp of differences in behaviors such as gesture, eye contact, slang, and nonverbal behavior to foster communication and prevent misunderstanding. On the organizational level, a competent agency continually assesses how its policies and practices, such as employee release time, dress code, celebrations and awards, documenting, and employee evaluation, include and support diverse perspectives.

Cultural Competence and the Long-Term Care Workplace

The Center for Community Integration at the University of Minnesota is currently developing a series of training modules for supervisory staff and newly hired New

Americans who work as direct support personnel in residences and programs that serve persons with developmental disabilities. Although targeted at a specific population, much of the curriculum may be applied to services for all populations in long-term care. Particularly instructive are the findings from a series of focus groups that were held with newly hired New Americans, their coworkers, and supervisors to obtain background information for developing the modules. Themes and challenges that arose from the immigrant groups included the following:

- ◆ **Communication:** Challenges included English spoken too quickly, misunderstanding jargon and slang, lack of patience in listening from coworkers, and problems with writing/documentation.
- ◆ **Socialization:** Problems included lack of personal affirmation, discrimination, failure to include New American workers in social activities, and assumptions that New Americans were not educated.
- ◆ **Training:** Issues ranged from the need for realistic job previews to orientations that overwhelmed new workers with information to lack of trust or confidence in workers’ abilities.
- ◆ **Cultural norms and employee practices:** Issues ranged from differences in perspectives on how disabled persons contribute to society to the impact of gender in providing personal care to perceptions of wage discrimination and lack of promotional opportunities.

Some of the issues and themes voiced by supervisors and coworkers were mirror images of the New Americans’ concerns, particularly in the area of communication. Here coworkers stated that they often did not know when New Americans understood their instructions (e.g., misleading nonverbal communication such as nodding), were afraid to initiate conversations for fear of misunderstanding, and needed to find ways of rephrasing, clarification, and checking-in. Other issues included difficulties in New Americans’ ability to use forms and document activities, different cultural perceptions on disabilities, the culture within the home/facility resisting New American hires, lack of competence with technology, legal and documentation problems in hiring, and problems in evaluating workers’ productivity.

Cross-cultural training directed to changing organizations and personnel often contain, as exemplified in the model currently being developed by the Center for Community Integration, several modules geared towards building competence. These include the following:

- ◆ **Understanding diversity:** Objectives include training supervisors and coworkers to define their own cultural identity and see how it influences interactions; training participants to assess organizational practices that foster/hinder cultural competence; and building effective cross-cultural communication.
- ◆ **Building teams that support New American workers:** Supervisors learn strategies, such as mentoring and peer support, for training and development; emphasis is on skill building in areas such as feedback to staff, conflict resolution, and social inclusion for working in cross-cultural settings.
- ◆ **Orienting and training New American workers:** Competency-based training for supervisors in teaching the knowledge/skills needed by support personnel, including content related to cultural norms; skills for training New Americans in the culture of disability in the United States, and the organization's culture and norms.
- ◆ **Recruiting, hiring and organizational practices:** A series of lesson plans in finding community resources that help in recruiting, communication techniques for interviewing, previewing jobs, and understanding the implications of immigration law for hiring and work issues related to New Americans.

In discussing the major cross-cultural challenges in training and retaining an immigrant workforce, the IIM's staff focused upon integration into the workplace as the major challenge Minnesota needs to face if it wants to tap the New American population as a source for long-term care workers. This is in contrast to training itself as the major issue. Challenges that the long-term care sector, particularly the nursing facility, faces include the following:

- ◆ **Job-enhancing relationships within the workplace:** Trainers at IIM echoed the Center for Community Integration's emphasis on the importance of teams for supporting the work of New Americans. They suggested the use of small work groups that are closely overseen by a nurse supervisor. These groups make

it easier to demonstrate and monitor standards of care, make it possible to distribute and rotate tasks among the varying talents and interests in the group, and are more natural to New Americans who typically work closely with one another and rely on each other for social as well as job-related tasks.

- ◆ **Flexibility in scheduling:** One of the appeals of the LTC sector to New Americans is that, unlike other work settings such as the hotel industry, there are more opportunities for overtime pay. Many New Americans are working double shifts. If supervisors allow workers to put in long hours, they need to be creative in designing schedules that won't burn out workers or jeopardize standards of care.
- ◆ **Effective work evaluations:** Work performance evaluations are a major challenge. Supervisors need to understand how to deliver feedback to workers from cultures that are not accustomed to a give-and-take dialogue. Evaluations that are not done properly end up discouraging workers and dampening motivation.
- ◆ **Valuing the nursing assistant staff:** Many facilities give this, at best, a superficial nod. In a work culture where importance is determined by your degree and training, nursing homes have to find a way to acknowledge the importance of nursing assistants who do the major work of long-term care. It is foolish to think that New Americans, any more than persons from the dominant culture, are willing to pursue, at least in the long term, jobs that are not appreciated.
- ◆ **Appreciation for the learning and cultural challenges facing the New American worker:** It takes more time for the New American worker than the mainstream worker to acclimate to the workplace. When coworkers, families, and consumers do not understand this, equity issues and other misunderstandings develop in the work place. The organization must promote the contributions that immigrant cultures bring to the work setting. Residents and families may at first be apprehensive about a worker who speaks English with difficulty, but with time they may learn to appreciate the attentiveness accorded by that person's help with bathing and other personal care tasks. Also, it is easy to assume that when things go poorly between residents and the New American nursing assistant, it is because of a communication or language problem. This may be

the case, but, on the other hand, the reason may be systemic to the LTC sector's approach to care.

Immigration Law Overview

For the United States, a country frequently referred to as a "nation of immigrants," immigration remains politically, economically, and morally controversial. Although traditionally designed to promote various social, humanitarian, and foreign policy goals, economic goals are increasingly shaping our nation's immigration policies. Such goals include competing in today's global economy and maintaining a quality workforce, while simultaneously promoting and preserving the interests of American workers. With the strong economy over the past few years, many employers maintain there are simply not enough people to fill all of the open jobs and that foreign workers are part of the solution. Accordingly, employers call for a loosening of federal immigration laws to expand access to this potential pool of workers. Yet the perceived risks of employing foreign workers are considerable, including exploitation of the worker through low wages and oppressive working conditions and the perception of immigrants as a labor source rather than as future members of our society (GAO 2000; Dunne 2000). Other risks extend to the domestic workforce, including the fear that immigrants will adversely affect the labor market and wages or displace U.S. citizens from their jobs.

Immigration laws regulate the nation's borders by controlling who may enter, how long they may stay, what they are permitted to do while in this country, and when they must leave. The Federal government has jurisdiction over immigration law and policy; the states have only a minimal role. The Immigration and Naturalization Act of 1952 (INA)⁸ consolidated previous immigration laws into one coordinated statute (Weisbrodt 1992). Amended often, the INA continues to provide the overall framework for immigration law today. The INA establishes the total number of immigrants allowed to enter per year, creates a hierarchy of preference categories, regulates the entry of refugees, regulates the naturalization process, and identifies grounds for exclusion and deportation. Authority to administer the laws related to immigration rests with the Department of Justice, with most duties delegated to the Immigration and Naturalization Service (INS).

The INA includes complex mechanisms for selecting immigrants, defined as aliens who legally enter and seek permanent residency in the U.S. The selection mechanisms are governed by three primary goals: family, employment, and humanitarian concerns. Since the establishment of a quota system in 1965, a web of per-country and categorical limits controls the number of immigrants. Most employment-related visas are subject to numerical limitations. Throughout the 1990s, between 660,000 and 900,000 legal immigrants entered the U.S. each year.

Whereas family unification remains the paramount goal of immigration policy, economic goals have become increasingly important. Recent immigration policy clearly recognizes that immigration is necessary and beneficial to economic growth and a substantial portion of immigration law is now designed to bring prospective employees into the U.S. rather than to keeping them out. The Immigration Act of 1990 amended the INA and increased the number of employment-based immigrant visas from 54,000 to 140,000 annually and allocated them among a hierarchy of five preference categories, ranging from "priority workers" to skilled workers in short supply, to "investors who will create at least ten U.S. jobs by investing in a new commercial enterprise benefiting the U.S. economy."⁹ The 1990 Act also increased the number of nonimmigrant (i.e., temporary) foreign workers admitted annually. For example, the number of visas granted under the specialty occupation (H-1B) program, the premier employment-based visa classification, was increased from 65,000 in 1992 to 115,000 in 2000. The bluntly-titled American Competitiveness in the 21st Century Act of 2000 raised this limit to 195,000 annually for the next three years (2001-2003).¹⁰

The nation's immigration laws are in continual flux as Congress frequently amends the INA in response to economic changes at home and geopolitical events abroad. Immigration laws targeting specific industries or professions are now common. For example, since 1990, Congress has passed several laws designed to spur the recruitment of foreign nurses to combat general or specific nursing shortages.¹¹

⁸ The Immigration and Naturalization Act of 1952, codified at 8 USC §§ 1101-1524

⁹ Immigration Act of 1990. Pub. L. No 101-649

¹⁰ American Competitiveness in the 21st Century Act (S. 2045)

¹¹ Recent immigration laws specific to nurses include:

◆ To respond to a sustained shortage of nurses, Congress passed the Immigration Nursing Relief Act of 1989, creating a new temporary visa classification (H-1A) exclusively for registered nurses. This national effort was successful in recruiting large numbers of foreign nurses. In 1988, prior to the passage of the legislation, there were approximately 73,000 such RNs in the US. By 1996, 110,000 nurses employed or residing in the U.S. had received their basic nurse education in a foreign country. The 51-percent increase in the number of foreign-trained nurses nearly doubled the 26-percent increase in all RNs during that same time period. As a result of the growth in the number of foreign

Recruiting Foreign Workers

Foreign workers can legally enter the U.S. to work either as immigrants (i.e., aliens seeking permanent residency) or as nonimmigrant (i.e., aliens entering the U.S. for a limited period of time and a limited purpose). Current laws allow foreign nurses to enter and work in the U.S. under one employment-related visa for immigrants and four separate employment-related visa programs for nonimmigrants. Foreign nurses therefore can enter and work in the U.S.

- ◆ as immigrants under the EB-3 employment-preference provisions of the INA;
- ◆ as nonimmigrant workers in specialty occupations under the H-1B provisions of the INA;
- ◆ as nonimmigrant workers (H-1C classification) in designated health professional shortage areas under the Nursing Relief for Disadvantaged Areas Act of 1999;
- ◆ as nonimmigrant nonagricultural workers under the H-2B provisions of the INA; and
- ◆ as nonimmigrant workers under the temporary entry provisions of the North American Free Trade Agreement (NAFTA).

Two of these programs (the permanent employment-based provisions and the temporary H-2B provisions) may also allow foreign nursing assistants to enter and work in the U.S. Other visa classifications that can be used for nurses or nursing assistants to enter and work in the U.S. include a variety of student or training visas (M-1, F-1 and J) and the religious worker (R-1) visa program. Regulations for each of these latter visa classifications, however, severely limit their utility for bringing aliens to the U.S. for employment as nursing personnel in LTC.

Recruiting Foreign Workers as Immigrants

The Immigration Act of 1990 (which amended the INA) allocates about 140,000 employment-based immigrant visas annually, distributed among a hierarchy of five preference categories. Only one of these, the third preference category (EB-3), applies to nursing personnel.

Both nurses and nursing assistants fall under the EB-3 classification of “skilled workers, professionals, and other workers.” “Skilled workers,” i.e., qualified immigrants capable of performing skilled labor (defined as work requiring at least two years of training or experience), includes nurses. Qualifying jobs for “professionals” are similar to the specialty occupations for the H-1B visa (discussed below) and rarely include nursing positions in LTC. “Other workers” include qualified immigrants capable of performing unskilled labor, such as nursing assistants.

The annual limit for the EB-3 category is currently 40,040, or 28.6 percent of all employment-based visas. As with all of the INA’s numerical limits, the actual number of visas issued for this category in any given year may exceed the number allocated because of the complex allocation scheme among all visa categories. Furthermore, people entering the U.S. under any of the employment-based visas are allowed to bring their families with them; thus the majority of immigrants in these visa classifications are, in fact, dependents who do not work.

The issuance of an EB-3 visa is linked to the existence of a worker shortage. To obtain such a visa, prior to entry into the U.S., the alien or the prospective employer must submit a petition to the Department of Labor. To protect American workers, the visa will not be issued unless the Secretary of Labor determines that: “a) there are not sufficient qualified [domestic] workers available at the place where the alien will be employed; and b) employment of the alien will not adversely affect wages or working conditions of similarly employed U.S. workers.”¹²

Amendments passed in 1996, ostensibly as quality control measures, may make it more difficult to recruit foreign nurses under the EB-3 visa classification by creating additional entry requirements. Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) established certification requirements for aliens who seek to enter the U.S. to work in certain health care occupations. This visa screening procedure applies to RN, LPN, and certain other health care occupations. Thus, workers in these specified occupations are not allowed to enter the U.S. to work unless 1) the Secretary of Labor documents a worker shortage and 2) they obtain

trained nurses, as well as the downsizing and restructuring within the health care industry and more new graduate nurses, Congress allowed the H-1A visa classification to sunset in 1995.

◆ Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 established a prescreening procedure for foreign trained nurses (and workers in certain other health care professions) to ensure that a basic level of competency is maintained (Pub. L. 104-208).

◆ The Nursing Relief for Disadvantaged Areas Act of 1999 (NRDAA) (Pub. L. 106-95) created special requirements for admission of non-immigrant nurses to work in hospitals in designated health professional shortage areas. The NRDAA responds to a very specific need for qualified nursing professionals in understaffed hospitals serving mostly poor patients in inner city and in some rural areas. The law allows qualifying hospitals to employ temporary foreign workers as Registered Nurses (RNs) for up to three years under H-1C visas. Only 500 H-1C visas can be issued each year during the four-year period of the H-1C program (2000-2003).

¹² 8 U.S.C. §1182(a)(5)(A)

a certificate that verifies that their education, training, licensing, experience, and English competency are comparable to American health care workers.¹³

Efforts in Minnesota to Recruit Foreign Nurses as Immigrants

The regulatory framework outlined above can be used to bring foreign nurses and nursing assistants to the U.S. as permanent immigrants to work in long-term care. Predictably, the severe labor shortage has generated a high level of interest in such efforts, particularly for recruiting foreign nurses.¹⁴ At least a couple of efforts are underway in Minnesota to bring foreign nurses to work in long-term care under the EB-3 employment-based preference program.¹⁵ One initiative, begun over two years ago with a goal of importing 50 to 60 nurses annually (with the first nurses scheduled to arrive in Minnesota in 2001), has focused on recruiting Filipino nurses.

The Philippines have long been a source of nurses for Minnesota and the rest of the nation as well. Of the 110,000 foreign-educated RNs working in the U.S. in 1996 (at the end of the five-year H-1A program to recruit foreign nurses), about 43 percent, or 47,400 nurses, came from the Philippines. Employers in the U.S. have targeted the Philippines for recruitment and Filipino nurses have come to the U.S. in large numbers for several reasons. Initially colonized by the U.S. in the late 1800, the Philippines have maintained close cultural links to the U.S. The historical colonial relationship between the two countries, which Americanized many Filipino values and aspirations, sustains the widespread desire among Filipinos to come to the United States. The Philippines also maintain extensive links with the United States through trade, foreign assistance, and (until recently) military bases. Their education programs in health care are patterned after those in the U.S. Finally, since English is the official language of the Philippines and the language of instruction in most training programs for health care professionals in the Philippines, most Filipino nurses should easily meet the English competency requirements of Section 343 of the IIRIRA.

Nonetheless, efforts to recruit substantial numbers of nurses from the Philippines or other countries to Minnesota must overcome a number of potential hurdles:

- ◆ Many western countries face current and projected shortages of nurses and they, too, have (public and/or private) initiatives to recruit foreign nurses. The international competition for the limited pool of nurses trained in programs comparable to those in the recruiting country is reported to be intense. Countries that only a few years ago were exporting nurses, such as Ireland and Canada, have now turned to foreign recruiting themselves (Bryant 2001).
- ◆ The process for recruiting foreign nurses into the U.S. as immigrants is lengthy. One local effort to recruit nurses from the Philippines, for example, filed petitions with the INS in late 1999 and expects the first nurses due to arrive in the U.S. sometime in 2001.
- ◆ The emigration of nurses to work in foreign countries poses serious challenges to the nurses' home country. Although the home countries may gain from earnings being sent home by the nurses who work abroad, the loss of qualified nursing staff may have negative consequences as well. Often, the most qualified nurses emigrate, leaving critically needed positions in health care services vacant or filled by less qualified personnel. The aggressive recruitment of Filipino nurses in the late 1980s, for example, led to the rapid turnover and high vacancy rates in nursing positions in the Philippines – ironically, precisely the same problems the recruitment efforts were meant to solve in the recruiting country (Ortin 1990).
- ◆ The most potentially disturbing effect of recruiting foreign nurses is harm to the health of the population in the nurses' home country. Although this impact has not yet been documented, the possibility of harm raises questions about the extent to which recruiters (and the recruiting country) have an obligation to protect the health of people in the countries from which they recruit health care workers.

¹³ To implement section 343, the INS published an interim rule on October 14, 1998 establishing a temporary procedure for immigrant workers to comply with the section's certification requirements. This interim rule applies only to nurses and occupational therapists: a second interim rule, published in April 30, 1999, extended the procedure to physical therapists. (Other professions identified in Section 343 are not covered by these interim rules and are thus not able to enter the US to work.) These occupations were selected due to a "sustained level of demand" for foreign-trained workers, defined here as "an existing demand that is expected to continue in the foreseeable future." (63 FR 55007) A final rule to implement Section 343 has not yet been promulgated. The purposes of Section 343 and its implementation rules are to establish temporary procedures that: "(1) allow the immigration of certain health care workers into the United States on a permanent basis in order to prevent the disruption of critical health care services to the public; (2) provide for the immigration of certain health care workers who were petitioned on a permanent basis prior to the enactment of the IIRIRA; and (3) establish a temporary mechanism to ensure that nurses and physical and occupational therapists immigrating to this country have education, experience, and training which are equivalent to a United States worker in a similar occupation." (63 FR 55007)

¹⁴ Even though NAs also fall under the letter of the laws and regulations of the EB-3 visa, practical and economic considerations argue against recruiting these foreign workers as well.

¹⁵ At this time, the level of discussion and interest in recruiting foreign nurses to Minnesota seems to exceed the level of activity.

Recruiting Temporary Foreign Workers

The INA includes multiple provisions pertaining to aliens who seek entry to the U.S. for a temporary period of time or for a limited purpose, such as training or employment. The sole purpose of temporary worker visa categories is to grant legal authorization to work in the U.S. With some notable exceptions, the U.S. had prohibited the temporary employment of foreign workers before the INA of 1952 was passed. The INA lifted the ban and admitted temporary workers to “alleviate labor shortages.” Since then, the U.S. has frequently amended its immigration laws, based on a better understanding of the role that foreign workers play in relieving labor shortages, to regulate the number and type of foreign workers permitted to enter.

Of the INA’s 18 major categories for nonimmigrant visas, most temporary foreign workers use the H visa category. The two subcategories that could be used to recruit nursing personnel for long-term care are H-1B workers in specialty occupations and H-2B temporary nonagricultural workers in short supply.¹⁶

Workers in Specialty Occupations (H-1B)

The H-1B is the premier employment-based visa classification. Typically, employers initiate the multi-step process to bring a foreign worker to the U.S. under the H-1B program, reserved for professionals and highly skilled workers in specialty occupations. To comply with a provision added in 1990, the prospective employer must first file a “Labor Condition Application” (LCA) attesting that the H-1B worker will be paid a wage that is similar to what the employer pays to other individuals similarly employed and that the working conditions of similarly employed workers will not be adversely affected. After the Department of Labor approves the LCA, the employer must then file a petition to the INS in which the employer attests that a bona fide job exists for the prospective H-1B worker and that the worker meets the qualifications for the designated specialty occupation. In contrast to the EB-3 immigration and H-2B temporary worker visas, the employer is not required to prove a shortage of U.S. workers to recruit an H-1B worker.

In its two-part review of an H-1B visa application, the INS considers whether the job requires someone in a “specialty occupation” and whether the specialty worker

meets the requirements of that occupation. Approval requires that both criteria be met. “Specialty occupation” is defined as an occupation that requires theoretical and practical application of a body of specialized knowledge and attainment of a bachelor’s or higher degree in the specific specialty. To meet this requirement, the alien must have a bachelor’s degree or higher, or experience in the specialty equivalent to the completion of such a degree, and possess a license (or at least an interim permit, if available) if that is required for practice in the state.¹⁷

Nursing in LTC usually is not considered a “specialty occupation” under the requirements of this visa since most long-term care employers routinely hire nurses who lack a four-year, Bachelor of Science in Nursing (BSN) degree. The H-1B specialty occupation visa is thus rarely used to bring foreign nurses into the U.S. However, if an employer could establish that a particular RN position requires a four-year degree (say for a supervisory position), an H-1B visa may be approved. Nursing assistants are clearly not eligible under this visa classification.

Temporary Non-agricultural Workers (H-2B)

In contrast to the H-1B classification, a foreign worker with an H-2B visa must be coming temporarily to the U.S. and have “a residence in a foreign country which he has no intention of abandoning.” Further, the H-2B alien must not displace U.S. workers capable of performing such services or labor, and their employment must not adversely affect the wages and working conditions of U.S. workers. Workers under this program are initially admitted for up to one year; they may receive one-year extensions, up to a total stay of three years. The number of H-2B visas is presently capped at 66,000 per year.

This category, which is sufficiently broad to cover nursing assistants, nurses, and all other LTC positions that do not typically require a four-year degree, is defined more by time than by occupation. The primary criteria require that both the job itself and the petitioning employer’s need for foreign workers must be temporary. To hire a foreign worker under this visa, the employer must provide a statement to the Department of Labor describing in detail the temporary situation or conditions that make it necessary to recruit aliens to the U.S. and whether the need is a “one-time occurrence,” “seasonal,” “peakload,” or “intermittent.”

¹⁶ The new H-1C visa classification is limited to foreign-born nurses who work in selected hospitals in federally-designated “Health Professional Shortage Areas.” As of May 2001, no hospital in Minnesota has been selected for this program.

¹⁷ Congress raised the number of H-1B visas that can be granted to 195,000 for fiscal year 2001. In fiscal year 1999, over 60 percent of H-1B visas granted were for Information Technology-related occupations. In contrast, the number of H-1B visas for medical and health occupations granted from October 1999 – February 2000 (the latest period for which data are available) were 4.1 percent (or 3,246) of the total. (GAO 2000) The initial period of admission under the H-1B visa is for up to 3 years; extensions are permitted with a maximum stay of 6 years. Steps taken by H-1B worker toward permanent residence do not, by themselves, signify an abandonment of non-immigrant status. That is, an H-1B worker can intend both to work temporarily and to establish permanent residency at some future time. This contrasts with the requirements for persons with all other H-type visas, who must intend to return to their home country.

Each of these terms is tightly defined in the regulations. For each of these situations, the requirement that the job for which the worker is recruited is temporary cannot be met if the underlying position continues after the temporary H-2B worker leaves. The persistent worker shortage in LTC would thus almost certainly disallow using the H-2B visa classification for recruiting foreign nurses or nursing assistants for positions in Minnesota's LTC sector.

North America Free Trade Agreement Workers

The North American Free Trade Agreement (NAFTA) includes RNs (but not LPNs) among the professionals allowed to enter from Canada or Mexico under the TN (or "Trade NAFTA") status. The TN visa, which applies exclusively to Canadian and Mexican citizens entering the U.S. to engage in business activities at a professional level, has no specific training requirements for RNs; the only requirement is a state or provincial license. Whereas an estimated 6,800 Canadian nurses came to the U.S. under NAFTA in 1994, and an additional 5,200 in 1995, these numbers are now probably sharply lower as Canada's own nursing shortage becomes more severe (Flaherty 1999; Bryant 2001). Since it is more difficult for Mexican nurses to qualify to work in the United States, because their education is typically not comparable to that of U.S. nurses, a much smaller (though unknown) number of Mexican nurses have entered the U.S. with a TN visa.

Obtaining a TN visa is relatively quick, easy, and inexpensive. Once admitted, a TN worker is granted an initial stay of one year and thereafter may request extensions of stay for one-year increments. There is currently no limit on the number of extensions that may be granted.

Religious Workers (R-1)

The 1990 amendments to the INA established the R-1 visa category for individuals in religious occupations who enter the U.S. to perform services in their religious vocation. The R-1 visa is fairly restrictive: to qualify, an alien must be coming to the U.S. solely to work for a bona fide nonprofit religious organization or denomination and must pursue a "religious vocation or occupation." The alien must prove membership in the denomination for at least two years prior to applying for an R-1 Visa. When applying for an R-1 visa, the petitioning employer must be affiliated to the same denomination of which the alien is a member. Despite these

restrictions, it may be possible for LTC employers affiliated with a religious organization to recruit aliens to be trained or employed as nursing personnel so long as the "work to be performed relates to a traditional religious function."

Student Visa Programs

The M-1 visa is available for a wide range of training programs, but excludes training provided primarily at or by an academic or vocational institution. Students who enter the U.S. temporarily to pursue study at a college, university, or other established academic institution typically use the F-1 visa instead. The goal of both student visa programs is to enable the U.S. to share its resources with foreign nationals while protecting the economic well-being of U.S. permanent residents and citizens. Accordingly, regulations aim to prevent their misuse as a vehicle for recruiting and placing ordinary workers or displacing U.S. workers with alien 'trainees' actually engaged in productive labor.

Exchange Visitors (J visa)

The very flexible J exchange visitor visa is designed to promote the interchange of persons, knowledge, and skills in the fields of education, arts, and sciences. Participants can include students and trainees obtaining on-the-job training. Employment for "J" exchange visitors depends on the terms of the program in which the visitor is participating. Participants in programs providing for on-the-job training, teaching, research, or other activities involving paid employment may accept such employment. Participants in programs that do not involve work may not accept outside employment. Though technically available to bring foreign nurses to the U.S. to work in LTC, the J visa has rarely, if ever, been used for this purpose.¹⁸ Table 6 summarizes the visa options for recruiting foreign nurses and nursing assistants for LTC.

Economics of Recruiting Foreign Workers

Whether it is economically viable for LTC employers to recruit foreign nurses or nursing assistants is not yet known. Costs of recruiting a foreign worker can vary tremendously, depending on the organizations used and their level of assistance. Some costs are fixed, including immigration fees (\$115 filing fee for immigrant worker visa, \$110 base fee for nonimmigrant visa, "training fee" of \$1,000 for H-1B visa) and testing fees, if any. The variable costs include the recruiting cost for finding a qualified foreign worker willing and able to come to the U.S. (e.g., fees for

¹⁸ Undocumented workers may also be a source of labor for LTC. More than 6 million illegal immigrants live in the U.S. Most of them entered the country illegally; the remainder entered legally but overstayed their visa. An unknown number of illegal immigrants live in Minnesota and some of them probably work in long-term care settings. The Immigration Reform and Control Act of 1986 ("IRCA"), focused almost exclusively on illegal immigration, imposes employer sanctions as the primary means of stifling illegal immigration and minimizing incentives to employ undocumented workers

Table 6 Visa options for recruiting foreign nursing personnel for long-term care							
VISA CATEGORY	DESCRIPTION	INITIAL AUTHORIZED PERIOD/RENEWAL PERIOD	NUMERICAL LIMIT FOR FY 2001	APPLIES TO			NOTES
				RNs	LPNs	NAs	
EB-3	Skilled workers, professionals, and other workers	Permanent	40,040	Yes	Yes	Yes	Nurses must meet certification requirements of Section 343 of IIRIRA. Rarely used to recruit nursing assistants
H-1B	Workers in "specialty occupations"	3 years/extension of up to 3 years. Total: 6 years	195,000	Yes	No	No	Position must require at least a 4-year degree and applicant must have at least a 4-year degree.
H-1C	Foreign-born registered nurses to work in "disadvantaged areas"	Up to 3 years/no extension	500	Yes	No	No	Limited to selected hospitals in federally-designated "Health Professional Shortage Areas." No MN hospital currently selected.
H-2B	Temporary non-agricultural workers	1 year/two one-year extensions Total: 3 years	66,000	Yes	Yes	Yes	Employers must document that the position itself and the employer's need for the worker are temporary. Criterion is rarely met by LTC providers.
TN	"Professionals" under the North American Free Trade Agreement (NAFTA)	1 year/extension of up to 1 year. No limit on number of extensions.	None	Yes	No	No	Available only to citizens of Canada and Mexico.
R-1	Religious workers	3 years/extension of up to 2 years. Total: 5 years	None	Yes	Yes	Yes.	Alien must pursue a religious vocation or occupation. Employers must be bona fide non-profit religious organization
M	Non-academic or vocational student visa	Typically up to 1 year/duration of studies	None	No	Yes	Yes	Student can engage in productive employment only if incidental and necessary to training.
F-1	Academic visa for students at colleges, universities, or other academic institution	Duration of studies	None	Yes	No	No	Student may work up to 20 hours/week.
J	Exchange visitor program	No specified time limit	None	Yes	Yes	No	Though technically available to nurses, rarely, if ever, used for such workers.

employment agencies in the worker's home country or transportation and related costs of a U.S. recruiter to locate, interview, and select a prospective immigrant worker), transportation and relocation costs, and attorney fees (from about \$2,500 on up). Combined, these costs can easily exceed the costs of recruiting a domestic worker, although precise comparisons are difficult given the wide range in the variable costs for recruiting a foreign worker.

Once the worker is on the job, some costs will likely remain unchanged. Immigration laws and regulations require employers to assure similar wages and working conditions for foreign and domestic workers.¹⁹ Foreign workers may, however, lead to higher costs for the employer if they require additional supervision or support to address cultural or language barriers.

The only anticipated savings from using foreign workers come from reduced turnover costs, on the assumption that the foreign workers will remain on the job longer. However, even though one employer sponsors an EB-3 immigrant's entry into the U.S., once the immigrant is in this country he or she is free to go to work for another employer, or to not work at all. Similarly, temporary H-visa category workers may change employers, without having to obtain a new visa. The extent to which foreigners recruited as immigrants or temporary workers in LTC have exercised these freedoms has not been studied, nor is data available comparing the employment tenure of foreign workers with that of LTC nursing personnel overall. Thus, the anticipated savings from reduced turnover of foreign workers remain conjectural.

¹⁹ Employers in other industries have not always complied with these provisions. For example, the GAO has documented numerous wage and benefit violations in the H-1B visa program and concluded that the Department of Labor's "limited legal authority" for questioning an LCA and initiating enforcement actions leaves this program vulnerable to abuse (GAO 2000).

Proponents argue that the cost of recruiting temporary or permanent foreign workers should be compared not with the cost of recruiting domestic employees, but with the (typically higher) cost of using pool agencies. The workforce shortage, according to proponents, has taken away the option of hiring domestic workers as LTC employees. On this comparison, they contend, recruiting foreign workers is economically viable. Cost data on this comparison are also not available.

Conclusion

Efforts to recruit foreign nursing personnel for jobs in LTC, either as permanent immigrants or as temporary workers, seek to expand the potential labor pool. By themselves, however, such strategies are at best a short-term solution and are unlikely to put a major dent in the current worker shortage. Current immigration law and regulations present formidable barriers to recruiting foreign nurses and nursing assistants. Recruiting them under the few applicable visa classifications is costly, lengthy, and difficult. Isolated initiatives are unlikely to bring significant numbers of foreign LTC workers into Minnesota. Without changes in immigration law or policy (such as reestablishing the H-1A visa classification for nurses) or a regional or national effort, the number of foreign nurses and nursing assistants coming to Minnesota will likely remain small. Finally, recruiting foreign health care workers may also be detrimental to the worker's home country.

Efforts to recruit New Americans to enter the long-term care workforce are likely to be more rewarding than recruiting foreign workers. The organizations that help New Americans obtain positions in LTC are uniformly convinced there is a pay-off for the added effort and resources needed to help the New Americans succeed. The New Americans, it is alleged, become good employees with lower turnover rates. But these views, so far, are supported primarily by anecdotal evidence and strong conviction.

Success for the LTC employer and New American employee will come when both learn to adapt to each other; cultural competency is reached on a two-way street. Eventually, the employer and employee may meet halfway, but at the beginning of the employment period, the employee should make every effort to meet the employer's expectations (such as issues involving time, dress code, and behavior) and the employer should anticipate that the New Americans will have difficulty adjusting. From a broader perspective, we again note that whereas adapting to cultural differences and meeting the special needs of New American workers are essential, these efforts by themselves are unlikely to reduce turnover rates or otherwise resolve the workforce crisis. Long-term care employers must also respond to the familiar barriers to recruiting and retaining nursing personnel to make nursing and frontline positions more appealing and rewarding.

Glossary

Alien

From the perspective of the U.S., an alien is any person who is not a citizen of this country.

“Green cards”

Alien registration cards (“green cards”) are issued to people who are granted permanent residence.

Illegal alien

Illegal aliens include persons who enter the U.S. without any sort of legal visa and persons who enter with a legal visa but remain beyond the authorized time limit.

Immigrant

Aliens entering the U.S. legally are immigrants if they seek permanent residency in the U.S.

Naturalized citizen

Immigrants become naturalized citizens after they have met residency requirements (usually 5 years) and fulfilled other criteria (including an interview, history exam, and oath).

Non-immigrant

All aliens entering the U.S. legally are non-immigrants if they enter for a limited period of time and usually for a limited purpose.

Refugee

A refugee is “a person who is outside his or her country of nationality and is unable or unwilling to return to that country because to persecution or well-founded fear of persecution” (refugees are eligible to adjust to immigrant status after one year of continuous presence in the United States).

Undocumented worker

Illegal aliens in the workforce are referred to as undocumented workers.

Visa

A visa is an authorization to enter the U.S. for a specified purpose and period of time.

Recommendations on Recruiting Immigrants and Foreign Workers

18. The LTC workforce commission should submit to the Commissioner of Human Services legislative initiatives to expand LTC training and employment opportunities for New Americans in Minnesota. The commission should develop strategies for the state, counties, and other local government units to increase public funding and for obtaining, to the extent possible, more federal money for LTC workforce training and development. Priority should be given to expanding LTC worksite-based English as a Second Language (ESL) programs, subsidizing early in-facility training and mentoring of New Americans, and other activities designed to help immigrants overcome cultural and language barriers to successful employment in LTC.
 19. Long-term care employers, individually and collectively, should step up their efforts to expand employment opportunities for New Americans in Minnesota by:
 - ◆ Developing new and adding to existing recruitment, training, and retention initiatives directed at New Americans before devoting resources to recruiting foreign workers;
 - ◆ Establishing new and enhancing existing partnerships with employment agencies, public and private human service organizations, and education institutions to recruit, train, and place New American workers;
 - ◆ Increasing the use of student and worker assessment tools to assure New Americans are directed to the most appropriate training programs and to determine graduates' job-readiness; and
 - ◆ Supporting a diverse workforce by becoming more sensitive to cultural issues, both in their workforce and in organizational practice.
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References

- Administration on Aging. 2001. *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families*. Washington, D.C.: Administration on Aging.
- Bryant, J. 2001. Hospitals go overseas for nurses. *Atlanta Business Chronicle*, May 8, 2001.
- Cross, T.L. 1989. Towards a culturally competent system of care. Georgetown, D.C.: Georgetown: Georgetown University Child Development Center.
- Dunne, E.M. 2000. The embarrassing secret of immigration policy: Understanding why congress should enact an enforcement statute for undocumented workers. *Emory Law Journal* 49:623-656.
- Flaherty, M. *Why are nurses coming to the states to work?* Nurseweek 1999 [cited. Available from <http://www.nurseweek.com/features/99-3/visas.html>].
- GAO. 2000. H-1B Foreign Workers: Better Controls Needed to Help Employers and Protect Workers. Washington, D.C.
- Kahn, K. 2000. *The Challenge of Recruitment*. Paraprofessional Healthcare Institute 2000 [cited 2000]. Available from <http://directcarealliance.org/sections/pubs/PHIRecruitOvrww.pdf>.
- Lynch, E.W., and M.J. Hanson. 1998. *Developing Cross-Cultural Competence*. 2nd ed. Baltimore, MD: Paul H. Brookes.
- Ortin, E.L. 1990. The brain drain as viewed by an exporting country. *International Nursing Review* 37 (5):340-344.
- Ronnigen, B.J. 2000. Immigrants in Minnesota: An Increasingly Diverse Population. St. Paul, MN: Minnesota State Demographic Center.
- Weissbrodt, D. 1992. *Immigration Law and Procedure in a Nutshell*. 3rd ed, *West Nutshell Series*. St.. Paul, MN: West Publishing Co.
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THE ROLE OF LONG-TERM CARE PROVIDERS

Recruiting and retaining nursing personnel is a serious challenge for long-term care, and likely to remain so. The high level of vacancies and turnover rates, compounded by low unemployment rates and fundamental social and demographic changes that will continue to both constrict the supply of workers as well as increase the demand for services, foreshadow an unprecedented labor crisis for long-term care in the near future. The current problem has been years in the making and will not be resolved overnight. Instead, assuring an adequate and qualified LTC workforce will require a sustained, multi-dimensional effort that includes short-term strategies targeting worker recruitment and retention, such as expanded initiatives to attract, train, and place New Americans in LTC positions, as well as broader, longer-term initiatives to modify the structure, organization, and delivery of long-term care.

Ironically, this looming crisis may also present the best opportunity yet for developing and implementing innovative and sweeping changes in long-term care. In addition to serving as the incentive for taking steps that have been difficult for policy makers and the long-term care sector, the current crisis also provides an opportunity to more critically examine the possible causes of the problem and appraise various untested reform strategies. In this chapter, we examine some of those issues, including the role of nursing homes in this problem and two corrective strategies that have not yet been pursued or actively promoted.

Nursing Home Administrative Issues

Our review of the literature and discussions with stakeholders in Minnesota regarding workforce shortages reveal a perception that LTC providers, particularly nursing homes, may be victims of these shortages due to circumstances beyond their control as well as contributors to the problem. Some of the factors affecting recruitment and retention are internal to an organization (e.g., job design, quality of supervision, human resource issues, and career advancement opportunities); others are external (e.g., local unemployment rate and per capita income). Characteristics of the LTC organization itself (e.g., rural or urban setting, profit or not-for-profit) may also effect recruitment and retention (Straker and Atchley 1999). Whereas the external factors and organizational characteristics are mostly beyond the control of individual employers and the long-term care industry in general,

employers acting alone or in concert can influence many of the internal factors, despite the often restrictive regulatory environment.

The argument for looking at nursing home behavior rests largely on the observation that nursing homes encompass varied degrees of personnel problems. As noted previously, sometimes nursing homes, including those within a few miles of each other, will have radically different staffing experiences. One nursing home may face rampant growth in its use of temporary labor pools, while its neighbor reports almost no pool usage. Turnover rates also differ significantly among facilities in the same geographic area. Since regulatory, economic, and other features of the external environment theoretically have a similar effect on nursing homes in the same locality, other explanatory factors, internal to the organization, must be at play. These factors include the culture of the organization and the way it conducts its business, including its administrative and management style. That problems with recruitment and retention of nursing personnel are caused, in part, by these internal factors is suggested by the following:

- ◆ Nursing homes receive a fixed reimbursement, per resident per day. To address worker shortages, temporary agencies (pools) may be used at a higher price for labor. Alternatively, nursing homes can develop management practices and employ other strategies to make their permanent positions more attractive. As noted above, there is substantial variation in the use of temporary workers in nursing homes in the same locality. In conversations with various constituencies, the heavy reliance on temporary workers is equated with poor management. For example, few if any nursing homes have developed contract arrangements with pools, which is common in other industries, in order to both prevent exploitation and ensure that they face more predictable expenditures for pool usage. Whatever one's views about how much pool use is appropriate, at least some nursing homes do not appear to use pools efficiently.
- ◆ Data suggest that management approaches and leadership styles are related to employee satisfaction, which in turn is linked to job turnover (Irvine and Evans 1995; Olson 2000). Many nursing homes have done relatively little to address supervision and leadership

issues to create a working environment that encourages staff to stay; some, however, pursue a broad array of activities. Among them are programs using feedback data on supervision to improve the working environment. One multi-site LTC organization in the Twin Cities, for example, periodically surveys all of its employees regarding their perceptions of the working climate and job satisfaction, with an emphasis on their relationships with and the effectiveness of their supervisors. Information gathered is then used to enhance supervisory effectiveness through additional training and skills development. Although it is too early for the organization to see any significant effects on turnover, providing feedback to supervisors and getting LTC staff involved in giving feedback clearly appear, on the surface, to be promising. Continuous improvement strategies, which combine employee surveys with follow-up activities that respond to any supervisory problems, should lead to improved supervision and engender a perception among the employer's staff that their views and ideas are valued.

- ◆ Nursing homes often promote workers who are inadequately prepared to assume managerial responsibilities to administrative or supervisory positions. Instead, workers are often left to their own devices, with no specific supervisory training and without adequate support and coaching. The impact on staff is dramatic. Paraprofessionals frequently report “working around,” or in many cases literally ignoring, their supervisors because of a perceived lack of effectiveness (Dostalík ET AL Management Consultants 2001).
- ◆ Focus groups of nursing assistants provide many examples of how they do not feel appreciated for the work they do. Suggestions from nursing assistants on how supervisors and employers could make them feel appreciated are “embarrassingly basic.”¹ The desired expressions of gratitude and common courtesy are too few and far between, according to nursing assistants, adding insult to injury to an already difficult and stressful job. These findings prompt questions about an industry whose employers are often seemingly disinclined to create an environment in which these familiar and easy expressions become routine instead of infrequent.

Long-term care providers, individually or collectively, can impact each of the issues. Yet, despite opportunities to enhance recruitment and retention by improving the working environment and redesigning LTC workers' jobs, long-term care employers in general have done relatively little. For nursing assistants in particular, LTC employers have relied on the “assumption of an endless supply of low-income, contingent workers” ready and willing to take positions that offer low pay, few benefits, and difficult working conditions (Frank and Dawson 2000). As the supply of workers continues to dwindle, however, LTC providers will have to find ways to make frontline workers feel more appreciated and more empowered.

Untested Strategies

As noted previously, neither the strategies we discuss in this report nor our recommendations to improve worker recruitment and retention are meant to be comprehensive. Here we briefly discuss two of the many other strategies that have been proposed but remain untested.

Separating Post-Acute Care From Long-Term Care

Long-term care providers are accustomed to meeting a number of different, sometimes conflicting, needs. They serve a diverse set of clients, whose needs may not be equally well met by a single venue. In the last decade, many nursing homes, for example, have actively pursued post-acute care (PAC), funded primarily by Medicare, because it paid much higher rates than traditional long-term care. The requirements for PAC are different, however, and it is unclear how well a facility operated and staffed to meet the needs of long-term care residents can simultaneously provide the right environment for high-quality post-acute care. In many instances, trying to do so may place even greater demands on already overstressed staff.

Post-acute care requires a rehabilitative strategy and capacity. In many instances the staff represent many of the therapies that populate rehabilitation. The emphasis is on active treatment, with a strong expectation of recovering function. By contrast, long-stay patients are typically expected to decline and the goals of their care are different. Good care may slow the rate of the decline and rehabilitative interventions, when they occur, are

¹ Among the suggestions from a series of focus groups of nursing assistants conducted by the Pennsylvania Intra-Governmental Council on Long-Term Care are:

- ◆ Just say “thank you” when I’ve done a good job
- ◆ Acknowledge my presence
- ◆ Say “Hello”
- ◆ Ask me how things are going
- ◆ Give me feedback
- ◆ Admit if you make a mistake (Dostalík ET AL Management Consultants 2001).

intended to stem this rate of decline or to prevent disease atrophy.

Separating PAC from LTC allows a facility to focus on a single line of business and to develop strategies for that effort. For example, quality-of-life issues become much more salient in the context of LTC. Although PAC patients may be willing to accept a more hospital-like environment, LTC residents should not be so restricted. Staff trying to serve both constituencies may find themselves in conflict trying to meet disparate needs. Staff prepared to provide supportive care may, for instance, lack the skills needed for active rehabilitation, whereas staff geared for rehabilitative care may lack the problem-solving skill, ability, desire, and patience for more chronic care. The types and ratio of staff needed also differ for the two types of patient populations. Long-term care residents need more personal attendance and less active rehabilitation.

Environments, training, and orientation will be hard enough to establish to meet the needs and expectations of one set of clients; trying to do it for two separate populations simultaneously adds even more stress. Co-mingling post-acute care and long-term care (and post-acute patients with long-term care residents) in a single institution thus may not serve either population well. The goal of staff retention by improving their sense of accomplishment would be easier to achieve if staff could focus their efforts on meeting the needs of a more homogeneous set of clients.

Recruiting Nursing Home Resident's Family Members

Strategies to address the worsening shortage of NAs and LPNs in nursing homes commonly seek to either change the number of people interested in this kind of work or the duration in which people hold these positions. An oft-proposed solution is to cast a wider recruitment net. Potential sources of new LTC workers, beyond the traditional pool of women aged 25-54, include students (particularly those interested in health careers), older workers and retirees, and former welfare recipients. Nursing personnel who no longer work in nursing positions, or who work part-time, are other sources of (already trained) workers. Recruiting, training, and placing workers from these groups in LTC jobs will require additional marketing and outreach activities, some broad-based and others more narrowly targeted. To succeed, the targeted activities will

need to be tailored to the particular interests and needs of the potential workers. For example, while job announcements posted on the Internet are likely to reach students, recruiting partnerships between long-term care employers and public or private human service agencies may be needed to recruit workers from other groups.

Beyond these typically targeted populations is an overlooked but potentially promising group – relatives of nursing home residents. Engagement of even a small percentage of the family caregivers of the 40,000 nursing home residents in Minnesota could substantially alleviate the shortage of nursing assistants and possibly LPNs.

Most nursing home residents have visiting family members who, as caregivers, resemble the people who are most inclined to be long-term nursing assistants. They are older adults, often living on fixed incomes (in rural Minnesota, 30% have an income under \$20,000), and they have a personal interest in nursing home caregiving. Older workers are motivated by concepts of service, in its altruistic and occupational sense. Such values are part of nursing home care.

There is reason to believe these persons would seek this kind of employment. Overall, one-half of employed persons want to work past 65 (albeit not full-time). The overall employment rate of persons aged 55 to 85 is 40%. This employment rate falls sharply at age 65; only 13% persons over age 65 are working, although this percentage is now increasing (Williams 2001). One out of every 12 unemployed persons who is 55 to 64 years old wants to work. Ironically, family caregiving responsibilities are a major reason why older people do not work.

Family caregivers would be able to perform most nursing assistant work. Older workers have superior attendance, learning, and productivity. They have a lower accident record but do stay out longer after an injury. Only one-fourth of persons aged 55 and older have work disability and only one of seven of them have a severe work disability.² In other words, 75 percent have no work disability. A year 2000 survey of 55 to 84 year-olds living in Mid-Minnesota showed that over 80 percent of those in both the 55 to 64 and 65 to 74 age groups were in excellent or good health, and that 55 percent of the 75-84 year-olds were in the same healthy condition. The overall share of the 55 through 84 year-olds who are active and feeling good is 76 percent (Hively 2001). A third of the

²US census, Chartbook on Work and Disability, 1998.

pool of potential nursing assistants aged 55 and older already provide care to sick or disabled family members, even without the adaptive aids and OSHA protections of a nursing home environment. Even so, careful attention to occupational health and safety will be required.

The nursing home (or assisted living facility) is a natural network to recruit and train family caregivers as NAs. Furthermore, nursing homes have the multidisciplinary staff that is currently required to meet the modest training requirements for family members who wish to become NAs.

Using family caregivers as NAs could have several advantages aside from alleviating a shortage of NAs. Foremost, the strategy would employ workers who are marginalized by the very fact of having a chronically ill loved one. Also, although there is no evidence to support the idea that this solution would improve patient care, family members in a nursing home would temper the depersonalization of residents by staff.

References

- Dostalick ET AL Management Consultants. 2001. In Their Own Words: Pennsylvania's Frontline Workers in Long Term Care. Harrisburg, PA: Pennsylvania Intra-Governmental Council on Long Term Care.
- Frank, B., and S.L. Dawson. 2000. Health Care Workforce Issues in Massachusetts. Boston: Massachusetts Health Policy Forum.
- Irvine, D.M., and M.G. Evans. 1995. Job satisfaction and turnover among nurses: Integrating research findings across studies. *Nursing Research* 44 (4):246-253.
- Straker, J., and R. Atchley. 1999. Recruiting and Retaining Frontline Workers in Long Term Care: Usual Organizational Practices in Ohio: Scripps Gerontology Center, Miami University.
- Williams, M.W. 2001. Reversing decades long trend, Americans retiring later in life. *New York Times*, Feb 26, 2001, A1, A13.
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IMAGINING THE FUTURE OF LONG-TERM CARE

How might the job description we posed in the introduction change if some of the proposals we offer were implemented? Consider the following job advertisement:

WANTED: Someone to help frail older persons maintain their quality of life. Entry-level job with possibility of advancement within the position or scholarships and training available for other health-related employment. Pay scales start low but with substantial increases as skills are acquired and with seniority. The work is hard but negative aspects, such as the handling of bodily wastes and dealing with demented individuals who may be abusive or unresponsive, are balanced by numerous advantages. Families and clients able to respond are appreciative. Supervisors regularly report on client progress documenting how the care provided benefits to its recipients. Advanced lifts and assistive devices minimize heavy lifting. Long-term care is increasingly using advanced technology and this job can combine your interest in helping people with exposure to cutting-edge caring methods.

Our Vision for the Future

Over the past year, this workgroup has spent many hours considering the state of long-term care in Minnesota and the challenges of assuring an adequate workforce for the future. Most of our time was spent discussing what is wrong and listening to people relate their problems and horror stories. Their frustration and pessimism often became ours. While some of our informants were optimistic and enthusiastic, these people were in the minority. People working on specific reforms fell into both categories. What seemed to divide their responses was attitude: people who were optimistic had a vision of a better future for long-term care and viewed their efforts as movement toward realizing that future.

Although our primary focus has been to advance change by providing and promoting a limited number of practical, short-term recommendations, it is also important to fit these recommendations into a larger vision of what the long-term care system in Minnesota could (and should) be in the future. Imagining this future is challenging, but essential, if these small steps are to be part of a larger reform. Although there is much disagreement among the various constituencies of long-term care about the specifics of reform, there is general agreement that without major changes the outlook is dismal.

Long-term care in Minnesota is becoming more diverse, with both public policy and private development fueling a transition from a system dominated by nursing homes to one that includes more funding for community-based services such as home care and assisted living. As this

transition occurs, staffing needs will also change. For this reason, the discussion of the future focuses less on nursing homes than the discussion of the current situation, which constitutes the majority of the report.

In our vision for the future, all long-term care settings would be better places to work and to live. Changes to improve working conditions, even if driven more by concerns over staffing issues than by quality of care, will benefit nursing personnel as well as those elders who require care. Working conditions is a broad term, encompassing compensation, physical space, supervision, as well as the specific tasks that must be accomplished. In our vision for the future, all these elements would change, reflecting our belief that there is no one solution to workforce issues in long-term care.

First and foremost, for long-term care to attract and retain a quality workforce, wage structures need to be revisited. In the future, frontline workers (such as nursing assistants and home health aides) would be paid a living wage; no one would be paid at rates that maintain many in poverty. The pay rates and benefit packages would be in accord with what other workers with similar skills are paid, both in other components of health care and in other fields. Pay scales would also reward longevity as well as the acquisition of skills or knowledge. Professional nurses' salaries would be competitive with those paid by hospitals and would reflect the amount of supervision and oversight they provide rather than the comparatively low acuity of their residents or clients. Better pay and benefits will have been instrumental in transforming long-term care and

securing a competent workforce but not sufficient; other changes will have been needed to assure adequate staffing in long-term care.

The nonwage components of working conditions would also be very different in our vision of the future. New and renovated physical plants would provide more space, better light, and the tools workers need. In nursing homes, rooms would be designed to make resident privacy easier (either single rooms or Y-shaped doubles) and include space for supplies and medications. Adaptive and assistive features (such as grab bars, appropriate switches, outlets, door handles, and step-free baths) would be available and incorporated into structures. Nursing homes, assisted living facilities, and home care would use monitoring technologies that assure safety. Employees would have spaces (locker rooms, break rooms, work stations) that are pleasing and reflect their value to their organization. The physical plants would be designed to incorporate communications and information technologies, whether this means wiring, other hardware, or space.

Even more important would be the less tangible aspects of the working conditions. For long-term care to attract and retain good workers, these workers need effective supervision and support. Better long-term care in the future depends on better managers. Future directors of nursing and administrators would be trained as effective supervisors and given feedback and additional training as needed. They would know how to communicate with the frontline workers about tasks and job performance. They would identify skill deficiencies and arrange training. Directors of nursing and other supervisors would be given the autonomy and power needed for this, yet they would still be supported by their organizations. In essence, good supervision and support of staff at all levels would be a core element of the organizational culture. Information systems would give the line workers a better sense of the effects their care was having on the lives of the residents in their charge, both over the long-term and even over each shift.

The tasks that nursing staff perform would also be altered in our vision for the future. Nurses would spend a small portion, rather than the majority, of their time on paperwork, thereby leaving more time for direct care and supervision of aides. Complete records and treatment protocols would be available at the bedside or the home and telemedicine would allow nurses to consult with other professionals as necessary. All

staff would spend more time on rehabilitation and restoration with the goal of encouraging independence.

In the future, all levels of staff will have been through training programs that provide them with the specific skills needed to care for frail and demented elders. Training would not end once a person is employed, but be ongoing and provide all levels of staff opportunities to acquire new skills or address specific problems. Training would become part of the career path and workers would have opportunities to advance. Scholarships and loan forgiveness programs would allow workers to pursue degrees in nursing or other health care professions. Graduate professional schools in health and human services programs would view long-term care experience favorably and give priority to applicants with this experience. Workers who choose to go into other fields would also be eligible for tuition assistance and provided training opportunities. Competencies would be established at the workplace to allow advanced placement into academic training. Nursing assistants with longer tenure would have advancement options that include becoming mentors, unit leaders, or specialists in specific aspects of care.

Key to improved supervision, reconfiguring of tasks, and better training, will be the adoption of various types of information technology. As in other industries, technology will have transformed work in long-term care. New technology would make needed information and protocols easily available and accessible to all staff, including paraprofessionals. Nursing assistants could easily document any changes in status and communicate these to nursing staff. Equally, if not more importantly, data collection and management techniques must be able to demonstrate to those who work in this field, elders receiving care and their families, regulators, and the general public, that long-term care makes a positive difference in peoples' lives.

Given the changing demographics, the LTC workforce of the future will be far more diverse. As the traditional labor source for nursing personnel, women aged 25-54, dwindles, long-term care would have successfully cultivated other sources of labor including students and retirees. The New American populations in Minnesota would be an even more important source of workers than in the past, particularly for paraprofessional positions. Long-term care providers, in partnership with educational institutions, employment agencies, and other organizations, would step

up their efforts to recruit, train, and place New Americans in LTC positions and help assure their success in the workplace. Employers throughout the long-term care industry would adapt to a more culturally diverse workforce and assure that their workplaces are more sensitive, both in personnel and in organizational practice, to cultural differences. Flexible schedules, training opportunities, and employee support programs would all allow long-term care to successfully recruit and retain a diverse workforce.

These combined changes in working conditions and training and education would result in lower turnover and easier recruitment. While there may not be a surplus of workers, providers would be able to find qualified nurses and nursing assistants. A core of employees would stay with the same employer for five years and longer, while students and other employees would work for a year or two in long-term care and then move on to other jobs. With better information, support, supervision, and training, stress would be reduced among long-term care workers. Improvements in lifts and other devices would reduce the risk of injuries.

Over time, these changes would slowly transform the image of LTC work. Within health care, long-term care experience would be valued and staff could move among the different types of care providers (acute, ambulatory, and long-term care) without losing status. The general public would recognize the need for and value of LTC workers, and students would be encouraged to work or pursue careers in the field. Administrators and directors of nursing would be active in their professions and recognized as important members of the community. Advanced nursing and medical students without some LTC experience would be the exception rather than the rule.

While the image of LTC among workers and the general public would slowly evolve as working conditions improved and demand for care increased, a focused effort by providers, academics, and advocates to promote long-term care as a career, not just a job, is also important. With time, increased public interest and commitment to quality long-term will provide the public support that will allow long-term care providers to recruit and retain an adequate workforce for Minnesota.
