

# The Staffing Crisis in New York's Continuing Care System

*A Comprehensive Analysis  
and Recommendations*



March 2000

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## EXECUTIVE SUMMARY

### Overview

This report provides evidence to support the fact that continuing health care providers are facing a crisis with respect to shortages in the health care labor workforce. Demographic data strongly indicate that health care providers, despite all best efforts to recruit and retain staff, are encountering serious difficulties in maintaining the levels of personnel required to furnish quality care to individuals receiving continuing care from nursing homes, home health care agencies, adult care facilities, assisted living facilities and other programs. This crisis is symptomatic of labor shortages in general, and reflects a variety of circumstances, including the fact that unemployment is at a 30-year low in our state and, indeed, the nation.

In addition to overall employment trends, multiple and complex factors are specifically contribute to the staffing crisis in continuing care, including the following:

- the growing need for continuing care services;
- supply and demand for qualified job applicants;
- federal immigration policy;
- competition among employers;
- workload and working conditions;
- employee turnover;
- wages and benefits;
- inadequate third-party reimbursement rates;
- social supports such as dependent care and transportation; and
- opportunities for education, training and career mobility.

This report also describes aggressive efforts undertaken by NYAHSa to address these shortages. NYAHSa has taken the lead on this issue, involving many stakeholders including regulators, legislators, and other parties. In addition, the report includes the results of NYAHSa's staffing surveys, and explains our opposition to proposed mandated staffing levels, recognizing that these levels represent a singular, limited, impractical and ineffective approach to the staffing crisis at hand. Alternatively, we propose strengthened regulatory language that would require nursing homes to establish appropriate master staffing levels based on residents' needs.

This document also provides details on other specific recommendations in the following key areas:

- the need for a funded system to allow health care providers to obtain criminal background information on prospective employees;
- funding sources needed to recruit, retain, provide transportation, offer dependent care, and other elements critical to optimizing providers' abilities to maintain sufficient numbers of staff;
- a series of workforce development initiatives aimed at expanding the supply of qualified job applicants;
- the need for enhanced training, education and career ladder opportunities;
- scope-of-practice issues which currently limit providers' abilities to most effectively and efficiently utilize staff; and
- a variety of research initiatives to study workforce shortages and the efficacy of various interventions.

### Charges to New York State Lawmakers

This report makes a number of recommendations to alleviate continuing care workforce shortages. We are asking state lawmakers to:

1. Reject legislation calling for mandated staffing levels.
2. Define "health worker shortage areas" or modify existing similar definitions to target state and federal funds toward recruitment and retention initiatives for professional and paraprofessional workers in continuing care.

3. Raise the income level for qualifying workers/families used for recruitment and retention initiatives through the Temporary Assistance to Needy Families (TANF) program to at least 200 percent of the federal poverty level. The final amount selected should take into account the prevailing wages for paraprofessional and professional continuing care employees throughout the state.
4. Include funding in the 2000-01 state budget to support a range of recruitment and retention initiatives including, but not limited to, child/elder care, education/training and transportation assistance. These initiatives could be funded through Medicaid using the workforce recruitment and retention grants model used during the nursing shortage of the late-1980s.
5. Restore previous cuts in Medicaid funding and increase state payments to adult care facilities (ACFs) to provide continuing care providers with additional resources to recruit and retain staff.
6. Closely monitor wage adjustment legislation in other states. Based on the results achieved in other states, consider instituting similar programs in New York state.
7. Expand the governor's proposed \$2 million "Hospital Wage Subsidy and Skills Training Demonstration" program to include workers in continuing care settings. Alternatively, explore using other TANF funds to target wage subsidies for continuing care shortage occupations.
8. Broaden the New York Health Care Reform Act of 2000 (HCRA 2000) health insurance initiative for uninsured home care workers to include all counties of New York state and other uninsured workers in continuing care settings.
9. Direct the New York State Department of Health and the New York State Department of Insurance, respectively, to give priority to applications involving continuing care organizations for the HCRA 2000 health workforce retraining and small employer health insurance initiatives.
10. Provide increased state funding to support dependent care initiatives including child care subsidies or vouchers for low-income workers, construction of new child care centers, social model adult day care programs for elders of low-income workers, and tax incentives supporting elder-care services needed by these persons.
11. Provide state funding to subsidize employees' transportation costs and for the development of additional public transportation infrastructure.
12. Target funds to support the costs to continuing care employers of apprenticeship training programs, similar to those administered by the New York State Department of Labor (NYS DOL).
13. Provide funding for a loan forgiveness program modeled after the federal Nursing Education Loan Repayment Program.
14. Create a new scholarship program or target moneys through the state's tuition assistance program to help subsidize education in the nursing profession and other shortage health occupations.
15. Enact NYAHS legislation for health care organizations to obtain criminal background checks for prospective employees.
16. Channel moneys generated from nursing home and adult care facility (ACF) survey fines into provider staffing initiatives.
17. Provide for grants/grant-funded research to examine a series of issues related to continuing care worker shortages and recruitment/retention initiatives.

### **Charges to the New York State Department of Health (NYS DOH)**

We are asking NYS DOH to:

1. Consider revising regulations to require nursing homes to establish intended (as opposed to mandated) staffing levels.
2. Accelerate Medicaid reimbursement time frames for capital expenditures related to labor-saving technologies (e.g., mechanical lifts, etc.).

3. Aggressively pursue measures to streamline cross-training of certified nurse aides (CNAs), home health aides (HHAs), and personal care aides (PCAs), and encourage demonstrations/pilots for such programs.
4. Revise aide training programs to include such areas as dementia care and dealing with patient/resident behaviors, teamwork and relationships with co-workers and family members, time and stress management, communication skills, occupational risk management, and cultural competence. Reimburse providers through Medicaid for any additional training costs resulting from these revisions.
5. Support federal revisions to the nurse aide training program to allow nursing students who have completed the equivalent of 100-hour training program to work as CNAs.
6. Support revision of federal regulations which currently prohibit nursing homes cited with any substandard quality-of-care survey deficiencies (even when unrelated to the CNA training program) to continue to conduct their own CNA training.
7. Revise state regulations to establish a certified nurse aide advanced (CNAA) level and corresponding scope of duties/educational curriculum.
8. Advocate for federal changes to allow for nutrition/hydration assistants in nursing homes (see Appendix 2).
9. Examine the possibility of work redesign within continuing care settings.
10. Work with the New York State Education Department on the initiatives outlined below.

### **Charges to the New York State Education Department (NYS ED)**

We are asking NYS ED to:

1. Re-examine all scope-of-practice issues posing unnecessary restrictions on providers and impediments to establishing career ladders.
2. Establish expanded opportunities for health and continuing care vocational training and/or work/study programs in the state's high schools.
3. Implement measures to assure inclusion of elder-care curricula/clinical rotations in nursing education programs.
4. Promote the inclusion of paraprofessional (i.e., CNA, HHA) training curricula into all nursing education programs in order to assure that all schools of nursing are approved training sites.
5. Work to improve the diversity of the workforce by promoting continuing care careers to racial and ethnic minority students during the secondary educational process.

### **Charges to the Federal Government**

We are asking the federal government to:

1. Reject legislation calling for mandated staffing levels.
2. Define "health worker shortage areas" or modify existing similar definitions to target federal funds toward recruitment and retention initiatives for professional and paraprofessional workers in continuing care.
3. Restore previous cuts in Medicare funding to provide continuing care providers with additional resources to recruit and retain staff.
4. Ensure that the Medicare prospective payment systems include skilled nursing facility-based and home health agency-based geographic wage adjustments, in lieu of the hospital wage index.
5. Create tax incentives to support continuing care employees who care for elders in their own families.
6. Revise federal law to allow nursing students who have completed the equivalent of the 100-hour nurse aide training program to work as CNAs.
7. Revise the requirement prohibiting nursing homes cited with any substandard quality-of-care deficiencies (even those unrelated to the CNA training program) from conducting their own CNA training.

8. Revise federal requirements, as necessary, to establish a certified nurse aide advanced (CNAA) level and corresponding curriculum.
9. Enact H.R. 5, the “Social Security Earnings Test Elimination Act,” into law this year.
10. Reconsider current restrictions on employment-based immigration to increase the supply of candidates for professional and paraprofessional positions in continuing care.
11. Enact legislation that would allow for nutrition/hydration assistants in nursing homes (see Appendix 2).
12. Examine the possibility of work redesign within continuing care settings.
13. Provide for grants/grant-funded research to examine a series of issues related to continuing care worker shortages and recruitment/retention initiatives.

## INTRODUCTION

The New York Association of Homes and Services for the Aging (NYAHSA) represents more than 560 not-for-profit continuing care providers located throughout New York state. NYAHSA members provide a full spectrum of continuing care to an estimated 500,000 elderly, disabled and chronically-ill New Yorkers each year. Over the last couple of years, many of our members have experienced growing difficulties maintaining their staffing levels, particularly clinicians such as certified nurse aides (CNAs), home health aides (HHAs), and licensed/registered nurses. Shortages in the health care workforce are critical in many areas of New York state.

This report provides evidence to support the fact that continuing health care providers are facing a crisis with respect to shortages in the health care labor workforce. The available data strongly indicate that health care providers, despite all best efforts to recruit and retain staff, are encountering serious difficulties in maintaining the levels of personnel required to furnish quality care to individuals receiving continuing care from nursing homes, home health care agencies, adult care facilities, assisted living facilities and other programs.

This crisis is symptomatic of broader labor shortages in New York state and throughout the country affecting many employers and occupations. These shortages reflect a variety of circumstances, including the fact that unemployment is at a 30-year low in our state and, indeed, the nation.

In addition to overall employment trends, multiple and complex factors are specifically contributing to the staffing crisis in continuing health care, including the following:

- the growing need for continuing care services;
- supply and demand for qualified job applicants;
- federal immigration policy;
- competition among employers;
- workload and working conditions;
- employee turnover;
- wages and benefits;
- inadequate third-party reimbursement rates;
- social supports such as dependent care and transportation; and
- opportunities for education, training and career mobility.

Although labor shortages are a pervasive and overriding concern for the overall economy, they pose particular problems for continuing health care. To put this in perspective, under-staffing at the neighborhood convenience store or restaurant can inconvenience retail customers. Staffing shortages in continuing care facilities and agencies can have a direct impact on the quality of life and well-being of vulnerable elderly and disabled persons who are dependent on these services. For this reason, staffing shortages in continuing care are a public health issue that demands special attention. Karl Pillemer, a prominent researcher from Cornell University, poignantly stated the issue in a recent presentation:

*"I would like you to imagine for a moment that I am standing before you and stating that New York's heavy industry is no longer able to operate because of a major shortage of steel, or that I am here telling you that New York's farmers can no longer grow food because there just aren't enough seeds. In either of those two scenarios, I believe we would, very appropriately, panic. No stone would be left unturned to solve these crises. What I am here to report today is nearly as urgent as my two imaginary cases. The long term care system in New York, and nationally, is running out of its most important resource: people. Because of the inability to find and retain qualified workers, our elderly and disabled citizens are being placed in jeopardy every day, and everywhere in the state."*<sup>1</sup>

Clearly, the staffing shortage in continuing care is a public health issue that demands immediate and decisive action. The breadth and scope of the problem calls for a range of short-term and long-range solutions to ensure high quality continuing health care to our state's dependent residents.

NYAHSA has taken on a leadership role to identify and work with others to address these shortages. In this process, we have reached out to many stakeholders including regulators, legislators, consumer and provider groups and other organizations. This report describes NYAHSA's staffing shortage initiative, identifies the scope of the problem and, most importantly, proposes a number of recommendations requiring a collaborative effort on the parts of all stakeholders to address the issue. It is a continuing work-in-progress, and will be periodically supplemented or otherwise modified when necessary as new information and/or strategies come to NYAHSA's attention.

## THE NYAHSA STAFFING INITIATIVE

NYAHSA has undertaken a concerted initiative with the goal of alleviating continuing care workforce shortages in New York state. This effort has taken a top priority within the association. Our approach has been comprehensive and has involved a broad range of stakeholders. The initiative has included the following activities:

- forming an internal NYAHSA staff task force which established the goals, processes and time frames for the initiative;
- forming a NYAHSA member-based task force which identified specific regulatory, legislative, and administrative measures that need to be taken to alleviate the labor shortage problem;
- conducting extensive research on relevant demographics, workforce trends, activities in other states, existing funding streams and potential staffing initiatives;
- conducting comprehensive member-based surveys on staff recruitment and retention;
- holding meetings with legislators, the commissioner of health and other New York State Department of Health (NYS DOH) officials, other provider associations, consumer and union representatives, researchers, and other organizations;
- drafting proposed legislation for establishing a funded system whereby health care employers can secure criminal background checks for prospective employees;
- advocating on the federal level for a new job classification, "nutrition-hydration assistants," in nursing homes;
- launching a periodical staffing newsletter, *S.O.S.—Scoop on Staffing*, which provides NYAHSA members with news on staffing trends, "best practices" and other practical information;
- developing and distributing public service announcements and op-ed articles on a statewide basis highlighting the positive aspects of the continuing care professions;
- dedicating an issue of NYAHSA's quarterly publication, *Communications Upbeat*, to describing a "day in the life" and the critical value of CNAs in the caregiving process; and
- developing a series of recommendations as described later in this report.

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<sup>1</sup> Dr. Karl Pillemer, remarks from a seminar entitled "The Current Crisis in Long-Term Care," Feb. 8, 2000, Albany, New York.

## BACKGROUND ON CONTINUING CARE PROVIDERS AND OCCUPATIONS

### Background on Continuing Health Care

Continuing health care, sometimes referred to as continuing care or long term care, is generally care for chronic conditions or those requiring rehabilitation which can be provided in a setting other than a hospital. A summary of types of continuing care providers—which include nursing homes, home health care agencies, adult care facilities and adult day care programs—is included as Appendix 1 to this document.

According to NYS DOH, there were 2,619 licensed or certified providers of continuing care services in New York state as of June 1, 1998. On average, these providers have an average daily census of over 300,000 individuals and over one million service encounters in any given year.

### Background on Occupations

In order to understand the problem of continuing care labor shortages, it is also important to understand the affected workforce and the roles of these workers. Following are brief descriptions of key paraprofessional and professional worker classifications.

**Certified nurse aides (CNAs)** provide the vast majority of direct personal care to nursing home residents. Working under the supervision of nursing and medical staff, nurse aides answer residents' call bells, deliver messages, serve meals, make beds, and help residents eat, dress and bathe. Aides also may provide skin care to residents, take temperatures, pulse and respiration, and blood pressure, and help them get in and out of bed and walk. They also observe residents' mental, physical and emotional conditions and report any change to the nursing and medical staff. Nurse aides who wish to work in a nursing home must complete an approved 100-hour New York state nurse aide training program, pass the clinical skills and written/oral nurse aide competency examination, and be listed in good standing on the New York State Nurse Aide Registry.

**Home health aides (HHAs)** carry out health care tasks in a patient's home under the supervision of a registered nurse or licensed therapist and may also provide assistance with personal hygiene, house-keeping and other related supportive tasks. Home health aides must successfully complete a basic training program (a minimum of 95 hours) in home health aide services or equivalent exam approved by NYS DOH.

**Personal care aides (PCAs)** provide patients assistance with nutritional and environmental support and personal hygiene, feeding and dressing and/or, as an extension of self-directed patients, select health-related tasks. PCAs are required to be under professional supervision by the home care agency. PCAs are certified at three different levels, with each successive level allowing the PCA to perform a broader scope of tasks.

**Licensed practical nurses (LPNs)** provide nursing care to patients under the direction of a registered professional nurse or licensed physician, dentist, or other licensed health care provider. They provide assistance to professional nursing and medical staff in such settings as a hospital, nursing home, physician's office, community health-care center, and rehabilitation facility. An LPN must be a high school graduate and have graduated from a practical or professional level nursing program registered by the New York State Education Department (NYS ED) or approved by the licensing authority in another state, territory, or possession of the United States as preparation for practice as an LPN, or determined by NYS ED to be the equivalent to such programs.

**Registered nurses (RNs)** provides general medical and nursing care and treatment to patients in such settings as nursing homes, hospitals, clinics, health centers and in the home. RNs may perform health assessments, do case management, provide health counseling, treat health problems, and execute medical regimens prescribed by a physician. An RN must have graduated from a nursing program at a college, university, or other institute whose program is registered by NYS ED or approved by a licensing authority of another state, territory, or possession of the United States as preparation for practice as a registered professional nurse, or be a graduate of a general nursing program of at least two years in length approved by the licensing authority of another country and acceptable to NYS ED.

## NYAHSA STAFFING SURVEYS

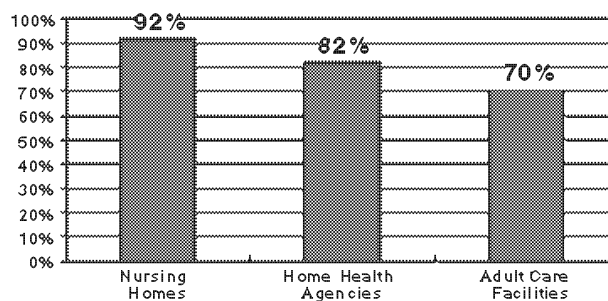
In 1999 and 2000, NYAHSA conducted two statewide provider surveys relating to staffing issues. This primary research played a critically important role in providing us with current information on the extent of staffing shortages and providers' attempts to respond to these shortages.

The first dealt with recruitment and retention of CNAs in nursing homes. It was conducted in collaboration with the New York State Health Facilities Association (NYSHFA) and the Healthcare Association of New York State (HANYS). Facilities were asked to answer survey questions reflecting activities for the one-year period of July 1, 1997 through June 30, 1998. Out of a total of 672 surveys sent to nursing home members of all three associations, the 250 returned surveys resulted in a 38 percent response rate. For ease of reference, this survey is hereinafter referred to as the "NYAHSA CNA survey."

To obtain data from a broader range of continuing care providers and occupational groups, NYAHSA conducted a focused telephone survey of a randomly selected stratified sample of its members in January 2000. A total of 86 providers participated in the telephone survey, encompassing most types of long term care organizations (i.e., nursing homes, home health agencies, adult care facilities and adult day care providers). This survey is hereinafter referred to as the "NYAHSA focused telephone survey."

The results of both surveys bear out the existing continuing care workforce shortages and confirm the underlying reasons for them. As indicated in Figure 1 below, NYAHSA's focused telephone survey of members reveals that most NYAHSA member nursing homes, home health agencies and ACFs are experiencing labor shortages.

**Figure 1. Percentages of NYAHSA Members Experiencing Labor Shortages**



Source: NYAHSA focused telephone survey, January 2000.

The NYAHS CNA survey shows that of those nursing homes reporting problems with recruiting CNAs, 66 percent express concern that the workforce is dwindling (or almost nonexistent, in some parts of the state) and the few workers remaining are of questionable quality or without the necessary training to succeed in the job.

Summaries of these surveys can be found in Appendices 3 and 4. Key results of these surveys are discussed throughout this report. NYAHS wishes to gratefully acknowledge the involvement of NYSHFA and HANYS in the administration and analysis of the CNA survey.

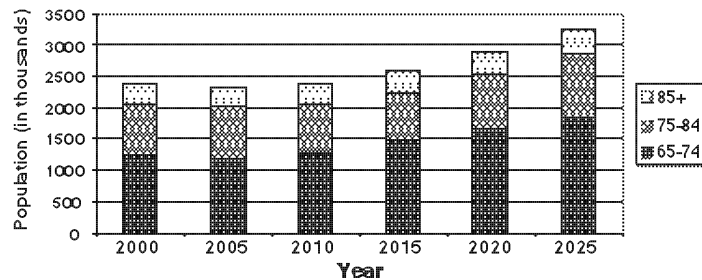
## THE GROWING NEED FOR CONTINUING CARE SERVICES

The demographics of aging have been well-publicized. According to the American Association of Retired Persons (AARP), the older population—persons 65 years or older—numbered 34.4 million persons in 1998, representing 12.7 percent of the U.S. population. The older population will continue to grow significantly in the future. By 2030, there will be about 70 million older persons in the United States, more than twice their number in 1998.<sup>2</sup>

Not surprisingly, elderly persons, particularly those who live alone or are otherwise vulnerable, are expected to dramatically increase the demand for continuing care and other health care services. According to the U.S. Census Bureau, 7.3 million Americans needed long term care services in 1994. The number is expected to be nine million this year, and to skyrocket to as many as 24 million by 2060. Of people 75 and older, 60 percent will need some form of long term care.<sup>3</sup>

New York state is not insulated from these broad demographic trends. Figure 2 below identifies the forecasted growth in the age 65+ population in New York state over the next several years. While the U.S. Census Bureau projects a modest decline in the overall number of New Yorkers aged 65+ until the year 2005, the 85+ population (the most frequent users of continuing care services) shows a steady increase over all years.

**Figure 2. Projected 65+ Population Growth by Age and Year, New York State**



Source: U.S. Census Bureau population estimates.

In 1998, New York had 2.4 million residents who were 65 or older, ranking it behind only California and Florida in this category. Based on NYS DOH estimates, over one million individuals received continuing care services from New York's nursing homes, adult care facilities, home care agencies and other community-based programs in 1997 alone. If this same usage rate were applied to New York's age 65+ population projections, this figure would grow to an estimated 1.35 million persons by 2025.

<sup>2</sup> *A Profile of Older Americans: 1999*, AARP and the Administration on Aging, U.S. Dept. of Health and Human Services, p. 2.

<sup>3</sup> *Nursing Homes* magazine, Oct. 1997.

## SUPPLY AND DEMAND FOR QUALIFIED JOB APPLICANTS

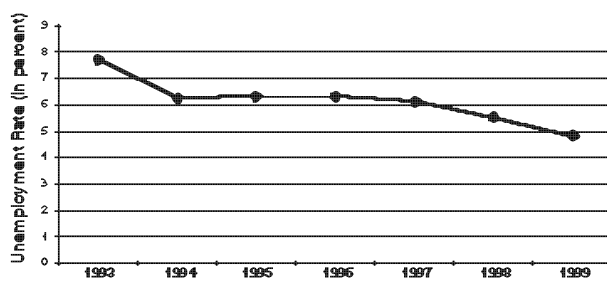
### Labor Market Trends

With the economy reaching the lowest unemployment rates in 30 years and the employed share of the adult population at an all-time high, one of today's primary concerns is labor shortages.<sup>4</sup> The nation's overall unemployment rate was 4 percent in January 2000, which was down from 4.3 percent one year earlier and 4.7 percent in January 1998, the lowest in almost 30 years. To illustrate the point further:

*"...even the broadest measure of available labor—including not just people who are officially unemployed but some part-time workers and others who might be tempted back into the labor market—has declined steeply, to 7 percent in September (1999) from 7.6 percent a year earlier. Joblessness among adults, 3.5 percent in October (1999), was near a three-decade low. Overall labor force participation is stagnant or down, and the growth of the labor force is slowing somewhat."<sup>5</sup>*

New York is part of this strong national trend towards full employment. According to the federal Bureau of Labor Statistics (BLS), New York's seasonally adjusted unemployment rate was 4.8 percent in December 1999, down from 5.4 percent one year earlier. Figure 3 illustrates the falling unemployment rate in New York state over the last five years.

**Figure 3. New York's Falling Unemployment Rate**



Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics for New York State. Figures are seasonally adjusted.

These trends are magnified in health care. The number of health care jobs has increased steadily since the 1950s—more than in any other comparable industry group—due to population aging, new technologies, and greater administrative requirements. Jobs in medical offices, clinics, and other organizations have grown rapidly as the health care sector tries to provide more services in less expensive ways.

Nationally, health-services employment is projected to increase by a staggering 3.2 million jobs between 1996 and 2006. During the one-year period ended December 1999, the numbers of persons working in nursing and personal care nationally rose by 3.7 percent, nearly double the overall growth rate for all non-agricultural employees.<sup>6</sup>

<sup>4</sup> Robert L. Lerman and Stefanie Schmidt, *An Overview of Economic, Social, and Demographic Trends Affecting the U.S. Labor Market*, The Urban Institute, Aug. 1999, p. 35.

<sup>5</sup> Richard W. Stevenson, "Hesitating at the Edge of a Shallow Labor Pool," *New York Times*, Nov. 12, 1999.

<sup>6</sup> "Nonagricultural Jobs by Industry," *New York State Employment Estimates*, Dec. 1999, New York State Department of Labor.

According to the New York State Department of Labor (NYS DOL), an estimated 840,900 individuals on payrolls were working in health services occupations in New York state as of the end of 1999. Based on 1997 payroll information, the U.S. Census Bureau estimated that New York's nursing homes and other facilities for the elderly employed nearly 136,800 individuals, and that 135,100 individuals were working in home health care. However, these payroll figures likely do not include workers from employment agencies, which anecdotal evidence suggests represent large numbers, nor do they include all employees in these health settings.

The occupational outlook for professional and paraprofessional nursing professions will be characterized by growing demand. According to BLS, the employment of RNs, LPNs, nurse aides and home health aides is expected to grow faster than the average for all occupations through the year 2006. In the case of RNs, this growth will create large absolute numbers of new positions, since RN is already the single largest health care professional occupation in the country with over 1.9 million jobs. The number of RN positions in nursing homes and home care is expected to drive much of this growth.

On average, nurses are becoming older without offsetting increases in nursing students. The average age of nurses nationally is 44 years, and "40 percent of the current crop of nurses will retire within ten years."<sup>7</sup> In the same article, Peter Berhaus of the Harvard University Nursing Research Institute states that "the nurse workforce is going to be aging itself out...and given the trend in demographics, it doesn't look to me that there is a hope to attract an adequate level of nurses for the future." According to a 1999 study by the American Association of Colleges of Nursing, bachelor's degree nursing enrollment fell by 4.6 percent nationally in 1999—the fifth consecutive year of declines. The largest percentage drop—7.4 percent—occurred in the northeastern region.<sup>8</sup>

Shortages of CNAs and HHAs, who provide an estimated 90 percent of all direct care to elderly residents in nursing homes and home care settings, are also expected to rise. According to BLS, job prospects for nurse aides will be good because of "fast growth and high turnover in this large occupation."<sup>9</sup> From 1996-2006 the number of aides needed nationally is anticipated to increase by 76 percent. Ninety-three percent of aides are low-income females, and 30 percent are black, Asian or Hispanic.

In New York state, the projected growth in demand for health care workers exceeds anticipated growth in other occupational groups. Information from the NYS DOL indicates that while the number of total jobs in all occupations will grow by about seven percent from 1996 to 2006, total jobs in health service occupations (which include CNAs and home health aides) will grow by 19.4 percent.<sup>10</sup>

### **Demographic Trends in the Workforce**

The fundamental imbalance in the supply and demand for health care workers is due, in part, to broad-based demographic trends. Changes in the state's and nation's populations are cited as significant contributing factors to shortages in the health care workforce. Among the more prominent of these demographic changes are: (1) migration patterns; (2) the aging workforce; (3) changes in the family circumstances of working age persons; and (4) increased racial and ethnic diversity.

For example, during the period 1990-1999, while New York state ranked second among the 50 states in population growth from international migration, it ranked 49<sup>th</sup> in net domestic migration. Nearly 1.9 million persons left New York for other states during this period.<sup>11</sup> Anecdotally, much of this out-migration occurred from upstate urban areas. This dynamic obviously impacts the available workforce required to meet the continuing care needs of a growing elderly and disabled population.

<sup>7</sup> Chris Schreiber, *Aging Today*, Vol. XX, No. 6, Nov./Dec. 1999, reprinted from *Nurse Week*.

<sup>8</sup> "Nursing School Enrollments Decline as Demand for RNs Continues to Climb," press release from the American Association of Colleges of Nursing, Feb. 17, 2000.

<sup>9</sup> 1998-99 *Occupational Outlook Handbook*, Bureau of Labor Statistics, U.S. Department of Commerce.

<sup>10</sup> *Occupational Outlook*, New York State Department of Labor.

<sup>11</sup> ST-99-2 State Population Estimates and Demographic Components of Population Change: April 1, 1990 to July 1, 1999. Source: Population Estimates Program, Population Division, U.S. Census Bureau, Washington, D.C.

The combination of more retirees and fewer workers will contribute to the labor shortage, and have other major economic consequences. In 1950, there were seven working age persons for every elderly person in the nation. By 2030, this ratio will be less than three to one.

Between the years 2000 and 2015, New York state's labor pool—workers aged 16-64—is projected to grow by 589,000 people (5.1 percent) to 12,246,000. This increase is heavily concentrated at the outer edges of the age spectrum, among the youngest and oldest workers. By contrast, the number of working persons in the middle years (ages 25-35, 35-44, and 45-54) will grow slowly or may even decline. This trend mirrors national population projections. During the same time period, the oldest component of New York's working-age population will expand substantially, rising by 933,000 or 23 percent. By the year 2015, these individuals will make up 19 percent of the working age population, up from 14 percent in 2000.<sup>12</sup>

Older workers could play a significant role in the provision of health care. Indiana's Purdue University developed a 200-hour curriculum for older workers and found that older workers were more likely to be reliable, have higher job satisfaction and be less likely to leave after a short time.<sup>13</sup> However, they represent a largely untapped resource due to a number of outdated policies, both private and public, that encourage retirement instead of continued employment. The demand for employment services by older workers will increase as the baby boom generation ages over the next 20 years. Nationally, the number of persons in the workforce who are aged 55 plus is projected to increase by 32.9 percent from 1995 to 2005.

The increasing number of mothers in the workforce is creating time conflicts for many families. Families are trying to find alternative ways to do the work traditionally done by the "stay-at-home" mother. Some of this work is taken up by other family members, some is purchased from third parties (day care workers, housekeepers, take-out restaurants, accountants, and the like), and some is simply left undone.

The proportion of working mothers with children under six rose even faster than the proportion of all women in the workforce. In 1998, almost three out of four women with children were in the workforce, though growth in the percentage of mothers with young children who worked had begun leveling off in the early 1990s, as did the growth for all women. Between 1969 and 1996, the number of married working women with children increased by 84 percent. By 1998, two-thirds of all mothers in married-couple families were employed.<sup>14</sup>

Masked in these other demographic changes are additional details of race and ethnicity. Immigration trends, coupled with varied birth rates, will bring more diversity to the American workforce. In 1995, the United States was estimated to be 83 percent white, 13 percent black, 1 percent American Indian, Eskimo, and Aleut, and 4 percent Asian and Pacific Islander.<sup>15</sup>

Figure 4 below depicts how the U.S. population is projected to change over time in terms of race and ethnicity. Clearly, the future racial and ethnic makeup of America will be considerably different than it is today. By 2050, the U.S. population is expected to increase by 50 percent, and minority groups will make up nearly half the population. Immigration will account for almost two-thirds of the nation's population growth. One-quarter of all Americans will be of Hispanic origin. Almost one in ten Americans will be of Asian or Pacific Islander descent.

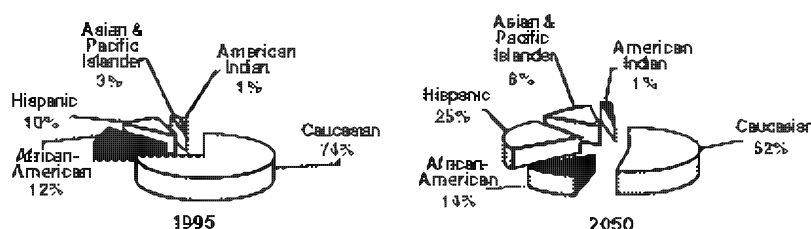
<sup>11</sup> ST-99-2 State Population Estimates and Demographic Components of Population Change: April 1, 1990 to July 1, 1999. Source: Population Estimates Program, Population Division, U.S. Census Bureau, Washington, D.C.

<sup>12</sup> "Composition of Working Age Population to Change," New York State Department of Labor, *Employment in New York State*, June 1999.

<sup>13</sup> Jennifer R. Salmon, et al., Dec. 15, 1999, p. 6.

<sup>14</sup> Hayghe, p. 42 and BLS Press Release, "Employment Characteristics of Families in 1998," <http://www.bls.gov/news.release/famee.toc.htm>, May 25, 1999.

<sup>15</sup> Jennifer Cheeseman Day, "Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050," U.S. Bureau of the Census, *Current Population Reports*, U.S. Government Printing Office, Washington, D.C. 1996; Feb. 1996, p.1.

**Figure 4. U.S. Population by Race/Ethnicity: 1995 Actual and 2050 Projected**

Source: U.S. Census Bureau data.

New York state's racial and ethnic makeup is changing even more dramatically than that of the nation. The U.S. Census Department projects that by 2025, non-Hispanic whites will comprise 53.4 percent of New York's population, down from 66.6 percent in 1995, representing the largest numerical decrease of any of the 50 states.

## IMMIGRATION POLICY

According to the American Immigration Lawyers Association, employment-based immigrants into the United States total 140,000 nationally each year. These are primarily skilled professionals with advanced abilities and other priority workers, immigrating to jobs for which U.S. Department of Labor has certified that no qualified U.S. worker is available.

The United States has enacted a number of immigration laws, with the Immigration and Nationality Act (INA) of 1952 being the country's basic immigration law. Among a number of significant amendments are 1965 changes which eliminated the natural origin provisions and implemented a new quota system, and the Immigration Act of 1990 which revamped the INA. The Immigration Act of 1990 has been seen by many as a barrier to bringing in individuals to fill health care employment vacancies in the United States, particularly in paraprofessional positions.

Experts have argued that the answer to the critical labor shortage is legal immigration. The President and Chief Executive Officer of the U.S. Chamber of Commerce, Thomas Donohue, supports this. In a 1999 speech in Nashville, Tennessee, he said that the economy would need 52 million new workers in the next ten years, and 30 million of them must come from sources other than the existing workforce, including immigration.<sup>16</sup>

Home care is currently classified as unskilled labor, resulting in waits of 10 to 15 years for work permits. The Committee of the New York Women's Bar Association proposed a new category of visas that would allow temporary employment of foreign home care workers when employers are able to certify that U.S. workers are unavailable. Under this proposal, home care work would be reclassified as skilled labor.<sup>17</sup>

According to the American Association of Homes and Services for the Aging, continuing care providers in many states are beginning to import limited numbers of workers, and are using third-party agencies to assist them in these efforts. Most imported workers are coming from the Philippines, Guam, the U.S. Virgin Islands or the Caribbean. Both nurse aides and nurses are being recruited in this way.

<sup>16</sup> Thomas Donohue, speech to the Tennessee Association of Business, Feb. 23, 1999.

<sup>17</sup> Mary Ann Wilner and Ann Wyatt, "Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long Term Care," conference paper prepared by AARP, Sept. 1998.

## COMPETITION AMONG EMPLOYERS

Continuing care providers directly compete for labor with retail businesses and industries, food service establishments and other service businesses, to name a few. A 1996 study of 250 nursing homes in ten states showed an average turnover rate of 32 percent in a six-month period. The factor that had the strongest effect on job turnover rates was the local economy—rates were higher in geographic areas where aides had more employment opportunities.<sup>18</sup>

In NYAHS's focused telephone survey, providers cited competition with other health care providers and local businesses as the primary reason for labor shortages. Employers other than continuing care providers are also facing supply-side labor shortages, particularly in paraprofessional service positions.

Employers in general are using a number of strategies to address workforce shortages. Among the most common are the following:

- improving recruitment by advertising positions, using employment agencies, reaching wider geographic areas and paying recruiting bonuses to employees;
- increasing overtime and converting part-time to full-time work;
- restructuring work in ways to adapt to the available workforce;
- substituting technology and other labor-saving devices for labor;
- expanding the supply of qualified workers through increased training;
- improving working conditions; and
- improving wages and benefits.

When NYAHS polled members during its focused telephone survey, approximately 90 percent of respondents reported having either implemented new strategies or enhanced existing measures in 1999 to better recruit and retain workers.

## WORKLOAD AND WORKING CONDITIONS IN CONTINUING CARE

Difficult working conditions in continuing care contribute to labor shortages. Working in nursing homes and for home health agencies requires specialized characteristics including the desire to care for others, compassion, patience, tolerance, and good communication skills in addition to the specific task-related, technical health care aspects of the work. The jobs are demanding, often requiring weekend, evening, holiday, night, and overtime hours. Clients may be disoriented or difficult, and present behaviors that are stressful to caregivers. These factors often make continuing care a less desirable place to seek employment compared to other businesses. The NYAHS's focused telephone survey results bear this out, with the work environment being reported as a top reason for retention difficulties.

Unlike private industry—where the injury and illness rate among employees has been stable or has declined since 1980—the rates for hospitals and nursing homes have increased by 52 percent and 62 percent, respectively. On-the-job injuries, such as back and needle stick injuries, are on the rise. Back injuries are a problem for nurse aides in nursing homes, who are called upon to do heavy lifting. According to 1996 data from the NYS DOL, the category of “nursing aide/orderly” had the most injuries and illnesses with days away from work of any occupation among private industry workers.<sup>19</sup>

Home health aides are also very susceptible to injuries on the job from falls and overexertion. Mechanical lifting devices available in institutional settings such as nursing homes are usually not available in clients' homes.

Nurses and aides are also exposed to minor infections and major illnesses such as influenza, hepatitis and HIV/AIDS, but are able to avoid infections by following proper exposure control methods. The pa-

<sup>18</sup> Jane Banaszak-Holl and M. A. Hines, “Factors Associated with Nursing Home Staff Turnover,” *The Gerontologist*, 1996, Vol. 36, No. 4.

<sup>19</sup> New York State Department of Labor, “Work Injuries and Illnesses resulting in Lost Worktime, Private Industry, New York State, 1996.”

tients they care for may be disoriented, angry, abusive, irritable or uncooperative, and the work can be emotionally draining in addition to physically demanding. Also, injuries that result from violence directed toward health care workers appear to be increasing.

Poor public perceptions of continuing care providers and caregivers contribute to the problem. The current heightened scrutiny on nursing homes, accompanied by a highly stringent surveillance environment, makes nursing home employees, in particular, vulnerable to criticism and being held to an exceptionally high set of standards. Negative media publicity further portrays nursing homes as an undesirable place in which to work or live.

## EMPLOYEE TURNOVER

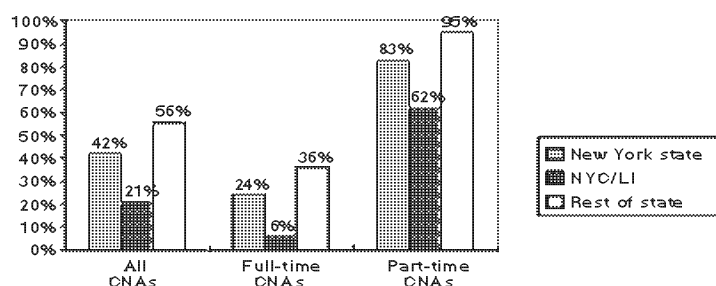
High employee turnover is a formidable barrier to ensuring high quality services in continuing care settings. While exact figures on job turnover are difficult to obtain due to variations in employee records and measurement techniques, statistics point toward high rates of turnover among paraprofessionals in particular.

A 1999 survey sponsored by the Business Council of New York State reveals that retention is a serious issue for the state's employers. According to the study, the health care profession has the highest turnover rate of 22.2 percent. The respondent pool included several hundred New York state businesses, and excluded retail stores and farms.

Annual turnover rates of nursing home aides are quoted at 105 percent in the research.<sup>20</sup> As for turnover rates for home care, various studies show rates of 40 percent to 60 percent in one year and 80 to 90 percent in two years. A more recent study in Ohio shows home care turnover rates ranging between 57 to 133 percent.<sup>21</sup> This same study reveals that actual turnover rates may be much higher than those reported based on poorly maintained data and incorrect calculations of turnover.

NYAHSa's focused telephone survey shows that 55 percent of nursing homes polled and 45 percent of home health agencies report retention difficulties. Top reasons cited for this problem were the working environment, wages and benefits, termination and family issues. As indicated in Figure 5 below, respondents to NYAHSa's CNA survey report that turnover is a serious issue for them. Our analysis of the survey reveals that average CNA turnover rates during 1997-98 were significantly lower for the New York City/Long Island (NYC/LI) region than the average for all other areas of the state.

**Figure 5. Reported 1997-98 CNA Turnover Rates in New York State**



Source: NYAHSa CNA survey, 1999.

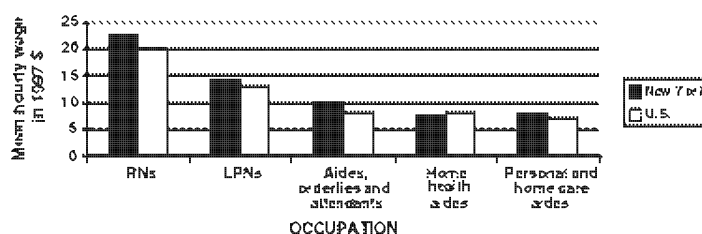
<sup>20</sup> Mary Ann Wilner and Ann Wyatt, "Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long Term Care," conference paper prepared by AARP, Sept. 1998.

<sup>21</sup> Jane Karnes Straker and Robert Atchley, "Recruiting and Retaining Frontline Workers in Long-Term Care: Usual Organizational Practices in Ohio," June 1999.

## WAGES AND BENEFITS

Wages and employee benefits have a definite bearing on providers' ability to recruit and retain qualified workers. Figure 6 below compares the mean hourly wages offered for RNs, LPNs, nursing aides, orderlies and attendants, home health aides, and personal and home care aides in New York state versus the nation. With the exception of home health aides, average hourly wages in 1997 tended to be higher in New York than the nation as a whole.

**Figure 6. Professional and Paraprofessional Wages, New York vs. U.S.**



Source: U.S. Department of Labor, 1997 Occupational Employment Survey.

The RN and LPN categories include wages paid for these professionals in settings that tend to pay higher wages than continuing care providers (e.g., hospitals, doctors offices, etc.). The category "nursing aides, orderlies and attendants" includes hospital personnel in addition to CNAs. The available information suggests that, on average, hospitals pay higher wages to these individuals than do nursing homes. Importantly, the above hourly wages do not reflect changes that have occurred in wage scales since 1997 in response to worker shortages in New York and other parts of the country.

We could not locate comparable data on employee fringe benefits at the occupational level. According to the Economic Policy Institute, an estimated 22 percent of the 1.8 million continuing care workers in the country are uninsured.

During the NYAHSAs focused telephone survey, members reported the inability to provide competitive wages and benefits as a primary obstacle to staff recruitment and retention. A Florida study revealed that salary is the least satisfying aspect of CNA work and that a direct correlation exists between salary, pensions, and health benefits and job tenure.<sup>22</sup> The NYAHSAs CNA survey reveals that 55 percent of the 250 respondents had made an increase in some aspect of the CNA wage scale. Home health agencies and ACFs that responded to the NYAHSAs focused telephone survey cited employee benefits as a major reason for staff shortages.

The New York Health Care Reform Act of 2000 (HCRA 2000) included a \$58 million pool to make health care insurance more widely available, but only to home care employees in New York City and Nassau and Suffolk counties. Other areas of the state are ineligible for the grants. The payments are made to qualifying home care agencies as Medicaid rate enhancements. Eligible workers include personal care and home health care workers whose employment is irregular, episodic or cyclical, and whose health care coverage is frequently disrupted.

HCRA 2000 also includes provisions that will assist small businesses in providing health care benefits to their employees. Under this initiative, businesses with 50 or fewer employees can apply to the state to receive insurance premium subsidies for a streamlined benefit package from a managed care organization.

<sup>22</sup> Jennifer R. Salmon, et al., Dec. 15, 1999, p. iii.

The employer must pay at least 50 percent of the premium for the employees and the state will contribute the balance. Under the plan, the state will provide stop-loss coverage to the managed care plan by paying claims above certain dollar thresholds from these employees. Covered health care benefits will include inpatient and outpatient services, emergency services, pharmaceuticals, and preventative services for both the employee and immediate family members. Beginning Jan. 1, 2001, all health maintenance organizations within New York state must participate in this program.

## INADEQUATE THIRD-PARTY REIMBURSEMENT RATES

A provider's capacity to offer competitive wages and benefits is determined, in large part, by the adequacy of its patient care revenues. Continuing care is labor-intensive; typically, 80 percent or more of total costs is related to staff compensation, the vast majority of which is for direct-care workers. As a result, increases in wages and benefits for professional and paraprofessional workers can have a major effect on providers' budgets, particularly if they are not recognized by major payers.

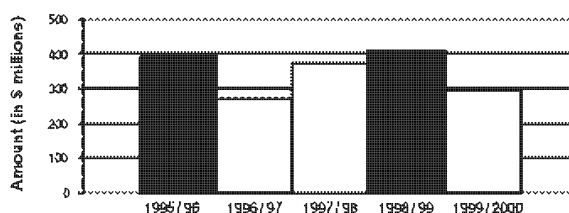
The major third-party payers—Medicaid and Medicare—are responsible for 80-90 percent of all patient care reimbursements to nursing homes and home care agencies. For nursing homes, Medicaid and Medicare pay for the care of approximately 80 percent and 10 percent, respectively, of all residents. While Medicaid is also the dominant payer for home care services, Medicare plays a greater role on a percentage basis.

Medicaid and Medicare are utilizing "pricing" systems for nursing home and home health services to save money and for other reasons. Under these systems, the payment amounts for services are pre-determined and inflation proxies are used to adjust for increases in input prices. Therefore, increases in providers' costs for staffing and other areas are not automatically reflected in payment rates. After years of government cutbacks, payment rates in these programs are inadequate to support the costs of maintaining adequate direct-care staffing and other operating expenses.

To further illustrate this point, previously-released NYAHSa analysis revealed that over 70 percent of all nursing homes received below-cost reimbursement from Medicaid in 1995, producing a total estimated statewide loss of \$211.8 million.<sup>23</sup> Medicaid was already paying less than actual nursing home costs in the aggregate during 1995, before one even considers the approximately \$1 billion of state cost-containment measures that have since occurred.

While the agreement underlying the HCRA 2000 legislation includes a pledge of no "new" Medicaid cuts for the next three fiscal years, it continues existing cuts of nearly \$350 million per year on nursing homes and home care agencies. Since 1995, New York's continuing care providers have sustained over \$1.6 billion in total Medicaid cutbacks, as shown in Figure 7 below.

**Figure 7. Medicaid Cost Containment in Continuing Care, 1995-present**



Source: NYAHSa estimates based on data from NYS DOH and the Division of the Budget.

<sup>23</sup> "Debunking Ten Key Myths About Medicaid Spending for Long Term Care in New York State," NYAHSa, March 1999, p. 6.

After years of budget cuts, Medicaid rates do not cover the actual costs of continuing care services. The HCRA agreement also reduces future annual inflation adjustments to Medicaid rates to account for price increases in the economy. These circumstances make nursing homes and home care agencies particularly vulnerable to the effects of staffing shortages, as well as rising drug costs and costly new mandates such as vaccination requirements and ergonomics standards.

The federal Balanced Budget Act (BBA) of 1997 [P.L.105-33] ushered in the most dramatic changes to the Medicare program since its inception. In an effort to save billions of dollars and contain future cost growth, Medicare is moving to prospective payment systems for skilled nursing facilities (i.e., Medicare-certified nursing homes) and home health agencies. According to federal budget estimates, these payment systems are expected to result in double-digit percentage reductions in Medicare reimbursements to these providers.

Nearly half of the residents of ACFs are recipients of Supplemental Security Income (SSI) congregate level II payments. These payments are made up of a federal component and a New York state supplement. The state has made no cost-of-living adjustment (COLA) in its state portion of the SSI payment since 1988. SSI payments to ACFs average \$27.35 per resident per day downstate and \$26.37 upstate.

In exchange, state laws and regulations require ACFs to provide room and board, personal care, medication supervision, transportation, recreation and other services. The NYS DOH estimates the current cost of providing state-mandated services at between \$45 and \$47 per resident per day.

## **SOCIAL SUPPORTS SUCH AS DEPENDENT CARE AND TRANSPORTATION**

Many continuing care workers are single parents, or have other particular difficulties finding adequate child care or caregivers for their own parents. Transportation to and from the job is also an issue for many workers. Many of these workers have other complications in their personal lives that can negatively affect their productivity on the job. For example, they may hold multiple jobs or have difficulties with abusive relationships.

The need for affordable child care constrains some adults from entering the workforce. Nationally, an estimated 10 to 20 percent of non-working mothers with young children do not seek employment because child care is not available or affordable. In addition, about 20 to 25 percent of employed mothers would work longer hours if they did not have child care constraints.<sup>24</sup> Also, given the current low wage scales for health care paraprofessionals, the inability to purchase child (day) care services can be a significant barrier to employment.

Providers that responded to NYAHSAs focused telephone survey cited the ability to assist with child care services as a major opportunity to enhance their ability to recruit and retain employees. The value of being able to offer child care services is confirmed by the NYAHSAs CNA survey results, which revealed that the average turnover rate for facilities that offer onsite or affiliated day care services was 30 percent (nearly one-third lower than the average turnover rate for all facilities).

Many workers must care for dependents other than children. About 7.3 million Americans age 15 and over, or four percent of the population residing in households, have difficulty performing one or more activities of daily living (e.g., bathing, dressing, eating, etc.). Over half of these individuals require help from another person to perform these activities. Family members are the primary source of such assistance. Spouses are the most common providers (38 percent), followed by children (27 percent) and other relatives (12 percent). Only nine percent of those needing assistance use paid providers. In 1996, almost 20

<sup>24</sup> Harriet B. Presser and Amy G. Cox, "The Work Schedules of Low-Educated American Women and Welfare Reform," *Monthly Labor Review*, April 1997, p. 26.

percent of American households provided informal care to a relative or friend age 50 or older. This percentage is estimated to more than double in the next five years.<sup>25</sup>

The long term trends portend additional growth in informal care. Between 2011 and 2029, the baby boomers will be reaching the traditional retirement age of 65. Their retirements will dramatically affect the workforce of the future. Not only will the demographic profile of the workforce change considerably, including a rise in the number of people with disabilities, but millions of Americans will face balancing work and family, particularly the care of elderly parents.<sup>26</sup>

A recent study by MetLife concludes that working caregivers can incur “significant losses in career development, salary and retirement income, and substantial out-of-pocket expenses as a result of their caregiving obligations.”<sup>27</sup> Of the caregivers interviewed in the MetLife survey, 84 percent report that they had to make adjustments to their work schedules including using sick time, decreasing their work hours, taking leaves of absence and quitting their jobs altogether.

Many nursing home and home care workers rely on public transportation that is often neither convenient nor dependable. In many cases, such transportation may not even be available or accessible. Transportation difficulties pose special problems for home care workers, who must travel from client to client to provide care.

Roughly one-third of the nursing homes that responded to the NYAHS CNA survey cited employee access to transportation as an issue. Although transportation may not be the only difficulty these particular facilities are facing, they reported employee turnover rates that were 81 percent and 63 percent higher than the statewide averages for full-time and part-time CNAs, respectively.

Some NYAHS members have reported reduced employee turnover as a result of offering employee assistance programs (EAPs) to their employees. EAPs provide these individuals with confidential counseling on a variety of problems encountered at home or on the job.

## OPPORTUNITIES FOR EDUCATION, TRAINING AND CAREER MOBILITY

A study currently being conducted by the Iowa CareGivers Association (and funded by the Iowa Department of Human Services) cites the primary sources of dissatisfaction for CNAs as education and training-related factors, relationships with supervisors, co-workers and administrators, teamwork problems, and aspects of the work itself.

CNAs report the lack of sufficient training as one reason for leaving work in the nursing home setting. The results of the NYAHS CNA survey confirm the fact that training has a significant bearing on employee turnover.

There is a growing recognition that the CNA training curriculum needs to be revised to include aspects critical to the nature of the work, apart from the specific tasks contained in the current curriculum. Examples of additional needed components are dealing with resident behaviors, cultural competence, teamwork, relationships with peers and supervisors, stress management, and communication skills. Research indicates that training should include time management and coping skills, as well as the instrumental tasks of the job. These address critical aspects of the nursing home culture and would enhance recruitment and retention efforts.

To combat occupational risks, the Institute of Medicine recommends more training for all health care workers in lifting and transferring patients and in using medications that do not require injection. The

<sup>25</sup> *Futurework: Trends and Challenges for Work in the 21st Century*, U.S. Department of Labor, September 1999, Executive Summary, p. 6.

<sup>26</sup> *Ibid*, Chapter 1, p. 1.

<sup>27</sup> “The MetLife Juggling Act Study: Balancing Caregiving with Work and the Costs Involved,” Metropolitan Life Insurance Company, 1999, p. 3.

Institute also believes that training programs need to include effective ways to control violence directed at nursing personnel by patients.<sup>28</sup>

Flexibility in training requirements is an issue in career mobility. Currently, CNAs employed in New York's nursing homes are required to receive 100 hours of training in order to be certified (the federal minimum requirement is 75 hours). HHAs working in home care settings are required to receive 75 hours of training. There is no reciprocity for these job classifications. In other words, a certified HHA applying to work in a nursing home must complete the 100-hour CNA training program, much of which is redundant and postpones the HHA's ability to join the staff of a nursing home. NYAHSa has consistently advocated for the development of a "core training curriculum" which would allow CNAs/HHAs to not have to complete an entire re-training when moving from one classification to another.

According to a recent study involving CNAs, a career ladder that would give credit for experience, education and competence would keep committed CNAs in nursing homes. The CNAs called for: (1) a longer training period; (2) classification of beginner and advanced CNA status; (3) opportunities for enhanced training to strengthen existing skills and learn new ones to provide better patient care; and (4) education for advancement to LPN or RN status.<sup>29</sup>

The HCRA 2000 legislation includes funding for a health workforce retraining initiative. Under the program, grants will be made on a regional basis to eligible organizations (including unions, hospitals, long term care facilities, health care trade associations, labor-management committees and educational institutions) to support the training and retraining of health care workers to address hospital layoffs and other changes in the health care workforce.

NYS DOH recently issued a request for proposals to interested parties, and will be awarding grants on or about Sept. 1, 2000. Eligible programs will need to help eligible workers obtain new positions, continue to meet the requirements of existing positions or otherwise meet the changing needs of the health care industry. Grant moneys will be available for the following types of services: (1) assessments to help determine training needs; (2) preparation in the English language or educational equivalency; (3) basic skills development; (4) reorientation; and (5) skills and educational enhancement, including college course work where appropriate.

Additional issues and proposals pertaining to the areas of education and training are found within this report.

## NEW YORK'S CONSUMERS AND PROVIDERS SPEAK OUT ON STAFFING ISSUES

During 1998, NYS DOH's Office of Continuing Care convened a Post-Acute Workgroup to discuss the future of continuing care services in New York state. The group, consisting of provider and consumer advocates, service providers and state/local government officials, reviewed continuing care services to identify: (1) missing supports/services; (2) barriers to creating, accessing and using services/ supports; and (3) approaches to overcome these barriers.

As part of its primary research, the group conducted a series of nine provider forums and 20 consumer focus groups across New York state to elicit information in the three areas cited above. Workforce issues figured prominently as a major concern for providers and consumers alike. In eight of the nine forums, providers cited their inability to recruit and retain an appropriate mix of qualified and trained staff as a barrier to delivering services. Among the specific concerns were: (1) low pay for aides who play key roles in care delivery; (2) too much competition for workers from other providers and other industries; and (3) inconsistent training requirements for CNAs, HHAs and PCAs.

<sup>28</sup> *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Institute Of Medicine, Division of Health Care Services Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes, Jan. 18, 1996.

<sup>29</sup> Daniel L. Segal, Sara Honn Qualls and Fred Feinsod, "A Community Focus on CNA Performance," *Nursing Homes* magazine, Oct. 1999, p. 79.

Consumers expressed the following concerns related to staffing: (1) not enough staff to perform needed services; (2) too many limits on the tasks that paraprofessionals can perform due to the Nurse Practice Act; (3) inflexible care schedules due to limited availability of staff, impacting patients' quality of life; (4) interruptions in care delivery when no substitutes are available to cover for HHAs who cannot come at the scheduled times; and (5) aides who aren't adequately paid, trained, screened for criminal backgrounds, and do not have access to reliable transportation.

Participants in both forums cited the following strategies to address these problems:

- revisit certification and scope of practice for CNAs, HHAs and PCAs;
- create career paths for paraprofessionals;
- set up a system to conduct criminal background checks;
- improve benefit packages for workers;
- eliminate duplication and inconsistency among CNA, HHA and PCA duties/requirements;
- create universal workers to allow for a broader scope of duties; and
- improve training for professionals and paraprofessionals.

Many NYAHSAs members have expressed their frustration at being unable, despite their best efforts, to recruit and retain qualified staff. Front-line employees have also voiced their concerns. The following are a very few paraphrased quotes from administrators and staff in NYAHSAs member nursing homes; these statements are representative of others in the profession.

#### **From CNAs:**

*"The residents are the ones that are suffering with this staffing shortage. We do not have the time to take to sit down one-on-one—not even for a few minutes."*

*"Frustration is the number one problem related to the staffing shortage. I feel I am rushing all the time and I hate that feeling. I try to smile and talk with my residents but sometimes this is difficult in view of my feelings."*

*"The staffing shortage has filled the residents and the staff with stress. The stress makes you feel you haven't done the job as you would have liked. I go home and feel inadequate."*

*"You don't have that special quality of time to spend with your residents."*

*"The residents are less likely to ask for someone's assistance for fear of pulling us away from someone who needs help more."*

*"The residents can't always get the help they need as fast as they need it."*

*"The residents don't always get the socialization with the staff due to the staffing shortage. The residents enjoy talking to the staff—in a way it's their connection with the outside world."*

*"Residents depend on us for love, care and conversation and because we are so pressed for time this is not happening like it used to. Some of the residents have no one else but us and we are in a short supply."*

*"The staffing shortage and the enormous stress the government has placed on nursing homes is making a lot of our good CNAs and nurses leave their jobs for jobs less stressful. We just can't go on like this."*

*"I have been a CNA for 23 years. I really like my work and have felt proud about what I do. Lately, however, I do not feel as satisfied when I go home at the end of a long day. This is because I no longer have the time to do the little extras for my residents. I feel as if I still give good care, but I have to rush my residents. They ask me to rearrange their things on the bookcase in their rooms or re-read the letter from a granddaughter, but I do not have time to do these things. This makes me feel terrible and that I am letting these wonderful seniors down. My other big concern right now is about the new CNAs who come here to work. I used to have time to help them learn their jobs here. Now it is rush-rush-rush! The new staff do not have the same compassion for the residents and commitment to their work, and then we make it even worse because we do not have time to teach and orient them."*

**From directors of nursing/other nurses:**

*"We just can't compete with other jobs. For instance, I have a great CNA who also holds another job at a Stewart's [retail] store. There she has gradually advanced and now she is thinking of leaving here, as the job at Stewart's pays her enough so that she can afford to leave the nursing home. I can't blame her, but we just can't afford to pay what they do."*

*"We've been trying to fill vacant RN positions for over a year. Due to the fact we have a union which the RNs are a part of—and outnumbered by CNAs, housekeepers, etc., our salaries compared to the hospital are not competitive."*

*"Long term care is the most highly regulated system and most punitive in the nation. We are rapidly losing the dedicated, long term employees to burnout. This is a major crisis and I'm fearful that we may not survive it. This nation is killing its own and if it doesn't change its course our elderly will significantly suffer!"*

*"Nurses and CNAs are hurrying to provide residents with the most basic of care. I can't imagine how the residents must feel. At a time in their lives when they deserve the most care, love, and attention, health care cannot meet their needs. This is such a sad commentary on our society. It was this generation that provided for us and built this nation."*

**From administrators:**

*"One reason I'm going to another facility is because I've really tapped out my ability to find and retain sufficient staff. I know there are problems all over, but the organization where I'm going doesn't experience the same level of staffing difficulties as where I am working now."*

*"I'm at the end of my rope. I've done everything possible, and I still can't keep staffing up to par."*

*"We can't compete with the local recreation industry. There are only 8,000 permanent residents here, and most of them choose to work in the lucrative ski areas, hotels and restaurants."*

*"This last survey was disastrous. Staffing was already difficult, but after the survey many nurses and CNAs left. It was direct fallout, leaving them completely demoralized. And now, because of the bad survey, we can't train our own CNAs, even though the survey deficiencies were unrelated to the CNAs. This just creates a vicious cycle...what good does it do to pull the training program for a facility that's already struggling to find good staff?"*

*"We are a rural facility in upstate NY. The area economy is supported by tourism from May until October and then again during ski season. Although we have a competitive wage and good benefits the type of work in LTC is demanding—physically and emotionally—and more difficult than any jobs in the area."*

**KEY FEDERAL & STATE JOB CREATION/DEVELOPMENT PROGRAMS**

Identified below are some existing federal and state programs that can be used to support job creation initiatives.

**1. Temporary Assistance to Needy Families (TANF)**

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [P.L. 104-193] replaced the Aid to Families with Dependent Children (AFDC) cash welfare program with a new block grant program known as TANF. States were given considerable new authority to determine how the block grant funds are used to aid the poor.

Participation in TANF-funded programs is limited primarily to low-income families with minor children. However, TANF funds can also be used in some cases to serve families who are not receiving cash

assistance, non-custodial parents, and childless teenagers and young adults, if the state changes its TANF eligibility rules to include such individuals within its definition of eligible families.

TANF offers a flexible platform for job opportunities at the state and county levels. State welfare agencies can earmark TANF funds for a public job creation program which they administer, or they can provide funds directly to other state, local, or non-profit agencies for this purpose. TANF funds can also be diverted from welfare recipient cash grants to wage subsidies for these recipients.

In state fiscal year (SFY) 2000-2001, New York state is expected to receive an additional \$1.667 billion in federal TANF funding than is needed to provide financial assistance to needy families through the state's Family Assistance Program. This "TANF surplus" can be used on a wide variety of programs that aim to end dependence on public assistance. Because of the flexibility built into TANF, New York could use these TANF funds to provide low-income families with child care, transportation assistance, job placement and retention services, and other supportive services.

While New York currently only provides TANF-funded services to families with incomes up to 100 percent of the Federal Poverty Level (FPL)—currently \$14,150 for a family of three—TANF rules allow New York to raise that eligibility level. In his SFY 2000-2001 Executive Budget, Gov. George Pataki has proposed raising the income level to 200 percent of FPL (i.e., \$28,300 for a family of three) for certain programs. Under TANF, New York has the option to raise eligibility for these programs even higher.

## **2. Welfare-to-Work**

Since the federal welfare reform legislation imposed a five-year lifetime limit for federal assistance on families receiving TANF benefits, there was a great deal of concern about their future employment prospects. To address this concern, the Balanced Budget Act of 1997 authorized the U.S. Department of Labor to create a \$3 billion Welfare-to-Work grants program for states and local communities. These grants assist long term welfare recipients and certain low-income non-custodial parents in high-poverty areas to get jobs and succeed in the workforce. This program is particularly important because the individuals remaining on the welfare rolls face particular challenges.

States receive 75 percent of Welfare-to-Work funds and are required to distribute 85 percent of their allocations to local private industry councils (PICs) under a pre-determined formula. The remaining funds are awarded through competitive grants by the U.S. Department of Labor to PICs, local governments and non-profit agencies. "Job creation through public or private sector employment wage subsidies" is specified as one of many activities permitted under the Welfare-to-Work program.

Continuing care providers have had mixed results with welfare-to-work clients, based on varying interpretations of the law at the local (i.e., county) level. The NYAHS CNA survey results did not reveal unusually high employee turnover for these clients relative to other employees. However, providers are reportedly unable in some cases to effectively screen out unlikely candidates, such as those who are uninterested in continuing care, have substance abuse problems or lack the personality attributes necessary to perform this type of work. This can lead to lost training costs and other adverse outcomes.

## **3. Workforce Investment Act**

Beginning July 1, 2000, the federal Workforce Investment Act of 1998 [P.L. 105-220] will replace the Job Training Partnership Act (JTPA), and is intended to provide job training to youth, adults (including older adults) and dislocated workers. The WIA establishes a flexible state framework for a national workforce preparation and employment system designed to meet the needs of employers, job seekers, incumbent workers and economic development priorities. It can be utilized for job training for older (primarily low-income) workers.

Each state wishing to continue receiving federal job training funds must receive approval for its plan to come into compliance with WIA by July 1, 2000. As under JTPA, the bulk of federal funds will be distrib-

uted to local Workforce Investment Areas. Local elected officials and local workforce investment boards will set policy and determine how WIA funds will be used.

WIA funds can be used to create transitional jobs to help low-income adults become employable through "paid work experience" and "on-the-job training" (OJT). In addition, WIA funds can be used creatively in conjunction with TANF and Welfare-to-Work funds to create paid, transitional jobs designed to provide work experience as well as to supplement wages. WIA funds can be used to provide paid work experience for a broader group of adults than TANF funds. (i.e., including those without children).

To administer its WIA program, the NYS DOL has established "one-stop centers" that provide access to a variety of employment services, including job referral and placement and education and training, as well as support services such as child care and transportation.

#### 4. New York State Economic Development

Health care in general is a major part of the state's economy. According to various estimates, health care accounts for 10 percent or more of the total payroll employees in New York state. According to 1992 U.S. Census Bureau data, health care establishments accounted for 34.9 percent of sales and 42.1 percent of payroll for all service-producing businesses in New York state. According to the 1997 economic census, New York's health care and social assistance sector generated revenues of \$51.4 billion and payrolls totaling \$33.4 billion. Of these amounts, continuing care providers (i.e., nursing homes, home health agencies and community care facilities for the elderly) generated \$11.1 billion in revenues and over \$5.4 billion in payroll.<sup>30</sup> Any discussion of employment and economic activity/development in New York state should reflect the significant role of health care in general and continuing care more specifically.

The New York State Department of Economic Development and Empire State Development Corporation jointly administer a variety of economic development programs. New York state created the Economic Development Zones Program in 1986 to stimulate economic growth in distressed areas. The program aims to assist such areas through financial and economic development incentives to attract new business and help existing businesses flourish by expansion and job creation. It involves job training, and social services and educational institutions to achieve the objectives of economic revitalization.

There are two zone programs, the Economic Development Zone Program and the Zone Equivalent Area Program. Unemployment rates, poverty rates and other factors are used to designate qualifying areas of the state. These programs offer a wage tax credit incentive to encourage job growth in areas that are designated as economically distressed by hiring the economically disadvantaged.

The Empire State Development Corporation administers an Empire State Economic Development Fund for projects that create or retain jobs. The corporation also provides financial assistance for projects such as child care facilities.

## RESPONSES IN OTHER STATES

Staffing shortages in continuing care are a national problem. According to a 1999 survey by the North Carolina Division of Family Services, nearly 90 percent of the responding 47 states reported that recruitment and retention of paraprofessionals was an issue for them. Therefore, it is not surprising that other states have taken measures to ensure sufficient staffing broadly and at the provider level. Twenty-one states including New York, have either enacted or proposed legislation relating to staffing shortages. Examples include the following:

- California recently passed legislation requiring its state health department to set staffing level standards for RNs and LPNs working in hospitals. It also limits those tasks that can be performed by unlicensed personnel.

<sup>30</sup> U.S. Census Bureau, *1997 Economic Census for New York: Health Care and Social Assistance*, August 1999, pp. 10-14.

- Wisconsin passed legislation in 1998 mandating certain staffing levels in nursing homes, and requiring employee background checks. A year later, the state authorized a five percent wage pass-through for CNAs.
- Maryland, Massachusetts, New Jersey, and a number of other states (including New York) have introduced or passed bills calling for mandated staffing ratios (caregiver to resident).
- Legislation passed last year in Connecticut authorized funding for increases in compensation or in the number of workers. A proposed bill would base Medicaid reimbursement partly on staffing levels.
- In 1998-99, Michigan enacted wage pass-through legislation which provided for payment increases for enhanced wages. Other states have provisions for wage-pass throughs as well.
- This year, Minnesota legislators have proposed a three percent cost-of-living wage pass-through for health care workers.

## MANDATED STAFFING LEVELS ARE NOT THE ANSWER

### NYAHSA's Position on Mandated Staffing Levels

NYAHSA is very aware of nursing home mandated staffing ratio proposals at both the federal and state levels. We have actively involved members in discussions on this subject and have organized internal groups as well as member task forces to examine this issue. In addition, we have engaged in dialogue with other stakeholders including state legislators, consumer advocacy groups, organized labor representatives, and NYS DOH officials.

Direct caregiver minimum standards were proposed as a result of the 1986-1987 Senate Special Committee on Aging study and were later modified and adopted by the National Citizens Coalition for Nursing Home Reform (NCCNHR) as the "Consumers Minimum Standard for Nurse Staffing in Nursing Homes."

In New York state, legislation was introduced in April 1999 [S.4926 (Hannon)/A.7689 (Gottfried)] calling for significantly higher staffing levels than the proposed federal standards. NYAHSA has conservatively estimated that the total cost for New York state nursing homes to comply with this legislation would run between \$2.5 and \$3.0 billion annually. This, of course, presumes that the additional staff are, in fact, available to be recruited at prevailing wage levels. As demonstrated elsewhere in this report, such an assumption cannot be validly made.

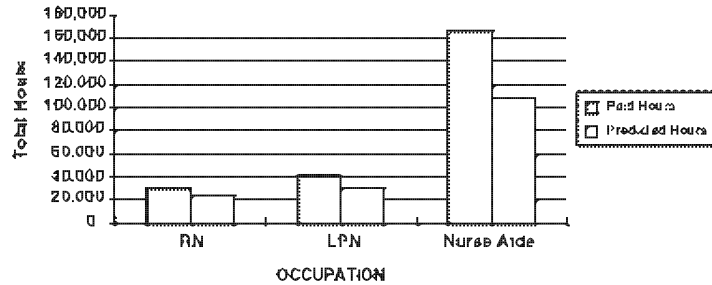
As previously indicated, Medicaid is the predominant payer for nursing home care in New York state. Since 1986, New York's reimbursement rates have been based on prospectively determined prices that take into account various factors including the estimated resources that residents require for their care.

Under this "case-mix classification system," each resident's clinical and functional needs are identified using a standardized assessment process. This information is then used to group each resident into one of 16 mutually exclusive categories called resource utilization groups (RUGs). Each RUG is associated with an estimated amount of direct-care staff time needed to meet the individual's care needs. This estimated staff time is referred to as the "predicted hours" of care. Essentially, the rate that Medicaid pays is largely predicated on how many hours of RN, LPN and CNA care each facility's residents are expected to consume.

NYAHSA was able to obtain matching Medicaid rate and cost reporting information for 1996 for 354 nursing homes in New York state, representing over half of all facilities in the state. We examined the actual paid hours of RN, LPN and CNA care reported by the facilities, and compared this data to the "predicted hours" of care reflected in the Medicaid rates paid to these facilities during the same time period. Our objective was to determine whether facilities seem to be staffing at the levels contemplated by the Medicaid rate methodology.

Figure 8 below compares the total number of paid hours for the three occupations to the total “predicted hours” used in the Medicaid rate computations for 1996:

**Figure 8. Paid Hours vs. “Predicted Hours” Reflected in Medicaid Rates**



Source: NYAHSa analysis using DOH data sources for 1996.

Figure 8 suggests that the 354 facilities in the sample were paying for more staff time in these direct-care occupations than the amount of staff time that was contemplated in their Medicaid rates. Total paid hours exceeded predicted hours by 23.8 percent for RNs, 38.2 percent for LPNs and 53.1 percent for nurse aides.

Some important caveats to this analysis are in order:

- These data are from 1996, a time period that likely pre-dates the severe labor shortages currently being experienced by nursing homes and other providers.
- We were unable to obtain complete Medicaid rate data for 1998 to be able to make this comparison. However, cost data suggest that these facilities increased their total paid hours for all three occupations from 1996 to 1998.
- The predicted hours reflect the care needs of all nursing home residents, including Medicare beneficiaries, who tend to have greater care needs than Medicaid recipients.
- The 354 sample facilities incurred at least \$24.1 million in expenses for agency personnel during 1996. The corresponding work hours are not available and, as such, are not reflected in the analysis.

This analysis strongly suggests that nursing homes are already staffing at the levels implied by the Medicaid reimbursement system. Therefore, any mandates for additional staffing need to be accompanied by commensurate increases in funding.

NYAHSa is convinced that staffing ratios are not a viable solution to quality-of-care concerns or workforce shortages in New York state. While the various proposed mandated staffing levels are generally intended to promote quality care for nursing home residents, for a number of reasons, implementation of these mandates may not achieve this goal. Those reasons include:

- Severe staffing shortages exist in many areas of the state, despite the existence of established and reasonable facility master staffing levels, as well as competitive salaries, benefits and incentives. These difficulties are widespread, affecting even those providers that have embraced the values of the “Nursing Home Pioneers” (a national group which advocates for culture change in nursing homes). The proposed mandated levels are impossible to achieve given existing staffing shortages and other circumstances.
- Numerical staffing ratios run completely counter to the philosophy of outcome-based measurements of care. New York’s nursing homes are taking steps to measure and improve quality through resident and patient outcomes, rather than to focus on paper and regulatory process compliance. Imposing staffing ratios ignores these efforts and inappropriately returns the focus to process.

- The levels/ratios do not afford providers any flexibility with respect to day-to-day variances in residents' care needs. In fact, the proposed levels may prove to be extremely insufficient for facilities that serve individuals requiring intensive services such as ventilator care and other forms of subacute care.
- The mandated levels also do not account for other facility variances such as building layout and design. In some physical plants, the resident unit layouts are such that high efficiencies can be accomplished, while others require greater staffing numbers to achieve the same level of care.
- The predominant payers (i.e., Medicaid and Medicare) currently under-fund nursing homes. These facilities are simply unable to comply with such a major staffing mandate without a commensurate increase in funding. Government repeatedly requires more stringent expectations yet cuts funding, which contradicts and compromises the credibility of the message that it is concerned with quality of care in our nation's nursing homes.
- Although not reflected in current written proposals, consumer advocacy groups argue that nursing homes should be required to spend a certain proportion of their Medicaid rates to fund direct-care staff. This concept would force providers to cut their budgets in other critical areas (e.g., food, maintenance, etc.) in order to compensate staff and still remain financially viable.

A 1996 Institute of Medicine report, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, stated that:

*"[t]here is...a serious paucity of recent research on the definitive effects of structural measures, such as specific staffing ratios, on the quality of patient care in terms of outcomes when controlling for all other likely explanatory or confounding variables." The report further states that "[p]art of the problem lies in the area of severity of illness and risk adjustment, where patient acuity is a significant factor. Across-the-board staffing ratios tend to assume that in some measure all patients are 'alike' and can be cared for with the same level and type of resources. Equally difficult is the task of establishing ratios that will be appropriate for all settings and situations. Staffing levels need to be specific to different types of acute care units and facilities."*<sup>31</sup>

### Alternatives to Mandated Staffing Levels

The issue of continuing care workforce labor shortages cannot be resolved by any single means, but must encompass a comprehensive, broad-based, multi-faceted strategy. This report proposes a number of measures to alleviate workforce shortages and address recruitment/retention issues. Other regulatory revisions we propose, and for which NYAHSa has drafted specific language, include changing existing New York state regulations to:

- assure that nursing homes establish intended minimum staffing levels (as opposed to externally mandated levels); and
- enhance the regulatory definition of "sufficient staff" by establishing a new position, certified nurse aide advanced (CNAA), and a corresponding scope of duties/educational curriculum.

These revisions could help to ensure that nursing homes establish appropriate master staffing levels to meet the needs of residents and also provide for "career ladder" opportunities for CNAs, as many such individuals do not have the opportunity or resources to pursue a nursing license or other higher educational opportunities.

NYAHSa maintains that alternatives to mandated staffing levels can provide more effective solutions to workforce shortages. We are aggressively pursuing a number of such alternatives and seek a collaborative approach with consumer advocates, regulators, and provider representatives.

<sup>31</sup> Prepublication copy of *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Gooloo S. Wunderlich, Frank A. Sloan, and Carolyn K. Davis, editors—Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes, Division of Health Care Services, Institute of Medicine—National Academy Press, Washington, D.C., 1996.

## RECOMMENDATIONS FOR ALLEVIATING SHORTAGES IN THE CONTINUING CARE WORKFORCE

### A. Definitions

**ISSUE:** Staffing shortages in continuing care are a broad-based public health issue that demands focused attention and a number of short-term and long-range solutions. In order to expeditiously and appropriately focus a number of the interventions on the professions at issue and the employees/potential employees requiring assistance, we should define certain terms in law or regulation.

**Recommendations:**

1. State and federal law should include a definition of "health worker shortage areas." These designations would apply to RNs and LPNs and, unlike the federal Health Professional Shortage Area designation,<sup>32</sup> would also include CNAs, HHAs, and other paraprofessional caregivers in continuing care. The definition could be applied at the local labor market level within the state, and be utilized to target a variety of state and federal funding sources to address the occupational shortages.
2. Alternatively, policy makers could utilize the "demand occupations" designation in the federal Workforce Investment Act to target WIA funds and a range of other federal and state funding sources to address continuing care worker shortages. Federal and state regulators could direct local workforce investment boards to include these occupations in their lists of demand occupations.
3. For purposes of utilizing TANF funding for recruitment and retention initiatives, New York should redefine the income level for qualifying workers/families based on an appropriate multiple of the federal poverty level (FPL). Based on prevailing wages for paraprofessional and professional continuing care employees, we suggest utilizing a figure of greater than 200 percent of the FPL for this purpose.

### B. Third-Party Reimbursement

**ISSUE:** Medicaid cuts in recent years, combined with Medicare reimbursement reductions authorized by the Balanced Budget Act of 1997, have diminished the ability of nursing homes and home care agencies to offer competitive wages and benefit packages. These providers have sustained reimbursement cuts to the point that quality of care is threatened for all New Yorkers, not just for Medicaid and Medicare beneficiaries.

**Recommendations:**

1. Include funding in this year's state budget to support a range of recruitment and retention initiatives including, but not limited to, child/elder care, education/training, employee assistance programs and transportation assistance. These initiatives could be funded through Medicaid using the workforce recruitment and retention grants model utilized during the nursing shortage in the late-1980s and early-1990s. This model featured a flexible, provider-based approach to addressing workforce shortages.
2. Restore previous cuts in Medicaid and Medicare funding to provide continuing care providers with additional resources to recruit and retain staff.
3. Ensure that the Medicare prospective payment systems include SNF-based and home health agency-based geographic wage adjustments, in lieu of the hospital wage index.

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<sup>32</sup> "Health Professional Shortage Areas" are designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

**ISSUE:** The state supplement of SSI payment rates for ACFs has not been increased since 1988. As a result, a number of facilities have either closed, or been forced to restrict their admissions of SSI recipients in order to remain in operation. Rising wage and benefit costs contribute to the problem.

**Recommendation:** Increase funding in this year's state budget for direct subsidies to ACF operators. NYAHS's March 2000 report, *Adult Care Facility Finance Reform: A Prescription for Affordable Assisted Living Care*, contains specific recommendations on how to structure these subsidies.

**ISSUE:** Some labor-saving technologies (e.g., mechanical lifting devices, etc.) are costly. While a mechanism exists for providers to be reimbursed for these costs, the providers may not have ready cash for the initial purchase of these items or be able to wait for several years to fully recover the cost of these items.

**Recommendation:** NYS DOH should accelerate Medicaid reimbursement time frames for capital expenditures related to labor-saving technologies. These payments can be accelerated by: (1) permitting continuing care providers to submit capital budgets prior to each year, and reflecting the budgeted capital items immediately in Medicaid rates rather than requiring providers to wait two years for reimbursement to begin; and/or (2) shortening the depreciation schedules used to recover the capital cost of these items.

### C. Improving Wages and Benefits

**ISSUE:** Inadequate wages and/or fringe benefits are cited as an issue affecting recruitment and retention in continuing care settings, particularly as they relate to competition with non-continuing care employers. Other states have authorized "pass-through" adjustments to Medicaid rates to increase compensation for front-line workers in continuing care. However, the short-term and long-range effects of such adjustments are not well understood.

**Recommendations:**

1. Closely monitor these programs in other states to determine: (1) their efficacy in terms of recruitment and retention; (2) preferred approaches for making these adjustments; and (3) the effects of these adjustments on the overall compensation and cost structures of continuing care providers. Based on the results achieved in other states, consider instituting such a program in New York state.
2. Consider expanding the scope and funding of Gov. Pataki's proposed \$2 million Hospital Wage Subsidy and Skills Training Demonstration Program to include workers in continuing care settings. This program would be funded with TANF moneys and administered by NYS DOL and NYS DOH to assist current and prospective health care workers who are public assistance recipients. Alternatively, explore using other TANF funds to target wage subsidies for continuing care shortage occupations.

**ISSUE:** The HCRA 2000 legislation authorizes a state-funded health insurance initiative for uninsured home care workers in New York City and Long Island. However, home care workers outside of these areas and other continuing care paraprofessionals and their employers are ineligible for this program.

**Recommendation:** State policy makers should consider broadening this initiative to encompass: (1) uninsured home care workers in all other counties of New York state; and (2) other uninsured workers in continuing care whose employment is irregular, episodic, cyclical or part-time, and/or whose health care coverage is frequently disrupted.

**ISSUE:** HCRA 2000 also authorizes a small employer health insurance initiative to encourage employers to offer insurance to their employees. This program could greatly assist small continuing care organizations to recruit and retain needed staff.

**Recommendation:** New York's lawmakers should direct the New York State Department of Insurance to give priority to applications involving continuing care organizations for the small employer health insurance initiative.

#### **D. Dependent Care**

**ISSUE:** NYAHSa's focused telephone survey reveals that the inability to provide child care services is a significant barrier in recruiting and retaining workers in continuing care. External sources of research reveal the growing need for elder-care services for continuing care workers.

**Recommendations:**

1. Provide additional funding for subsidies or vouchers to help lower-income health care workers purchase child care services. Additional funding could be made available by increasing the governor's proposed \$230 million transfer from the federal welfare grant to the State Child Care Block Grant (administered by the Office of Children and Families), or through recruitment and retention grants administered by NYS DOH.
2. Provide priority capital funding for construction of on-site provider-based child care centers through the new \$15 million Child Care Facilities Development Program Capital Projects Fund, administered by the State Office of Children and Family Services.
3. Increase state funding to the New York State Office for the Aging (SOFA) for start-up costs for provider-based intergenerational day care programs to offer child care to continuing care employees.
4. Provide dedicated funding for social model adult day programs through SOFA, with priority given to programs serving elders of low-income health care workers.
5. Create state and federal tax incentives supporting elder care for employees in health care and other professions. Possible options include instituting direct tax credits for caregivers, and changing the federal/state earned income tax credit program for low-income taxpayers to count dependent elders (in addition to dependent children) in the calculation of the credit.

#### **E. Transportation**

**ISSUE:** Transportation to work sites is a hardship for many continuing care workers. This is particularly true for those working in home settings or organizations inaccessible via public transportation. Nearly one-third of the respondents to the NYAHSa CNA survey indicated that transportation is a problem for these workers.

**Recommendations:**

1. Subsidize the costs of transportation to and from work sites for continuing care employees through transportation allowances/vouchers, providing passes or tokens for mass transit, and reimbursing for mileage and other automobile-related expenses. Funding could be made available from TANF funds or through NYS DOH-administered recruitment and retention grants.
2. Provide grants to providers and localities to expand group or mass transportation options in geographic areas where transportation is a particular problem. Such options could include shared arrangements between continuing care providers or with other agencies (government-related or private sector) for the use of buses or vans.

## F. Employee Training

**ISSUE:** Currently, there is no training reciprocity for CNAs and HHAs. In other words, a HHA applying to work in a nursing home must complete New York's 100-hour CNA training, much of which is redundant and postpones the person's ability to make the change.

**Recommendations:**

1. Revise the relevant state regulatory requirements to permit reciprocity of training requirements.
2. Encourage provider demonstrations/pilots to explore innovative methods for combined training programs that avoid duplication of material and enhance aides' career mobility.

**ISSUE:** CNAs report lack of sufficient training as a factor in job satisfaction, and a reason for leaving the profession. Other studies confirm the relationship between training and turnover/employee satisfaction. As the racial and ethnic diversity of continuing care workers and patients increases in future years, cultural competence training will be increasingly important.

**Recommendations:**

1. Revise aide training programs to focus on such areas as: (1) dementia care and dealing with patient/resident behaviors; (2) teamwork and relationships with peers/supervisors; (3) stress management; (4) time management; (5) communication skills; (6) occupational risk management; and (7) cultural competence.
2. Ideally, these additional areas should be included in the context of the existing time requirements (i.e., 100 hours for CNAs, 75 hours for HHAs). If this is not possible, perhaps they can be accommodated in ongoing in-service training programs, with parameters on the time frames in which each topic should be presented.
3. Reimburse providers through the Medicaid program for any additional training costs (particularly if the required hours are expanded), and for staff replacement costs to "backfill" for aides during the time they are receiving this additional training.

**ISSUE:** Nursing students who have completed the equivalent of the CNA 100-hour training program in their nursing studies are not permitted to work as CNAs unless they complete the actual CNA training program or their nursing school is an approved training site.

**Recommendation:** Any nursing student who completes the equivalent of the 100-hour nurse aide training program including 30 hours of supervised hands-on care, should be permitted to work as a CNA without further training.

**ISSUE:** Currently, some schools of nursing education (including all BOCES programs in New York) are approved CNA training sites. This enables nursing students to complete the CNA training curriculum early in their coursework so that they can work as CNAs until they complete their nursing education. Students enrolled in schools that are not approved CNA training sites are required to complete nursing home/other approved CNA training prior to being employed as CNAs.

**Recommendations:**

1. Federal law should be revised to allow nursing students who have completed the equivalent of the 100-hour CNA training program to serve as CNAs and in other paraprofessional capacities, as appropriate.
2. In the absence of federal law changes, NYS ED should promote the inclusion of paraprofessional (i.e., CNA, HHA, etc.) training curricula into all nursing education programs in order to assure that all schools of nursing are approved training sites.

**ISSUE:** Under existing enforcement regulations, nursing homes cited with deficiencies at the substandard quality of care level lose their ability to conduct their own CNA training, even if the deficiencies are unrelated to the training program.

**Recommendation:** Revise this requirement to apply only to those facilities in which substandard quality-of-care deficiencies are clearly the result of the quality of the facility's CNA training program.

**ISSUE:** HCRA 2000 authorizes a health workforce retraining initiative to train/retrain displaced workers. This program could greatly assist continuing care organizations to recruit and retain needed staff.

**Recommendation:** New York's lawmakers should direct the NYS DOH to give priority to applications involving continuing care organizations for the health workforce retraining initiative.

## G. Education

**ISSUE:** Preparation for work in health care professions is not a focus in high school classrooms, internship programs or vocational training centers. According to the 1997 National Employer Survey of about 7,000 employers, an extraordinary 74 percent said they were participating in school-to-work partnerships and nearly 24 percent reported they were using internships. Hiring and training young people as interns may allow many firms to expand their workforces.<sup>33</sup>

**Recommendations:**

1. NYS ED should establish expanded opportunities for health and continuing care vocational training and/or work/study programs in the state's high schools.
2. State funding should be made available and/or targeted to support the costs to continuing care employers of apprenticeship training programs, similar to those administered by NYS DOL. These costs include instructional costs, support services (e.g., dependent care and travel, etc.) and lost staff time.

**ISSUE:** Educational institutions providing nursing education generally do not include curricula and/or clinical rotations for eldercare.

**Recommendation:** NYS ED, in collaboration with nurse credentialing bodies and trade associations representing nurses and continuing care providers, should take steps to ensure that elder-care curricula/clinical rotations are included in nursing education programs.

**ISSUE:** Studies have shown that existing health care workers, particularly paraprofessionals, seek educational opportunities to advance in their careers and enhance their educational backgrounds. However, they may not have the financial resources to do so. At the same time, nursing school enrollments are dropping as the need for continuing care nurses increases.

**Recommendations:**

1. Provide state funding for a loan forgiveness program modeled after the federal Nursing Education Loan Repayment Program, administered by the Public Health Service. Under this program, nurses who make commitments to practice in nursing shortage areas for certain time periods can have a portion of their qualifying education loan balances repaid.
2. Create a new scholarship program or provide targeted funds through the state's Tuition Assistance Program to help subsidize education in the nursing profession and other shortage health occupations.

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<sup>33</sup> Lerman and Schmidt, pp. 49-50, Aug. 1999.

## H. Workforce Development

**ISSUE:** “Older adults” (i.e., over age 55 and/or after retirement) could play a significant role in providing continuing care, but represent a largely untapped resource due to outdated policies that encourage retirement instead of continued employment. “Displaced homemakers” (i.e., women who are divorced or widowed) represent another potential resource for continuing care employees.

**Recommendations:**

1. Current federal/state employment and training programs such as WIA should increasingly target these individuals through specialized training and outreach programs.
2. Federal lawmakers should enact H.R. 5, the “Social Security Earnings Test Elimination Act,” into law in 2000. This important legislation would remove the existing cap on earnings from employment for individuals who have attained retirement age, thereby eliminating a financial disincentive to post-retirement work.

**ISSUE:** Many paraprofessionals are not able to or interested in pursuing professional nursing licensure or other higher educational opportunities, but would be interested in career advancement within their profession.

**Recommendation:** Establish a position titled “certified nurse aide advanced” (CNAA) in state regulations. Any current CNA who is in good standing on the New York State Nurse Aide Registry could become a CNAA if he or she is properly trained to perform additional functions (note: specific functions and a training curriculum would be established in regulation) such as: (1) tube feeding for certain residents with gastrostomy tubes; (2) wound care for stable skin surfaces; (3) application of certain prescription creams and ointments; and (4) rehabilitation nursing activities under the supervision of an RN. Nursing homes could elect to voluntarily participate in this program.

**ISSUE:** The Immigration Act of 1990 and other aspects of federal immigration policy have been seen by many as a barrier to bringing in individuals to fill health care employment vacancies in the United States, particularly paraprofessional positions.

**Recommendation:** Federal policy makers should reconsider current restrictions on employment-based legal immigration to increase the supply of candidates for professional and paraprofessional shortage occupations in continuing care.

**ISSUE:** New York will become more racially and ethnically diverse in the future, and the population requiring continuing care services will reflect this diversity.

**Recommendation:** In addition to promoting cultural competence through training requirements, state policy makers should increase their efforts to improve the diversity of New York’s continuing care workforce. One way of doing so is to engage students and educators early and frequently during the secondary educational process in health professions-related activities. Further research is likely needed to understand the issue and to identify a broader range of possible solutions.

## I. Scope Of Practice

**ISSUE:** In some cases, professional practice/regulatory requirements inhibit flexibility and innovation in care delivery. For example, certain mental health care settings are permitted to utilize specially trained paraprofessionals to administer medications, a concept that the governor has proposed in his assisted living legislation. However, this practice is not permitted in other health care settings. Another example is that of feeding nursing home residents, which is essentially restricted to CNAs and/or nurses, with significant restrictions on unlicensed/

**uncertified staff. NYAHSA recognizes that task-oriented, segmented care delivery may not be ideal as opposed to a more holistic, “universal worker” approach. However, given current critical staffing shortages, providers need flexibility to deliver quality care in a variety of appropriate ways.**

***Recommendations:***

1. Support federal legislation permitting nursing homes to use “nutrition/hydration assistants” to feed residents (see Appendix 2).
2. Examine all scope of practice/regulatory restrictions on providers. One possible vehicle for this could be a NYS DOH staffing task force, which has been under discussion for a considerable period of time.
3. Examine the possibility of work redesign within continuing care settings, with a focus on “universal” or multi-skilled worker approaches that permit wider scopes of practice and increased flexibility. This will require a broad-based dialogue involving a variety of stakeholders including continuing care employees, organized labor, consumers, providers, researchers and regulators.

## **J. Criminal Background Checks**

NYAHSA's CNA survey showed that of the 250 responding nursing homes, 20 percent (representing 26 counties) indicated they perform criminal background checks on prospective employees. Of those facilities, 92 percent indicated they rejected 0-20 percent of applicants based on the information gleaned from the checks, and five percent indicated they rejected 21-40 percent of applicants.

**ISSUE: A reliable, honest workforce is critical to quality health care delivery and staff retention. No current state methodology exists for health care providers to obtain criminal background checks on prospective employees. Past proposed legislation has not addressed how to fund the cost of these checks, and has been limited to nursing homes and home care agencies, which presents dangers to care-dependent individuals in other health care settings and further stigmatizes employment in continuing care. Providers are left to their own limited devices for securing criminal background information for job applicants.**

***Recommendation:*** To be effective, criminal background check legislation should: (1) be administered on a statewide or national basis; (2) include all new direct-care hires in all health care settings; (3) be fully funded with government dollars; (4) result in timely checks; and (5) address the issue of employer liability for adverse hiring decisions. State lawmakers should enact NYAHSA's criminal background check legislation, which encompasses all of these important features.

## **K. Survey Fines**

**ISSUE: Fines are sometimes levied on nursing homes and ACFs that are found to be out of compliance with regulations. In a number of these cases, the underlying cause for the cited deficiencies is the inability to recruit and retain sufficient numbers of qualified staff. In other cases, the facility is actually cited for having insufficient numbers of staff, as well as related quality-of-care issues. Enforcement regulations dictate the issuance of fines for serious deficiencies.**

***Recommendation:*** Establish a system for channeling nursing and ACF survey fines into provider staffing initiatives. This system could operate at the aggregate level or at a facility level. At an aggregate level, all such fines could be channeled into a state “quality-of-care improvement fund account” (similar to that proposed by Gov. Pataki in his assisted living legislation) and used to carry out various recommendations contained in this report. At the facility level, survey fines could be eliminated or reduced on the condition that the facility utilize that amount of money toward staff recruitment/retention initiatives.

## L. Research

**ISSUE:** While various data sources document the current shortages of continuing care workers, state policy makers and other stakeholders do not fully understand the dynamics of labor supply and demand, and how they are likely to change over time.

**Recommendation:** A study is needed as soon as possible to forecast the supply and demand for direct-care employees in continuing care settings over the next one to three years. The study would: (1) identify current staffing levels, vacancies and turnover; (2) identify providers' anticipated hiring plans over the next one to three years; (3) forecast changes in demand for continuing care services; and (4) forecast changes in the supply of potential job applicants. The study should carefully examine regional variations in supply and demand. Funding could be provided either at the federal level through the National Center for Health Workforce Information and Analysis or at the state level through the NYS DOL and/or NYS DOH.

One example of a legislatively mandated study is the *Recruitment, Training, Employment, and Retention Report on Certified Nursing Assistants in Florida's Nursing Homes*. This study, with specifics detailed in Florida's House Bill (HB) 1971, Section 28, reviewed the performance of CNA training programs, identified factors likely to improve employment rates and retention of CNAs, and assessed the extent and impact of CNA shortages within major regional Florida job markets. The study was narrowly focused on CNAs, but could provide a model for a broader study mandate.

**ISSUE:** Difficult working conditions and negative public perceptions affect recruitment into continuing care professions, but neither the effects nor the potential solutions are fully understood.

**Recommendation:** A research study could carefully examine such questions as: (1) how pervasive are negative public perceptions of employment in continuing care; (2) what motivates individuals to work in continuing care or leave the field; (3) how aware are potential job applicants of the opportunities in continuing care; and (4) what sort of public relations campaign could be utilized to promote employment in continuing care professions?

**ISSUE:** Various surveys have revealed that training and relationships with other employees (i.e., supervisors and colleagues) have a material bearing on employee satisfaction/turnover. However, these relationships are not fully understood, nor is there a consensus on how to effect positive change in these areas.

**Recommendation:** Provide research funding to study the impact of initial certification training and follow-up (i.e., "in-service") training, as well as relationships with other employees on professional and paraprofessional job satisfaction in continuing care establishments.

**ISSUE:** Various studies on retention have indicated that supportive relationships with the immediate supervisor and peer supports/good communication are key factors in retention. Yet, there is little training specifically designed to make nurse managers effective supervisors.

**Recommendation:** Provide funding through adjustments to the Medicaid rate or another funding source for demonstration grants in this area. Alternatively, use an existing NYS DOH funding model to encourage practice improvement in this area. In this funding model, the state contracted with Northeast Health (a Troy, NY-based multi-service provider) to manage grants on innovation in dementia care, which are supported by funds received through the state. We suggest a similar initiative focused on staffing and recruitment best practices.<sup>34</sup>

<sup>34</sup> The Foundation for Long Term Care (FLTC), a NYAHS affiliate, has considerable experience in grant management and education of long term care providers. It has extensively studied staff upgrading programs and best practices in nursing homes. The FLTC has just contracted for an additional research project in which it will synthesize existing in-service programming for CNAs.

**ISSUE:** In order to minimize staff turnover, provide the best care, and prevent employee injuries, continuing care providers need to maximize their efficiencies with respect to time management techniques and labor-saving devices.

**Recommendation:** Conduct research studies to explore enhancing continuing care workforce on-the-job efficiencies such as utilization of labor-saving devices and time management techniques/strategies.

**ISSUE:** Telemedicine technology has the potential to mitigate workforce shortages (particularly in home care), to reduce the burden on family caregivers and to permit patients to take on a more active role in their own care.

**Recommendation:** Federal and state funding should be made available to conduct research on potential new uses of telemedicine in continuing care settings, particularly the patient's home.

## CONCLUSION

NYAHSa's primary and secondary research provides strong evidence that continuing care providers in New York state and elsewhere are experiencing severe shortages of key professional and paraprofessional employees, in spite of increased efforts to recruit and retain these individuals.

This staffing crisis is symptomatic of broader labor shortages in New York state and throughout the country affecting many employers and occupations. These shortages reflect a variety of circumstances, including the fact that unemployment is at a 30-year low in our state and in the nation.

In addition to overall employment trends, multiple and complex factors specifically contribute to the staffing crisis in continuing health care, including a growing need for services, challenging working conditions, oftentimes inadequate wages and benefits, and other factors.

Although labor shortages are a pervasive and overriding concern for the overall economy, they pose particular problems for continuing health care. This is because such shortages can directly impact on the quality of life and well-being of vulnerable elderly and disabled persons who are dependent on these services. For this reason, staffing shortages in continuing care are a public health issue that demands immediate attention.

The breadth and scope of the workforce shortage problem in continuing care calls for an integrated strategy of short-term and long-range measures. To succeed, this strategy will require the concerted efforts of federal and state lawmakers, regulators, continuing care employees, organized labor, consumers, providers and researchers. Given the growing difficulties in recruiting and retaining individuals to work in continuing care and future demographic trends, the time to act is now.

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## APPENDIX 1

### DEFINITIONS OF PROVIDER TYPES

**ADULT CARE FACILITIES (ACFs)** or adult homes provide room and board, congregate meals and personal care with activities. The typical adult home is a facility that consists of two-person rooms with shared baths but no in-room cooking facilities. While some adult homes have nursing personnel on staff, they do not have the capacity to provide intensive medical or nursing services. The New York State Department of Health (NYS DOH) provides regulatory oversight. Reimbursement mechanisms include private pay, Medicaid, and federal/state Supplemental Security Income (SSI) payments.

**ADULT DAY CARE** is a service which provide continuous oversight for senior and disabled citizens while their friends or relatives works outside the home or take care of personal business. The service is intended to alleviate the need for higher levels of care through routine monitoring, early interventions, etc. Adult day care is offered at two levels:

- adult day health care which has a medical component (i.e., “medical model”)
- social adult day care, which offers social approaches to day care services (i.e., “social model”)

Regulatory oversight for adult day health care is provided by NYS DOH. Funding for the medical model is through Medicaid. Private pay and the NYS Long Term Home Health Care Program (LTHHCP) may reimburse both models.

**ASSISTED LIVING PROGRAM** is a level of care between the adult care facility and the nursing home.

Assisted living services range from shopping and housekeeping to personal care, and may include home health care and therapy, depending on the individual's needs. New York state-certified assisted living programs enter into contracts with certified home health agencies (CHHAs) and LTHHCs to offer in-house personal care, home health care and/or therapy to the residents. NYS DOH provides regulatory oversight. The reimbursement mechanism includes private pay and SSI payments.

**CERTIFIED HOME HEALTH AGENCIES (CHHAs)** are certified by NYS DOH and are qualified to participate in Title XVIII (Medicare) and Title XIX (Medicaid) of the Federal Social Security Act. At a minimum, CHHAs must provide the following services which are of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home: nursing services; medical supplies; home health aide services; and equipment/appliances suitable for home use. Additionally, the CHHA must provide at least one of the following services: physical therapy (PT), nutritional services, social work services; occupational therapy (OT); and speech/language pathology (SLP). CHHAs are regulated by NYS DOH. Reimbursement mechanisms include private pay, private insurance, Medicare, Medicaid, and the LTHHCP.

**LICENSED HOME CARE SERVICES AGENCIES (LHCSAs)** are non-profit or proprietary organizations granted a license from NYS DOH to provide either directly or through contract, at least one of the following services: nursing; home health care; and personal care. LHCSAs are regulated by NYS DOH and are reimbursed through private pay, Medicaid, and LTHHCP.

**NURSING HOMES** (*a/k/a skilled nursing facilities, nursing facilities or residential health care facilities*) provide 24-hour medical care, activities, supervision and social services to frail elderly and chronically-disabled persons. These represent the most complicated and therefore the most expensive level of continuing care and are aimed at providing services to those persons who need 24-hour medical care and supervision. Services provided by nursing homes can cover a wide range and include rehabilitation (e.g., physical therapy, occupation therapy, speech and language pathology, etc.) and management of specialty services to residents with AIDS, traumatic brain injuries (TBI), Alzheimer's disease and other dementias, as well as other life-threatening conditions. NYS DOH regulates nursing homes. The payers are Medicaid, Medicare, private pay and various insurance policies.

## APPENDIX 2

### FEDERAL ISSUE BRIEF: NURSING HOMES UNABLE TO EFFICIENTLY UTILIZE STAFF TO FEED RESIDENTS

#### Background

Because of regulations promulgated by the Omnibus Reconciliation Act of 1987 (OBRA '87), nursing homes (or nursing homes) are unable to maximize staff resources in order to feed their residents. Laws and regulations dictate that only professional licensed staff and certified nurse aides (CNAs) may feed residents.

#### Issue

While there is some "leeway" to permit volunteers to feed under certain circumstances, many facilities are unable to recruit sufficient numbers of volunteers for feeding purposes, and would choose to utilize non-professional, uncertified (but appropriately trained) staff for this task (e.g., housekeepers, social workers, etc.) if needed. However, due to current regulatory constraints, such staff are not permitted to feed residents.

#### NYAHSR Recommendation

The Health Care Financing Administration (HCFA) needs to expeditiously establish protocols for "nutrition/hydration assistants." This concept responds to a focus of President Bill Clinton's Nursing Home Initiative announcement of July 1998, in which he called for more stringent standards for nursing homes.

The nutrition/hydration program should allow for any and all appropriately trained staff to feed nursing home residents. Protections should be incorporated to assure that residents with particular feeding difficulties (e.g., swallowing disorders, feeding tubes, etc.) are fed only by licensed professional nurses or other specially trained staff.

Such a program could be established (as proposed by the American Association of Homes and Services for the Aging) by amending Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act to include:

"(H) Non-Nursing Personnel Performing Limited Duties"

- (i) Nursing homes may permit personnel other than nurse aides to provide assistance with eating without completing the NATCEP or CEP if they have acquired the necessary knowledge and skills through an inservice training program established by a professional organization such as the American Dietetic Association that includes dining skills and assistance with eating; and that has been reviewed and approved by the regulatory authority; and they have been found competent to perform their duties.
- (ii) The determination of ability to provide assistance with eating and dining skills will be made by an interdisciplinary team, to include, at minimum, licensed nursing, dietary, speech therapy, and occupational therapy staff responsible for the care of the resident. The determination will be based on the needs and potential risks to the resident as observed and documented in the comprehensive resident assessment and care plan.
- (iii) The facility will document that the interdisciplinary team has assessed the resident to determine that his or her health status does not require this particular task to be performed by nursing personnel. Non-nursing personnel providing assistance with eating and dining skills may augment, but not replace, existing staff, and cannot be counted toward meeting or complying with requirements for nursing care staff and functions.

Nutritional well being is at the root of every individual's overall quality of life (indeed, life itself), and government must make an aggressive effort to assure that nursing home residents receive the appropriate nutrition they need and deserve.

*The New York Association of Homes and Services for the Aging (NYAHSR) represents more than 550 not-for-profit and public providers of continuing care services to over 500,000 elderly and disabled New Yorkers annually. If you have any questions on this issue brief, please contact Nancy Tucker, NYAHSR's director of nursing home policy at 518-449-2707, ext. 129, via e-mail to ntucker@nyahsa.org, or via fax to 518-449-8210. Refer to Doc. ID #24402001, March 2000.*

## APPENDIX 3

### NYAHSA CNA SURVEY SUMMARY

During 1998, NYAHSA became increasingly concerned about the growing workforce crisis affecting continuing care providers, specifically, the high degree of certified nurse aide (CNA) shortages and turnover in nursing homes. In an attempt to assess the severity of this problem throughout the state, NYAHSA developed a survey and invited the Healthcare Association of New York State (HANYS) and the New York State Health Facilities Association (NYSHFA) to join in this effort.

In December 1998, all three associations forwarded the survey entitled "Survey on CNA Staffing" to their respective members. Providers were directed to answer survey questions for the one-year period of July 1, 1997 through June 30, 1998. Out of a total of 672 surveys sent to nursing home providers throughout the state, 250 surveys were returned, resulting in a 38 percent response rate.

The following excerpts from the survey results provide the reader with key findings and observations relating to each major issue.

#### I. Facility Staffing

A possible indicator of staffing shortages is that 73 percent of responding facilities were not employing additional staff during peak times. This report will later place more attention on the overwhelming turnover rates for part-time CNAs throughout the state. Although it appears that nursing homes are struggling to recruit and retain part-time workers, other measures have been instituted to both meet the needs of CNAs and maintain quality services for the residents living in the facilities.

For instance, 66 percent of responding providers reported that CNA hours are scheduled differently from the traditional shifts (i.e., 7-3, 3-11 and 11-7.) Of those facilities, 77 percent offer 6 am to 2 pm (or 6:30 am to 2:30 am) shifts, and 12 percent allow for 12-hour shifts (generally between 7 am and 7 pm). *(Of those facilities that do schedule additional CNAs during peak times, almost all of them reported offering four-hour shifts in the evening, such as 4 pm to 8 pm and 5 pm to 9 pm.)*

Also unexpected was the finding that 40 respondents (16 percent) use agency staff as part of their baseline staffing. Those facilities use an average of 10.3 agency staff CNAs per day, whereas some providers almost rely solely on agency staff.

#### II. CNA Wages

The following section examines hourly wages for CNAs, which reflect facility wage levels as of Jan. 1, 1998. Within each county, wages generally varied from below average to up to \$2.00 per hour above average. However, a few counties showed a variance of greater than \$3.00 per hour, with one county showing more than a \$5.00 per hour variance (i.e., the Bronx showed a wage range of \$8.00 per hour to \$13.06 per hour).

The lowest starting hourly rate for CNAs without experience was found in Cortland County at \$5.15 per hour (minimum wage), whereas the highest wage was found in the Bronx, at \$13.06 per hour. The lowest wage levels were typically associated with higher than average employee turnover rates.

To determine if the converse was true, facilities in the Bronx were examined. Salary differences among facilities in that borough appeared to have little effect on turnover rates. In fact, the highest paying facility of \$13.06 per hour showed an average turnover rate of 31 percent for part-time employees, while the lowest paying provider, offering an \$8.00 per hour salary, had retained all of its part-time employees during the one-year period in question.

When asked if wages had increased since 1/1/98, 137 (55 percent) of the 250 respondents indicated they had made an increase in some aspect of the CNA wage scale. The tables below show the statewide average wages, as of 1/1/98, as well as average wages for various regions throughout New York state.

| Statewide Averages                               |           |                                               |           |                              |           |
|--------------------------------------------------|-----------|-----------------------------------------------|-----------|------------------------------|-----------|
| Starting Hourly Wages of CNAs without Experience |           | Starting Hourly Wages of CNAs with Experience |           | Average Hourly Wages of CNAs |           |
| Full-Time                                        | Part-Time | Full-Time                                     | Part-Time | Full-Time                    | Part-Time |
| \$8.27                                           | \$8.30    | \$8.65                                        | \$8.66    | \$9.41                       | \$9.24    |

| Regional Averages                                                              |                                |                              |                             |
|--------------------------------------------------------------------------------|--------------------------------|------------------------------|-----------------------------|
| Regions                                                                        | Number of Facility Respondents | Average Starting Hourly Wage | Average Overall Hourly Wage |
| Sullivan, Delaware, Broome, Tioga, Chenango, Tompkins                          | 11                             | \$6.58                       | \$7.30                      |
| Fulton, Montgomery, Herkimer, Oneida, Otsego, Schoharie                        | 24                             | \$7.01                       | \$7.57                      |
| Madison, Onondaga, Cortland, Cayuga, Oswego, Jefferson, St. Lawrence           | 23                             | \$6.59                       | \$7.95                      |
| Wayne, Seneca, Schuyler, Yates, Ontario, Livingston, Orleans, Niagara, Wyoming | 16                             | \$7.76                       | \$8.63                      |
| Chautauqua, Cattaraugus, Allegany, Chemung, Steuben                            | 12                             | \$6.52                       | \$7.77                      |
| Erie                                                                           | 17                             | \$6.82                       | \$7.64                      |
| Monroe                                                                         | 20                             | \$7.73                       | \$8.69                      |
| Clinton, Franklin, Essex, Warren                                               | 9                              | \$7.32                       | \$8.16                      |
| Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Washington        | 25                             | \$7.23                       | \$8.37                      |
| Dutchess, Ulster, Rockland, Orange, Westchester                                | 25                             | \$9.97                       | \$10.38                     |
| Bronx, Kings, New York, Queens, Richmond                                       | 28                             | \$11.09                      | \$12.09                     |
| Nassau, Suffolk                                                                | 26                             | \$10.03                      | \$12.20                     |

### III. Retention and Turnover

New York state is no exception when it comes to extremely high turnover rates for CNAs in nursing homes. Providers are having particular difficulties retaining part-time employees. In fact, for the one-year period between 7/1/97 and 6/30/98, nursing home providers experienced an average turnover rate of 83 percent for part-time CNAs. By excluding New York City (NYC) and Long Island (LI) facilities from the equation, the statewide average turnover rate for part-time employees increases to 95 percent.

However, consistent with the law of averages, our survey found facilities that were below the mean turnover rate as well as above. For instance, ten percent of the respondents reported turnover rates for part-time CNAs of 200 percent or greater, with numbers falling into the 300, 400 and 500 percentile range. High part-time turnover rates appear to be the most severe in the western part of New York state. Regional averages, as identified later in this section (see charts below), show part-time turnover rates of over 100 percent in this area of the state. The New York City metropolitan area, showing the lowest turnover rates for part-time CNAs, nevertheless shows an average part-time turnover rate of 55 percent.

Fortunately, nursing homes have found some stability with full-time employees, which represent roughly two-thirds of all CNAs employed. The statewide average turnover rate for full-time CNAs, for the

period between 7/1/97 and 6/30/98, was 24 percent. As alluded to earlier, the NYC/LI regions tend to bring down the statewide averages, since their turnover rates are significantly lower (i.e., six percent) than those of the rest of the state (and they employ larger numbers of CNAs relative to other regions in the state). Several factors seem to contribute to these uncharacteristically low turnover rates, including the high degree of unionization. Excluding the NYC/LI regions, the statewide average turnover rate for full-time CNAs is 36 percent.

Clearly, turnover is a major issue and an immediate concern for nursing homes. The following charts show the statewide and regional average turnover rates for nursing homes during the period of 7/1/97 to 6/30/98.

| <b>Statewide Averages</b>                                                                                                                                                              |                                                  |                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------|
| <b>Average Turnover Rates for Part-Time CNAs</b>                                                                                                                                       | <b>Average Turnover Rates for Full-Time CNAs</b> | <b>Average Turnover Rates for all CNAs</b> |
| 83%                                                                                                                                                                                    | 24%                                              | 42%                                        |
| <i>(Excluding the New York City/Long Island facilities, the average turnover rate for part-time CNAs is 95 percent; for full-time employees, 36 percent; and overall, 56 percent.)</i> |                                                  |                                            |

| <b>Regional Averages</b>                                                        |                                  |                                                  |                                                  |
|---------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------|--------------------------------------------------|
| <b>Regions</b>                                                                  | <b># of Facility Respondents</b> | <b>Average Turnover Rates for Part-Time CNAs</b> | <b>Average Turnover Rates for Full-Time CNAs</b> |
| Sullivan, Delaware, Broome, Tioga, Chenango, Tompkins                           | 11                               | 82%                                              | 44%                                              |
| Fulton, Montgomery, Herkimer, Oneida, Otsego, Schoharie                         | 25                               | 135%                                             | 44%                                              |
| Madison, Onondaga, Cortland, Cayuga, Oswego, Jefferson, St. Lawrence            | 21                               | 97%                                              | 29%                                              |
| Wayne, Seneca, Schuyler, Yates, Ontario, Livingston, Orleans, Niagara, Wyoming  | 16                               | 127%                                             | 22%                                              |
| Chautauqua, Cattaraugus, Allegany, Chemung, Steuben                             | 12                               | 133%                                             | 32%                                              |
| Erie                                                                            | 16                               | 122%                                             | 62%                                              |
| Monroe                                                                          | 19                               | 67%                                              | 52%                                              |
| Clinton, Franklin, Essex, Warren                                                | 8                                | 70%                                              | 12%                                              |
| Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Washington         | 22                               | 86%                                              | 37%                                              |
| Dutchess, Rockland, Orange, Westchester                                         | 26                               | 62%                                              | 22%                                              |
| Bronx, Kings, New York, Queens, Richmond                                        | 32                               | 55%                                              | 6%                                               |
| Nassau, Suffolk                                                                 | 27                               | 69%                                              | 6%                                               |
| <i>(Note: Ulster County was not represented in this portion of the survey.)</i> |                                  |                                                  |                                                  |

As mentioned at the beginning of this report, nursing homes received the CNA staffing survey in December of 1998. When asked whether the overall turnover rates had changed since 1/1/98, almost a full year later, the majority (59 percent) of providers answered no. Nearly one-third (28 percent) of the respondents reported an increase in turnover rates since 1/1/98, while the remainder of facilities (13 percent) suggested a decrease. For those providers who said that their turnover rates had increased, the causes they cited included: (1) more employer competition for the same workforce pool; (2) conflicts of the position with family issues such as child care; and (3) the lack of availability of full-time positions. For facilities indicating their turnover rates had decreased, the major reasons centered on (1) increased wages; (2) improved managerial skills of nurse managers and supervisors; and (3) the addition of a mentoring program for new hires.

On the whole, the three most significant reasons for turnover were identified as termination, family issues, and illness/injury. In relation to termination, respondents indicated that if the employee initiated the separation, the prevailing reason was because the employee's expectations of the job were incompatible with the position's demands. Employer-initiated termination was generally reported to be related to the employee's excessive absenteeism or poor work ethic. Two other noteworthy reasons for CNA turnover were found to be inadequate benefit packages and leaving after receiving CNA training from the facility.

#### IV. Recruitment

Finding qualified candidates for the arduous work required of a CNA seems to be just the beginning of the battle. Nursing homes throughout the state are struggling to find qualified candidates to fill the numerous CNA positions available. In fact, when asked if the ability to recruit CNAs has changed since 1/1/98, 35 percent of respondents reported that it had become more difficult. Over half (55 percent) of the providers felt that their ability to recruit CNAs hadn't changed. This is a possible indication of being in the midst of a shortage that began at an earlier point in time. Only ten percent of the facilities indicated that recruitment improved over this same period.

Upon further analysis, we discovered that recruitment difficulties were most closely associated with a small labor pool and competition among other health care providers as well as local businesses/industries. Of those facilities that reported problems with recruiting CNAs, 66 percent indicated that the general workforce was dwindling (or almost non-existent) and the few workers remaining were of poor quality (i.e., had little or no work ethic) or were without the necessary training to succeed as a nurse aide. Practically all remaining comments focused on the facilities' inability to compete in the market due to factors such as low wages, minimal benefits, inability to offer more full-time positions and the physical and emotional demands of the job. Several providers simply mentioned that the good economy meant more job opportunities for non-skilled laborers with which nursing homes could not compete for the abovementioned reasons.

Not surprisingly, those facilities that reported less difficulty in recruiting CNAs gave reasons such as: (1) increased wages; (2) offering improved benefit packages; and (3) providing more CNA training (or having collaborative relations with local BOCES programs that offer training).

Facilities were also asked to identify from a list of 21 options the strategies they use to recruit and retain CNA staff. The most frequently used methods were: (1) an annual pay increase of three percent or greater; (2) injury reduction and prevention programs; (3) weekend differentials; (4) pension packages; and (5) employee recognition programs.

Additionally, when questioned about the types of recruiting tools used when seeking CNAs, the following were most often identified: (1) advertisements; (2) educational institutions; (3) unsolicited applications; and (4) job fairs. Surprisingly, a large number of providers reported unsolicited applications (65 percent of respondents) as being one of the main sources of recruitment. Conceivably, these applicants may be the same workers that are later found to be of poor quality (i.e., lacking a good work ethic and/or necessary training to succeed in the field).

## V. Criminal Background Checks

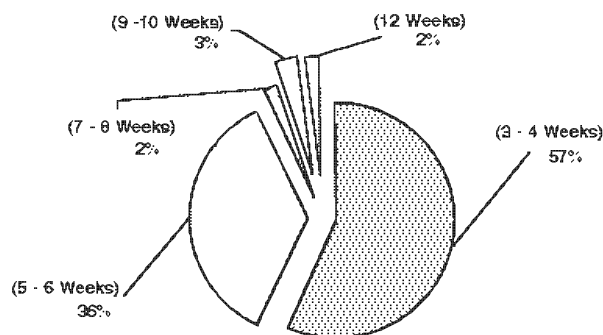
Of the 250 respondents, 49 facilities (20 percent) in 26 counties indicated they performed some type of criminal background checks on potential employees. The majority (84 percent) of facilities that have initiated this type of pre-hiring procedure did so between 1995 and 1998. Providers that perform background checks are scattered throughout the state with some clusterings found in Broome, Chemung, Monroe, Nassau and Oneida counties. Of those 49 facilities, 92 percent indicated they had rejected up to 20 percent of the applicants based on the information they learned from those checks, while five percent indicated they had rejected 21-40 percent of the applicants over a specified time period.

Questions were also asked about the cost of criminal background checks and the average turnaround time for checks to be completed. Counties reported a wide range of costs for background check reports. The average statewide cost was \$20.56 per applicant. Prices ranged from no cost in several counties to as high as \$100.00 per report in others. Incidentally, providers rarely paid the same amount per check as their counterparts in their other counties. Most facilities (82 percent) reported an average turnaround time for criminal background checks of one to two weeks, and over half (55 percent) of those respondents received the reports within one week. However, four percent of providers indicated an average turnaround time of greater than five weeks.

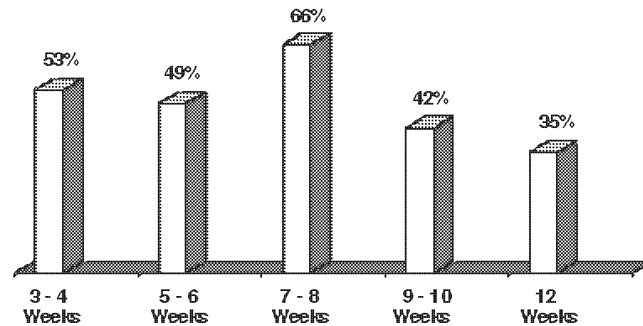
## VI. 100-Hour CNA Training Program

A significant portion (43 percent) of nursing home respondents offered the 100-hour CNA training course for nurse aides during the entire period of 7/1/97 to 6/30/98. The length of the training programs varied among providers, with the greatest number of providers offering the course over a three-to-four week period. The next chart shows the percentage of facilities that offered their training programs over various time periods, ranging from three to 12 weeks.

Figure 9. Length of CNA Training Programs



The correlation between length of CNA training programs and ability to retain CNAs was examined next. With the exception of one facility that tended to skew the results, an inverse relationship appears between length of programs and associated turnover rates. In other words, increasing the length of time over which the program is offered was generally associated with decreases in turnover, as indicated in Figure 10.

**Figure 10. Length of Training Programs vs. Average Turnover Rates**

Facilities were asked to identify the percentage of CNAs who were certified prior to being hired by the organization. A large number of facilities reported high numbers of CNAs having already received the 100-hour training course prior to becoming employed. Approximately 20 percent of the counties in the sample reported that at least 90 percent of new employees had completed the training program prior to being hired. Another 61 percent of counties reported an average of 56 percent of new hires having already received the training. Only 19 percent of the counties showed low percentages of trained CNAs. Those facilities had percentages falling between five and 29 percent of new hires having already received the 100-hour course.

Evidently, CNAs move a great deal within the health care field. We also know that a number of educational organizations (i.e., BOCES) conduct CNA training programs, which contribute to the high number of CNAs trained prior to being hired by facilities. The figures from the survey indicate a possible positive relationship between turnover and hiring previously trained CNAs.

The reverse also appears to be true; specifically, that hiring untrained individuals was associated with evidence of higher turnover rates. This leads us to conclude that: (1) the 100-hour training program may fall short of providing newly certified CNAs with the skills necessary to succeed in this very demanding and challenging field; and/or (2) the unlicensed candidates in the labor pool are less familiar with the demanding nature of the work than those individuals who are already certified. However, additional research is needed in this area in order to draw more solid conclusions.

## **VII. Other Issues**

### **A. Onsite or Affiliated Child Day Care Services**

Although a relatively small group of providers (15 percent) located throughout the state offer onsite child day care services, this benefit appears to assist facilities with retaining qualified CNAs. The average CNA turnover rate for facilities that offer onsite or affiliated day care services was determined to be 30 percent (nearly one-third lower than the statewide average). Practically half (47 percent) of these nursing homes subsidize the cost of day care, which could also contribute to the lower-than-average turnover rates experienced by those providers.

### **B. Welfare-to-Work (WTW) Clients**

Survey respondents were asked whether they were working with the local Department of Social Services to employ/train WTW clients. Out of the 53 facilities who responded "yes" (or 22 percent of respondents), 83 percent of them employed fewer than five WTW individuals as CNAs during the

period between 7/1/97 and 6/30/98. In fact, over half of these 53 respondents didn't actually employ any such persons during that time.

Of nine providers throughout the state that hired anywhere from five to 16 WTW clients during the one-year period, only two facilities had lower-than-average turnover rates (based on the statewide average turnover rate of 42 percent for all CNAs) for the WTW population. However, turnover rates for WTW CNAs appeared to be consistent with the overall turnover rates for each individual provider. Seemingly, the retention of WTW clients had less to do with the individual CNA and more to do with the overall factors affecting turnover rates for those facilities identified.

### C. Transportation Issues

When asked if access to transportation was an issue for employees, 78 facilities (32 percent) located throughout the state replied that transportation was in fact a problem for CNAs. Unfortunately, only 30 percent of those facilities were also able to report that they had taken measures to address the problem. When examining the degree of CNA turnover for these facilities, as expected, their turnover rates were found to be higher than the statewide averages. The average turnover rate for part-time employees was 135 percent (or 163 percent higher than the statewide average), whereas the average turnover rate for full-time employees was 40 percent (or 181 percent higher than the statewide average).

### D. Market Competition

When the economy is good, work is plentiful and competition becomes a key component in the ability to attract and retain qualified employees. Nursing homes are finding it difficult to recruit and retain qualified CNAs who are willing to perform the demanding—and sometimes demeaning—aspects of the job for non-competitive wages and benefits relative to what is available elsewhere in the market place.

The remaining survey questions revolved around competition with other health care providers and competition with other businesses (of a non-health care nature). Virtually all providers (95 percent) directly compete with other health care providers (including hospitals) and numerous respondents (79 percent) compete with other businesses as well. More interesting are the reported turnover rates for those providers that do not report this type of direct competition (whether other health care organizations or other businesses).

Although the average turnover rate for part-time CNAs in facilities that did not directly compete with other health care organizations was similar to the statewide average, the average turnover rate for full-time CNAs was markedly lower than the statewide average. The part-time average turnover rate was 84 percent and the full-time average turnover rate was three percent (or 88 percent lower than the statewide average). Clearly, competition with other health care organizations is a major issue in the recruitment and retention of CNAs.

Still, does the absence of other competing businesses also equate to lower turnover rates for affected nursing homes? As expected, these providers did experience below-average turnover rates. However, the retention levels were only slightly better than statewide average levels. The average turnover rate for part-time CNAs was 74 percent (compared to the statewide average of 83 percent), while the average turnover rate for full-time CNAs was 21 percent (compared to the statewide average of 24 percent.)

## VIII. Conclusion

With the possible exception of the New York City metropolitan area, nursing homes are overwhelmed with CNA shortages. This “war on staffing” may be the greatest operational challenge to nursing homes today. As the research suggests, providers are greatly disadvantaged when it comes to competing with the general market. The wages offered in many regions of the state are relatively low, forcing full-time CNAs to attempt to survive on annual salaries of less than \$14,000 per year. With a booming economy, the best workers apparently seek out higher-paying, less-demanding job opportunities, oftentimes leaving less qualified and less motivated candidates to seek jobs in continuing care.

The following represent the key findings of this study:

- Counties offering the lowest wages for CNAs are consistently reporting some of the highest turnover rates in the state (i.e., in excess of 100 percent per year for part-time CNAs.). Salary differences in these counties appear to have an impact on the ability to compete with other health care providers and businesses.
- Roughly one-third of nursing home providers reported that turnover rates have increased since 1/1/98. Slightly more than a third of respondents also believe that recruitment of CNAs has become more difficult since 1/1/98. Reasons for these problems were attributed to:
  - (1) small labor pool (or almost non-existent in some parts of the state);
  - (2) poor quality job applicants (lacking either work ethic or necessary training to succeed as a CNA);
  - (3) competition among health care providers and other businesses;
  - (4) family issues such as child care;
  - (5) access to transportation;
  - (6) lack of ability to offer full-time positions;
  - (7) inability to offer competitive salaries and benefit packages; and
  - (8) physical and emotional demands of the job.
- More than half of all providers in the survey showed no change in the ability to recruit and retain staff since 1/1/98. Nevertheless, these same providers cite many of the issues mentioned above, leading us to conclude that the “crisis” began sometime earlier than mid-1997.
- In 1998, 20 percent of nursing homes were performing criminal background checks on potential employees. Turnaround times can be lengthy and the cost per check can be quite expensive. The statewide average for a background check was determined to be \$20.56, with some facilities paying as much as \$100 per check.
- Unionization presents challenges to providers. Unions tend to drive up the hourly wages/benefit packages for CNAs and restrict management's ability to discipline employees, implement change, and offer salary differences to more experienced CNAs.
- The existing 100-hour training program for CNAs is evidently not preparing newly trained CNAs for the rigorous nature of the job. Whether the duration and/or content of the course is at issue, the answer is clear—something needs to change, and quickly. Facilities that mostly hire inexperienced nursing assistants show alarmingly high turnover rates (i.e., the average turnover rate for part-time CNAs was found to be 153 percent for those facilities). Providers that offer extended CNA training programs did appear to have slightly better turnover rates than facilities providing the training courses over shorter (i.e., three- to four-week) periods.

As with many dilemmas, there is no one answer. Nursing homes across New York state have been frantically searching for solutions to CNA shortages for the past couple of years. With much dismay, they have reluctantly begun to acknowledge that this “crisis” is beyond their control. This document supports their views that legislative and administrative assistance is critical to help find and retain qualified, caring and skilled CNAs for this vitally important segment of the continuing care system.

## APPENDIX 4

### NYAHSA FOCUSED TELEPHONE SURVEY SUMMARY

As a follow-up to the CNA staffing survey, NYAHSA conducted a focused telephone survey in January 2000 to a randomly selected, stratified sample of NYAHSA members. A total of 86 providers participated in the telephone survey, encompassing most types of continuing care organizations (i.e., nursing homes, home health agencies, adult care facilities and medical and social model adult day care providers). This survey was necessary to better understand the severity of workforce shortages in various continuing care settings in New York state. The survey focused on the following occupations:

- certified nurse aide (CNA)
- home health aide (HHA)
- personal care aide (PCA) (a/k/a resident care aide)
- registered nurse (RN)
- licensed practical nurse (LPN)
- other non-clinical paraprofessionals (e.g., dietary, housekeeping, maintenance), etc.

The following are excerpts from the survey results and provide the reader with key findings and observations relating to each provider type surveyed.

#### I. Nursing Homes

Although minor differences exist among various regions of the state, statewide employee vacancy rates for nursing home providers were found to be very high for clinical positions. For instance, 74 percent of respondents reported current vacancies for CNAs; 61 percent of respondents reported current vacancies for RNs and another 61 percent of respondents reported current vacancies for LPNs. Compared to the statewide average vacancy rate for non-clinical positions (i.e., dietary, housekeeping, maintenance, etc.), vacancy rates for clinical positions (i.e., RNs, LPNs and CNAs) were nearly twice as high.

Respondents had difficulty identifying the one job category which was the most difficult to fill, and in a number of cases identified more than one type of worker, showing relatively equal difficulties in hiring for each of the clinical categories (i.e., RNs, LPNs and CNAs). However, when identifying the type of worker that was least problematic to hire, CNAs were discovered to be less difficult to hire than LPNs and RNs. Not surprisingly, non-clinical positions were found to be the least difficult positions to fill.

When asked to identify reasons for labor shortages, providers most often cited: (1) competition with local employers; (2) a small labor pool in the region; and (3) the inability to afford higher salaries and better benefits. Retention of existing employees was also a compelling factor, with 63 percent of respondents identifying this as a major reason for labor shortages. Also noteworthy were the lack of transportation and child day care for employees, which were contributing factors for some providers.

Common responses to labor shortages by providers were: (1) requests that existing staff work additional hours (i.e., overtime shifts leading to overtime pay); (2) hiring agency or per diem staff; and (3) asking staff to perform duties not normally associated with their positions (e.g., LPNs performing CNAs duties, nurse managers working as direct-care nurses, etc.). Although a few nursing homes found themselves taking drastic measures such as temporary halts to new admissions or only admitting less medically complex patients, many providers used overtime incentives to respond to shortages.

In an effort to better identify the type of competition continuing care providers face, NYAHSA asked respondents where workers find employment upon leaving the nursing home. Although this was a relatively subjective question, 88 percent of respondents reported that workers sought out jobs with other health care organizations. Anecdotally, surveyors repeatedly heard that many workers seek positions in hospitals simply because of the higher wages/better benefits being offered.

Although employee retention was not reported as an issue by all respondents, it was a factor for 55 percent of nursing homes surveyed. As remarkable as it was that approximately 45 percent of providers were not reporting retention difficulties, it became evident that the majority of these respondents were located in either the New York City/Long Island or Hudson Valley regions, areas that tend to have greater unionization.

Facilities most often attributed retention difficulties to the following three reasons: (1) termination (irrespective of employee or employer initiation); (2) wages; and (3) the working environment. Generally, it appears that facilities are forced to terminate employment during the probationary period due to poor work ethics of employees (e.g., attendance/tardiness issues, lack of effort/commitment on the job, etc.) and lack of preparation/training to succeed in the position. Retention issues pertaining to the work environment included such problems as physical demands of the job, job stress due to staffing shortages, and physical/verbal abusiveness from residents.

Respondents were asked to select three solutions out of a list of nine choices as ways to improve recruitment and retention of clinicians. An overwhelming number of providers identified having a larger labor pool followed by higher wages as the most meaningful answers. The need to provide better benefits and additional training to employees were the next most frequent responses. These suggestions were consistently the most often cited throughout the entire state.

Although the abovementioned "solutions" were cited most often by nursing homes, NYAHSA members have implemented many other strategies in an attempt to improve their ability to recruit and retain health care workers. Nursing homes have tried just about everything imaginable (with mixed results), including annual raises, sign-on and referral bonuses, scholarship funds, tuition assistance, shift differentials, career ladders, job enrichment activities, etc. Some providers have gone as far as to pay potential applicants to "shadow" existing staff while they perform a typical day's work. In many cases, it appears that facilities have initiated much more intense marketing and recruitment activities than ever in order to attract more candidates. Roughly 90 percent of nursing home respondents reported having either implemented new strategies or enhanced existing measures in 1999 to better recruit and retain workers.

## II. Home Health Agencies

Like nursing homes, home health agencies also seem to be struggling with workforce shortages. These agencies tend to employ RNs, LPNs, HHAs, PCAs and some non-clinical workers. One-half of all respondents reported current vacancies directly related to labor shortages in the following categories: HHAs, PCAs, and RNs, while 43 percent of HHAs reported LPN shortages.

As with nursing homes, HHAs are increasingly faced with difficulties in hiring health care workers. When asked which types of positions were the most (and least) difficult to fill, it became obvious that home health agencies found RN positions to be the most problematic. Responding agencies cited LPNs as the least difficult positions to fill relative to the other clinical categories.

Similar to nursing homes, most agencies (i.e., 82 percent) reported current labor shortages. Also consistent with nursing home providers, the most significant reasons (i.e., top three reasons) for labor shortages were: (1) competition with local employers; (2) a small labor pool in the region; and (3) the inability to afford higher salaries and better benefits. Retention of existing employees and lack of transportation for workers were also frequently cited.

Home health agencies were not only forced to hire agency/per diem staff or pay overtime to existing employees during 1999; but they also found themselves redefining positions and service areas in an effort to respond to sometimes severe staffing shortages. For instance, some respondents had taken extreme measures such as only serving patients within a three-mile radius, requiring patients to receive care in the afternoon, or equipping patients' homes with digital cameras so monitoring could be done from offices as opposed to actual home visits. Additionally, 22 percent of respondents reported having stopped taking new patients during peak staffing shortages.

Another contributing factor for home care labor shortages that was uncovered was the reality of a changing patient population and the need to find RNs who are bilingual and can communicate with such diverse populations including Russian, Chinese, Korean and Philippine immigrants, for example.

Responding home health agencies, similar to nursing homes, cited other health care organizations as the major competitor for workers. Also noteworthy and cited by approximately half of the respondents were local industries, retail jobs and food/dining establishments as other major competitors.

Surprisingly, almost 55 percent of home health agency respondents reported no retention difficulties. Of those providers struggling to retain workers, all identified the “working environment” as being a major contributor. Simply stated, the types of hours, shifts, on-call requirements, traveling and physical demands of the job play a major role in retention of workers. Low wages were also cited as a major reason for high turnover of home health care workers.

Home health agencies, with some success, have also initiated a variety of strategies to improve their ability to recruit and retain workers. Aggressive recruitment efforts were the most often cited strategy. For instance, one provider reported reaching out to the Korean community in an attempt to attract more employees.

When asked for the top three strategies to enhance recruitment/retention, all home health agencies surveyed identified higher wages as being the most needed change. A larger labor pool was the second most frequently recommended response, followed by the ability to provide better benefits to employees. Evidently, wages and benefits are a prime consideration in attracting and retaining home health care workers. But the issue of simply finding qualified job applicants was just as commonly identified as a concern by these agencies.

### III. Adult Care Facilities

Adult care facilities (ACFs) reported being less affected by labor shortages and/or retention of health care workers than nursing homes or home health agencies. ACFs generally employ RNs, LPNs, PCAs and non-clinical workers. Unlike nursing homes and home health agencies, however, ACF respondents reported no vacancies for RN positions. Similarly, only 17 percent of providers reported LPN vacancies—far less than the percentage of ACFs that identified vacancies for non-clinical workers (i.e., 40 percent.) Among direct-care staff, PCA vacancies were cited by the most respondents (i.e., 56 percent).

ACFs reported no major difficulties with hiring RNs, but more than one-third reported difficulties with hiring LPNs, despite fairly low vacancy rates. Meanwhile, consistent with vacancy rates, PCAs were identified as the most difficult positions to fill, with 67 percent of survey respondents acknowledging difficulties. Given their limited usage of RNs, ACFs reported these positions as being the least difficult to fill.

Overall, 70 percent of ACFs reported labor shortages, albeit most generally related to vacant PCA positions. As with nursing homes and home health agencies, the top three reasons for labor shortages were determined to be: (1) competition with local employers; (2) a small labor pool in the region; and (3) the inability to afford higher salaries and better benefits. Incidentally, transportation was the fourth most frequently cited reason for difficulties with recruiting/retaining qualified workers.

Anecdotally, ACFs cited issues with the quality of applicants as a major problem. In this regard, respondents identified such concerns as workers lacking self-direction or the desire to work, language skills and the lack of training.

Although more than half of the survey respondents did not need to take additional steps to offset labor shortages in 1999, of those providers that did, 100 percent of them offered overtime pay to existing employees. ACFs with severe shortages also took measures such as hiring agency staff (33 percent of respondents) and/or substituting job categories (50 percent of respondents.)

Competition for the ACF labor market appears to be less with other health care providers than with retail businesses and food and dining establishments.

Retaining qualified workers is apparently less of a problem for ACFs than finding candidates for this type of work in the first place. Approximately 70 percent of the ACFs surveyed reported having no employee retention problems. However, for those facilities that acknowledged difficulties, the “working environment” appeared to be the greatest factor in worker turnover. Once again, reasons such as not enough full-time positions available, workers having problems with the responsibilities of the job (e.g., not wanting to be CPR/first aid-trained or being responsible for medication administration, etc.), shifts/hours and job stress were cited in this regard.

However, with this group of facilities, another reason for retention was identified—further education for employees. It was evident that some ACFs may be losing workers to other sectors of the health care field, for instance, direct-care workers who leave to take the CNA training program.

Wage increases, improved benefits, staff bonuses and increased job enrichment activities, in addition to more advertising and focused recruitment strategies, were all common measures taken by ACFs to attract and retain health care workers. When asked what would help providers to better recruit/retain workers, the overwhelming majority cited a larger labor pool and the ability to provide higher wages. Once again, this segment of the continuing care field reports relatively competitive wages while at the same time showing additional funding for wages as a crucial element in the war against staffing shortages.

The ability to offer an improved benefit package, address transportation and child day care issues were also commonly cited by ACF providers as necessary components of any solution to workforce shortages.

#### **IV. Adult Day Care Programs**

Among the provider types surveyed, adult day care (ADC) programs seemed to be the least affected by staffing shortages. In fact, many of these providers report having a surplus of direct-care workers, which often come directly from the nursing homes or other providers that sponsor the adult day care programs. ADC programs represented 24 percent of all survey respondents.

Medical model ADC providers tend to employ CNAs, RNs, LPNs and non-clinical workers, whereas social model providers usually hire PCAs or CNAs and non-clinical workers. Although medical model participants reported vacancies in each job category of workers, neither group of respondents (medical model or social model) reported significant numbers of vacancies (i.e., the highest percentage was 25 percent of social model providers reporting vacancies for PCAs).

Medical model respondents showed RNs as the most difficult positions to hire, and CNAs as the least difficult workers to recruit. Social model ADC providers reported non-clinical workers as the most difficult to find and PCAs as the easiest (contrary to reported vacancy levels).

More than half of all ADC respondents reported no labor shortages, with 50 percent of medical model ADC providers identifying shortages, and only 38 percent of social model providers reporting shortages. For both types of day care providers, respondents facing labor shortages cited competition with local employers, a small labor pool in the region and the inability to afford higher salaries and better benefits as the main reasons for shortages. Issues with retention of workers, transportation and child day care for employees were also raised as concerns.

As with other types of continuing care providers, a few adult day care providers (both social and medical model) faced severe enough labor shortages that required them to provide overtime pay to existing employees, hire agency staff, substitute categories of workers and even redefine positions.

Although competition is less of a factor for ADC programs than for other provider types surveyed, the majority of respondents with retention issues cited other health care organizations as their major competitor for labor.

Retention doesn't appear to be much of a concern for ADC providers with 69 percent of medical model respondents reporting no problems, and 88 percent of social model participants showing no difficulties in this area. Respondents with turnover issues cited similar reasons as other continuing care providers (i.e., wages, benefits, family issues, working environment, termination, etc.).

Many ADC programs reported doing nothing different in 1999 to better recruit/retain staff, unlike other continuing care providers. However, those providers that took some sort of action (i.e., either enhanced existing programs or implemented new strategies) most frequently identified having increased wages and/or benefits, provided job enrichment activities or initiated more focused advertising and recruitment strategies as actions they took.

As with other survey respondents, ADC providers were asked to identify three changes that would enhance their ability to recruit and retain health care workers. Half of all ADC respondents stated that changes were not needed. However, those participants that felt assistance was necessary, like other continuing care providers, identified higher wages, increased benefits and a larger labor pool as solutions. Additionally, child day care and more training for workers were commonly cited.

## V. Provider Type Comparison

NYAHSR concludes that all provider types surveyed are affected by workforce shortages in varying degrees. To better understand the dynamics among continuing care providers, key findings for each sector of the field need be compared. The following charts allow the reader to compare and contrast various statistics for each type of provider.

| A. Prevalence of Labor Shortages and Retention Difficulties |                                                   |                                                          |
|-------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------|
| Type of Provider                                            | Percentage of Providers Reporting Labor Shortages | Percentage of Providers Reporting Retention Difficulties |
| Nursing Home                                                | 92                                                | 55                                                       |
| Home Health Agency                                          | 82                                                | 45                                                       |
| ACF                                                         | 70                                                | 30                                                       |
| ADC-Medical                                                 | 50                                                | 31                                                       |
| ADC-Social                                                  | 38                                                | 12                                                       |

| B. Reasons for Labor Shortages and Retention Difficulties |                                                                                          |                                                                       |
|-----------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Type of Provider                                          | Top Reasons for Labor Shortages<br>(in descending order)                                 | Top Reasons for Retention Difficulties<br>(In descending order)       |
| Nursing Home                                              | (1) competition (2) labor pool<br>(3) wages/benefits (4) retention                       | (1) working environment<br>(2) termination (3) wages                  |
| Home Health Agency                                        | (1) competition<br>(2) labor pool and wages/benefits                                     | (1) working environment (2) wages<br>(3) transportation and retention |
| ACF                                                       | (1) competition and labor pool<br>(2) transportation<br>(3) wages/benefits and retention | (1) working environment<br>(2) family issues                          |
| ADC-Medical                                               | (1) competition (2) labor pool and wages/benefits (3) retention                          | (1) wages (2) family issues                                           |
| ADC-Social                                                | (1) wages/benefits<br>(2) competition and labor pool                                     | (1) wages and benefits and working environment                        |

| <b>C. Recommendations for Better Recruitment and Retention of Health Care Workers</b> |                                                                                                                                              |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Type of Provider</b>                                                               | <b>Top Changes Recommended to Enhance the Ability to Recruit and Retain Workers in Continuing Care Settings <i>(In descending order)</i></b> |
| Nursing Home                                                                          | (1) increased wages<br>(2) larger labor pool<br>(3) improved benefits and more/better training                                               |
| Home Health Agency                                                                    | (1) increased wages<br>(2) larger labor pool<br>(3) improved benefits<br>(4) child day care services and more/better training                |
| ACF                                                                                   | (1) increased wages<br>(2) larger labor pool<br>(3) improved benefits, transportation and child day care services                            |
| ADC-Medical                                                                           | (1) increased wages<br>(2) improved benefits<br>(3) larger labor pool<br>(4) child day care services                                         |
| ADC-Social                                                                            | (1) increased wages<br>(2) child day care services and more/better training                                                                  |

## VI. Conclusion

Clearly, the ever-shrinking labor pool is a major issue for continuing care providers. As a group, each provider type showed overwhelming percentages of providers with recruitment concerns. A common recruitment strategy for all provider types during 1999 was an increase in advertising and related activities. Vacancies and difficulties filling positions were found to be most pronounced for nursing homes and home health agencies. However, ACFs showed some significant issues for a number of job categories as well.

It is evident that increased wages and better benefits are a commonly cited issue, but other strategies, such as assisting providers in offering child day care and transportation services, are also important. However, other problematic areas have received little attention thus far and will demand greater emphasis if workforce issues are to be fully resolved. These include significant issues with the work environment and training needs for continuing care workers.

Few would argue that continuing care clinicians perform arduous work every day. Between the physical and emotional demands of the job, providers find themselves struggling to find new ways to attract qualified candidates for this type of work. With a depleted labor pool and often less desirable workers remaining, providers are discovering that typical training programs fall far short of preparing this type of worker for the responsibilities/demands of the job.

Surely a comprehensive approach to New York's growing workforce crisis for continuing care providers is needed. Such an approach must incorporate a range of creative solutions and appropriate funding mechanisms. However, the ultimate solution, although extremely unrealistic, is a drastic increase in the number of qualified and motivated job applicants in the labor pool or a fundamental change in the way continuing care is provided.