Who Will CARE *for* Us?

Addressing the Long-Term Care Workforce Crisis

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with
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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Institute for the Future of Aging Services

The Urban Institute

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Contents

INTRODUCTION 2

Executive Summary 3

The Long-Term Care Frontline Workforce 3

What Is the Problem? 3

Factors Affecting the Supply and Quality of Workers 4

Public and Private Efforts to Develop a Qualified, Stable Frontline Workforce 5

INTRODUCTION 8

Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis 9

The Long-Term Care Frontline Workforce 10

The Long-Term Care Worker Problem: Definition and Magnitude 12

Factors Affecting the Supply and Quality of Frontline Workers 16

Health and Long-Term Care Policy 18

Public and Private Efforts to Develop a Qualified, Stable Frontline Workforce 25

Developing Policy through a Research and Demonstration Agenda 33

References 35

ABOUT THE AUTHORS 39

INTRODUCTION

The paraprofessional long-term care workforce- nursing assistants, home health and home care aides, personal care workers, and personal care attendants- forms the centerpiece of the formal long-term care system. These front-line workers provide hands-on care, supervision, and emotional support to millions of elderly and younger people with chronic illness and disabilities. Low wages and benefits, hard working conditions, heavy workloads, and a job that has been stigmatized by society make worker recruitment and retention difficult.

Executive Summary

Long-term care providers report unprecedented vacancies and turnover rates for paraprofessional workers. Increasingly, the media, federal, and state policymakers and the industry itself are beginning to acknowledge the labor shortage crisis and its potentially negative consequences for quality of care and quality of life. These shortages are likely to worsen over time as demand increases. This paper, developed with support from the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, provides a broad overview of the long-term care frontline workforce issues.

The Long-Term Care Frontline Workforce

Most paid providers of long-term care are paraprofessional workers. After informal caregivers, these workers are the most essential component in helping older persons and younger people with disabilities maintain some level of function and quality of life. According to recent U.S. Bureau of Labor Statistics (BLS) data, nursing assistants held about 750,000 jobs in nursing homes in 1998, while home health and personal care aides held about 746,000 jobs in that same year. Like informal caregivers, the overwhelming majority of frontline long-term care workers are women. About 55 percent of nursing assistants are white, 35 percent are black, and 10 percent are Hispanic. Most workers are relatively disadvantaged economically and have low levels of educational attainment. While these paraprofessional workers are engaged in physically and emotionally demanding work, they are among the lowest paid in the service industry, making little more than the minimum wage. National data on the number of workers with health benefits is lacking, but state and local studies suggest the rate of uninsurance is high.

What Is the Problem?

The severe shortage of nursing assistants, home health and home care aides, and other paraprofessional workers is the primary trend influencing the current wave of concern about the long-term care workforce. National data on turnover rates show wide variation, depending on the source of the data: One source suggests that turnover rates

average about 45 percent for nursing homes and about 10 percent for home health programs, while other data place average annual nursing home turnover at over 100 percent a year. High rates of staff vacancies and turnover have negative effects on providers, consumers, and workers: The cost to providers of replacing workers is high; quality of care may suffer; and workers in understaffed environments may suffer higher rates of injury.

The future availability of frontline workers does not look promising. There will be an unprecedented increase in the size of the elderly population as the "baby boom" generation ages. BLS estimates that, in response to this rising demand, personal and home care assistance will be the fourth-fastest growing occupation by 2006, with a dramatic 84.7 percent growth rate expected. The number of home health aides is expected to increase by 74.6 percent and that of nursing assistants by 25.4 percent. While these projections suggest that the demand for workers will increase, the actual number of jobs may be tempered by the rate of economic growth and the extent to which purchasers are willing or able to pay. At the same time, as baby boomers approach old age, the pool of middle-aged women who have traditionally provided care will also be substantially smaller. Finally, with very low population and labor force growth, even a "normal" business cycle recession would likely yield only a modest increase in the number of unemployed who could become part of a frontline worker pool.

Factors Affecting the Supply and Quality of Workers

The success of efforts to recruit, retain, and maintain a long-term care workforce is dependent on a variety of interdependent factors. One important influence on individuals' decisions to enter and remain in the long-term care field is how society values the job. Frontline worker jobs in long-term care are viewed by the public as low-wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people. This image is exacerbated by media reports that feature poor quality care by providers.

Conditions in the labor market are also important influences on the decision to join the long-term care workforce. Several studies have identified the strength of the local economy as a major predictor of turnover rates in long-term care. A study conducted in North Carolina found that fewer than half the individuals trained as nursing assistants in that state over the last decade were currently certified to work in that occupation, with most "leavers" working at higher-wage jobs.

Health and long-term care policies also significantly affect workforce recruitment and retention. Medicare and Medicaid account for almost three-fifths of long-term care expenditures and therefore play a substantial role in determining provider wages, benefits, and training opportunities. Regulatory policy on long-term care focuses primarily on protecting consumers, rather than on responding to workers' concerns. Regulation tends to emphasize entry training, with limited attention to continued career growth or development. One major policy issue for workforce development is the extent to which states allow nursing assistants to perform certain tasks currently performed by nurses (e.g., administering medications or providing wound care). Giving frontline workers added responsibility and autonomy may motivate them to remain in the job or encourage others to seek these positions. Program design features, such as whether consumer-directed home care is provided, can also affect the size of the labor force by making it easy or hard for relatives and friends to be paid for care provided.

Labor policy plays an important role in determining the size of the pool of frontline long-term care workers. The federal government invests more than $8 billion annually to prepare primarily low-income and unemployed individuals for new and better jobs. Ironically, state and federal employment agencies indirectly prevent the long-term care industry from participating in training support programs by requiring that program graduates secure wages that are higher than typical frontline worker salaries. While these policies are designed to protect trainees from being shunted into poverty-level jobs, they essentially preclude graduates from entering the paraprofessional long-term care labor force. The federal Work Investment Act of 2000 does not include the same requirements, but the effects of the new law are unclear.

Federal welfare initiatives are particularly relevant to the development of this workforce. The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created the Temporary Assistance for Needy Families (TANF) program, which replaced the cash welfare system with a new block grant program and provides flexibility to states in developing job opportunities. Many states follow a "work first" strat-

egy that discourages skill-based training; although such policies are designed to get recipients into the work force, they conflict with federal nursing home and home health aide training requirements.

Given the current labor shortage and gloomy projections about the future pool of workers, many providers have expressed interest in immigration as a tool for expanding the potential labor pool. But immigration of low-wage workers would have to substantially increase to keep pace with population aging and new long-term care demands. Policymakers must recognize that having low-skilled immigrants fill entry-level jobs in the long-term care industry would likely mean a sharp cultural discontinuity between the client and the caregiver.

The confluence of the above factors and individual employer and employee decisions are played out in the workplace. Organizational arrangements, social factors, physical setting, and environment and technology all affect the successful development of the frontline workforce. A review of the literature reveals that little empirical research on workplace interventions has been done. Most of the research has been conducted in nursing homes and tends to be descriptive, rather than analytical, describing various management/job redesign efforts, training activities, and financial and nonmonetary reward programs. In the 1980s, several small, qualitative studies of nursing assistants identified the organization's management style (e.g., supervisors with "good people skills," promotion of worker autonomy) as the most important predictor of higher job satisfaction and lower turnover rates. A later study examined factors determining nursing assistant turnover, and found that local economic conditions had the strongest effects on turnover rates. One of the latter study's most important findings was that homes in which nurse supervisors accepted nursing assistants' advice or simply discussed care plans with the aides reported turnover rates that were one-third lower than those without these practices. Other studies have underscored the importance of including nursing assistants in care planning and providing feedback to help assistants understand the connection between interventions and resident outcomes.

Research on home care workers has been more difficult to conduct because it must be carried out in individual homes. The most comprehensive study of home care worker satisfaction and turnover, conducted over a decade ago, assessed the impact of salary increases, improved benefits, guaranteed number of service hours, and increased training and support on worker retention. In the aggregate, the interventions reduced turnover rates by 11 to 44 percent. The study found that while financial rewards were important to worker satisfaction, motivation, and retention, job qualities such as good personal relationships between management and workers and between the worker and the client were more important. Disappointingly, when research funding terminated, agencies reverted to their former practices.

Public and Private Efforts to Develop a Qualified, Stable Frontline Workforce

As noted previously, recruiting and retaining frontline long-term care workers have become a priority for many states. State initiatives have included the following options:

- Establishing "wage pass-throughs," in which a state designates some portion of a public long-term care program's reimbursement increase to be used specifically to increase wages and/or benefits for frontline workers.

- Increasing worker fringe benefits, such as health insurance and payment for transportation time.
- Developing career ladders by establishing additional job levels in public programs, training requirements, or reimbursement decisions.
- Increasing and improving training requirements.
- Developing new worker pools, including former welfare recipients.
- Establishing public authorities to provide independent workers and consumers ways to address issues about wages and benefits, job quality, and security.

Providers, too, are experimenting with a range of interventions. The literature contains numerous descriptions of programs in nursing home and home care settings that have attempted to address recruitment and retention (although few such programs have been evaluated). For example, the "Pioneer Homes" approach to changing nursing home culture does not focus specifically on recruiting and retaining workers, but it tries to link the facility to the outside world and create a community: Plants and animals abound, children interact with residents, and workers are respected as an essential part of the care team. Evaluations of this model have not been completed.

The Wellspring model of quality improvement is another approach to changing nursing home workplace culture. Wellspring is a consortium of 11 freestanding nursing homes whose top management have made a philosophical and financial commitment to a continuous quality improvement initiative. The three-pronged approach includes intensive clinical training, periodic analysis of outcomes data to monitor quality, and a management change/job redesign effort, in which nursing assistants become essential members of care teams and are empowered to make certain decisions.

Cooperative Home Care Associates, a worker-owned company located in New York, Boston, and Philadelphia, is staffed overwhelmingly by former welfare recipients. After three months' employment, a worker can purchase shares in the company. Wages are higher than the average for home care aides, and workers receive fringe benefits as well as guaranteed hours. Workers are encouraged to advance their careers and earn higher pay and status as associate trainers or by assuming administrative positions.

Many frontline long-term care workers have developed their own initiatives to improve their status, compensation, and job opportunities. These include the Iowa Caregivers Association, the National Network of Career Nursing Assistants, and the Direct Care Alliance. Unions, particularly the Service Employees International Union (SEIU), have made major inroads in organizing both nursing home and home care workers in selected states across the country.

Developing a Research and Demonstration Agenda

This broad overview of long-term care frontline worker issues has identified a number of knowledge and information gaps that need to be addressed to further the development of a qualified, sustainable workforce: We need a better understanding of the sources of the problem, the effects of policy interventions, and which elements in different approaches succeed and fail . We need an updated profile of the frontline workforce in all long-

term care settings that describes their demographic characteristics, wages and benefits, geographic distribution, levels of education, and health literacy. Policymakers need to better understand the magnitude of the long-term problem so that they are more motivated in developing this workforce, the barriers to doing so, and the possible consequences of different policy interactions. Research is needed to assess state strategies' effectiveness at ameliorating the short-term crisis, as well as to determine whether such strategies as wage pass-throughs could be replicated successfully. Finally, we need to develop and test creative ways of developing new pools of workers to meet the demand for services in the future.

Federal and state agencies and private foundations have begun to invest in applied research that will help provide some solutions. The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) is collaborating with the Robert Wood Johnson Foundation to develop a research and demonstration agenda on this issue, and other private foundations and agencies of the federal government are also supporting similar research efforts.

The future of the frontline long-term care worker is, in many ways, a barometer for the health of our aging communities. Stakeholders at the federal, state, and local levels and in the public and private sectors must come together to find creative solutions to this problem.

INTRODUCTION

The paraprofessional long-term care workforce-nursing assistants (NAs), home health and home care aides, personal care workers, and personal care attendants-forms the center of the formal long-term care system. These frontline workers provide hands-on care, supervision, and emotional support to millions of people with chronic illnesses and disabilities, and work in a variety of settings, including nursing homes, assisted living and other residential care settings, adult day care, and private homes. The care they provide is intimate and personal. It is also increasingly complex and frequently both physically and emotionally challenging. Because of their ongoing, daily contact with the care recipient and the relationships that often develop between the worker and the client, these frontline workers are the "eyes and ears" of the care system. In addition to helping with activities of daily living, such as bathing, dressing, toileting, eating, and managing medication, these workers provide the personal interaction that is essential to quality of life and quality of care for chronically disabled individuals.

Who Will Care for Us?

Addressing the Long-Term Care Workforce Crisis

Low wages and benefits, hard working conditions, heavy workloads, and the stigma attached to long-term care jobs make recruitment and retention of workers difficult, even when unemployment rates are high. While concerns about this workforce have varied over the past two decades (Crown et al. 1992; Bayer et al. 1993; Atchley 1996; and Wilner and Wyatt 1998), there is growing concern about the current and future supply of long-term care paraprofessionals, in large part because of the very strong economy (Rimer 2000; Stone 2000). Indeed, many observers refer to the the current difficulty of attracting workers as a crisis.

Estimates of turnover rates for NAs working in nursing homes range from 45 percent to 105 percent, depending on the source. Estimates of home care worker turnover are lower, although anecdotal evidence points to great variation across agencies and among independent providers (AHCA 1999; Burbridge 1993; MacAdam 1993; Crown et al. 1995). As higher-paying jobs with better working conditions have opened up for women who have typically worked in nursing homes or home care, long-term care workers have become increasingly hard to find. With the national unemployment rate falling to 4.1 percent in May 2000 (BLS 2000), recruitment and retention problems are likely to persist. Finding qualified, committed NAs or home care aides has become a second-order priority, as many nursing homes, residential care providers, home care agencies, community-based care organizations, and families look for anyone available to provide frontline care.

Issues related to frontline long-term care workers have historically received little attention from policymakers, researchers, and the general public. Recently, however, the media has begun to document the crisis status of this labor shortage, underscoring its potential negative effects on quality of care and quality of life. Policymakers at the federal and state levels are also beginning to acknowledge this problem. Officials from 42 states responding to a 1999 national survey on long-term care workforce issues identified recruitment and retention of frontline workers as a major priority, and those from 30 states reported engaging in a workforce initiative (NCDFS 1999).

Difficulty in recruiting nursing and home health aides is likely to become worse as the number of people needing long-term care increases relative to the number of people between ages 20 and 64, who make up most of the workforce. Between 1998 and 2008, BLS estimates there will be 325,000 more nursing assistant and 433,000 more personal care and home health aide jobs (BLS 2000), but there is little evidence that there will be enough people to fill them. Reflecting the growing emphasis on provision of long-term care at home or in alternative residential settings rather than institutions, total employment in nursing homes is projected to grow less quickly than in home and community-based settings. A sharp economic downturn could end the current worker shortage, but the long-run demographic imbalance between the demand for and supply of workers will only worsen over time.

This paper provides a broad overview of the issues affecting the long-term-care frontline workforce. The first section provides a profile of the workers and describes the nature of their jobs across the continuum of long-term care settings. That section is followed by a discussion of the urgency and magnitude of the problem from both short- and long-term perspectives. We underscore the need to address the immediate crisis related to the shortage of workers, as well as the more systemic problem of developing a qualified, committed, stable frontline workforce. The third section reviews the factors influencing the supply and quality of frontline workers. At the macro level, these include how society views this occupation, the status of the economy, and policies affecting health and long-term care, labor, welfare and immigration. At the micro level, factors affecting the supply and quality of frontline workers include organizational arrangements, social factors, environmental characteristics, and technology. In the fourth section, we identify public and private sector efforts to increase the supply of frontline workers and to develop a qualified, sustainable workforce. The fifth section outlines a research and demonstration agenda that will help inform the development of policies and programs to ensure the availability of a trained, committed, and caring pool of frontline workers in the 21st century.

The Long-Term-Care Frontline Workforce

The Long-Term Care System

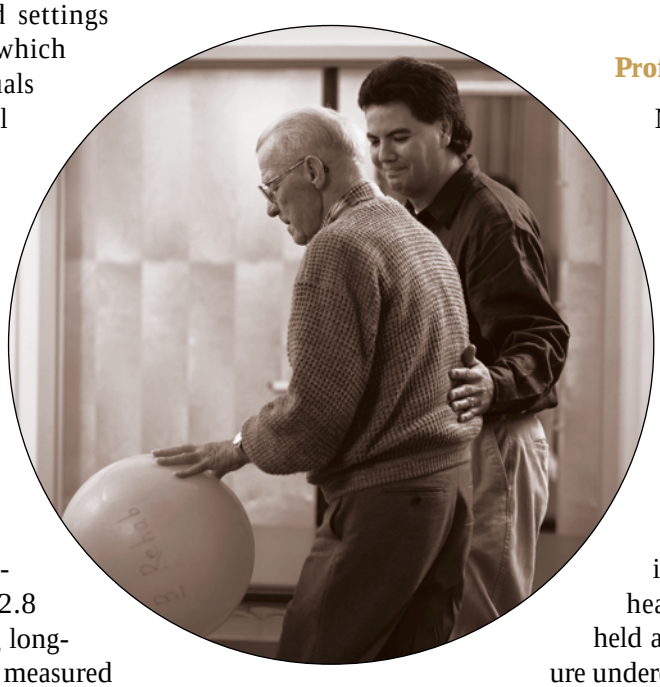
Long-term care encompasses the broad range of types of help with daily activities that chronically disabled people need for prolonged periods of time. These primarily low-tech services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning, and include assistance with basic activities of daily living (ADLs) such as bathing, dressing, eating, or other personal care. Services may also help with instrumental activities of daily living (IADLs), including household chores, such as meal preparation and cleaning, and life management, such as shopping, medication management, and money management. The services include hands-on and stand-by or supervisory assistance. Long-term care also encompasses social and environmental needs and is therefore broader than the medical model that dominates acute care (Stone 2000).

Long-term care is provided in a range of settings, depending on the recipient's needs and preferences, the availability of informal support, and the source of reimbursement. Among the care silos that have been created primarily by reimbursement policy, the nursing home (or nursing facility, as it is referred to by Medicare and Medicaid) is the major institutional setting for long-term care. In 1996 there were 16,840 nursing homes in the United States, for a total of 1.8 million beds (Rhoades and Krauss 1999). Approximately 13 percent of these facilities had Alzheimer's special care units, which accounted for 73,400 beds. An additional 28,500 beds were located in distinct rehabilitation and/or subacute special care units.

"Home and community-based care" is a catchall phrase that refers to a wide variety of noninstitutional long-term care settings, ranging from various types of congregate living arrangements to individuals' own homes. The boundaries between institutional and noninstitutional environments are far from clear. Many assisted living and board and care facilities are large buildings that strongly resemble nursing homes or hotels in physical appearance and philosophy. Other residential care sites are small and homey, offering privacy and choice to residents. In contrast to nursing homes, which are licensed and regulated by the federal government because they receive significant Medicare and Medicaid

reimbursement, states and local jurisdictions are largely responsible for the licensing and regulation of residential care. Consequently, there is no consensus on the definition of "residential care" or on the number of facilities nationwide. One recent national study of assisted living reported that there were 11,472 facilities, with approximately 650,500 beds, in 1998 (Hawes et al. 1999). A 1991 study estimated that there were 28,188 licensed board and care homes, serving over 500,000 people (Clark et al. 1994). These data, however, underestimate the total board and care population, as the number of unlicensed facilities is unknown.

Other community-based settings include adult day care, in which disabled elderly individuals receive supervision, personal care, social integration, and companionship in a group setting, usually during the workweek from nine to five. Most long-term care users live at home, either in their own homes (with or without a spouse), or in the home of a close relative.



The long-term care population is diverse in terms of age and level of disability. Of the estimated 12.8 million Americans reporting long-term care needs in 1995, as measured by the need for assistance with ADLs or IADLs, 57 percent were over the age of 65. Another 42 percent were younger adults, and 3 percent were children (National Academy on Aging 1997). Family and friends (i.e., unpaid caregivers) are the major providers of long-term care. Nearly 75 percent of people ages 18 to 64 receiving long-term care assistance in the community (i.e., outside of nursing homes) rely exclusively on unpaid caregivers; only 6 percent of the younger disabled rely exclusively on paid services. Another 138,000 persons ages 18 to 64 reside in nursing homes (Tilly et al. 2000). Similarly, about 60 percent of the 3.9 million elderly receiving long-term care in the community rely exclusively on unpaid caregivers, primarily spouses and children; only 7 percent rely solely on paid services. About 1.4 million older persons reside in nursing homes.

Over the past decade, the nursing home population has become older and more severely disabled. In 1996, 83 percent of the residents had three ADL limitations, compared to 72 percent in 1987 (Rhoades and Krauss 1999). These residents are also more likely to be cognitively impaired (Spillman et al. 1997). Elderly persons receiving long-term care in the community report lower levels of disability than those in nursing homes, with approximately 17 percent reporting limitations in three or more ADLs (Alecxih 1997).

Profile of Frontline Workers

Most paid providers of long-term care are paraprofessional workers. After informal caregivers, these workers are the key to helping older persons and younger people with disabilities maintain some level of function and quality of life. According to recent BLS statistics (2000), NAs held about 750,000 jobs in nursing homes in 1998, and home health and personal care aides held about 746,000 jobs. This figure underestimates the total number of home care workers, since many aides are hired privately and may not be included in official federal statistics. According to a study of independent home care workers in California, for example, the state employs more than 200,000 workers through its In-Home Supportive Services (IHSS) program, 72,000 in Los Angeles County alone (Cousineau 2000). In their national study of home care workers providing assistance to the Medicare population, Leon and Franco (1998) found that 29 percent of the workers were self-employed.

As is true with informal caregivers, most frontline long-term care workers are women. According to national data on this work force from 1987 through

1989 (Crown 1994), an estimated 93 percent of NAs and home care workers were female. A 1995 survey of home care workers reported that 96 percent of those employed by agencies- and 100 percent of the self-employed- were female (Leon and Franco 1998). Crown (1994) estimated that almost 7 out of 10 workers were white; 27 percent of the NAs and 29 percent of home care aides were black. More recent data from BLS (1999) indicate that 35 percent of NAs are black and 10 percent are Hispanic. There is also significant geographic variation in the racial profile of frontline workers. A recent study of home care workers participating in California's IHSS program found that 32 percent of the agency workers and 41 percent of the independent providers (including paid family caregivers) were white (Benjamin et al. 2000). Forty-five percent of the agency workers and 30 percent of the independent providers were Hispanic; comparable estimates for black workers were 15 percent and 20 percent, respectively.

Most of these frontline workers are relatively disadvantaged economically. According to data from the late 1980s, they tend to have low levels of educational attainment: Approximately 25 percent of NAs and 38 percent of the home care workers had not completed high school (Crown et al. 1994). Median earnings for NAs and home care aides in the late 1980s were $9,000 and $5,200, respectively, and many current workers live at or below the poverty level. Many are also juggling work and family responsibilities: 50 percent of the NAs and 33 percent of the home care workers, for example, have children under the age of 18.

While long-term care providers are engaged in work that is physically and emotionally demanding, their occupation is among the lowest paid in the service industry. Paraprofessionals in nursing homes, home care, and other long-term care settings tend to make little more than the minimum wage (BLS 2000). In 1998, median hourly wages for NAs working in nursing and personal care facilities were $7.50; for those working in residential care, the rate was $7.20 per hour. The lowest 10 percent earned less than $5.87 and the highest 10 percent earned a little more than $11.33. The median hourly wage for home health aides in 1998 was $7.20; for personal and home care aides, it was between $6.00 and $7.00, depending on the job category. The lowest 10 percent of these workers earned less than $5.73 per hour and the highest 10 percent earned a little more than $10.51 per hour. In the study of California's IHSS workers that Benjamin et al. (1998) conducted, the mean hourly wage for agency workers was $6.22; for client-directed, independent providers, it was $4.79.

Information on the proportion of workers nationally with benefits such as health insurance and sick leave is not available. The most recent national profile of frontline workers, which used data from the late 1980s (Crown et al. 1995), indicated that 28.5 percent of NAs and 38.9 percent of home care workers had no health insurance coverage. Independent workers and those employed by small residential care providers or home care agencies were less likely to receive this benefit. It is not clear, however, whether this coverage applies only to full-time workers and how much the employer actually contributes. If the employee's share of the premium cost is too high, workers generally opt out of the benefit (Wilner and Wyatt 1998). Cousineau (2000) found that 45 percent of the 72,000 independent home care workers hired through the IHSS program in Los Angeles are uninsured. Two-thirds work at least 25 percent time, and 10 percent work full-time or more. One in three workers maintain one or more jobs in addition to the IHSS position.

The Long-Term Care Worker Problem: Definition and Magnitude

The severe shortage of NAs, home health and home care aides, and other paraprofessional workers is the primary cause of concern about the long-term care workforce. Various media reports have underscored the inability of nursing homes, residential care providers, home care agencies, community-based organizations, and individuals and their families to find workers. According to recent anecdotes (Rimer 2000), some frustrated providers and families are willing to give up the search for quality employees as long as they can find people to fill the positions. This crisis is not limited to the United States. It is a global problem, particularly in the European Union and Japan, where the proportion of the population that is elderly is much higher than in the United States (Christopherson 1997).

While this crisis has received significant attention over the past six months, the phenomenon is not new. In fact, during the late 1980s, tight labor markets in many communities created significant worker shortages that catalyzed policy debate, state and provider initiatives, and

several seminal research activities, including the development of the first national profile of the paraprofessional workforce (Crown 1994; Crown et al. 1995). This time, however, there is growing recognition that an economic downturn will not solve the problem. Demographic, economic, and policy trends suggest that without serious intervention, the inadequate supply of frontline workers will remain a problem that could worsen over the next few decades.

The problem, however, is not simply one of supply. The more fundamental, long-term dilemma is how to develop a committed, stable pool of frontline workers who are willing, able, and prepared to provide quality care to people with long-term care needs. Both the short- and long-term problems must be addressed if we are to design quality systems of care to meet the needs of people with chronic disabilities.

The Current Problem

Across the country, long-term care providers are reporting paraprofessional labor vacancies and high turnover rates. Nursing homes, assisted-living and other residential care providers, home health agencies, community-based home care and adult day care programs, and individuals and their families all report significant difficulties in recruiting and retaining frontline workers. Nationally, data on turnover rates show wide variation. One source suggests that turnover rates average about 45 percent for nursing homes and about 10 percent for home health care programs (Hoechst Marion Roussel 1996). Feldman (1994), citing Marion Merrell Dow data, reports that turnover among home care workers for private agencies is 12 percent, while turnover among those working for public agencies is much higher. Other data place average annual nursing home turnover at 105 percent (Wilner and Wyatt 1998).

Officials from 42 state Medicaid or aging offices responding to a North Carolina Division of Facility Services' 1999 survey reported significant recruitment and retention problems among their paraprofessional workforce. A more recent survey of all long-term care providers in Pennsylvania found that nearly 70 percent of providers reported significant problems with either recruitment or retention; 35 percent reported that the problems were extreme (Leon et al. 2001). California nursing homes reported an overall employee turnover rate of 67.8 percent, with the annual NA turnover rate estimated to be even higher (Ruzek et al. 1999). A 1999 survey of New York nursing homes and home health agencies, conducted by the New York Association of Homes and Services for the Aging, found that the average NA turnover rate between 1997 and 1998 was 42 percent for the entire state: 21 percent for the New York City/Long Island area, and 56 percent for the rest of the state. Straker and Atchley (1999) found NA turnover rates ranging from 88 percent to 137 percent in Ohio nursing homes, with home health aide turnover rates ranging from 40 percent to 76 percent. In addition, the authors observed that nursing homes- particularly those that saw turnover as a serious problem- were very likely to underestimate their turnover rates. Annual NA turnover rates in North Carolina reportedly exceed 100 percent; the comparable estimate in adult care homes is over 140 percent (NCDFS 1999). Furthermore, the number of inactive NAs in North Carolina's nurse aide registry is greater than the number of active NAs, suggesting that these individuals are not seeking jobs in the long-term care sector. A Florida Department of Elder Affairs report to the state legislature noted that only 53 percent of trained NAs were working in health-related fields one year after certification (cited in Bucher 2000).

Worker shortages, however, vary across and within states, as well as between providers. Massachusetts's nursing home administrators reported an 11 percent vacancy

rate in frontline worker positions in 1999 (MHPF 2000). The Home Care Association of New York State also acknowledges a major worker shortage, noting that it takes providers at least two to three months to fill aide positions (Home Care Association of New York State, Inc. 2000). Leon et al. (2001) found that only 8 percent of responding long-term care providers in Pennsylvania identified the problem as severe. This estimate was significantly higher for privately owned nursing homes (12 percent) and home health agencies (18 percent). Although the job vacancy rate for all frontline workers in Pennsylvania was 11 percent, the rates were highest among certified home health agencies (15 percent), licensed noncertified home health agencies (14 percent), and privately owned nursing homes (13 percent). Across the state, 13 percent of providers reported vacancy rates exceeding 20 percent. But while all types of nursing homes had chronic levels of job vacancies, only 6 percent of government facilities had high job vacancy rates, compared with over 19 percent of the privately owned nursing homes reporting vacancy rates of greater than 20 percent. A disproportionate percentage of home health and home care agencies had high vacancy rates, with more than 25 percent of the certified home health providers and 27 percent of licensed, noncertified agencies reporting rates greater than 20 percent.

High rates of staff vacancies and turnover have negative effects on the major stakeholders within the long-term care system: providers, consumers (individuals and their families), and workers (PHI 2000). Labor shortages and high turnover also affect federal and state policymakers, who are responsible for ensuring that the programs they either fund or directly operate are providing quality care.

Turnover is expensive for health care providers. Several studies suggest that staff turnover and vacancy costs- for recruitment, training, increased management expenses, and lost productivity- ranges from worker to worker. The turnover cost of a nursing home NA has been estimated at four times the employee's monthly salary, translating into a replacement cost of $3,840 (Pillemer 1996). Zahrt (1992) documented the costs of replacing home care workers, including the costs of recruiting, orienting, and training the new employee and the costs related to terminating the worker being replaced (e.g., exit interview, administrative functions, separation pay, unemployment taxes): The total cost associated with each turnover was $3,362. In addition to the financial costs of the initial hire, there are costs associated with lost productivity during the time it takes for the recently hired worker to complete the learning curve (Atchley 1996). Furthermore, this estimate does not include the costs of the attrition that occurs between initial hires, training, and retention. White (1994), for example, found that out of 351 potential home care worker recruits who completed a scheduled interview, 216 were actually accepted into the training program, 133 actually started classes, 106 graduated, and only 46 were still with the agency six months after they were placed.

Across all Pennsylvania providers, the estimated total annual (recurring) cost of training due to turnover in 2000 was at least $35 million (Leon et al. 2001). Nursing homes' training costs accounted for $23.9 million, and home health/home care agencies' costs accounted for $4.8 million. The regions encompassing large metropolitan areas accounted for 75 percent of the costs. In addition to the recurring turnover costs, one-time state training costs for filling currently open jobs were estimated at $13.5 million.

Labor shortages and high turnover rates may also have negative consequences for consumers. While there is little empirical evidence to establish causal links, anecdotes and qualitative studies suggest that problems with attracting and retaining frontline workers may translate into poorer quality and/or unsafe care, major disruptions in the continuity of care, and reduced access to care (Wunderlich et al. 1996). Because of the important role that workers play in meeting the most basic needs of long-term care users and the close personal relationships that are frequently established between aides and care recipients, the reduced availability and frequent churning of such personnel may ultimately affect clients' physical and mental functioning. Several studies have observed that inadequate staffing levels, an inevitable byproduct of worker shortages, are associated with poorer nutrition (Kayser-Jones and Schell 1997) and preventable hospitalizations (Kramer et al. 2000) among nursing home residents. A reduced pool of workers also places more pressure on family caregivers, who are already providing the bulk of care to disabled individuals in the United States.

Nursing assistants, home care aides, and other workers who enter and remain in these jobs may also suffer

from the effects of labor shortages and high turnover. Workers who are providing care in understaffed environments may experience higher levels of stress and frustration, which may lead to poorer quality of care. Workers in nursing homes may be responsible for the care of too many residents, leaving them unable to dedicate adequate time to individuals. In home care, short staffing may limit aides' personal interaction with their clients.

Short staffing may also result in increased rates of injury and accidents, although there have been no studies documenting such a direct relationship. These workers are already employed in one of the most hazardous occupations in the service industry (Wise 1996): The injury incidence rate per 100 full-time NAs was 16 percent in 1996; the comparable rate for home health care aides was 9 percent (SEIU 1997). Some researchers have speculated that overworked and frustrated staff may also be more likely to physically or emotionally abuse nursing home residents or home care clients (PHI 2001) or become the victims of abuse from underserved care recipients.

Finally, high turnover and increased vacancies may leave new workers with fewer mentors for on-the-job learning and peer support (PHI 2001). Overworked supervisors, furthermore, have less time to train and support frontline workers. In focus groups with nurse supervisors employed by several nonprofit nursing homes in Kansas, Long and Long (1998) found that understaffing was a major contributor to nurses' decisions to leave the facility.

The Long-Term Outlook

During the 21st century, there will be an unprecedented increase in the size of the U.S. elderly population as the baby boom generation ages. While most elderly people are not disabled, the likelihood of their needing long-term care increases with age. The number of people age 85 and over- those most likely to need long-term care- is projected to increase fivefold in the next 40 years: Estimates range from 8.3 million to 20.9 million in 2040, depending on assumptions about fertility, mortality, and immigration patterns (Stone 2000). Recent analyses of national and international data indicate a decline in disability rates among the elderly over the past decade (Manton et al. 1997; Christopherson 1997; Waidmann and Manton 1998), but that trend is probably not sufficient to counteract the significant increase in the size of the elderly population over the next 40 years. Using various mortality and disability scenarios, Kunkel and Applebaum (1992) estimated that by the year 2020, the number of older Americans needing long-term care will be between 14.8 and 22.6 million people.

Assuming reasonable rates of economic growth, baby boomers are likely to have higher real incomes during their retirement years than today's retirees (Manchester 1997). Those facing long-term care decisions may be more willing and able to purchase formal services than to rely solely on informal care. This trend, coupled with the aging of the population, will contribute to an increased demand for formal long-term care services over the next 30 years.

The future availability of informal caregivers is less predictable. The ratio of the population in the average caregiving range (ages 50 to 64) to the population age 85 and older is projected to decrease, from 11 to 1 in 1990 to 4 to 1 in 2050 (RWJF 1996). But this estimate does not include the large number of elderly spouses, particularly wives, and the increasing number of adult children who may be available to care for their parents. The parents of the baby boom generation have a larger average pool of family members than did the Depression-era generation. During the next 50 years, however, older

people's average number of adult children is expected to fall. A large proportion of working-age women will be in the labor force, and more will be juggling parenting and elder care responsibilities. A recent survey of private geriatric care managers (Stone 2001) suggests that the number of people purchasing care for relatives who do not live nearby is growing, which could place more demands on the formal long-term care system.

According to BLS (1998), personal and home care assistance is projected to be the fourth-fastest growing occupation. The number of home health aides is expected to increase by 74.6 percent between 1996 and 2006; the comparable estimate for the nursing home aide occupation is 25.4 percent.

A variety of factors, however, may offset the long-term demand for and supply of paraprofessional workers (Wilner and Wyatt 1998). The actual number of available jobs may be tempered by both the rate of economic growth and the effective demand- that is, the extent to which purchasers are willing or able to pay (Crown et al. 1992). Some analysts (Bishop 1998) suggest that the dramatic slowdown in the growth of all health care costs in the 1990s, attributed to market forces and the pressures of managed care, will reduce the number of health care jobs available, particularly in terms of unskilled jobs. For example, recent home health care policy changes, including reductions in Medicare payments, may diminish the future growth rate.

In the aggregate, the trends described above suggest that the demand for NAs, home care aides and other direct care workers will increase. There is, however, serious concern about the availability of these workers. By 2010, as baby boomers approach old age and begin to require assistance, the pool of middle-aged women available to provide low-skilled basic services will be substantially smaller than it is today (Feldman 1997). The pool of "traditional" caregivers- women between the ages of 25 and 54- is predicted to increase by only 7 percent during the next 30 years. More importantly, the pool of potential entry-level workers- women age 25 to 44 in the civilian workforce- is projected to decline by 1.4 percent during the next six years (PHI 2000). The baby boom workforce has passed through this age range, and the rate of increased participation of women in the workforce is slowing considerably.

The educational level among minority women- those most likely to enter the paraprofessional workforce- is also improving dramatically. While the educational status of both white and black women improved between 1990 and 1998, the increase was most striking for the latter group. The proportion of black women age 25 or over with a high school education increased from 51.3 percent to 76.7 percent over that period; the proportion with four or more years of college increased from 8.1 percent to 15.4 percent (U.S. Bureau of the Census 1998). These more-educated women may be less willing to work in the same low-wage, low-benefit jobs as those who preceded them (Burbridge 1993).

The official unemployment rate in the United States is at a historic low, and a dramatic increase in unemployment in the near future seems unlikely. With very low population and labor force growth, even a "normal" business cycle recession will likely yield only a modest increase in the number of unemployed (Judy 2000). Therefore, the unemployed do not offer a large untapped pool of potential frontline workers. While individuals moving from welfare to work represent another potential source of labor, a substantial proportion of these individuals have already been absorbed into the economy (MHPF 2000). Those who remain on public assistance may have multiple physical, mental, and lifestyle barriers to employment, particularly with respect to the type of caring yet demanding work required of NAs and home care aides. Many policymakers and providers in the United States, as well as in Western Europe and Japan, view immigrants as a potential pool of workers. But, as will be discussed in the next section of this paper, reliance on a major new influx of immigrants to solve the labor shortage may have significant negative consequences for our society.

The long-term outlook for the paraprofessional labor market is not promising, even without considering the more fundamental issue of developing a qualified, committed workforce. The lack of a well-trained, well-qualified workforce for long-term care- professional and paraprofessional- is an even graver problem than financing and delivery problems (Stone 2000). There are few financial or cultural incentives for workers to obtain training or to pursue careers in the care of people with chronic illness and disabilities.

Factors Affecting the Supply and Quality of Frontline Workers

The successful recruitment, retention, and maintenance of a committed, prepared long-term care workforce are

dependent on a variety of factors that intervene at different levels. At the highest level, the value society places on direct care work interacts with economics and public policies- including health and long-term care reimbursement, regulation and program design, labor and welfare training, and workforce development and immigration- to influence the supply and quality of paraprofessional workers. At the workplace level, organizational arrangements, social factors, the physical setting and environment, and technology all influence employers' ability to attract and retain workers. Policymakers and providers need to consider the interactions of the factors described below, including the countervailing effects of certain initiatives, in enhancing or impeding the development of a qualified, sustainable frontline workforce.

The Value of Frontline Caregiving

One important influence on individuals' decisions to enter and remain in the long-term care field is how society views and values the job. Although there has been progress in reducing ageism, many still believe that growing old is an inevitable evil leading to decrepitude and death- an idea the mass media often reinforces. This negative image is matched by the ubiquitous fear of long-term care. "I'd rather die than be in a nursing home," and, "I will never be a burden on my children," are the mantras of some middle-aged adults, many of whom are already engaged in some level of caregiving for their parents. Frontline jobs in nursing homes, assisted living, and home care are viewed by the public as low-wage, unpleasant occupations that involve primarily maid services and "butt-wiping" of incontinent, cognitively unaware elderly people.

This image is exacerbated by reports in the mass media that feature very negative stories about living and working conditions in long-term care facilities and about widespread fraud and abuse in home care. While quality concerns are certainly warranted, the current climate is intolerant of mishaps or bad results (Kapp 1997). As Kane (2000) noted, "We are at risk of turning the great bulk of well-intended, hard-working long-term care providers into a depressed and beleaguered group, who are too fearful of missteps to exercise creativity or even common sense in their daily work."

The adversarial relationship between consumers and regulators on the one hand, and providers on the other, has significantly tarnished the long-term care industry's image, ultimately affecting the reputation of the frontline worker. The strict regulatory approach championed by several leaders on Capitol Hill, undertaken by the Health Care Financing Administration (HCFA), and embraced by many consumer advocates may have unintended negative consequences for the paraprofessional workforce. Anecdotes informally reported to us by workers at a consortium of Wisconsin facilities reputed to provide quality care suggest that these aides are depressed and demoralized by aggressive survey inspection and enforcement activities and by the way the media portrays their jobs and work environment. In Florida, the recent rash of litigation against nursing homes is not only causing liability insurers to pull out of the market, it is also discouraging potential employees from applying for jobs in the industry (Bucher 2000).

Status of the Economy

Several policymakers and researchers, when discussing the current shortage of NAs, home care aides, and other direct care workers, have argued, "It's just the economy, stupid!" They perceive this crisis as a short-term problem that will be ameliorated by an economic downturn. While the problem is more entrenched and complicated, there is no doubt that the status of the local economy is a major determinant of the supply and stability of the frontline workforce. Several studies (Crown et al. 1995; Feldman et al. 1990; Banaszak-Holl and Hines 1996) have identified the strength of the local economy as a major predictor of turnover rates in nursing homes and home care. Experience in several local markets during the early and late 1980s demonstrated that the ability to attract and retain frontline workers ebbed and flowed with economic cycles (Feldman 1997).

Recruitment, retention, and turnover are related to conditions in both the long-term care labor market and the overall labor market (Atchley 1996; Burbridge 1993). When the general labor market is tight, there are more jobs for qualified people, who are likely to find better opportunities outside long-term care. Likewise, when the long-term care labor market is expanding, competition for new staff intensifies among providers, recruiting may become less selective, and retaining existing staff

becomes more difficult. More attention is paid to hiring workers than to searching for individuals who have the requisite personalities and/or skills for the job.

Policymakers and providers have expressed keen interest in understanding the extent to which there is intra-sectoral movement (from one nursing home to another or from one setting to another) versus movement out of the long-term care or health sector altogether. Informal discussions with providers suggest that many workers quit to take a job with another facility or agency, supporting the notion that providers are "stealing from one another." Feldman (1994) has observed that as hospitals de-emphasize inpatient hospital care, they are beginning to offer subacute care and various forms of community-based care. Nursing homes have increasingly specialized in rehabilitation and subacute care and have branched out into home care. As a result, the nursing home and home care industries are converging and are beginning to compete for people in the same labor pool, contributing to the shortage of frontline workers.

Konrad (1999) examined the extent to which trained NAs in North Carolina are currently employed in the long-term care sector, identified other concurrent or subsequent jobs these individuals hold, and determined the annual earnings of active versus inactive NAs. The study found that less than half of the 180,000 North Carolinians trained to work as NAs during the last decade are currently certified to work in this occupation. Even among those who are certified, many apparently work only part-time as NAs, supplementing their income with earnings from unrelated jobs in low-wage industries. Most of the individuals who are no longer certified as NAs have left the long-term care field and appear to have more stable jobs at higher wages in other industries.

Health and Long-Term Care Policy

Health and long-term care policies at the federal and state levels significantly affect the recruitment and retention of the frontline workforce, influencing employer and employee decisions through reimbursement, regulation, and program design.

Reimbursement Policy

Medicare and Medicaid, the major sources of public funding for health care, account for most long-term care expenditures (Stone 2000). In 1995, approximately $106.5 billion was spent on long-term care, with public resources accounting for 57.4 percent of the amount. The largest part of public funds, 37.8 percent, came from Medicaid (21.1 percent federal and 16.7 percent state). Medicare paid 17.8 percent of the $106.5 billion, and other federal and state programs supplied lesser amounts (e.g., Veterans Affairs, Older Americans Act, Social Service Block Grant, state general assistance).

Medicare provides coverage for short, post-acute stays in skilled nursing facilities and for home health services to community-dwelling beneficiaries who need skilled nursing, particularly following a hospitalization. Medicaid, the federal/state health care program for the poor, provides coverage for more traditional, chronic, and nonmedical services in nursing homes and institutions for people with mental retardation. Using waivers and state plan options, Medicaid also covers home and personal care for people who meet the low-income requirements.

Because these programs are major sources of long-term care funding, reimbursement policy plays a substantial role in determining workers' wages, benefits, and training opportunities. Nationally, Medicaid finances care for about two-thirds of all nursing home residents. At the extremes, Medicaid covers just over 50 percent of residents in three states, while in four states the program finances over 80 percent (Manard and Feder 1998). These third-party payers influence the price of labor by determining the amount of money public agencies and private insurers are willing to pay (PHI 2000). While providers have some flexibility in setting wages and benefits, that flexibility is limited by this third-party payer constraint (Atchley 1996). If payment rates fail to keep up with the true cost of providing services, organizations have less flexibility to offer competitive wages and benefits.

For years, states have tried to control Medicaid nursing home and home care expenditures by placing limits on reimbursement (HCIA-Sachs and Arthur Andersen LLP 2000). Many home health providers relied on Medicare to make up for Medicaid shortfalls. Recent Medicare cuts, however, have significantly curtailed this practice. Specifically, the Balanced Budget Act of 1997 (BBA) reduced payments to home health agencies by requiring that reimbursement limits be held to a below-inflation rate of growth. The federal government has

placed similar limits on Medicare reimbursement for nursing home care, which dropped by 12.5 percent in 1999.

There are few empirical data to support or refute the argument that reimbursement rates are too low to allow providers to pay adequate wages and benefits to direct care workers. Consumer advocates argue that reimbursement would be adequate to pay frontline staff if the dollars were not being spent on high salaries for managers and on corporate overhead. Frank and Dawson (2000) make the case that within Massachusetts's highly competitive labor market, the third-party payer dynamic has played a significant role in keeping wages and benefits artificially low, below the levels necessary to attract and retain quality staff.

One source of reimbursement that has not received much attention but that influences recruitment and retention of workers is the State Supplemental Payment (SSP) to the federal Supplement Security Income (SSI) benefit. SSI is a cash benefit program for low-income elderly or disabled individuals; states have the option of supplementing this benefit. Most low-income individuals living in residential care settings, particularly board and care homes, rely on their SSI benefits to cover room and board. A number of states also use SSP funds to augment SSI payments to facilities. Several residential care providers have indicated that because the SSP reimbursement is so low, they are not able to offer the wages necessary to attract direct care workers in the current labor market.

Regulatory Policy

Regulatory policy in the long-term care area focuses primarily on protecting the consumer, and pays little attention to the needs or concerns of frontline workers. Although regulations do address the need for training, they do not fully address the range of educational and on-going support activities that paraprofessionals need in order to assume increasingly complicated and complex responsibilities.

At the federal level, major nursing home reform was introduced with the passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA), which officially acknowledged the importance of NAs by mandating that they complete 75 hours of prescribed training. This legislation, however, focused only on entry training, and paid little attention to the necessity for continued career growth or development of competencies other than to require 12 hours of in-service training per year. States also require that NAs be trained, but the number of hours and the specific requirements vary widely.

The federal government has enacted guidelines for home health aides whose employers receive reimbursement from Medicare. Federal law requires home health aides to pass a competency test covering 12 areas, and also suggests at least 75 hours of classroom and practical training supervised by a registered nurse. Training and testing programs may be offered by the employing agency, but they must meet the standards set by the Health Care Financing Administration (HCFA). Training programs vary depending on state regulations. Home care and personal care workers employed by agencies that are reimbursed by Medicaid or other state programs may also be subject to certain training requirements, but this practice varies by state and local community.

One major issue for the development of the residential care frontline workforce is the degree to which states are willing to modify their nurse practice regulations to allow aides to perform certain tasks, such as administering medication, caring for wounds, and changing catheters (Kane 1997). A number of states, including Oregon, Kansas, Texas, Minnesota, New Jersey, and New York, have enacted nurse delegation provisions, but the latitude and interpretation of the provisions vary

tremendously. This issue is important because it gets to the heart of the debate about autonomy for workers as well as consumers. The assisted living philosophy asserts that residents should live in a homelike environment and should be able to make choices about their care, including decisions that may put them "at risk." Workers, too, should be allowed to make decisions about the care provided. Opponents of nurse delegation, particularly state boards of nursing, argue that aides do not have the skills (and cannot be trained) to engage in such activities as medication management, and that patient safety would be jeopardized if workers were allowed more responsibility and autonomy. Proponents, meanwhile, argue that with the appropriate training and proper supports, nurse delegation would provide more intrinsic rewards for workers, perhaps expanding the pool of individuals attracted to these jobs.

Program Design

Medicare-covered skilled nursing and home health care and Medicaid-covered nursing-home care are entitlements with little room for innovation. States, however, have much more discretion in developing home- and community-based service programs financed through Medicaid waivers, the personal care state plan option, or state-only funds. Many states have developed consumer-directed programs that allow beneficiaries to hire and fire their workers. At least 35 states allow family members to be paid as home or personal care providers. The flexibility in these programs may have helped expand those states' potential pool of workers. Researchers studying the IHSS program in California, for example, found that one-fifth of the paid family providers were new to caregiving; that is, they did not provide informal care before participating in the IHSS program (Benjamin et al. 2000). This finding suggests that some family members not predisposed to informal caregiving might join the pool of formal care workers under certain circumstances.

Labor Policy

Federal and state labor policies have an important role to play in the expansion of the pool of frontline long-term care workers. The federal government invests more than $8 billion annually to prepare primarily low-income and unemployed individuals for new and better jobs (PHI 2000). Ironically, state and federal employment agencies indirectly prevent the long-term care industry from participating in training support programs by requiring that participants graduating from those programs secure wages that are higher than typical frontline worker salaries. While they are designed to prevent trainees from being shunted into poverty-level jobs, these policies essentially preclude graduates from entering the paraprofessional long-term care labor force.

The federal Work Investment Act (WIA), which replaced the Job Training Partnership Act in July 2000, establishes a flexible state framework for a national workforce preparation and employment system designed to meet the needs of employers, incumbent workers, and job seekers. States wishing to continue receiving job training funds were required to submit final plans for federal approval by October 2000. WIA offers opportunities for experimentation with training initiatives in the long-term care field. Funds can be used to create transitional jobs to help low-income adults become employable through "paid work experience" and on-the-job training. The program is so new, however, that its implications for the development of a frontline workforce remain to be seen.

The Occupational Safety and Health Administration (OSHA) is the federal agency responsible for overseeing and monitoring the workplace for activities that may harm workers' physical or mental well-being. As noted previously, frontline long-term care work is a potentially hazardous occupation, and OSHA has historically focused most of its attention on identifying and applying negative sanctions to employers in violation of certain regulations. In 1992, however, OSHA began experimenting with a new approach that replaces inspections, enforcement tactics, and bureaucratic relationships with a partnership with employers to prevent workplace accidents and injuries (Wise 1996).

As of the summer of 1996, 12 such programs had been approved or were being implemented. To be approved by OSHA, state programs had to (1) use data such as workers' compensation claims or OSHA logs; (2) provide employers the choice of a partnership approach through the establishment of a comprehensive safety and health program; (3) include an enforcement component; (4) show a measurable impact in reducing illness, injury, and death in the affected workplaces; and (5) include outreach activities and consultation with labor, management, and other interested parties during the development of individual programs.

Welfare Policy

Three federal welfare initiatives are particularly relevant to the development of this workforce. The Temporary Assistance for Needy Families (TANF) program, created by the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), replaced the cash welfare system with a new block grant program. States now have considerable authority to determine how the block grant funds are used to aid the poor. TANF gives states flexibility in developing job opportunities at the state and county levels, including the creation of public job creation programs and the option of offering wage subsidies in lieu of direct cash grants to welfare recipients.

Although PRWORA was designed to increase work opportunities for welfare recipients, some provisions in the legislation may undermine that goal. Many states follow a "work first" strategy that sees placement in a job—any job— as preferable to entry-level, skill-based training (PHI 2000). States adhering to this philosophy encourage former welfare recipients to secure jobs as quickly as possible. Ironically for the long-term care profession, however, PRWORA conflicts with federal nursing home and home health aide requirements for skill-based training, making it harder for former welfare recipients to join the pool of qualified frontline workers. According to PHI (2000), policymakers have recently begun to recognize the problems with the work-first philosophy, and new state regulations may encourage skill-based training.

Recognizing the need to develop employment prospects for TANF participants, who face a five-year lifetime limit on benefits, the 1997 BBA authorized the U.S. Department of Labor to create a $3 billion Welfare-to-Work grant program for states and local communities. These grants help long-term welfare recipients and certain low-income noncustodial parents in high-poverty areas get jobs and succeed in the workforce. Job creation through public- or private-sector employment wage subsidies is permitted under the Welfare-to-Work program. Selected experiences with the Welfare-to-Work program are highlighted in the sections on state and provider efforts. It is important to note, however, that the success rate with this population has varied widely. Many former welfare recipients are not predisposed to join the long-term care workforce and lack the basic work skills to assume the responsibilities of a caregiver. Without proper training, ongoing mentoring, and adequate supports (e.g., subsidized child care), this program could be setting individuals up for failure.

Immigration Policy

Given the current labor shortage and gloomy projections about the future pool of workers, many providers have expressed interest in using immigrants to expand the potential labor pool. Countries such as Japan, Italy and Germany that are far "grayer" than the United States have already begun to pursue an aggressive immigration strategy: For example, Italy recruits from Peru, and Japan has begun to encourage immigration from the Philippines.

Immigration currently accounts for 40 percent of the labor force growth in the United States (SEIU 1997). Forty percent of immigrants are in two occupational groups: operator/laborer/fabricator and service worker (Fix and Passel 1994). Almost two-thirds of immigrants come to the United States for family unification, and are not seeking high-skilled employment opportunities. They comprise a current and future labor pool for low-skilled jobs, including the paraprofessional long-term care workforce (Stone 2000). Consequently, policies to limit the entry of low-skilled immigrants, particularly by limiting family-based immigration, may diminish the future labor pool of NAs and home care workers (Camarota 1998).

Recent immigration initiatives have been designed to expand the pool of skilled workers, particularly in the high-tech industry. In the health and long-term care sector, rules have been loosened to address the severe nursing shortage in hospitals and, to a lesser extent, nursing homes. Little attention, however, has been paid to the paraprofessional workforce.

Rogers and Raymer (2001) assessed immigration's possible "population-rejuvenating" effects in the United States and found little evidence of it, given past, recent, and current levels of inflows. Their analysis of the data from 1950 to 1990 indicates that although immigration's impact has contributed to higher worker-to-elderly ratios, the amount of immigration over the past decades has been insufficient to counteract the much stronger impact of population aging. While the dependency ratio is not a proxy for the frontline worker-to-elderly ratio, these findings do suggest that immigration policy would have to be designed to allow a large influx of low-skilled

immigrants if it were to address the demand for long-term care workers.

An immigration policy strategy for ameliorating the worker shortage has some appeal during our current period of economic prosperity. But it is important to recognize that immigrants reduce the employment opportunities of low-skilled workers in areas where the local economy is weak (Fix and Passel 1994). This negative effect, furthermore, tends to fall disproportionately on people of color, many of whom are employed as frontline workers (Wilner and Wyatt 1998). Finally, policymakers must also recognize that some low-skilled immigrants who fill entry-level positions in low-wage occupations in nursing homes, assisted living, or home care may need various forms of public assistance, particular if the economy weakens.

Workplace Level

While societal values, demographics, economics, and public policies influence how the workforce develops, the workplace is where the interactions between these factors and individual employer and employee decisions are played out. The four workplace dimensions- organizational arrangements, social factors, physical setting, and environment and technology- are all key to the successful development of the frontline workforce.

Organizational arrangements include the goals and strategies of the provider organization, the formal structure and administrative policies, and the reward systems. Rewards include wages and benefits, bonus and nonmonetary recognition programs, and career development/promotion opportunities.

Social factors include organizational philosophy and values, management style, interactions with employers, the behavior and attitudes of other employees and residents/clients, and individual personality attributes, life histories, and lifestyles.

The physical setting/environment includes the workplace's character (e.g., whether it is homelike or institutional); physical design, which may enhance or impede the worker's ability to provide care; and the extent to which the setting is ergonomically healthy.

Technology encompasses a wide range of factors, including job and role design, training programs, the availability of assistive devices and adaptive technology to facilitate care, the availability of clinical protocols and other care tools, and the role of information technology in enhancing the work life of NAs, home care aides, and other frontline workers.

A review of the literature reveals a paucity of empirical research related to workplace interventions (Stone 2001). Most of the research has been descriptive rather than evaluative, identifying various management/job redesign efforts, training activities, and financial and nonmonetary reward programs. Much of the "best practice" work has been anecdotal, summarizing the attributes of innovations (reported by either the providers or their peers) with little critical analysis. Furthermore, studies tend to focus on specific settings, with few attempts to compare workers' situations across the continuum of long-term care. The majority of studies have been conducted in nursing homes, with less attention focused on home care and virtually no empirical work on this issue in residential care.

Nursing Home Research

A number of researchers have examined the factors associated with job satisfaction, burnout, and turnover in nursing homes. In the 1980s, several small, qualitative studies of nursing assistants identified the management style of the organization (e.g., supervisors with good people skills, promotion of worker autonomy) as the most important predictor of higher job satisfaction and lower turnover rates (Waxman et al. 1984; Tellis-Nayak and Tellis-Nayak 1988). In a diagnostic study of NA jobs in 21 nursing homes, Brannon and colleagues (1988) assessed levels of skill variety, task significance, autonomy, and feedback. They identified several areas of job design warranting significant improvement and, in particular, the need for administrators and supervisors to increase NA autonomy.

Bowers and Becker (1992) conducted in-depth, qualitative interviews with NAs in nursing homes where annual turnover rates ranged from 120 to 145 percent. They found that NA trainees were given a lot of information during their orientation but received little guidance about how to respond to multiple simultaneous demands. The "long stayers" had the ability to integrate multiple demands, learned how to effectively juggle responsibilities, and had the autonomy to do so; those who left often did not.

Banaszak-Holl and Hines (1996) examined factors affecting NA turnover in 254 facilities in metropolitan areas of 10 states. They assessed the effect of intrinsic rewards (e.g., job satisfaction and sense of belonging), extrinsic rewards (e.g., wages and benefits), in-house training, workload, and elements of job design (e.g., how often NAs are included in resident care assessment and planning). They also examined the role of facility characteristics, such as ownership patterns, bed size, and percentage of Medicaid patients at the facility, as well as the economic health of the community.

Not surprisingly, local economic conditions had the strongest effects on turnover rates; stronger economies with greater low-wage market competition were associated with greater NA turnover. Among the facility characteristics, only ownership status proved significant, with for-profit facilities reporting higher turnover rates than homes in other categories. One of this study's most important findings was that homes in which nurse supervisors accepted NAs' advice or simply discussed care plans with the aides reported turnover rates that were one-third lower than those without these practices. Turnover rates were not affected by increases in aide training or greater involvement in resident assessment.

In interpreting these findings, the authors suggested that NA involvement in care planning meetings might give the aides a greater sense of responsibility for and authority over actual resident care, as well as making them feel like part of a team. Input into resident assessments is not sufficient; frontline workers must be able to observe a direct link between the information they gather about residents and subsequent action taken. This study also underscores the importance of formal communication between management and the paraprofessional staff, and the value of group problem solving.

One approach to managing staff that studies show has positive effects on staff turnover and work performance is the use of self-managed work teams (SMWTs). SMWTs are groups of employees, typically ranging from 3 to 15 people, who are responsible for the management and technical aspects of the job. Several researchers have used this strategy, originally applied in manufacturing settings, in health care settings (Becker-Reems 1994). Yeatts and Seward (2000) differentiate between interdisciplinary teams and SMWTs, using the former to refer to a small group of professionals who come together to address a specific task and the latter to describe groups who work together daily, depending on each other and routinely making management decisions related to their work. In a qualitative study of SMWTs operating at different performance levels in a Wisconsin nursing home, Yeats and Seward identified a high- and a low-performing team, each consisting of three NAs with a registered nurse (RN) supervisor. The teams were expected to make decisions such as who should serve which residents, the procedure to be followed in serving the residents, and who would have time off on major holidays. Members of the high-performing team were more involved in the decisionmaking, and the information they used for making these decisions came directly from their experiences working with the residents. Members of the low-performing team had much less opportunity to make decisions; the RN made most of the decisions without consulting the NA team members.

Burgio and Seilley (1994) have emphasized the need for supervisors to be actively involved, using frequent monitoring, performance feedback, and incentives. This thesis is supported by findings from a study of the effectiveness of a prompted-voiding procedure to treat urinary incontinence (Schnelle et al. 1990). The researchers found that without a staff management system in place, aides did not maintain the intervention in spite of having been assigned only responsive residents and having received both classroom and "hands-on" training in prompted-voiding procedures. Other studies have

underscored the importance of including NAs in care planning and helping them understand the links between interventions and resident outcomes through ongoing feedback (Hawkins et al. 1992; Schnelle et al. 1993). Burgio and Burgio (1990) have proposed a behavioral supervisor model for nursing homes that builds on a staff management system developed and evaluated by Reid and colleagues (1989) for individuals with developmental disabilities. The system incorporates participative management procedures that require active involvement of NAs in the management process.

As part of a larger study of nursing home turnover and absenteeism among six self-identified high-quality nursing home members of the Kansas Association of Homes and Services for the Aging, Long and Long (1998) used an ethnographic approach to examine predisposing factors, organization-based reinforcing and enabling factors, and interpersonal reinforcers influencing turnover, absenteeism, and internal rewards of organizations. The researchers found that paraprofessional behavior is driven by predisposing circumstances that can set up a cycle of powerlessness and unfamiliarity with the skills and rewards associated with performance and achievement in the workplace. Such situations are compounded by the NAs' place in the organizational hierarchy, at the bottom of the formal power structure, leading them to seek control through informal, and often inappropriate, means (e.g., ignoring nurse supervisors' instructions about schedules; sabotaging care plans). This, in turn, leads to organizational policies that are intended to alleviate staffing shortages but that end up punishing reliable and high-performing aides (e.g., requiring the best performers to work overtime; assuming that the best performers are better able to work when the facility is short of staff). There is also a widespread mutual lack of empathy among workers of differing ranks and roles, leading to a negative interpersonal climate that encourages workers to look for other jobs. In addition, most aides (as well as nurses and managers) have poor interpersonal skills that fuel misunderstandings, resentment, and work conflict. NAs, furthermore, see nursing homes as a place of grief at the death of residents, fostering the belief among potential employees that such work is unrewarding and unappealing. Finally, nursing homes are seen as places where the residents, but not the workers, are valued.

Home Care Research

Research on home care workers has been more difficult to conduct because there are fewer opportunities to observe the interpersonal dynamics between supervisors, workers, and other stakeholders within individual homes. Interventions targeted to home health and home care aides employed by certified agencies are easiest to assess because there are some parameters within which the employees are hired, trained, and retained. The most comprehensive study of home care worker satisfaction and turnover was conducted over a decade ago (Feldman et al. 1990). Feldman and colleagues designed a case-control study with a sample of 1,289 workers in five cities. They assessed the impact of salary increases, improved benefits, guaranteed number of service hours, and increased training and support on worker retention. The Ford Foundation subsidized the costs of the improvements, with total costs ranging from 6 to 17 percent above reimbursed rates.

In the aggregate, the interventions reduced turnover rates by 11 to 44 percent. The study found that financial rewards were important to worker satisfaction, motivation, and retention, but several job qualities proved to be even more important. Workers were more satisfied and likely to remain in the job if they felt personally responsible for their work and received ongoing feedback from their supervisors. The researchers concluded that good personal relationships between management and workers and between the worker and the client are essential for successful recruitment and retention.

One of the most disconcerting findings from this study was that all the agencies participating in the project reverted to their former practices when the foundation's study was finished and funding was withdrawn. This demonstrates the need for mechanisms to ensure the long-term sustainability of interventions. As one participant of an evaluation currently being conducted by this paper's author noted, "Work-life change is like losing weight. You can't go on and off a diet; it has to become a way of life!"

The first major study of independent home care workers, funded by the U.S. Department of Health and Human Services and conducted by Benjamin and colleagues (2000) in California, did not specifically address worker turnover and retention issues. These researchers did find, however, that those workers indicating greater

choice or discretion about how they do their work reported less stress (about family issues, client behavior, and negative personal emotions) and more job satisfaction (more independence and flexibility). While worker choice in the workplace may be constrained by either supervision from a home care agency or direction from a client, the degree of (perceived) choice within the work setting seems to have consequences for the frontline workers.

Public and Private Efforts to Develop a Qualified, Stable Frontline Workforce

State and Local Efforts to Address Frontline Worker Concerns

As noted previously, problems with recruiting and retaining frontline long-term care workers have become a priority for many states. This crisis has also raised awareness, at least rhetorically, about the need to develop and sustain a qualified, caring workforce. Several studies over the past several years have documented the range of state legislative and administrative initiatives that are either being implemented or on the drawing board (NCDFS 1999; NCDFS 2000; NCCNHR 2000; GAO 2000). The major categories of activities are identified and briefly described below.

Wage Pass-Throughs

The most prevalent state initiative is the "wage pass-through" (WPT), in which a state designates that some portion of a reimbursement increase for one or more public funding sources for long-term care (typically Medicaid, but sources may also include Older Americans Act Funds, state appropriations, etc.) is intended to be used specifically to increase wages and/or benefits for frontline workers. Typically, WPTs have been implemented either by designating that some specified dollar amount per hour or client/resident day be used specifically for wages/benefits or by designating that a certain percentage of a reimbursement increase be used for wages/benefits.

WPT initiatives are not new. Massachusetts, for example, passed WPT legislation in the early 1980s, and again later in the decade, to address episodic labor shortages (Feldman 1994). According to the 2000 NCDFS survey, 18 states had recently approved or implemented some form of WPT: 9 targeted only home care workers, 6 targeted nursing home aides only, and 3 targeted both. States reported being satisfied with their accountability procedures for monitoring whether the WPTs were used as intended. Few data exist, however, to substantiate whether this mechanism has directly influenced recruitment or retention in long-term care settings. Historical data from Michigan show an overall drop in aide turnover rates between 1990 and 1998, which the state attributes, at least in part, to WPT implementation (as reported by the NCDFS 2000 survey). There have, however, been no evaluations examining the short- or long-term effects of the WPT strategy and differences in outcomes based on variations in the methodology.

Some policymakers and providers have expressed great skepticism about WPTs' potential to significantly ameliorate long-term recruitment and retention problems. WPTs are used primarily when labor markets are tight, and therefore offer only temporary relief. While the NCDFS survey respondents reported having little concern about their ability to monitor WTP implementation, a recent *Sacramento Bee* (2001) article highlighting the failure of many nursing homes to pass increases directly on to frontline workers underscores the difficulty of tracking this mechanism's effectiveness.

Financially strapped providers in a number of states (e.g., Wyoming, Minnesota) did not accept the WPTs because of their concern about the employer's share of fringe benefits required to be paid to staff receiving increased wages. The president of the Minnesota Health and Housing Alliance, the state association of nonprofit long-term care providers, notes that apparent successes can come with costs (AAHSA 2000). The Alliance led a coalition of providers, consumers, and workers that convinced the state legislature to provide an extra $30 million in Medicaid dollars in the form of a 3 percent WPT for direct caregivers and a 3 percent cost-of-living increase. This pass-through, however, could be used only to increase wages for current staff, not to hire additional staff. In addition, the WPT did not take into consideration the additional costs to the facilities of paying more taxes as a result of the wage increases. The campaign to enact the legislation, furthermore, raised workers' expectations and created major conflicts between current and newly hired aides, who would not benefit from the pass-through.

The Minnesota experience highlights the limitations of the WPT strategy and underscores the need for policymakers, providers, and consumers to pay attention to the details and unintended consequences of such initiatives. More importantly, the WPTs have been relatively small increases in hourly wages, and have not been designed to markedly improve the financial status of frontline workers.

Enhancement Incentives

States can use other mechanisms to increase reimbursement rates and encourage quality of care. Rhode Island, for example, has passed legislation that ties nursing home and home care reimbursement rates to increased performance by both providers and staff (NCDFS 1999). While not yet fully implemented, this legislation has set up varying reimbursement rates based on several measures, including the level of client and worker satisfaction, the level of resident/client disability, the provider's accreditation, and the extent of care continuity. This initiative also provides higher reimbursement rates for workers on night or weekend shifts. California is offering monetary awards to nursing homes that provide exemplary care to the highest number of Medicaid residents, as well as financial grants to stimulate innovative programs. While these initiatives may be well intended, successful implementation of these efforts depends on the extent to which outcomes such as degree of care continuity, client and worker satisfaction, and "exemplary" care can actually be defined and measured in specific facilities.

Health Insurance Coverage

As noted earlier, the lack of or inadequate access to benefits such as health insurance may discourage potential workers from entering or remaining in long-term care jobs. Several states have programs or are exploring mechanisms to expand health insurance coverage (NCCNHR 2000). Hawaii and Vermont have strong safety-net programs for all low-income workers to obtain health insurance and access to prescription drug coverage. Over the last decade, many states (e.g., Hawaii, Minnesota, Vermont) have relied on Medicaid Section 1115 research and demonstration waivers to extend health care coverage to families and other working adults; more recently, states have begun to expand coverage through Medicaid Section 1931 disregards (Academy for Health Services Research and Health Policy 2001). In 1998, Rhode Island, which already covered children whose family income was up to 250 percent of the federal poverty level (FPL) through the state's 1115 Medicaid waiver, began covering parents of eligible children with incomes up to 185 percent FPL. After observing that significant numbers of enrollees switched from commercial products to this program, the state enacted Health Reform RI 2000, which establishes a premium assistance program designed to support, but not replace, existing private coverage. Massachusetts and Wisconsin have received federal approval to pay for private family coverage using State Children's Health Insurance Program (SCHIP) funds in cases where it is cost effective. Wisconsin's BadgerCare Program is providing coverage to all children up to age 18 (and their parents) not covered by Medicaid whose family incomes are up to 185 percent of the FPL (Alberga 2001). Combining Medicaid expansion with SCHIP coverage may provide better access to health insurance to low-income workers, including those employed in long-term care settings. Inadequate outreach efforts associated with all these initiatives, however, have limited worker awareness about coverage opportunities (Academy for Health Services Research and Health Policy 2001). Furthermore, there are no estimates of the number of long-term care aides who are currently receiving coverage through any of these programs.

New York's Health Care Reform Act of 2000 (HCRA 2000) authorizes the establishment of a state-funded health insurance initiative to cover uninsured home care workers. The legislation, however, only applies to workers in the New York City/Long Island area, a decision attributed to the strong unionization in that area (NYAHSA 2000). The New York Association of Homes and Services for the Aging (NYAHSA), the state association for nonprofit long-term care providers, has recommended that this legislation be expanded to cover all home care workers, as well as workers in nursing homes and residential care settings across the state. New York and Washington have also developed health insurance initiatives to help small employers- including long-term care providers- gain access to coverage for themselves and their employees.

Transportation Subsidies

Several states have included transportation reimbursement as part of an incentive package to attract and retain workers. Washington, for example, will reimburse agencies for the commuting time that is required for home health aides and personal care workers to get from one place to another (NCDFS 1999). Florida's Department of Elder Affairs is also exploring the possibility of providing transportation reimbursements for NAs and home care workers (Bucher 2000).

Career Ladders

Several states are exploring the development of career ladders for frontline workers by establishing several job levels in their public programs, their training requirements, or their reimbursement decisions (NCDFS 1999). Illinois, for example, has a bill pending to create a "resident attendant" category for nursing home workers; individuals would undergo training to provide basic supportive services to fully trained, experienced NAs. Delaware is considering developing a three-level career ladder- intern, team member, and team preceptor- that would be tied to increases in pay.

In the early 1990s, the New York City Human Resources Administration supported a study to test the effectiveness of a new home care position: the field support liaison (FSL), a home care worker hired and trained to visit attendant workers in order to identify problems and provide peer support in the community. A case-control evaluation found that agencies employing FSLs reduced their turnover by 10 percent over a two-year period, compared with those not using FSLs (Feldman 1993). This demonstration, however, never became an operational program because of a lack of city and state funding.

As part of a comprehensive, multi-year workforce strategy, Massachusetts has created a $5 million Extended Care Career Ladder Initiative to support the development and implementation of career ladder programs using innovative caregiving and workplace practices. Grantee nursing homes must form partnerships with workforce development organizations and other long-term care providers (e.g., home health agencies, assisted living providers, vocational rehabilitation providers), and must provide paid release time (at least 50 percent of workers' time) for work training and project participation. Researchers affiliated with the Corporation for Business, Work, and Learning in Boston are currently evaluating this demonstration.

Training

Approximately one-third of the states have regulations mandating hours of training above the federally required 75 hours for NA certification (NCCNHR 2000). California, Maine, and Oregon are at the high end, requiring at least 150 hours of training. At least 10 states are currently exploring strategies to improve training of frontline workers in all long-term care settings; California and Oklahoma are focusing special attention on dementia care. Nine states have been able to use civil monetary penalty funds resulting from nursing home enforcement activities to strengthen their worker training programs.

States have developed training initiatives for long-term care workers over the past two decades. In the mid-1980s, for example, New York awarded $2 million in grants to 39 organizations to develop basic home care training programs and programs focusing specifically on Alzheimer's and related dementias. By 1993, however, the budget had been cut to $578,000, raising the question of the initiative's long-term sustainability (NYAHSA 2000). As part of a larger initiative, Massachusetts recently appropriated $1.1 million for training,

including adult basic education and job supports, and another $1 million for a scholarship program. In 2000, California passed new legislation creating a statewide training initiative focused on innovative nursing home practices. North Carolina is funding a pilot project in 10 sites across the long-term care continuum to test the effects of seven new training programs (NCDFS 2000). The state will provide financial incentives to encourage aides to complete the training, and will evaluate the subsidized program's effects on aide retention. North Carolina also intends to develop a statewide mentoring program for NAs and home care workers, and the North Carolina General Assembly appropriated $500,000 for the State Board of Community Colleges to develop on-site internet training in nursing homes and other innovative programs to help increase recruitment and retention.

Developing New Worker Pools

Given the current labor shortage and projections that the pool will continue to shrink over time relative to increased demand, states are looking for alternative sources of workers. Some states have already experimented with attracting high school students to the field through programs established by the School to Work Opportunities Act of 1994. Wisconsin, for example, received funds to create a Youth Apprenticeship Program for NAs in nursing homes and assisted living. Several Colorado public high schools created a specific NA training curriculum through the state's School-to-Career Pathway program.

Many states, including New Jersey, New Mexico, Florida, and Arkansas, are trying to broaden the pool of potential aides by considering former welfare recipients as candidates (NCDFS 1999). New York has used some of its Welfare-to-Work grants to develop training programs for former welfare recipients and to encourage placement in a range of long-term care settings. A recent NYAHSA (2000) survey of its members found that providers have had mixed results with this population. While turnover rates were no higher for former welfare recipients than for other workers, some providers expressed concern about not being able to adequately screen out inappropriate candidates. This problem translated into wasted training and administrative costs.

Data from one study of a targeted NA training program offered by the New England Gerontology Academy, a consortium of public and private institutions of higher education in Rhode Island, substantiate problems with relying on former welfare recipients (Filinson 1994). The training program consisted of an intensive three-week, 120-hour curriculum covering a range of clinical, ethical, and management issues. Clinical placements in nursing homes alternated with didactic training, beginning on the fourth day, for a total of 40 hours of clinical training. Special efforts were made to recruit displaced (divorced) homemakers, welfare recipients, immigrants, and other disadvantaged groups. Staff provided child care and transportation assistance. In addition, efforts were made to help graduates find further education. Students were not required to pay tuition, and received their uniforms and shoes free of charge. The researcher sent questionnaires to 460 graduates of the program, with a 90 percent response rate. The impact of training was measured by employment at three and six months following graduation, current employment status, public assistance status, and education or training pursued after the program. The most significant predictor of success was being a nonrecipient of public assistance at entry. The training program appeared to be best suited for those in transition- homemakers recovering from a divorce, the recently unemployed, and new immigrants- and inadequate for those who have been more permanently removed from the labor force.

On the other hand, many providers have had positive experiences with the welfare-to-work strategy. The Service Employees International Union (SEIU) Local 250 developed a nurse aide training program in California that draws primarily from a pool of former welfare recipients. All participants must complete a two-week job readiness course, followed by an intensive eight-week training program that addresses clinical and other job skills, as well as a range of issues, such as how to deal with diversity of residents and staff, and personal skills development (e.g., money management). Graduating trainees are guaranteed a job in a nursing home, and are paid a regular NA salary during the training period. In its initial year, the program graduated 14 participants, all of whom became NAs.

In the early 1990s, the Colorado public school system experimented with a novel but somewhat risky strategy:

partnering with local homeless shelters to recruit and train NAs. "Operation Opportunity" offered a 100-hour, fast-track curriculum to pre-screened homeless individuals. The program was a community collaboration: Homeless shelters provided training in job skills and counseling; local nursing students served as mentors; nursing homes offered clinical space; and local businesses provided cash grants to help support the program. In 1990, 91 homeless people were trained, with an 81 percent employment rate. There was no formal evaluation, and the current status of this program is unknown.

In 1997, the Borough of Manhattan Community College (BMCC) in New York City developed a direct care worker training demonstration funded by the U.S. Department of Labor's Employment and Training Administration (Melendez and Suarez 2001). Nineteen Hispanic students completed a six-month program of bilingual vocational training to become paraprofessionals in the field of mental retardation and developmental disabilities. Designed and taught by instructors with years of practical experience in the field, the program provided training, financial, and academic assistance and an internship in a community residence or treatment agency. It also offered ongoing supervision and advocacy services for participating students. The program was designed as an entry point for a career ladder in the health industry, offering English language skill development in the context of job-related content and basic academic skills. To structure contextual and experiential learning, this demonstration combined classroom instruction with a 126-hour workplace internship. By the end of the program, students were matched with employers and also earned state certifications and three credits toward a college degree.

Evaluators found that 80 percent of the students completed the program, and 63 percent were placed in jobs. Interviews with program staff, students, and employers indicated that the initial success of this effort was based on a strict selection of students who had received prior orientation and counseling, the availability of support services, and the active participation of and connection to employers and the industry. The whole curriculum was designed to integrate vocational education with English as a Second Language and other scientific concepts necessary to work in the mental retardation field.

Injury and Accident Prevention

Since worker injury and accident rates may be a deterrent to recruitment and retention as well as a barrier to quality of care, states should pay attention to this aspect of the workforce issue. In the decade prior to 1993, Maine had one of the worst rates of workplace injuries in the nation. The Maine OSHA office developed a pilot to target the 200 employers in the state that were experiencing the highest number of injuries, illnesses, and fatalities in 1991. Twenty-two nursing homes were among the 40 health care industry employers targeted through this project (Wise 1996). Those who agreed to participate were placed on a Secondary Inspection List. The major incentive for participation was the opportunity to develop a relationship with OSHA based on the premise that if the employers were proactive, then OSHA would recognize that effort, assist whenever possible, and avoid issuing citations and penalties if the employers were operating in good faith. Employers agreed to implement comprehensive safety and health programs with employee involvement, designed to reduce injuries and accidents and bring the workplace into compliance with current OSHA standards.

The Maine Department of Labor's Safety and Health Consultation Service provided assistance to the nursing homes, including technical presentations to assist in the transfer of knowledge about "best practices." Nursing homes established injury prevention programs aimed at reducing musculoskeletal stress, primarily by eliminating single-person lifting/moving of residents. A review of the injury and illness data for the 40 health care facilities, including the nursing homes, between 1991 and 1996 indicated that 63 percent reduced their injury rates. This program is still operational, and has received the Innovations in American Government Award from the Ford Foundation.

Involvement of Public Authorities

Independent home care and personal care workers not employed by a formal organization have few avenues for addressing issues related to wages, benefits, and job quality and security. Consumers who choose to direct their workers also need assistance in fulfilling their role as employers. In the early 1990s, California consumers and workers were looking for ways to improve the publicly

funded In-Home Supportive Services program, in which 84 percent of clients received care from independent providers (San Francisco IHSS Public Authority 1998). Barriers to quality included difficulty finding screened workers, very low wages and few fringe benefits, and a lack of training opportunities. In 1995, the Board of Supervisors of San Francisco City and County voted to create the IHSS Public Authority, a quasi-governmental agency with four objectives: to create and operate a central registry of screened workers; to provide for and arrange training and support services for consumers and workers; to become the employer of record for IHSS independent providers; and to provide formal opportunities for consumer and worker leadership in program and policy development. Other California counties with public IHSS authorities include Los Angeles, Alameda, and Sacramento. San Francisco collaborates with these other public authority councils to address common issues such as how to increase wages and benefits.

Building a Positive Image

In 1999, the Wisconsin Bureau of Aging and Long-Term Care Resources awarded grants to 28 counties through its Community Options Program to help strengthen or expand the workforce serving community long-term support participants. Believing that the shortage of long-term care workers is an issue of more than wage and benefits, the Kenosha County Division on Aging and the Kenosha County Long-Term Care Staffing Task Force used their grant to develop a campaign to improve the image of work in this field (KCDHS 2001). This initiative targeted four groups: newly retired or recently widowed adults looking to supplement income or fill empty hours; college students looking for part-time work or high school students looking for job options; retail or food-service workers looking for more meaningful jobs; and homemakers looking to be paid for their caregiving skills. A community outreach specialist worked with a social marketing consultant and a community advisory committee to develop the campaign strategy, logo and slogan, and dissemination plan. Strategies included mailing postcards; posting ads in the newspaper and on the radio, billboards, and bus boards; distributing posters, including information in payroll slips and church bulletin inserts; and distributing notepads and note cards. All materials featured a number to call for information about jobs and training. A project coordinator was hired to do outreach presentations, assist with calls, collect campaign data, develop training opportunities, and forge relationships with employers.

The project's gerontological consultant conducted a descriptive pre-post evaluation (no control or comparison group) that examined retention, turnover, and worker satisfaction. Findings suggest that the campaign may have contributed to increased retention rates and improved employee attitudes in a range of long-term care settings. The campaign was less effective in increasing the number of new applicants or reducing the turnover among newer employees. It did, however, result in more inquiries and enrollees for the local technical college's nursing assistant classes. The evaluation also found that lower-cost marketing techniques (e.g., mailing postcards) were more effective than more sophisticated, multi-media advertising. The campaign organizers are now exploring the possibility of a statewide replication of this imitative.

Provider Initiatives

Providers across the long-term care continuum have experimented with a range of interventions to enhance their ability to recruit and retain workers and to develop a quality workforce (Straker and Atchley 1999; NYAHSA 2000). Nursing home, home care, and residential care providers are responding to the current labor shortage by offering signing, retention, and referral bonuses; annual raises; subsidized child care and transportation; tuition assistance; and other financial incentives to attract frontline workers. Many have implemented special recognition and award programs, and have instituted career ladders to encourage workers to remain with their organization. Providers have also developed special training programs focusing on specific clinical or management issues or special populations, such as people with dementia. Some have created mentoring and peer support initiatives to enhance workers' self-image and to encourage them to grow in their jobs.

The literature contains descriptions of programs in nursing home and home care settings that have attempted to address problems related to the recruitment, retention, and ongoing maintenance of the paraprofessional long-term care workforce. The vast majority of these initiatives have not been evaluated, so these "best

practices" are meant to be illustrative rather than comprehensive.

In the nursing home industry, the Pioneer homes approach to culture change in long-term care is receiving attention from providers, consumer advocates, policymakers, and the media. Nursing Home Pioneers is an informal association of providers who have a shared vision of how life and care in facilities must be transformed. The media have extolled the virtues of the Eden Alternative, a model developed by Dr. William Thomas to combat loneliness, helplessness, and boredom in nursing facilities. While not specifically focused on recruiting and retaining workers, this model celebrates community by linking the facility to the outside world-plants and animals abound, children interact with residents, and workers are empowered as an essential part of the care team. Several states, including New Jersey, New York, and Texas, have provided financial incentives for providers to "edenize" their facilities. Evaluation projects are currently underway at some of these sites, but findings are not yet available.

Some Pioneer homes (e.g., Evergreen and Lakeview in Wisconsin; Fairport Baptist Home in Rochester, NY; Mount St. Vincent Nursing Home in Seattle) have focused special attention on innovative environmental design as well as significant management transformation. Each facility has created neighborhood units, with kitchen and dining areas serving as focal points. NAs are empowered to develop teams and to provide individualized care and attention to residents. All food is cooked to order and the residents are encouraged to participate in meal preparation. Housekeeping staff are assigned to "neighborhoods" and are cross-trained as NAs.

Researchers at the Institute for the Future of Aging Services, the University of Wisconsin-Madison, and Texas A&M University are currently evaluating the Wellspring model of quality improvement in Wisconsin (Reinhard and Stone 2001). Wellspring is a consortium of 11 freestanding nursing homes that developed an alliance in the mid-1990s to facilitate group purchasing and to market their services to managed care. While the managed care opportunity never materialized, the consortium soon recognized their collective potential for improving quality in their respective facilities. Top management made a philosophical and financial commitment to a continuous quality improvement initiative through the consortium. The centerpiece of this activity is a major management change/job redesign effort, in which NAs become essential members of care teams and are empowered to make decisions that affect the quality of life for residents and workers. The consortium hired a geriatric nurse practitioner, who has developed a series of clinical and management training modules and who serves as the liaison between management and nursing staff across facilities. Professional and line staff (i.e., administrative, nursing, and non-nursing staff) receive intensive training offsite, and, through a train-the-trainer and mentoring approach, all staff members learn to work in teams around a range of clinical protocols (e.g., incontinence, skin care, and pain management). Nursing coordinators and NAs collect data related to these clinical domains and periodically analyze, assess, and compare their outcomes within and across the Wellspring facilities. This model has already expanded to several other alliances in Texas and Illinois. Findings from the Commonwealth Fund- supported evaluation are anticipated in late 2001.

The St. Martin's Outreach Certified Nursing Assistant Program, established in 1994 in Hartford, Connecticut, by St. Martin's Episcopal Church and the Seabury Retirement Community, was designed to develop job opportunities for the primarily low-income,

West Indian population in the surrounding area. Seabury has helped to develop this state-licensed NA training program and has made its skilled nursing and assisted living center available as the clinical training site for this outreach program. Classroom and seminar space are also provided at the retirement community. As of 1999, 250 students had graduated from the training program (with a 200-person waiting list), and the majority are gainfully employed as aides in nursing homes, assisted living, or home health care. This program's success has been measured as a reduction in unemployment in Hartford's large West Indian community.

An innovative program at Luther Manor in Dubuque, Iowa, trains experienced NAs in the skills they need to effectively mentor new nursing assistants. This user-friendly program gives participants information about teaching methods, such as effective presentation and communication skills, providing constructive feedback, and managing individual behavior. Luther Manor has reported improved retention of new hires, higher morale among NA staff, and improved quality of care as a result of the program, which is being promoted nationally and is currently being piloted in several other states.

In 1989, the Masonic Home of New Jersey instituted a preceptor program for experienced NAs to orient new frontline workers to the unit, act as a clinical resource, aid in the socialization of new staff members, assess new workers' performance, and provide positive feedback as well as suggestions for improvement (Shemansky 1998). Mentors receive two days of training and then are assigned to a new NA, with whom they work closely during the orientation period. The preceptors meet regularly to share progress and problems, and participate in program evaluations every six months. During the mentoring period, the preceptors receive an additional 50 cents an hour, as well as recognition with identification tags. Internal evaluations of the program over the past nine years show a reduction in turnover rates and high satisfaction ratings among old and new employees. This program received the 1997 National Geriatric Nursing Association Innovations in Practice Award.

In the early 1990s, Genesis Eldercare, a multi-facility provider headquartered in Pennsylvania, developed a comprehensive three-level career ladder program. Geriatric Nursing Assistant Specialists (Level 1) had to complete a six-month training program at a local community college. Senior Nursing Assistants (Level 2) served as team leaders for NAs after 30 hours of leadership training. Senior Aide Coordinators (Level 3) assumed management responsibilities for teams of NAs and served as liaisons between direct care workers and nurse supervisor. Although this program was never formally evaluated, Genesis management staff reported a decrease in turnover rates and improved worker morale as a result of the implementation of this career ladder initiative. Unfortunately, financial problems and corporate restructuring have reduced the commitment of top management to this program, and its future is uncertain.

The Wisconsin Alzheimer's Institute at the University of Wisconsin- Madison is working with three assisted living providers and one home care agency to test the efficacy of a multi-faceted approach to recruiting and retaining frontline workers in residential care. This project, sponsored by the John A. Hartford, Retirement Research, and Helen Bader Foundations, combines intensive life-skill training (adapted from a North Carolina program for training child care workers), peer mentoring, and financial incentives from employers. Researchers at the University of Wisconsin are currently evaluating this project, including the extent to which the intervention reduces turnover and increases retention rates.

Cooperative Home Care Associates (CHCA), founded in 1985 in the Bronx and replicated in Boston and Philadelphia, employs more than 400 workers, with an annual turnover rate of 18 percent (Wilner and Wyatt 1998). After three months' employment, the worker can purchase shares in the company. All employees are members of worker councils; 6 of the 10 board members are worker-owners. Prospective employees are carefully screened and receive extensive training. Their wages are higher than the average for home care aides, and they receive fringe benefits as well as guaranteed hours. Workers are encouraged to advance their careers and earn higher pay and status as associate trainers or by assuming administrative positions. Former welfare recipients comprise almost 85 percent of the workforce. The organization's success at enterprise development distinguishes it from many other efforts at job training or at promoting transition from welfare to work. It has integrated its training program with its capacity to create and sustain employment opportunities and its social goals with business planning and management skills. As noted

by Pitegoff (1999,112), "It is fundamentally an economic development approach driven by social values- an employer-based sectoral strategy to create quality jobs for workers and upgrade the status of the home health care work force, to provide quality home care for clients, and to demonstrate the capacity of poor working women for sophisticated enterprise."

As part of a demonstration project, the Huntington Memorial Hospital Senior Care Network in Pasadena, California, built a consortium of eight home care agencies in the early 1990s to recruit, train, and place workers and to collectively develop retention strategies (Beeman 1994). Formerly competitors, these agencies developed common standards and processed all referrals through one organization. Unfortunately, the formal consortium dissolved after the demonstration ended, although anecdotal reports suggest that the agencies continue to informally share ideas and practices.

Worker Initiatives

Many frontline long-term care workers have developed their own initiatives to improve their status, compensation, and job opportunities. The Iowa Caregivers Association is a formal membership organization of certified nursing assistants that advocates for workers in Iowa and other states, offers targeted education and training, and conducts research from the worker perspective. The National Network of Career Nursing Assistants, created in Ohio nearly 25 years ago, provides information and education for workers and conducts both leadership conferences and national forums on nursing assistant issues. The Direct Care Alliance (DCA), housed at the Paraprofessional Healthcare Institute in the South Bronx, is a new national grassroots coalition of direct care workers, consumers of long-term care, and concerned healthcare providers. They have come together to pursue a common goal of stimulating broad-based reforms- within both public policy and industry practice- to ensure a stable, valued, and well-trained direct care workforce that can meet consumers' demands for high-quality paraprofessional services. DCA has begun several activities, including cross-stakeholder dialogues, public education, advocacy, and the development of a national clearinghouse on legislation, regulations, and best practices.

Unions in general, and the Service Employees International Union (SEIU) in particular, have made major inroads in organizing both nursing home and home care workers in selected states across the country. SEIU has focused special attention on organizing California's independent home care workers, who are some of the lowest-paid individuals in the field and who have had great difficulty obtaining benefits and training. In addition to using collective bargaining, SEIU has developed several innovative training programs with local providers and has explored various strategies for expanding health insurance coverage to this population.

Although they have developed collaborative relationships with the unions in some communities, many providers strongly resist unionization. For example, Human Rights Watch cited several case studies of significant provider resistance to unionization among south Florida nursing homes (Compa 2000). Compa also reported the view that the problem is related to excessive regulation, not unionization, quoting one manager as saying, "We are very pro-worker, but when a union comes in they can't do anything about the wage base or benefit base. . . . Union facilities get poorer surveys from state regulators because unions make it hard to get rid of bad employees. . . . It's all sales and marketing. The union comes in and promises everything. . . . They promise what they can't deliver."

Developing Policy through a Research and Demonstration Agenda

This broad overview of the frontline long-term care issues has identified a number of knowledge and infor-

mation gaps that need to be addressed if we are to create policies that further the development of a qualified, sustainable workforce. Some would argue that research support is a wasted investment, that we know what to do and just need to move forward. But as this discussion has emphasized, the labor shortage and quality problems have existed for the past 20 years and are only expected to worsen in the future. Consequently, we do need to have a better understanding of the sources of the problem, the interactive effects of policy interventions, and the elements of success and failure in the different approaches to solving the problem.

First, we need an updated profile of the frontline workforce across settings- workers' demographic characteristics, wages and benefits, racial and ethnic diversity, geographic distribution, levels of education and health literacy, and other critical information- to help us make informed policy decisions. We need to compare workers' characteristics, skills, training, and responsibilities across settings to determine the extent to which potential workers are similar and could be affected by similar initiatives such as cross-training.

We also need to better understand the magnitude of the long-term problem in developing this workforce, the barriers to such development, and the possible consequences of different policy interactions on the nature and scope of the problem. The workforce issue is complicated and complex, and requires multidisciplinary research that examines both micro- and macro-level factors and their interactions.

Although states are forging ahead with a number of strategies to ameliorate the short-term crisis, there is little evaluative information to guide these decisions. What can we learn from state initiatives? What impact have wage pass-throughs, career ladder strategies, enhanced training efforts, and other mechanisms had on recruitment, retention, and quality? We also need to look at whether and how such strategies can be replicated in other areas and how best to translate findings into practice.

The literature is replete with self-reported "best practices," but there is very little information about what really works. Although policymakers and providers are searching for a "magic bullet," we all know it does not exist, so we need to have a better understanding of the constellation of interventions that is optimal for developing and sustaining the frontline workforce. Coming to such an understanding will involve developing better measures of both the interventions and success. Assuming we do identify the optimal set of interventions, we will also need to figure out how to sustain the success over time.

Finally, we need to explore creative ways of developing new pools of workers who can meet the demand for these services in the future. Large influxes of immigrants or cadres of former welfare recipients will not solve the problem. It is imperative that we develop and test new strategies for expanding the potential pool, including exposing young students and elderly retirees to the possibility of obtaining quality jobs that improve the lives of the people in their care.

Federal and state agencies and private foundations have begun to invest in applied research that will help provide some solutions to this dilemma. The U.S. Department of Health and Human Services' (DHHS) Health Resources and Services Administration is supporting several efforts to explore trends in the supply and demand for frontline workers, and the Department of Labor is funding training research and demonstrations in injury prevention in long-term care settings. The Agency for Healthcare Research and Quality has several new initiatives focused on patient safety and worker conditions in a range of settings and has sponsored a workshop and teleconference on the issue for state policy officials. DHHS' Office of the Assistant Secretary for Planning and Evaluation has collaborated with the Robert Wood Johnson Foundation to support three panels that will examine in more detail a number of the issues raised in this paper. Other private foundations, including the Commonwealth Fund, the John A. Hartford Foundation, the Mott Foundation the United Hospital Fund, Retirement Research Foundation, the Helen Bader Foundation, the California Endowment and the California Healthcare Foundation, and the Kate B. Reynolds Foundation, have also supported efforts in this area.

The future of the frontline long-term care worker is, in many ways, a barometer for the health of our aging communities. Stakeholders at the federal, state, and local levels and in the public and private sectors must come together to find creative solutions. We must bridge the worlds of policy, practice, and research to develop viable alternatives.

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