



The Long-Term Care Workforce: Can the Crisis be Fixed?

Problems, Causes and Options

Prepared for

National Commission for Quality Long-Term Care

By

Institute for the Future of Aging Services

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The Institute for the Future of Aging Services (IFAS) is a policy research institute whose mission is to create a bridge between the practice, policy and research communities to advance the development of high-quality health, housing and supportive services for America's aging population. IFAS is the applied research arm of the American Association of Homes and Services for the Aging (AAHSA). AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. AAHSA's commitment is to create the future of aging services through quality people can trust.

National Commission for Quality Long-Term Care

The National Commission for Quality Long-Term Care is a non-partisan independent body charged with improving long-term care in America. The appointed commissioners reflect a diversity of experience in government, academia, quality improvement, and long-term care. The Commission was convened in October 2004. It grew out of an industry-led quality initiative called *Quality First, A Covenant for Healthy, Affordable, and Ethical Long-Term Care*. Funding for the Commission's work is provided by the Alliance for Quality Nursing Home Care, the American Health Care Association, and the American Association of Homes and Services for the Aging. The Commission was originally convened and housed at the National Quality Forum, but is now an independent commission at The New School.

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The Long-Term Care Workforce: Can the Crisis be Fixed?

Problems, Causes and Options

Section I. The Workforce: Today's Crisis and Future Trends

The long-term care workforce is a much scrutinized phenomenon. From the Institute of Medicine (IOM) and the U.S. Departments of Health and Human Services (HHS) and Labor (DOL), to the National Commission on the Nursing Workforce for Long-Term Care, the Citizens for Long-Term Care, the National Alliance for Caregiving (the Alliance) and more than 35 state commissions and task forces, thoughtful groups of stakeholders and other experts have come together to examine workforce issues and lay out potential solutions.¹ Most recently, the National Commission for Quality Long-Term Care (the Commission) itself released a report, *Out of Isolation: A Vision for Long-Term Care in America*, laying out the case for long-term care reform including confronting workforce problems (National Commission for Quality Long-Term Care, 2006).

These organizations and groups largely have agreed on three issues:

1. There is a well-documented shortage of competent professional and paraprofessional personnel to manage, supervise and provide long-term care services in facility-based and home care settings—the result of high turnover, large numbers of vacancies and difficulty attracting new employees.
2. The instability of today's long-term care workforce has contributed to:
 - service access problems for consumers and, in many cases, has seriously compromised their safety, quality of care and quality of life;
 - excessive provider costs due to the need to continuously recruit and train new personnel and use temporary, higher-cost contract staff;
 - extreme workloads for both nurses and paraprofessional staff, inadequate supervision, less time for new staff to learn their jobs and high accident and injury rates exceeding those in the construction and mining industries.
3. As a result of growing demand from aging baby boomers and a shrinking of the traditional caregiver labor pool, the future will be immeasurably worse without decisive action by both the public and private sectors.

¹ See for example the following reports: National Commission on Nursing Workforce for Long-Term Care, 2005; HHS/DOL, 2003; Citizens for Long Term Care, 2002; National Alliance for Caregiving, 2001; Wunderlich and Kohler, 2001.

Unfortunately, there is no silver bullet that can solve today's shortages and meet future demand. Actions are required at many levels, on many different fronts. Many will be costly—and not all will agree about how or where to start. Perhaps most importantly, confronting workforce shortages is inextricably related to all other aspects of long-term care reform—from defining what the long-term care system is expected to do and how it should be financed to how to promote quality, employ technology and develop and implement new models of organization and service delivery. How the United States chooses to meet growing demand for long-term care in the future will have a significant impact on the number and types of personnel that will be needed, from where they will be recruited, how they should be compensated and trained, the nature of their work and the settings in which they work. This is the Commission's challenge.

Scope and Purpose of this Paper

This paper addresses long-term care workforce problems affecting frail and disabled older adults (63 percent of the long-term care population) who receive care in nursing homes, assisted living and other residential facilities, and home and community-based settings—principally their own homes and apartments. It is divided into three sections:

- Section I describes the composition of the long-term care workforce, why it is perceived to be in crisis by so many stakeholders today and the trends that are likely to drive it in the future.
- Section II lays out a range of options the Commission may wish to consider to ensure an adequate supply of competent long-term care professionals and paraprofessionals.
- Section III identifies high-priority information gaps that, if addressed through new research and demonstration, will strengthen the evidence base for future workforce improvement.

The Make-up of the Direct Care Workforce

According to Bureau of Labor Statistics (BLS) 2000 data, there are an estimated 1.85 million employees working in facility-based and home care settings, not including informal caregivers and caregivers employed directly by consumers and their families. This paper focuses on three groups of direct caregivers:

- **Licensed professionals** who include physicians, nurse practitioners, nursing home and assisted living administrators, other home health and community services agency directors and chief executive officers, registered nurses (RNs), and licensed practical and vocational nurses (LPNs/LVNs);
- **Paraprofessionals** who include home health aides, nursing aides, orderlies, attendants and personal and home care aides, as well as independent providers employed directly by consumers and their families; and
- **Informal caregivers** who voluntarily provide three-quarters of all long-term care to elderly family members.

There are also an estimated 1.65 million support personnel, including therapists, management and administrative staff, cleaning and maintenance staff, food preparers and servers, social services personnel, etc. These personnel are not addressed in this paper.

The characteristics of the direct care workforce are described below.

Licensed Professionals

Physicians: Physicians are formally involved in long-term care as nursing home and home health agency medical directors and as the individuals who are required to sign off on nursing home and home health care plans. Some physicians also continue to treat their elderly patients after they are placed in a nursing home or assisted living facility. Since 1990, nursing homes reimbursed by Medicare or Medicaid are required to have a physician medical director who is responsible for implementing medical care policies and coordinating medical care. The practical meaning of these responsibilities is not well defined. Home health agencies are not required to have a medical director, although many do. Few physicians within or outside the long-term care system are geriatricians or have training in geriatrics to prepare them to carry out these roles effectively.

Most observers agree that little medical care is found in nursing homes (Wunderlich and Kohler, 2001). A review of the literature suggests that most medical directors have limited authority over nursing home staff or internal nursing home practices (Levy, Epstein, Landry, Kramer, Harvell and Liggings, 2005). About 84 percent report they are part-time, and 87 percent also are attending physicians of residents in the facility for which they are responsible. A 2003 study of medical directors by HHS found:

- 86 percent reported spending eight hours or less per week in a facility;
- 62 percent reported visiting the facility one time per week or less; and
- 70 percent reported that from one percent to 10 percent of their overall medical practice was devoted to their medical director role (U.S. Department of Health and Human Services, Office of the Inspector General, 2003).

In a recent effort to elevate the medical director's role, the Center for Medicare and Medicaid Services (CMS) instructed nursing home surveyors to examine the adequacy of their performance and link deficiencies in their performance to resident outcomes (Levine, Savino, and Siegel, 2006).

Physician involvement with the elderly homebound clients of home health agencies is also problematic. Coordination and communication between home health agencies and physicians has long been regarded as inadequate.

Nurse practitioners (NPs): NPs are registered nurses with additional education in health assessment, diagnosis and management of illness and disease. Medicare has reimbursed NPs since 1998. These nurses may have the potential for playing a bridging role between the worlds of medical care and long-term care; however, the number of NPs now employed by long-term care providers is not known. Studies of NPs in nursing homes suggest they enhance the medical services available to residents and prevent unnecessary hospital admissions (McAiney, 2005). A survey of nursing home medical directors found that they perceived NPs to be particularly effective in maintaining physician, resident and family satisfaction (Rosenfeld, Kobayashi, Barber, and Mezey, 2004).

Nursing home/other long-term care administrators: The federal government requires states to license nursing home administrators, although there are no national standards. Wide variations in licensing requirements exist across states (Langelier and Wing, 2004). The credentialing of administrators in assisted living facilities, home health agencies and other home and community-based services agencies is left up to states. The National Association of Boards of Examiners of Long Term Care Administrators (NABE) estimates there are between 22,000 and 25,000 licensed nursing home administrators, of which 16,000 to 17,000 are currently employed in skilled nursing facilities. These individuals are responsible for all facets of facility life, including the supervision and management of staff and compliance with fed-

eral and state regulations. Most states require prospective nursing home administrators to serve an unpaid apprenticeship prior to obtaining a license.

Over the past several years, there have been sharp declines in the number of new individuals entering nursing home administration and high rates of turnover among current job holders (National Association of Boards of Examiners of Long Term Care Administrators, 2001). One study of more than 400 nursing homes found an annual turnover rate of 43 percent. Administrator turnover has been linked to poor quality outcomes in nursing home residents (Castle, 2001). Recent data suggests that the decline in new applications for licenses may have leveled off; however, the causes of past declines, or the reasons why the decline may have reversed, are not known (Stoil, 2005).

There are few studies of administrators in other long-term care settings and no information at the national level on their numbers, turnover or vacancy rates.

Nurses: An estimated 500,000 RNs and LPNs/LVNs make up the vast majority of long-term care professionals (American Health Care Association, 2004). RNs in long-term care settings compose only a small percentage of the total RN workforce, most of whom are employed in hospitals. They are relatively evenly distributed between home health agencies and nursing homes, while LPNs are concentrated in nursing homes. About 90 percent of RNs are white women, although increasing numbers are immigrants. About four percent are both foreign born and foreign trained (Health Resources and Services Administration, 2004).

Most RNs in nursing homes hold administrative and supervisory positions, including directors or assistant directors of nursing or head nurse. Their primary role is to assess resident health, develop treatment plans and supervise LPNs and paraprofessional direct care staff. Increasing numbers of studies have demonstrated the impact of adequate numbers of RNs on quality outcomes for nursing home residents (Bostick, Rantz, Flesner, and Riggs, 2006; Harrington, Carrillo, and Wellin, 2001). RNs in nursing homes are older than RNs in other health care settings—36 percent are aged 50 or over and 10 percent are over age 60 (Spratley, Johnson, Sochalski, Fritz and Spencer, 2001). Home health RNs assess patients' home environments, care for and instruct patients and their families and supervise home health aides. Unlike in nursing homes, there is little research on the impact of nurses employed in the home health industry on quality of care. The job satisfaction of RNs in all health care settings is low in comparison to the job satisfaction of other professionals and is lowest of all in nursing homes and other facility-based settings (Spratley et al, 2001).

LPNs account for 46 percent of licensed long-term care nurses. They provide direct patient care including taking vital signs and administering medications. The LPN workforce is somewhat younger than the RN workforce, and the racial diversity of the workforce is greater. About 26 percent of LPNs are black and almost all are U.S. born (Seago, Spetz, Chapman, Dyer and Grumbach, 2001). LPN scopes of practice are more limited than that of RNs; however, they play an extremely important role in nursing homes. According to surveys conducted by the National Council of State Boards of Nursing, more than 60 percent act as charge nurses or team leaders with responsibility for supervising and directing the care provided by paraprofessional direct care staff. A study of nursing hours in nursing homes found that LPNs provided more hours of nursing care per day than did RNs (Harrington et al, 2003).

Both RNs and LPNs are licensed at the state level. RNs typically take two to four years to complete their nursing education, while LPNs usually can obtain a license after 12 to 18 months. According to the BLS, the median annual wage in 2005 for RNs employed by home health agencies was \$54,550, and

\$51,510 for RNs employed in nursing homes (RNs employed in hospitals earned \$57,820 per year). The median annual wage for LPNs in nursing homes was \$37,520 in 2005, and \$37,810 in home health agencies.

High turnover and vacancy rates and difficulty recruiting and retaining RNs and LPNs are reported across the spectrum of long-term care providers. Analysis of a 2001 survey of nursing homes conducted by the American Health Care Association (AHCA) found annual turnover among RNs averaged almost 49 percent, and LPN turnover averaged more than 50 percent. Facility respondents reported that 18.4 percent of RN positions were vacant, as were 14.4 percent of LPN positions. They also reported that recruitment problems were getting worse. These trends are consistent with results of similar studies at the state level. A study of RN turnover in home health agencies as reported by the U.S. General Accounting Office (GAO) found a 21 percent annual turnover rate (U.S. Government Accounting Office, 2001). The final report of the National Commission on Nursing Workforce for Long-Term Care estimated that 96,000 new nurses are needed just to fill current nursing home vacancies.

Paraprofessionals

These personnel are considered the “hands, voice and face” of long-term care, responsible for helping frail and disabled older adults carry out the most basic activities of daily life. The majority work in nursing homes and assisted living facilities; however, increasing numbers provide in-home supportive and health-related services. Estimating the size of the home care workforce is particularly difficult—many are missed in surveys because they are directly employed by consumers and/or their families. A recent study suggested their numbers are significantly undercounted (Montgomery, Holley, Deichert and Kosloski, 2006). According to 2006 BLS data, the total paraprofessional direct care workforce in both the health and long-term care sectors consists of:

- 1,391,430 nurse aides, orderlies and attendants, largely employed in nursing homes;
- 663,280 home health aides, a slight majority of whom work in home-based care settings; and
- 566,860 personal care and home care aides, two-thirds of whom work in home-based services.²

The majority of these direct care workers are employed in long-term care settings.

Women make up about 90 percent of the paraprofessional workforce. About 50 percent are racial or ethnic minorities, including 33 percent who are African American and 15 percent who are either Hispanic or other persons of color. A recent study by Montgomery based on the 2000 Census, points out that the characteristics of paraprofessional nursing home and home care workers diverge in some important ways. For example, Hispanics are somewhat more likely to work in home care settings, and African Americans are more likely to work in nursing homes. Direct care staff employed in home care agencies are also more likely than nursing home staff to be foreign born and less likely to be U.S. citizens, perhaps indicating that home care is an entry-level job for new immigrants. Home care workers are also older than nursing home direct care workers, with a mean age of 46 (compared to age 36 for nursing home workers). The percentage of home care workers over age 65 is three times that of direct care workers in nursing homes. Home care personnel are also less likely to be married. Importantly, 50 percent of nursing home workers are employed full-time, while only about a third of home care workers are employed full-time. These differences may have implications for developing recruitment and retention strategies.

Certification requirements for paraprofessional workers across all long-term care settings are usually low or non-existent. Federal law requires nursing assistants and home health aides to have less than

² Montgomery, based on an analysis of the 2000 Census, estimated there are almost 800,000 home care aides, including personnel employed privately by families and those employed in home care agencies who have been missed in other estimates.

two weeks of training, although most states add on to these requirements. Federal law does not require training for home care workers, and state requirements for these workers vary widely. Twenty percent of nursing assistants and home health aides have not graduated from high school; however, more than 30 percent have some college education (Health Resources and Services Administration, 2004). The median annual wage in 2005 for personal and home care aides was \$17,710; for home health aides, \$18,850; and for nurse's aides and orderlies, \$21,480 (Bureau of Labor Statistics, 2006). Wages are generally comparable to or somewhat higher than other service industry jobs with minimal entry requirements. For example, according to the BLS, in 2005 the median annual wage for teaching assistants was \$21,102; for maids and housekeepers, \$18,000; cashiers, \$17,300; and food preparers and servers, including those in fast-food business, \$15,500. One in four direct care paraprofessionals employed in nursing homes and two in five employed in home care agencies also lack health insurance. Nursing home workers are also twice as likely to be uninsured as hospital personnel. High injury rates may make them especially vulnerable without adequate insurance coverage (Paraprofessional Health Care Institute, 2006).

While the number of paraprofessionals in the health care workforce grew 40 percent between 1988 and 1998, vacancies and turnover has become a serious problem (U.S. Government Accounting Office, 2001). The AHCA survey of nursing homes found annual turnover rates among nurse aides of more than 76 percent and vacancy rates of almost 12 percent (American Health Care Association, 2003). A national survey of 44 states conducted in 2003 found that 80 percent of state respondents (33 states) indicated direct care worker shortages were a serious problem (Paraprofessional Health Care Institute, 2006). A 2005 American Association of Retired Persons (AARP) report cites numerous studies of high vacancy and turnover rates among paraprofessional direct care staff (Wright, 2005). One national study of assisted living reported annual turnover rates of about 40 percent among personal care workers and nurse aides. A 2002 Wisconsin study found turnover rates among direct care paraprofessionals of 77 percent to 164 percent in assisted living, from 99 percent to 127 percent in nursing homes and 25 percent to 50 percent in home health agencies. A 2002 North Carolina study found turnover rates for aides of 95 percent in nursing homes and 37 percent for home care agencies.

Research confirms that the most important reason direct care paraprofessional workers stay in their jobs is the relationships they have with older adults in their care. Turnover and job dissatisfaction is clearly linked to poor pay and benefits (PHI, 2004). However, compensation issues alone do not explain overall satisfaction or turnover. Direct care staff whose work is valued and appreciated by their supervisors, and who are listened to and encouraged to participate in care planning decisions, have higher levels of job satisfaction and are more likely to stay in their jobs (Bowers, Esmond and Jacobson, 2003; Harris-Kojetin, Lipson, Fielding, Kiefer and Stone, 2004).

Informal Caregivers

There are an estimated 34 million informal caregivers of older adults. About three-quarters of older adults who receive long-term care at home rely entirely on informal caregivers, primarily spouses and children who may provide paid or unpaid care. Almost all states pay families to provide care to some degree, either in one of their state programs or through the Medicaid home and community-based waiver program (Feinberg, Newman, Gray and Kolb, 2004). The scale of these programs and their impact on moderating demand for formally delivered services is not known. Federal law does not require paid informal caregivers to have any training, although some states impose training standards comparable to other direct care paraprofessionals. Informal caregivers are generally between the ages of 45 and 64, and two-thirds are women. These caregivers may experience tremendous rewards from their caregiving roles; however, they also may experience emotional, physical and financial hardships

(Alecxi, Zeruld and Olearczyk, 2002). In 2001, the U.S. Administration on Aging, recognizing the dominant and critical role of informal caregivers in the nation's long-term care delivery system, created a new national family caregiver support program that has allocated several hundred million dollars to states to support informal caregivers.

Factors Influencing Workforce Recruitment and Retention

A variety of factors influence the recruitment and retention of the long-term care workforce. The impact of some of these factors is immediately apparent—the impact of other factors is much more uncertain.

Short-Term Factors

A variety of factors influence the recruitment and retention of both professionals and paraprofessionals regardless of the setting in which they work. Among them are:

- 1. The Economy:** When the economy is strong, as it was in the late 1990s, and unemployment is low, the pool of personnel—particularly women who may have in the past chosen long-term care—have more options. The tighter the labor market, the more difficult it may be to attract personnel to long-term care jobs.
- 2. Industry Stereotyping:** The very image of the long-term care industry makes workforce recruitment more difficult. Ageism in the larger culture, the tendency to equate long-term care with nursing homes—a setting older people want to avoid—and sensational stories in the media about nursing home fires, abuse and scandal combine to bias the public's view. According to a Kaiser Commission Survey, nursing homes are ranked below drug companies and just above health insurance companies in the share of adults who think they do a good job. Four in 10 respondents said they do not believe nursing homes provide a high quality of service, six in 10 said nursing homes make people worse off and only two in 10 said they make people better off (Kaiser Family Foundation, 2006).
- 3. Pay and Benefits:** Salary is a critical issue for all categories of the long-term care workforce. The level at which salaries would have to be set to attract sufficient numbers of physicians, nurses and paraprofessionals to long-term care is not known. Wages and benefits of the paraprofessional workforce are particularly problematic given the level of responsibility they are expected to assume, the heavy workloads they must endure and high injury rates. Almost 30 percent live at or below the poverty line. They are less likely to have health insurance than the average worker in the United States, and 75 percent have no employer-sponsored pensions. Compounding the problem of low wages is the high proportion of paraprofessional workers who work part-time (Salsberg, 2003). Wage increases have been shown to have a substantial impact on their recruitment and retention. An evaluation of a San Francisco County initiative that doubled the wages of In-Home Supportive Services (IHSS) personnel found that the wage hike resulted in a 54 percent increase in the number of IHSS personnel employed over the period of the study.³ Annual turnover also fell 30 percent (Howes, 2002).
- 4. Poor Working Conditions:** As is often true in the larger health care sector, the long-term care industry tends to follow an almost military, hierarchical approach to workplace organization and management. Mentoring, coaching, the use of teams and collective involvement of staff in decision making is the exception rather than the rule. Both nurses and aides complain about managers who lack respect for the knowledge and skills they bring to the job and refuse to share information, as well as poor supervision and a feeling that they are powerless to change their work environment (Bowers et al, 2003; Kimball and O'Neil, 2002). The retention of long-term care personnel will not be accomplished without significant changes in human resource practices and systems.

³ The wage increase resulted from county passage of a living wage ordinance and union bargaining with the county public authority, the employer of record for IHSS personnel who are employed directly by consumers.

- 5. Inadequate/Misplaced Investments in Long-Term Care Workforce Education and Training:** The professional long-term care workforce is not trained to address the special health and medical care needs of elderly consumers. Nationwide, there are few nurses or physicians trained in geriatrics. Nursing home administrators—the chief executive officer in nursing homes— only may need to have a high school diploma and pass an exam. Training requirements governing administrators in other settings such as assisted living or home health range from rigorous to minimal. (Miller and Mor, 2006). Nursing schools, community colleges and technical schools typically do not cover long-term care nursing in more than a cursory way in their curriculum. Anecdotal evidence suggests they may discourage nursing students from even considering long-term care careers. Nursing schools largely fail to prepare RNs to carry out administrative roles—although that is a primary responsibility in long-term care nursing. They do not adequately prepare RNs or LPNs in effective supervisory approaches, although one of their principal responsibilities is to supervise paraprofessional staff. Nurses also are trained poorly to understand the workforce implications of a culturally diverse paraprofessional workforce or the growing ethnic and racial diversity of older adults who are the consumers of long-term care.

To become certified as nursing assistants or home health aides, individuals are required to have less than two weeks of training. Home care aides are not subject to any federal requirements, and few states require training. Most direct care paraprofessionals appear to learn what is expected of them and how to do their jobs after they have been hired. As a result, large numbers are unprepared for the demands placed upon them and leave their jobs within the first few months. Continuing education requirements for both professional and paraprofessional personnel are minimal. They are typically perceived as book learning without any real link to the reality of the tasks they must perform on a daily basis. There are few rewards for keeping up with the latest information on evidence-based practices or the availability of new technologies. Raising education requirements also could have an undesirable effect if it discourages or delays prospective personnel from entering long-term care jobs; however, improving training may be the only path to creating higher-quality jobs that are more competitive in the labor market.

- 6. Limited Data on Long-Term Care Workforce Supply and Demand Imbalances:** There are large geographical differences within and across states with respect to workforce shortages in the long-term care delivery system. The ability of public and private agencies to track supply, demand and labor shortages is weak. Consistent definitions of the various categories of long-term care employees, as well as measures of supply and demand, are lacking. Workforce planning, policy development, quality improvement, evaluation of what works and information for consumers all require better data on the various components of the long-term care workforce (Moore, 2003).
- 7. Limited Dollars to Add New Personnel:** Seventy percent of long-term care costs are paid from public funds (Georgetown University Long-Term Care Financing Project, 2007). Public reimbursement rates are critical factors in determining both the supply of and demand for long-term care. Because government financing policies largely have been driven by cost containment motives, they limit the number of new employees that providers are willing to add to the labor pool. While the relationship between raising reimbursement rates to providers and increased staffing levels is not well understood, assumptions that the private market will take care of workforce shortages without additional public dollars are probably far-fetched.

A number of recruitment and retention issues also affect professionals and paraprofessionals in the long-term care workforce somewhat differently. For example:

- Most **physicians** have office-based practices. Most nursing home residents (as well as many

other older adults with chronic illness and disability) cannot get to doctors' offices without extreme difficulty, if at all. Until Medicare and Medicaid provide sufficient monetary incentives to compensate physicians for time spent traveling to and working in a nursing home or in the individuals' own home if they are homebound, inadequate oversight of and coordination of medical care and long-term care services will continue to be a problem.

The National Association of Boards of Examiners of Long Term Care Administrators has identified several special barriers to the recruitment and retention of qualified **nursing home administrators**, including: (1) the lack of a national registry of licensed administrators to inform recruitment and retention, education and training preparation and standards development and licensing practices; (2) state licensure requirements that demand months of necessary but unpaid apprenticeship before licensure is completed; and (3) uneven training and licensure standards that limit workplace mobility and may contribute to poor performance and the inability to quickly place qualified administrators where they are needed most.

- While **RN** shortages are influenced by inadequate wages and poor working conditions, recruitment efforts also are exacerbated by the lack of faculty to teach nursing students. Surveys conducted by the American Association of Colleges of Nursing found that U.S. nursing schools turned away 41,683 qualified applicants from baccalaureate and graduate nursing programs in 2005 because of a shortage of faculty a lack of clinical sites and space and budget constraints. Almost three quarters of nursing schools responding to the survey reported that faculty shortages prevent them from accepting all qualified students (American Association of Colleges of Nursing, 2006). Paperwork burdens, the result of federal and state regulatory requirements, also have become particularly burdensome for nurses in nursing home and home health settings—detracting from their ability to supervise and mentor staff, oversee quality and introduce innovation to the workplace. **LPNs**, the dominant nursing presence in nursing homes, may be hampered by restrictive scopes of practice. State regulation of nursing practice does not necessarily reinforce the role that the LPN must play in assessing residents, planning care, delegating tasks and supervising direct care personnel.
- The dilemmas peculiar to the recruitment and retention of the **paraprofessional workforce** are perhaps the most complex and difficult to resolve. Wages are not adequate to support young families with children. The job is often not well-designed, creating inefficiencies, unnecessary job burdens and subjecting occupants to high rates of injury. There are few opportunities for career advancement. Supervision is poor or non-existent. In addition, low unemployment rates for all entry-level personnel, coupled with increasing levels of education among minority populations, provide this labor pool with far more choices than low-income women have had in the past.

Long-Term Trends

1. The **“Emerging Care Gap”**: Between now and 2015, demographers point out that the population aged 85 and older—those most likely to require long-term care—will increase by 40 percent. At the same time, the native-born population aged 25 to 54—the pool of individuals from which both paid and informal caregivers have largely come—will not increase at all. After 2015, the older adult population really will begin to accelerate and will continue to do so until 2050. When the baby boomers turn 85, they simply will not have the number of children to help take care of their long-term care needs as do today's 85-year-olds. The BLS predicts a 45 percent increase in demand for long-term care by 2010—equivalent to about 800,000 new jobs for nurse aides, home care personnel and personal care. The increase in demand will be greatest in home care settings, followed by assisted living and other forms of residential care. The demand for nursing home personnel is expected to grow

more modestly. One study has calculated that to maintain the current ratio of paid long-term care personnel to the oldest old (those over 85) would require the long-term care workforce to grow by two percent a year from now until 2050, and to add more than four million new long-term care personnel (Friedland, 2004). Government estimates are even higher (Levy et al, 2005).

2. **Shift from Institutional Care to In-Home and Community-Based Care Settings:** The number of older adults in nursing homes declined from 4.2 percent to 3.6 percent between 1985 and 2004. One recent study found that declines in nursing home use were steepest among older adults aged 85 and older—the population who is most likely to be disabled and in need of long-term care (Alecxi, 2006). During this time period, alternatives to nursing homes have rapidly emerged—particularly assisted living and home and community-based services. The shift to home and community-based services will influence the number and types of caregivers that will be needed in the future, as well as regulatory requirements regarding credentialing and ongoing training.
3. **Decline in Disability Rates:** Disability rates among older adults declined between 1984 and 1999. If these patterns persist, the demand for long-term care services could be substantially less than would be predicted based solely on the growth of the elderly population. To date, there is little if any consensus regarding future disability trends. However regardless of whether they decline at the rate they have in the past, level off or go up, the number of older people with disabilities is expected to dramatically increase (Center for California Health Workforce Studies, 2006).
4. **More Ethnically and Racially Diverse, Better Educated and Wealthier Older Adults:** Baby boomers will look different than past elderly cohorts. They will be more racially and ethnically diverse—only 64 percent non-Hispanic white in 2050 compared to 83 percent in 2000; more likely to be high school and college graduates; and more likely to have higher incomes (Center for California Health Workforce Studies, 2006).
5. **Movement to New Models of Care:** The organization of the long-term care system of the future will be different. The traditional nursing home may not even exist. Home and community-based services will dominate long-term care service delivery. Tomorrow's older adults will no doubt manage far more of their care than they do today. While wealthier people always have been able to manage their own services by purchasing them in the private market, the consumer-directed care movement is bringing this type of autonomy and control to the public market, as well. Consumer-directed care enables older adults with disabilities rather than professionals to make decisions about the services they want, who they want to deliver them and how and when they are delivered. A 2002 survey conducted for AARP found that more than 85 percent of people aged 50 and over wanted to manage their own long-term care services rather than have an agency manage them on their behalf. Studies of consumer-directed services have concluded that participants were more satisfied than under traditional agency-directed models, reported a higher quality of life, had fewer unmet needs and said they got more care for their money (Kassner, 2006).

The proliferation of consumer-directed models will require a considerable reorientation of the direct care workforce. The workforce must adapt to consumers who have the right to hire and fire them and to make care decisions. They also must deal with issues of potential exploitation around scheduling, wages and benefits. Already, public models of consumer direction raise several policy issues, such as whether there should be requirements for quality oversight, training and worker protections, how much workers should be paid, how federal and state tax withholding requirements can be assured and whether consumers need training to supervise workers. California, Washington and Oregon have begun to address such concerns by establishing public authority models, which act as the employer of record for workers hired directly by consumers.

6. **Introduction of New Technology:** The future impact of new technology on the supply and demand for personnel is promising but uncertain. The introduction of labor-saving technology may reduce paperwork burdens and rates of injury and improve worker efficiency, allowing fewer personnel to do more with less.
7. **Immigration Policy:** Labor growth between 2000 and 2020 will rely on immigrants and people aged 55 and over. Immigrants are a particularly important source of labor in the home care sector. They are a growing force in the nursing profession. They may be more willing than U.S.-born natives to work in caregiving occupations with lower wages. Changes in immigration laws can have a big impact on their supply.

Responses to short-term issues and longer-term trends impacting the workforce are not likely to be the same—yet both need to be addressed. Clearly resolutions to the “emerging care gap” will require some dramatic changes from “business as usual,” for example:

- modernizing the image of long-term care;
- reducing negative stereotyping of the industry;
- attracting large numbers of new and qualified personnel;
- making jobs more competitive;
- reforming working conditions to make them more attractive;
- introducing more flexible and relevant approaches to education, credentialing and ongoing training;
- providing personnel with more career mobility;
- moderating the demand for new personnel, e.g., facilitating movement between health-related occupations, redesigning jobs to be more efficient, introducing new labor-saving technology, enabling older adults to self manage more of their care; and
- reinventing the whole paradigm of long-term care services financing, organization and delivery.

Section II. Potential Goals and Strategies

This section is organized around six broad goals for addressing present and future shortages of competent personnel in the long-term care system. To have an impact, these goals must fit within a broader vision of long-term care organization, financing and service delivery. Addressing any one goal in isolation from others is not likely to have much success. Concrete benchmarks to measure progress toward selected goals need to be established. History has also shown that effective implementation of workforce improvements is dependent upon the collaboration of multiple stakeholders—employers, consumer advocates, professional associations, unions and other worker groups, educational institutions and government entities. If these disparate stakeholders cannot unite to achieve common goals, the most elegant strategies are likely to fail.

Goal 1. Expand the Supply of Personnel Coming into the Long-Term Care Field

The long-term care workforce is dominated by women. Its professional ranks lack ethnic and racial diversity. The nursing workforce is aging, and many are nearing retirement. The labor pool that has historically supplied both paid and informal caregivers is shrinking and will continue to do so for many decades to come. Throwing warm bodies at the long-term care problem will not solve the vexing financing and quality problems that are at the heart of the need to reform long-term care. However, most stakeholders would agree that new sources of caregivers must be attracted to meet future demand—regardless of the vision that will drive long-term care in the future.

Potential initiatives include:

- **Track Long-Term Care Labor Shortages:** Mandate HHS and DOL to work with the Regional Centers for Health Workforce Studies (funded by the Health Resources Services Administration) to track supply, demand and workforce shortages across regions and states. This would entail the development of common definitions of worker categories; common measures of vacancies, turnover and projected need; and the development and implementation of new data systems. DOL also could be asked to join with the regional centers to provide technical assistance to states to promote long-term care workforce planning. The status of the long-term care workforce should be reported to Congress every two years.
- **Create State-Level Long-Term Care Workforce Development Blue Prints:** DOL and HSS could jointly request each state to prepare a detailed plan for addressing long-term care workforce shortages in the state. The plan could be based on the collaboration of all stakeholders, identify current shortages at the state and sub-state level, project future needs and set goals for meeting needs, identify concrete benchmarks for measuring progress, identify policy and practice barriers to reaching agreed-upon goals and lay out a staged five-year action plan. The requirement could be tied to the state Medicaid plan or, alternatively, states could be provided special grant funding.
- **Modernize the Image of the Long-Term Care Industry:** Large employers could be encouraged to band together to develop and launch marketing and recruiting campaigns aimed at modernizing the image of long-term care as a career choice. Such campaigns could highlight the growing demand for long-term care jobs, particularly in caring for older adults with chronic illness and disability in their own homes; the leadership, managerial, clinical and caregiving skills needed; the transferability of these skills across the health care sector; and career advancement opportunities.
- **Target Information on Long-Term Care Careers to Post-Secondary Education and Professional Schools:** Recruiters for large employers could target deans and faculty in institutions of higher

education, medical schools and other graduate schools and programs and develop joint initiatives that expose students to long-term care career options and opportunities.

- **Target Labor Sources Underrepresented in the Long-Term Care Field:** Recruitment campaigns and incentives could be targeted at sources of labor that have been poorly tapped, such as Hispanics and African Americans who are underrepresented in nursing careers, unemployed immigrants who were trained in health care in their native countries, young people coming out of high school who might never have considered a career in long-term care, individuals with disabilities, unemployed males or mothers with young children and retirees who may only want to work part-time. Such campaigns should involve planning and financial support from coalitions of employers, unions and other worker groups, professional associations and educational institutions. They could be implemented in areas where workforce shortages are acute.
- **Support Independent Long-Term Care Providers:** The supply of independent providers hired directly by consumers to deliver long-term care services needs to expand to support consumer-directed services. This could be accomplished by encouraging states and municipalities to: (1) develop registries of independent providers to make it easier for direct care workers and consumers to identify each other; and (2) experiment with developing and implementing various public authority models that help to protect workers from exploitation, provide needed training, support workers and consumers with payment and tax issues and assure adequate compensation.
- **Provide Candidates for Long-Term Care Jobs with More Financial Incentives to Complete Education and Credentialing Requirements:** Candidates for long-term care careers may need financial assistance to complete training and credentialing/certification. Federal funders and employers need to understand the extent to which a lack of resources to pay for training is a barrier to recruitment and to assist where financial help is needed. Additional financial incentives could include expanding scholarships and loan forgiveness programs, developing new work-study programs and apprenticeship opportunities. Such efforts can be tied to commitments to work in long-term care or in specific long-term care settings and/or to particular workforce shortage areas.
- **Channel Existing Workforce Development Funding to Long-Term Care:** The connection between government-supported workforce investment activities and the needs of long-term care employers for qualified personnel should be strengthened. Federal workforce development funds are directed at promoting sustainable economic growth in communities across the country (such as activities supported under the Workforce Investment Act, TANF and the Perkins Act). Funding for such programs totaled \$5.3 billion in 2005. National, state and municipal efforts need to be launched to channel more of these resources to the recruitment and training of the long-term care workforce.

Goal 2. Create More Competitive Long-Term Care Jobs through Wage and Benefit Increases

Almost all stakeholders agree that low wages and limited employer-based health insurance coverage makes recruiting and retaining personnel in the long-term care industry more difficult. Wages and benefits in hospital-based settings are consistently higher for nurses and direct care paraprofessionals. The lack of health insurance for paraprofessionals is widely regarded as a significant barrier to permanent employment. Employers argue that they cannot afford to raise wages or offer health insurance because of their dependence on public reimbursement. In the long term, improving wages and benefits for long-term care personnel is tied to fundamental reforms in how long-term care is financed and reimbursed. In the shorter term, states and providers—in partnership with federal funders—could attempt a number of strategies.

Potential initiatives include:

- **Achieve Wage Parity Between Long-Term Care and Acute Care:** A federal/state working group should be established to examine wage and benefit parity between acute and long-term care settings and to recommend financing and reimbursement options for achieving wage parity where it does not exist. Such an effort might be carried out in conjunction with the National Governors Association (NGA).
- **Leverage Current Federal Financing for Long-Term Care to Raise Wages and Benefits:** A working group of the American Association of Homes and Services for the Aging (AAHSA), AHCA, the Alliance, NGA and the National Conference of State Legislators could be established to identify, propose and disseminate state and provider strategies for raising wages and providing health insurance to direct care personnel. Among the issues the working group could examine are: (1) implementing “pay for performance” schemes that provide higher reimbursement to providers who demonstrate high-quality care and excellent working conditions; and (2) improving the impact of “Medicaid wage pass-throughs”—a policy that increases Medicaid reimbursement to providers with the expectation that such an increase will be directly passed through to personnel in the form of higher wages or benefits. Research evaluating the impact of wage pass-throughs has been mixed. Some experts suggest that states need to implement better accountability mechanisms to track how earmarked funds are actually used to insure higher wages and benefits. The federal government could be required to evaluate the cost and impact of these strategies.
- **Reinvest Savings from Reducing Temporary Personnel to Enhance Wages and Benefits:** The national provider associations also could investigate the extent to which temporary and contract personnel are being used by their members and the added costs of these temporary staff. Based on the investigation, technical assistance could be offered to members to help them: (1) calculate savings that could be achieved by reducing the use of temporary personnel; (2) implement workforce improvements to reduce turnover; and (3) track the cost effectiveness of reinvesting the savings in salary and benefit enhancements.

Goal 3. Improve Working Conditions and the Quality of Long-Term Care Jobs

Higher wages and better benefits will not be sufficient in and of themselves to attract a high-quality workforce. High turnover is a sign of unhappy employees. Most experts agree that working conditions and the quality of the job must be improved. While many providers have gotten the message and made changes in the way staff are valued, developed and treated, too many others have not. Without significant changes in working conditions, workforce shortages are likely to continue.

Potential initiatives include:

- **Develop Effective Long-Term Care Leaders and Managers:** Such an effort would involve individual providers, professional associations and educational institutions willing to collaborate to identify strong candidates for leadership positions in provider agencies and facilities, create effective development programs and support prospective leaders to obtain training and receive ongoing support.
- **Increase Participation of Racial and Ethnic Minorities in Long-Term Care Management:** Ethnic and racial minorities are underrepresented in the professional ranks—particularly in RN positions. This lack of diversity may contribute to worker shortages and poorer quality care if administrators and supervisors are not familiar with cultural differences among personnel and consumers.

Initiatives could be developed to identify and provide career paths for promising LPNs, nursing assistants and aides from within facilities and agencies, as well as to recruit new candidates. One possible target—licensed nurses who have come to the United States from other countries.

- **Reward Long-Term Care Employers and States that Improve Working Conditions:** Financial incentives and regulatory relief could be granted to states and long-term care employers that have achieved real progress in improving working conditions while maintaining high standards of quality. The federal government, state agencies and accrediting organizations could develop indicators of workforce performance such as reductions in turnover and vacancy rates and the use of temporary employees and acknowledge and reward employers that achieve certain standards.
- **Invest in Information Technology to Reduce Paperwork Burdens in Long-Term Care Settings:** Federal and employer investments should be encouraged in the development, testing and evaluation of information technologies to reduce paperwork burdens on administrators and nurses. A major complaint of administrators and directors of nursing is the amount of paperwork required to comply with federal regulation of long-term care settings. Such paperwork restricts the amount of time they are able to spend on leading, motivating and mentoring staff and overseeing and providing clinical care.
- **Promote Long-Term Care Employers' Self-Assessment of Working Conditions:** Provider associations should be encouraged to identify and develop self-assessment tools their members can use to evaluate and report on working conditions and job quality. Associations could acknowledge publicly those providers that have adopted innovations that have made a significant impact on job satisfaction and employee retention.
- **Improve Federal Fair Labor Standards/Other Mandated Worker Protections for Long-Term Care Personnel:** DOL is responsible for administering and enforcing fair labor standards and other mandated worker protections. The agency could be asked to study working conditions for direct care personnel in both home care and institutional settings. The agency could be asked to: (1) work with unions and other worker groups to identify the major cause of workforce stress and injury; (2) fund and evaluate the impact of new standards and protections such as eliminating mandatory overtime and implementing injury prevention interventions on worker safety, turnover and quality of care; and (3) develop appropriate legislation and regulations based on demonstration findings.
- **Develop Pathways to Career Advancement in Facility-Based and Home and Community Care Settings:** Employers could be encouraged to develop, implement and evaluate the impact of career advancement opportunities such as career ladders and career lattice approaches. Partnerships of professional associations, unions, educational institutions and provider groups could pool resources to invest in the development and dissemination of programs to: (1) provide financial assistance to home health aides, home care aides and nursing assistants who want to become LPNs and RNs, or LPNs who want to become RNs; (2) create more flexible training opportunities that combine work and study so that career advancement opportunities can be pursued; and (3) develop lateral career pathways so nursing assistants and home health aides can move into similar positions in other parts of the health care sector or can move to more specialized positions in long-term care, such as dementia care and medication aides.
- **Establish "Center(s) on Long-Term Care Leadership, Management and Supervisory Innovation":** One or more centers could be established to develop, identify and disseminate effective educational and training programs and best practices for improving leadership, management and supervisory skills among long-term care administrators, directors of nursing, charge nurses and

team leaders. The center could offer internships to groom nurses and aides for leadership positions and improve their leadership, management and supervisory skills. It also could compile lists of experts at the state and sub-state level from the business community, universities and colleges and consulting firms who could help providers assess working conditions in their facility or agency and provide technical assistance on supervision and management improvements.

Goal 4. Make Larger and Smarter Investments in the Development and Continuing Education of the Long-Term Care Workforce

The preparation, credentialing and ongoing training of administrators, nurses and direct care paraprofessionals needs to be rethought and redesigned in light of what has been learned about the composition of the workforce and the settings in which they choose to work, the causes of job dissatisfaction, high turnover and vacancies and the realities of a changing workplace and future needs. Investment in more relevant and productive education and training should be increased.

Potential initiatives include:

- **Encourage Government to Match Long-Term Care Provider Investments in Workforce Development:** Federal and state financial incentives could be offered to long-term care employers that are willing to make significant investments in workforce development. Employers who invest in workforce development do it largely with their own resources and through private grant funding. Encouraging this type of entrepreneurial behavior could pay dividends for improved staff training.
- **Request the Institute of Medicine (IOM) to Review Federal Regulations Governing the Preparation and Credentialing of the Professional and Paraprofessional Long-Term Care Workforce:** The IOM could be asked to conduct an evaluation of federal regulations that influence the preparation, credentialing and ongoing training of professional and paraprofessional long-term care personnel, including federal requirements for credentialing certified nursing assistants and home health aides. The study should examine the extent to which these regulations are evidence-based; how they affect recruitment, job retention and job performance including quality of care; and whether and how they should be modified. Study results should be reported to Congress with recommendations for improvements.
- **Encourage State Reform of Education and Training Requirements:** The present education/training system is not serving the workforce or the public. States should be encouraged and supported to lead a comprehensive reexamination of how administrators, nursing students, nursing assistants and home health aides are prepared and credentialed for administrative and direct care careers in long-term care, as well as the relevance and effectiveness of their continuing education experiences. Such an examination could address: (1) how prospective professional and paraprofessional personnel learn about long-term care careers as part of their training; (2) the adequacy of their training in administration, management, clinical methods, geriatrics and the cultural diversity of the long-term care workforce and its consumer base; (3) the effectiveness of teaching methods to which they are exposed; (4) their level of exposure to long-term care practice settings; (5) the content of continuing education offerings and its responsiveness to staff-identified needs; and (6) the relationship between continuing education requirements and improved competencies and performance in the work setting. The examination should involve collaboration with nursing schools, community colleges, professional associations, unions and other worker groups.
- **Make Education and Training Opportunities More Accessible, Particularly in Rural Areas:** Incentives could be provided to nursing schools, community colleges and other educational ven-

dors to broaden participation in formal courses of instruction for nurses and aides. Techniques such as satellite broadcasts, Web-based courses, flexible scheduling of courses, easily accessible locations and on-the-job training opportunities such as DOL's apprenticeship models should be pursued.

- **Improve Medical Directors' Performance:** The preparation of physicians to assume the position of medical director should be enhanced, and they should be provided with the incentives and authority needed to do the job. Nursing home and home health agency providers should collaborate with the American Medical Directors Association and CMS to develop policies to improve the preparation of physicians to be medical directors, to obtain training in geriatrics, to develop guidelines for providing them with the authority they need to do their jobs and to develop reimbursement options that compensate them for the time and commitment they are expected to make.
- **Improve Competencies of Nursing Home Administrators:** AHCA and AAHSA should work with NABE to develop model standards for licensing nursing home administrators. States and/or facilities should pay nursing home administrators for time spent in apprenticeship programs prior to licensing.
- **Strengthen Long-Term Care Nurse Competencies in Geriatrics, Administration, Management and Supervision:** Directors of nursing and other nurses employed as administrators and supervisors in long-term care settings need incentives to develop competencies in geriatrics, administration, management and supervision. Long-term care providers could join together to identify nurses and paraprofessional staff with strong leadership potential and develop this potential. Schools of nursing should significantly increase the level of training and education in geriatrics for all nursing students, increase the availability of clinical preceptorships in long-term care settings and offer preparation in frontline leadership and supervision essential to the effectiveness of the long-term care nurse.
- **Reassess Scopes of Practice of RNs and LPNs Working in Long-Term Care Settings:** Scopes of practice for nurses in long-term care settings may need to be modified in light of the tasks, activities and responsibilities placed upon them. This should involve state regulators, professional associations and accrediting agencies working with employers and educational institutions to examine what regulatory changes may be needed and their impact on resident/client safety and quality.

Goal 5. Moderate the Demand for Long-Term Care Personnel

It is unlikely that the need for new long-term care personnel ever can be completely reconciled with the growth in demand for long-term care services resulting from the aging population—particularly given the shrinking numbers of potential caregivers. While as yet unrealized medical breakthroughs—such as the prevention of Alzheimer's disease—could have a gigantic impact on the demand for long-term care personnel, investments in the prevention and cure of chronic illnesses are beyond the scope of this paper. There are, however, other strategies that might improve the efficiency of the workforce or lessen the need for hands-on care. These strategies may require changes to licensure, accreditation and reimbursement policy.

Potential initiatives include:

- **Identify and Disseminate Labor-Saving Service Delivery Strategies:** Home health and other long-term care provider associations and innovative employers should be encouraged to work with CMS to identify more efficient, less labor-intensive strategies for delivering in-home services.

This should involve identifying the regulatory and practice barriers that impede the development and widescale implementation of more efficient delivery strategies, as well as designating resources to pilot test and evaluate these strategies in actual practice settings and how they impact staffing, cost and quality.

- **Support Government Investment in Promising Technologies to Reduce the Demand for Direct Care Personnel in Nursing Homes and Home Health Care:** Such investments would be similar to what the government has been willing to make in advancing the biomedical and space industries. Since Medicaid is the leading public payer of long-term care services, federal and state governments should have ample incentives to fund the development of new labor-saving technologies.
- **Facilitate Self-Managed Care among Frail and Disabled Older Adults:** New systems and technologies are needed to help older adults with disabilities manage more of their own care. Collaborations among consumer advocates, long-term care provider groups, physician practices with expertise in “house call” type programs, experts in chronic disease management, geriatricians, nurse practitioners, university schools of engineering and technology centers should help develop and test such innovations.
- **Facilitate Lateral Transfers Across Health and Long-Term Care Settings:** Health and long-term care employers and unions should join together with regulators and educational institutions to determine if easier movement between the health and long-term care sectors and between positions within various long-term care settings would help alleviate demand for new personnel. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.
- **Strengthen Support of Family Caregivers:** A number of strategies could be pursued to help family caregivers continue to shoulder the bulk of caregiving responsibilities, including giving Social Security credits to those who leave the workforce to perform full-time caregiving and further developing information and referral programs so families know where to turn to for help. The government and states also should invest in studies to determine the impact of paying stipends to family caregivers and the extent to which the demand for formal services is reduced.

Goal 6. Develop New Models of Long-Term Care Services Organization and Delivery

Discrete interventions aimed directly at workforce improvements may help alleviate workforce shortages and increase supply in the short run. However, in the long run, most experts would probably agree that narrow approaches are generally stop-gap measures and that more comprehensive interventions are required—based on a complete reexamination of how care is provided and staffed. A number of new models of care have emerged over the past decade, each of which attempts to put the customer at the center and provide direct care personnel with new skills and a voice in how work should be done. Examples include Wellspring; the Eden Alternative; Linking Employment, Abilities, and Potential (LEAP); and the Greenhouse initiative. While some evaluation of the outcomes of these new models has been conducted, as yet none has been widely replicated or brought to scale. Their long-term impact on staff recruitment, retention and turnover, as well as quality of care, while promising in some cases, has not been determined.

Potential initiatives include:

- **Create a New Public/Private Long-Term Care Investment Fund for Developing, Evaluating and Disseminating New Models of Services Organization and Delivery:** An investment fund, collectively funded by foundations, large long-term care employers and federal and state government could be created to support the development, evaluation, replication and dissemination of new

models of services organization and delivery. A new semi-public agency could be established to administer the fund. Funding would have to be assured for five to 10 years to see tested results.

- **Consolidate Current Long-Term Care Grants to States:** In lieu of piecemeal and fragmented funding of long-term care improvement efforts, states could be offered the opportunity to consolidate multiple grants currently received from DOL and HHS. Interested states could develop a consolidation plan aimed at testing and bringing to scale new and comprehensive models of long-term care financing, organization, service delivery and quality improvement. Approval of the consolidated grant program could be tied to integrating workforce improvement goals into the state consolidated plan.

Section III. New Research Initiatives

There are a number of policy-related and practice issues that, if systematically explored through new research and demonstration programs, would significantly improve the capacity of the public and private sector to respond to existing and projected shortages of competent long-term care personnel. The following is a list of topics for the Commission's consideration:

Research

- 1. Develop Measures of Supply, Demand and Workforce Shortages:** Research is needed to develop a consistent set of workforce measures to provide data to track supply, demand and shortages among professional and paraprofessional personnel at the regional and state level.
- 2. Studies of Staff Turnover and Vacancy Rates:** Accurate measures need to be developed that can be used nationwide to determine turnover and vacancy rates in long-term care facilities and home health/home care agencies. These measures need to be applied to large-scale studies of staff retention, including testing the use of payroll data to measure retention. Large-scale studies should address the impact of turnover among direct care paraprofessionals and nurses on resident outcomes.
- 3. Descriptive Studies of How Work Is Performed in Long-Term Care Settings:** Data are not routinely collected on the major activities performed by various categories of long-term care personnel. Information on the tasks performed and the time they take to perform is needed to redesign jobs and the organization of the work and to determine staff mix and minimum staffing ratios and hours.
- 4. Characteristics of the Professional Long-Term Care Workforce:** Although several surveys have been conducted or are in the design stage to examine the characteristics of the paraprofessional workforce, much less information is available on the professional workforce. Surveys and other studies of physicians, nurses and administrators should be conducted to learn why they choose long-term care careers and the particular setting they choose, why so many physicians and nurses avoid long-term care careers, what factors account for retention and turnover, where they go when they leave long-term care jobs, their perspectives on the adequacy of their training, wages and benefits and the quality of the job.
- 5. The Impact of Baby Boomers on Long-Term Care Demand:** Baby boomers will be different than today's elderly cohort. Information is needed on how the demand for formal and informal long-term care is likely to be affected by the interaction of the growing population of aging baby boomers, their improved economic status and better health and new treatments and technologies for diagnosing and treating chronic illnesses.
- 6. The Role of Immigration in Long-Term Care Service Delivery:** Immigrants are already a critical part of the paraprofessional workforce and could play a key role in reducing shortages among the ranks of professionals. The following types of questions need to be explored: What role are immigrants playing in helping to fill the demand for professional and paraprofessional long-term care jobs? How and where has it expanded/changed over the past 10 years? Why do they choose long-term care jobs? How are their attitudes toward long-term care careers similar to or different from those of native-born Americans? How does their retention compare with other personnel? What jobs did they hold before coming to the United States? What types of training did they have in their own countries before they came? What types of training and support do they need to be successful in comparison to native-born personnel? What is their use of public social and benefit programs? What is the cost

to federal and state government of their participation in these programs?

7. **The Impact of Wages and Benefits on Recruitment and Retention of the Long-Term Care Workforce:** Although wages and benefits are important factors in recruitment and retention, it is not clear how the level of wages and benefits should be structured to attract personnel to the long-term care industry and keep them. There is considerable natural variation in the level of wages and availability of benefits. Research should take advantage of these variations to address the impact of different wage and benefit structures on recruitment and retention of professional and paraprofessional employees; how wages versus other factors influence whether personnel choose to enter and stay in long-term care jobs; and if these factors are the same or different than other comparable labor markets.
8. **The Relationship Between Improved Working Conditions, Recruitment and Retention and Quality Outcomes:** There is some information on the impact of discrete interventions to improve working conditions; however, little is known about how more comprehensive approaches work. Research should address the organizational approaches and human resource practices within the provider community that work best to improve job satisfaction, retention, efficiency and quality of care; the staff competencies, staffing configurations and occupational mix that are needed to achieve and maintain high-quality care; the attributes and practices of long-term care providers who are successful in recruiting and retaining personnel; and the impact of new models of long-term care such as assisted living and consumer direction on recruitment, retention and job satisfaction of the workforce.
9. **The Relationship Between Job Satisfaction and Long-Term Care Quality:** Regulators, payers and consumers are interested in links between employee satisfaction and quality of care and whether indicators of job satisfaction may be used as a proxy for quality of care.

Potential Demonstration/Evaluation Initiatives

Over the next several decades, the government and private sector should increase the level of investment in comprehensive demonstration and evaluation of new ways of financing, reimbursing, organizing, staffing and delivering services, and assuring the quality of long-term care. Of particular relevance to workforce improvements are the following types of interventions:

1. **Demonstration of Comprehensive Long-Term Care Workforce Development/Improvement Innovations:** Such demonstrations need to address multiple factors related to the organization and staffing of the workplace, such as wages and benefits, working conditions, education and training and how comprehensive workforce reforms influence recruitment, retention, job satisfaction and quality of care.
2. **Demonstration of Wage and Benefit Enhancements:** Large-scale demonstration and evaluation are needed of the costs of raising wages and increasing health benefits and their impact on the recruitment and retention of paraprofessional direct care personnel.
3. **Demonstration of Comprehensive Education and Training Reforms:** These demonstrations would experiment with comprehensive changes to the education, credentialing/certification and continuing education of nurses and direct care paraprofessionals and evaluate the impact of changes on cost, recruitment, retention, job satisfaction and quality of care.
4. **Demonstrations of Organizational and Staffing Innovations:** Demonstrations should be aimed at developing and testing more innovative and flexible ways of organizing work tasks and activities such as selecting, assigning, managing and supervising staff.

5. **Demonstrations of Injury Prevention Interventions:** Injury rates to both home care and nursing home personnel are higher than virtually any other occupation. Interventions designed to create safer work environments should be developed and evaluated.
6. **Demonstrations to Bridge Long-Term Care and Medical Care:** People in need of long-term care are also likely to suffer from serious chronic illnesses. Demonstrations could be designed to test the impact of greater physician and nurse practitioner involvement in the coordination and delivery of medical care in nursing homes, assisted living facilities and in-home and community-based care settings.
7. **Demonstrations of the Impact of Payments to Family Caregivers:** Although stipends to caregivers are fairly common, they have not been done on a large enough scale to allow a rigorous test of whether they can reduce formal demand for care.

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