November 2001

Desperate Times:

Labor Shortages in New York's Continuing Care System

EXECUTIVE SUMMARY

In spite of increased efforts to recruit and retain staff, continuing care providers—nursing homes, home care agencies and adult care facilities—are encountering serious difficulties in maintaining the levels of personnel required to furnish quality care to their residents and patients.

NYAHSA's March 2000 report, *The Staffing Crisis in New York's Continuing Care System,* reviewed the factors affecting recruitment and retention of direct care workers in continuing care settings. The report provided compelling evidence of serious and worsening shortages of these personnel, and contained several recommendations for alleviating the shortages aimed at federal and state policymakers.

To gain more recent insight into the problem and employer responses, NYAHSA conducted follow-up research. *Desperate Times: Labor Shortages in New York's Continuing Care System* analyzes the results of employer surveys conducted earlier this year on: (1) the extent of labor shortages; (2) the degree of difficulty in filling job vacancies; (3) employee turnover rates; (4) trends in worker availability over time; (5) the effects of shortages; (6) employer measures taken to confront shortages; and (7) needed interventions.

The results point to ongoing crisis-level shortages of professional and paraprofessional workers in continuing care settings. This crisis reflects broader labor shortages that stem from a variety of circumstances, as well as factors specific to continuing health care employment.

The report also provides strong evidence of geographic variations in demand and supply of specific occupations, the current state of the labor shortages, the effects of shortages on quality and access, employer responses and needed interventions. Although the worker shortages are geographically widespread and affect a broad range of professional and paraprofessional occupations, they are not homogeneous throughout New York state.

Labor shortages in continuing care remain a public health issue that demands immediate and decisive action. Based on NYAHSA's extensive research, this report makes ten specific recommendations to address continuing care labor shortages. The government, provider and education sectors need to work together closely to address this crisis.

New York's continuing care providers are facing persistent labor shortages.

Major conclusions of the report are as follows:

- **Shortages of nurses and aides are widespread and severe, with over 90 percent of providers reporting this problem in 2001. Aides provide the majority of "hands on" care in continuing care settings.**
- **Non-clinical direct care staff, such as housekeepers and food service workers, are also in short supply in certain areas of the state, but not to the same degree as nurses and aides.**
- **Suburban providers are experiencing more severe shortages of paraprofessionals—aides and non-clinical staff—than either rural or urban providers, suggesting more keen competition for available workers in these locations.**
- **Overall employee vacancy rates approximate or exceed 10 percent for nearly all professional and paraprofessional direct care occupations. Vacancy rates for part-time positions greatly exceed those for full-time positions.**
- **Vacancy levels for direct care professionals and paraprofessionals vary significantly according to geographic region and location type (i.e., urban, suburban, rural).**
- **Among the various direct caregiver occupations, RN and LPN vacancies take the longest time to fill.**
- **Employee turnover rates for nurses, aides and non-clinical staff remain relatively high (i.e., 30-40 percent annually), with significant variations at the regional, location-type and provider levels.**
- **In most regions of the state, worker availability in 2001 is generally worse than it was in 2000.**
- **Over 75 percent of survey respondents indicated that worker shortages are impacting quality of care and quality of life, whereas about one third reported that such shortages were impacting access to services.**
- **Providers have generally increased wages beyond established inflationary factors, offered a wide range of employee fringe benefits, and used additional strategies to combat worker shortages, all of which are proving to be costly.**
- **Providers cited competition with other health care providers and inability to offerhigher wages as the biggest barriers to employee recruitment. Wage levels and the physical/emotional demands of the work were reported as the biggest workerretention barriers.**
- **Urban and suburban providers tended to seek assistance to enhance wages and increase the pool of job applicants, whereas rural providers most often called for worker supports such as enhanced benefits, child and respite care, transportation, and training.**

INTRODUCTION

This report follows up on NYAHSA's March 2000 report, *The Staffing Crisis In New York's Continuing Health Care System,* which relied on primary and secondary research to establish that continuing care providers are facing serious workforce shortages for a variety of reasons. The 2000 report also surveyed a variety of governmental programs that provide assistance with labor recruitment and retention activities. It concluded that state and federal policymakers must acknowledge the magnitude of the problem, develop a comprehensive plan encompassing short-term and longer run initiatives, and take decisive action on such a plan.

A growing body of evidence indicates that continuing care providers—nursing homes[1], home care agencies[2] and adult care facilities (ACFs)[3]—continue to experience severe shortages of nurses, direct care aides and key support staff such as housekeepers and dietary workers, and that these shortages are getting worse. In an effort to test this hypothesis and to gain a better understanding of employer responses to apparent worker shortages, NYAHSA conducted two different surveys of its member providers.

Our first survey ("Survey #1") was sent out in January 2001 to 158 NYAHSA member nursing homes, home care agencies and ACFs. We received 49 completed responses, for a 31.0 percent response rate. This survey gathered extensive information on:

- work hours;
- full-time and part-time employment;
- temporary agency worker usage;
- hourly wages;
- employee benefits offered;
- worker vacancy rates; and
- employer responses to shortages.

The second survey ("Survey #2") was sent out to approximately 475 nursing homes, home care agencies and ACFs. We received 163 responses, representing a 34.3 percent return rate. This survey asked respondents a series of questions about:

- the extent of labor shortages;
- the degree of difficulty in filling job vacancies;
- employee turnover rates;
- trends in worker availability over time;
- the effects of shortages on quality and access;
- employer measures taken to confront shortages; and
- necessary interventions.

These surveys focused on workers who provide direct care to individuals receiving services from continuing care providers. Following are brief descriptions of the professional and paraprofessional occupations included in the two surveys:

- *Registered nurses (RNs)* provide general medical and nursing care and treatment in such settings as nursing homes and patients' homes. RNs may perform health assessments, do case management, provide health counseling, treat health problems, and execute medical regimens prescribed by a physician. RNs must graduate from an approved nursing program at a college, or other institution.
- *Licensed practical nurses (LPNs)* provide nursing care to patients under the direction of an RN or licensed physician, dentist, or other licensed health care provider. LPNs must be high school graduates and graduate from an approved practical or professional-level nursing program.
- *Certified nurse aides (CNAs)* provide most of the direct personal care to nursing home residents. Working under the supervision of nursing and medical staff, they answer call bells, deliver messages, serve meals, make beds, take vital signs and help residents eat, dress, ambulate and bathe. CNAs must be trained, tested, and listed in good standing on the New York State Nurse Aide Registry.
- *Home health aides (HHAs)* are supervised by nurses or licensed therapists and may assist a patient with personal hygiene, housekeeping and other related supportive tasks in his/her home. Home health aides must successfully complete a home health aide training program or an equivalent approved exam.
- *Personal care aides (PCAs)/Resident care assistants (RCAs)* help patients with nutritional and environmental support and personal hygiene, feeding, dressing and other services. PCAs must be professionally supervised and are certified at three different levels, with each successive level allowing the PCA to perform a broader scope of tasks. RCAs are often unlicensed and therefore unable to perform tasks that require training and certification (e.g., feeding). These individuals work in nursing homes, ACFs and patients' private residences.
- *Non-clinical direct care staff persons* are paraprofessionals who provide supportive services to residents in facilities. These individuals, who include dietary and housekeeping workers, are not required to be licensed or certified to perform their duties, which do not entail "hands on" care.

INFORMATION ON RESPONDENTS

The respondents to each of the surveys were geographically diverse. Figure 1 identifies the respondents by NYAHSA region, whereas Figure 2 illustrates respondents' self-reported location (i.e., urban, suburban and rural).

As will be demonstrated throughout this report, survey respondents' region and location type often has a major bearing on the nature of worker shortages, the strategies used to confront shortages, and needed interventions.

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(1) Nursing homes are licensed by the state and federal governments to provide a range of services including room and board, 24-hour nursing care, restorative and other therapies, medical care, social services and activities. New York currently has 683 licensed nursing homes, representing 120,415 total beds.

(2) Home care agencies—which in New York state include certified home health care agencies, long term home health care programs and licensed home care services agencies—provide nursing, personal care, therapy and other services in patients' homes.

(3) Adult care facilities (ACFs)—which include adult homes, enriched housing programs and assisted living programs—provide room and board, personal care, activities and other services in predominantly small facilities. New York currently has 587 such ACFs, representing approximately 41,000 total beds.

Figure 1
Survey Respondents by Region

NYAHSA Region	Counties in Region	% Responses Survey #1	% Responses Survey #2	% of Total Providers[4]
Capital	Albany, Columbia, Delaware, Fulton, Greene, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Washington	14.3%	14.1%	14.1%
Central	Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego	10.2%	11.7%	8.8%
Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	8.2%	9.2%	13.7%
Northern	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren	4.1%	6.1%	4.1%
NYC/Long Island	Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk	20.4%	26.4%	26.6%
Rochester	Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	12.2%	9.8%	10.8%
Southern Tier	Broome, Chemung, Chenango, Cortland, Tioga, Tompkins	14.3%	7.4%	6.8%
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	20.4%	15.3%	15.1%

Figure 2
Survey Respondents by Location

Location Type	% Responses Survey #1	% Responses Survey #2
Urban	38.8%	41.7%
Suburban	32.7%	33.7%
Rural	26.5%	24.5%

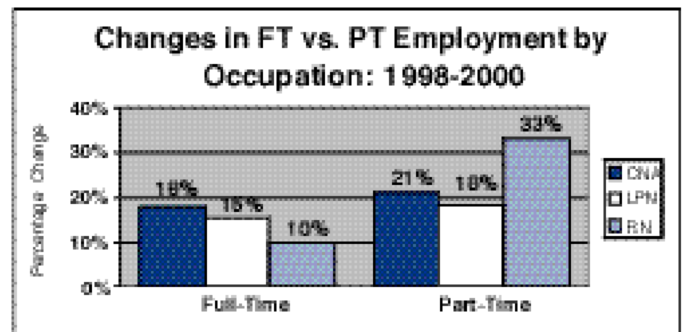
EMPLOYMENT AND COMPENSATION

Continuing care is a labor-intensive service. In Survey #1, we asked respondents to identify the number of full-time and part-time employees in their organization and total hours paid during the years 1998 through 2000.

The average nursing home respondent had a total capacity of 198 beds, employed 90 full-time (FT) and 43 part-time (PT) certified aides and licensed nurses, and paid for approximately 255,000 hours of employee aide and nursing time in 2000. The average ACF, which had 61 beds, employed 12 FT and 9 PT certified aides and nurses in 2000, accounting for nearly 63,000 hours of paid time. For home care agencies, we were unable to identify the average agency size (due to how the services are licensed) and average number of employees and hours, due to data limitations.

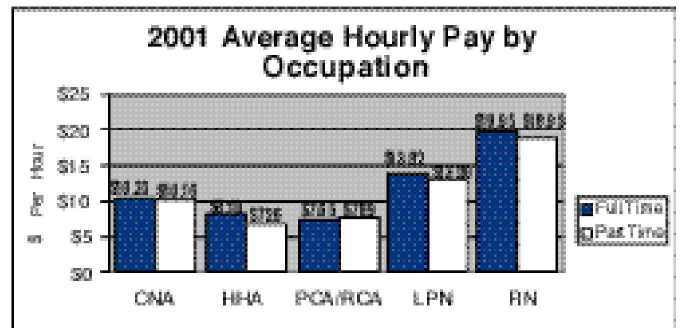
We also examined 1998-2000 employment data to determine relative changes in the numbers of FT and PT employed CNAs, LPNs and RNs. As shown in Figure 3, the total number of FT and PT employees for the survey respondents increased for all three occupations from 1998 to 2000. Interestingly, PT employment grew faster than FT employment during this period, accelerating between 1999 and 2000. Our hypothesis is that competition for FT employees increased due to labor shortages, and that continuing care providers responded by relying more on PT employees.

Figure 3



In Survey #1, we asked respondents to identify their facility's/agency's average hourly wages for FT and PT employed CNAs, HHAs, PCAs/RCAs, LPNs and RNs for 1998 through 2001. Figure 4 identifies the average hourly earnings by occupation for 2001. In nearly every case, FT average wages exceeded PT wages.

Figure 4



In the same survey, we asked respondents what types of fringe benefits they offer to their employees. For each benefit listed, Figure 5 identifies the percentage of providers that offer that particular benefit. In the case of health and dental insurance, the data distinguish between FT and PT employees.

As shown, health, life and dental insurances are widely offered. For health insurance, respondents most often pay for 100 percent of the cost of individual coverage and 80 percent of family cover-

(4) *Represents the percentage of the total NYAHSA nursing home, home care agency and adult care facility membership located in each region.*

Figure 5

Employee Benefits Of fered by Respondents

Employee Benefit	Percentage of Respondents Offering
Health Insurance	
• Single for FT Employees	100.0%
• Single for PT Employees	75.5%
• Family for FT Employees	95.9%
• Family for PT Employees	75.5%
Dental Insurance	
• FT Employees	81.6%
• PT Employees	59.2%
Life Insurance	79.6%
Bonuses	32.7%
Child Care Assistance	10.2%
Employee Assistance Program	55.1%
Loan Forgiveness Programs	6.1%
Pre-Tax Child Care Expense Program	40.9%
Pre-Tax Medical Expense Plan	46.9%
Transportation Assistance	6.1%
Tuition Reimbursement	65.3%
Uniforms Allowance	57.1%
Other	22.4%

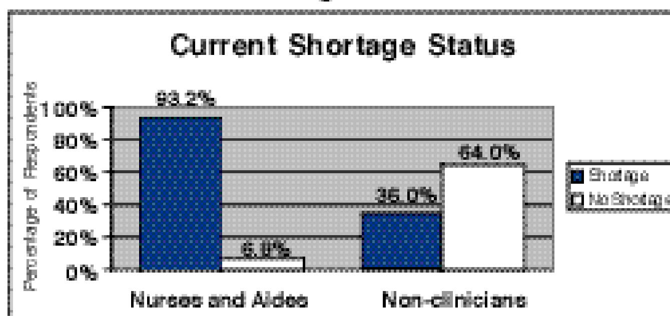
age. The category “other” includes written-in categories such as retirement plans (which are much more widely offered than this figure suggests), long-term disability insurance coverage and scholarships.

EXTENT OF LABOR SHORTAGES

In a NYAHSA telephone survey conducted in 2000, we found that 92 percent of nursing homes, 82 percent of home health agencies, and 70 percent of ACFs polled were experiencing labor shortages at that time.

In Survey #2, respondents were asked if their facility/agency is currently experiencing shortages of two different categories of personnel (i.e., as of April 2001). The first category was made up of RNs, LPNs and/or direct care aides (i.e., CNAs, HHAs, PCAs). The second category included other non-clinical direct care staff, such as dietary and housekeeping workers. As shown in Figure 6, the vast majority of survey respondents are currently experiencing shortages of nurses and/or aides, with a lower percentage encountering shortages of non-clinicians.

Figure 6

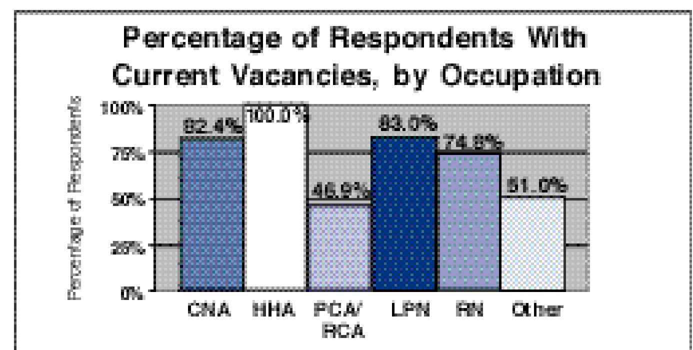


The incidence of shortages varied by region and type of location (i.e., urban, suburban and rural). Regionally, the percentage of respondents reporting nurse and/or aide shortages ranged between 80 percent and 100 percent, with the Northern and NYC/LI regions showing the lowest percentages and 100 percent of the Hudson Valley, Rochester and Southern Tier respondents reporting shortages. The degree of regional variation was much greater for non-clinicians. Whereas only 9.5 percent of NYC/LI respondents indicated they were experiencing shortages of dietary, housekeeping and other non-clinical staff, 75 percent of Rochester region employers reported such shortages.

We found only minor variation in the incidence of shortages of nurses and/or aides by type of location—91.2 percent for urban, 94.5 percent for suburban and 94.9 percent for rural locations. However, the differences for non-clinicians were striking, with 19.4 percent of urban providers, 32.5 percent of rural providers and 59.3 percent of suburban providers reporting shortages. These figures suggest that the local supply of workers, availability of transportation, and degree of competition for workers are major determinants of shortages.

Providers were also asked to indicate whether they had current unfilled openings for each type of worker. Figure 7 identifies the percentage of respondents employing each type of worker that reported current vacancies. As shown, the occupations with the highest incidence of vacancies were HHAs, LPNs and CNAs, followed closely by RNs.

Figure 7



The percentages of respondents with vacancies in each occupation varied by region and type of location as follows:

- For *RNs,* the percentages of providers with vacancies ranged from a high of 88.1 percent (NYC/LI region) to 54.2 percent (Western region), with most other regions in the 65-80 percent range. By type of location, urban providers most tended to have vacancies, followed by suburban and rural providers.
- For *LPNs,* the degree of variation among regions was less than for RN positions. The highest percentage of providers reporting vacancies was in Rochester (93.8 percent); the lowest was in the Capital region (72.7 percent); most other regions ranged between 80-90 percent. By type of location, rural providers most tended to have vacancies, followed closely by urban and suburban providers.
- For *CNAs,* the percentages of providers with vacancies ranged between 100 percent (Rochester region) and 66.7 percent (NYC/LI region), with most regions in the 80-90 percent range. Suburban providers were most likely to have unfilled CNA positions, followed by rural and urban providers.

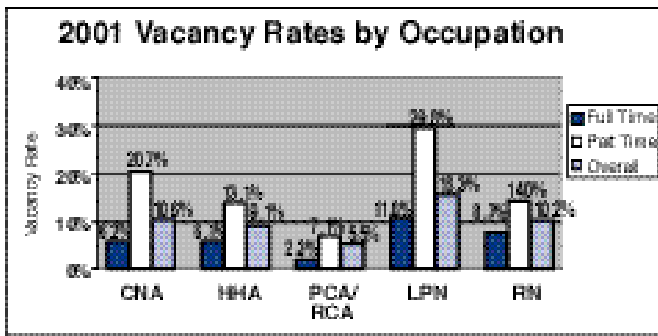
- The amount of variation among regions and locations was much greater for *non-clinical direct care staff* than for nurses and aides. Regionally, the percentages of providers reporting vacancies for these positions ranged from 78.6 percent in the Rochester region to 23.1 percent in the Hudson Valley region, with other regions in the 45-60 percent range. Providers in suburban locations were far more likely to have vacancies than rural providers, and somewhat more likely than those in urban locations.

We were unable to draw meaningful conclusions by region and location for the PCA and HHA occupations due to relatively small sample sizes.[5]

In Survey #1, we asked respondents to furnish us with the numbers of vacant FT and PT positions (as of January 2001) for aide and nursing occupations, as well as total FT and PT employment. We then calculated vacancy rates by dividing the number of vacancies by the sum of total employees plus the number of vacancies.

Figure 8 identifies overall employee vacancy rates of 10.6 percent for CNAs, 9.1 percent for HHAs, 5.5 percent for PCAs/RCAs, 16.3 percent for LPNs and 10.2 percent for RNs. PT vacancy rates consistently exceeded FT vacancy rates, most often by a factor of two to three times.

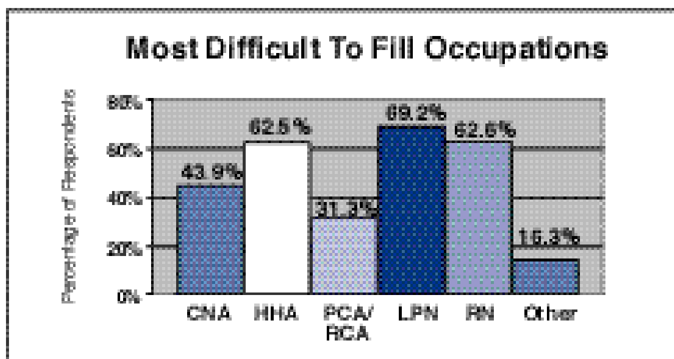
Figure 8



DIFFICULTIES IN FILLING VACANCIES

Respondents were asked to indicate those positions that are most difficult to hire. Figure 9 shows the percentage of respondents employing each type of worker who indicated that that particular type of worker was most difficult to hire. Many respondents selected more than one type of worker, and not all respondents employ the same types of workers, which explains why these percentages do not add up to 100 percent. These results closely tracked the percentages of respondents with current vacancies (see Figure 7), with LPNs, RNs, HHAs and CNAs the most difficult workers to hire, in descending order.

Figure 9

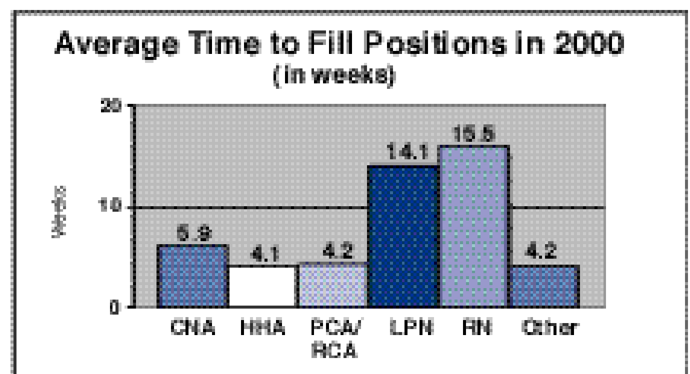


The degree of difficulty associated with hiring each type of worker also varied by region and type of location:

- The percentages of respondents who indicated that *RN* positions were most difficult to fill was highest in the NYC/LI region at 76.2 percent, with most other regions in the 50-65 percent range. By type of location, urban providers most often considered RNs difficult to hire, followed by rural and suburban providers.
- The Rochester (81.3 percent) and Central (77.8 percent) regions reported the highest degree of difficulty in hiring *LPNs;* the lowest was in the Northern region (55.6 percent); all other regions ranged between 66-69 percent. By type of location, rural providers most often considered LPNs difficult to hire, followed closely by urban and suburban providers.
- For *CNAs,* there was greater variation in the reported degree of hiring difficulties than for the nurse positions. While only 19.0 percent of NYC/LI respondents said CNA positions were most difficult to fill, the corresponding figure was 71.4 percent for the Western region. Most other regions were in the 50-65 percent range. By far, suburban providers reported the most difficulty hiring CNAs, followed by rural and urban providers.
- Downstate respondents do not consider *non-clinical direct care staff* positions to be the most difficult to fill, with only 2.8 percent of NYC/LI respondents and no Hudson Valley respondents reporting hiring difficulty. The western part of the state (i.e., the Rochester, Western and Southern Tier regions) most tended to report these positions as difficult to fill. Providers in suburban locations were far more likely to characterize these positions as most difficult to fill than rural or urban providers.

Respondents were also asked to indicate how long it took to fill vacancies in each of the six occupational categories during 2000. As shown in Figure 10, the overall average time needed to fill nursing vacancies was between three and four months, and between one month and six weeks for the aide positions and other paraprofessional positions.

Figure 10



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(5) *This data limitation also applies to other sections of this report.*

Figure 11

Factors in Employee Recruitment

Factor	Average Ranking by Occupation				
	CNA	HHA	PCA/RCA	LPN	RN
Competition with other providers	***3.8***	***4.1***	3.2	***4.0***	***4.3***
Competition with non-health employers	3.3	3.5	***3.5***	2.6	2.7
Inability to offer higher wages	***3.7***	3.5	***3.6***	***3.8***	***4.0***
Inability to offer more benefits	2.8	3.0	2.7	2.8	2.8
Lack of transportation	2.7	3.1	2.5	2.0	1.7
Lack of child care	2.9	***3.7***	3.0	2.4	2.2
Lack of respite services	1.5	1.2	1.2	1.4	1.4
Lack of employee assistance programs	1.5	2.1	1.9	1.6	1.4
Lack of flexible work schedules	2.0	2.6	2.1	2.0	1.9
Difficult hours/shifts	3.0	3.4	2.8	2.8	2.7
Difficult job responsibilities	3.0	3.1	2.8	2.6	2.8
Negative perception of continuing care	2.9	2.8	1.9	2.7	2.8

Note: The two highest rated responses for each occupation appear in bold italics.

For individual respondents, the average fill times ranged between one week and 52 weeks for LPN and CNA vacancies; two weeks to 52 weeks for RN positions; two to eight weeks for HHA vacancies; one to 12 weeks for PCA/RCA vacancies and one to 16 weeks for other vacancies. Consistent with the data on vacancy rates shown in Figure 8, PT vacancies generally took longer to fill than FT vacancies.

Average times needed to fill vacancies varied by region and type of location. They are as follows:

- For *RNs,* average fill times were highest in the Hudson Valley, Central and Southern Tier regions, and lowest in the Western region. Urban providers reported the longest fill times; suburban and rural providers both averaged 15 weeks.
- By region, the findings for *LPNs* were very similar to those for RNs, with the highest average fill times reported in the Hudson Valley, Southern Tier and Central regions, and the lowest in the Western region. By location type, urban providers again reported the highest fill times, followed by rural and then by suburban providers.
- For *CNAs,* the Capital (7.6 weeks) and Central (7.1 weeks) regions reported much higher fill times than the 5.0 to 5.8 week averages for all other regions. Suburban respondents, which were most likely to report CNA vacancies, took the longest time to fill these positions, followed by rural and then urban providers.
- For *non-clinical direct care staff,* providers in the Hudson Valley and Rochester regions took the longest to fill vacancies. Suburban respondents had slightly higher fill times than rural respondents, followed by urban respondents.

In NYAHSA Survey #1, we asked respondents to rate (on a scale of 1 to 5) how each of a series of factors is affecting their ability to recruit health care workers. Figure 11 summarizes the average numerical responses by occupation. The higher the number, the more important that factor is in explaining employee recruitment problems.

Across most occupations, the most important barriers to recruitment were reported to be competition with other health care providers and inability to offer higher wages. Lack of transportation and child care supports were seen as more significant barriers to hiring aides than licensed nurses. Respite care and employee assistance programs received the lowest average importance ratings among the listed factors.

EMPLOYEE TURNOVER RATES

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

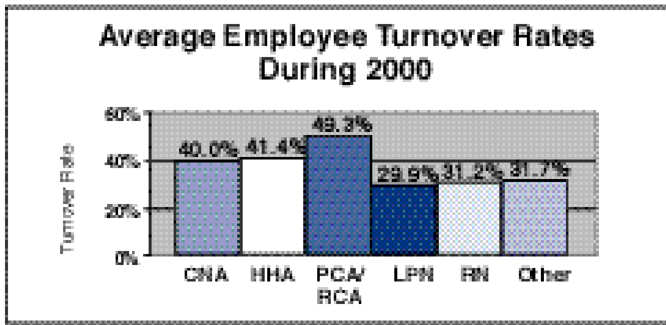
NYAHSA's previous research revealed that average annual turnover rates for CNAs in New York state were 24 percent for full-time positions, 83 percent for part-time positions and 42 percent overall.[6] The available research suggests annual turnover rates in continuing care settings ranging between 25 percent and 100 percent, with higher rates associated with paraprofessional positions than for professional nurses.

As part of the NYAHSA survey, we asked respondents to calculate their turnover rates by dividing the total number of employees who were separated from service (i.e., voluntary and involuntary terminations) during 2000 by the facility/agency's total number of employees as of December 31, 2000. These figures included both FT and PT employees.

Figure 12 identifies the average employee turnover rate for 2000 by occupational category. As shown, annual turnover rates for professional nurses and for the other paraprofessional positions approximated 30 percent; aide positions were associated

(6) *"The Staffing Crisis in New York's Continuing Care System," NYAHSA, March 2000. Figures were based on 250 completed survey responses for the period 7/1/97 through 6/30/98.*

Figure 12



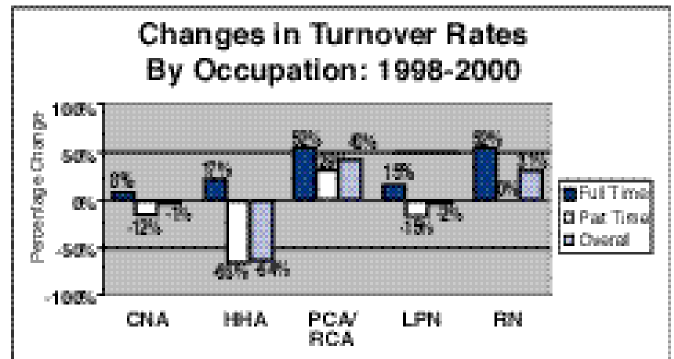
with relatively higher turnover rates. Individual providers reported turnover rates during 2000 of between 0 percent and 200 percent. We also found that turnover rates for PT positions were two to three times higher than for FT positions. These results are consistent with the vacancy rates shown in Figure 8, NYAHSA's previous research, and other research on the subject.

We examined the data more closely be region and location type and found that:

- For *RNs,* turnover rates were highest in the Southern Tier, Capital and Hudson Valley regions, and lowest in the NYC/LI region. Rural and suburban respondents reported higher RN turnover rates than urban providers.
- For *LPNs,* the Capital, Central and Hudson Valley regions reported the highest turnover; NYC/LI had the lowest by a considerable margin. Rural providers reported considerably more difficulty in retaining LPNs than either suburban or urban providers.
- The Capital and Southern Tier regions reported the highest *CNA* turnover figures; NYC/LI again reported the lowest average turnover figure by far. Rural and suburban respondents reported higher CNA turnover rates than urban providers.
- For *non-clinical direct care staff,* providers in the Southern Tier and Capital regions experienced the highest turnover in 2000, whereas the Northern and NYC/LI regions experienced the lowest. Suburban respondents had the most difficulty retaining these workers; rural and urban respondents reported similar figures.

Using data from Survey #1, we calculated FT, PT and overall turnover rates by occupation for the years 1998-2000. As Figure 13 shows, FT turnover rates increased from 1998 to 2000 for all occupations. PT turnover rates declined or remained flat for four out of the five occupations. This again suggests more keen competition for FT employees due to labor shortages.

Figure 13



We asked Survey #1 respondents to rate (on a scale of 1 to 5) how each of a series of factors is affecting their ability to retain health care workers. Figure 14 summarizes the average numerical responses by occupation. The higher the number, the more important that factor is in explaining employee turnover.

Across most occupations, the most significant causes of turnover were wage levels and physical and emotional demands of the job. For paraprofessional aides, family issues were reported to be a significant factor. Intensive regulatory oversight was seen as

Figure 14
Factors in Employee Turnover

	Average Ranking by Occupant				
Factor	CNA	HHA	PCA/RCA	LPN	RN
Terminations due to poor performance	3.0	2.3	2.3	2.2	2.0
Intensive regulatory oversight	2.6	1.9	1.7	2.8	***3.2***
Wages	***3.5***	***3.6***	***3.9***	***3.5***	***3.5***
Benefits	2.5	2.6	2.5	2.6	2.5
Illness/injury	2.9	2.2	2.3	2.2	2.1
Relationship with immediate supervisor	2.3	2.2	2.0	2.0	2.0
Mandatory overtime	2.3	1.2	1.7	1.9	1.9
Physical/emotional demands of job	***3.5***	2.9	2.7	***2.9***	3.0
Lack of flexible work schedule	2.6	2.3	1.9	2.3	2.3
Family issues	***3.6***	***3.8***	***2.8***	2.7	2.7
Promotions	2.2	2.0	1.8	1.9	2.1
Relocation of individual's family	1.5	1.2	1.2	1.5	1.5
Retirement	1.6	1.2	1.1	1.5	1.5

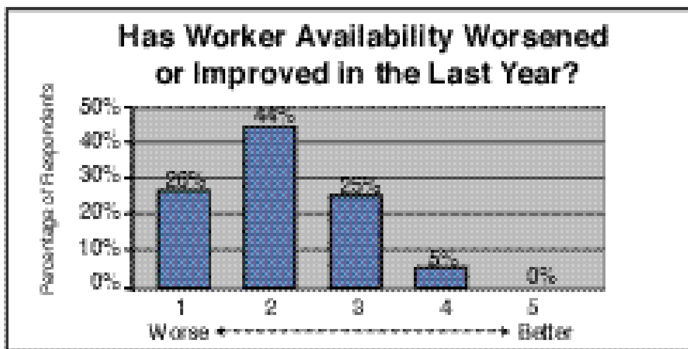
Note: The two highest rated responses for each occupation appear in bold italics.

a major factor in RN and LPN turnover. Respondents rated relocations and retirements as the least significant causes of employee turnover, on average.

TRENDS IN WORKER AVAILABILITY

In an effort to obtain comparative information on the severity of shortages over time, Survey #2 asked respondents to indicate whether the availability of professional and paraprofessional caregivers had worsened or improved compared to one year earlier. As indicated in Figure 15, 95 percent of the respondents indicated that worker availability was the same or worse in early 2001 than one year earlier. Only 5 percent believed that it had improved during that time.

Figure 15



The degree to which respondents reported that worker availability worsened varied by region and location. While employers in the Southern Tier (91.7 percent), Capital (81.8 percent), Rochester (81.3 percent) and Western (80.0 percent) regions most often reported reduced availability, employers in the Central and Northern regions most often reported no change in availability from one year to the next.

Urban (73.1 percent) and suburban (70.6 percent) respondents were slightly more likely to conclude that worker availability had in fact worsened than their rural (65.0 percent) counterparts.

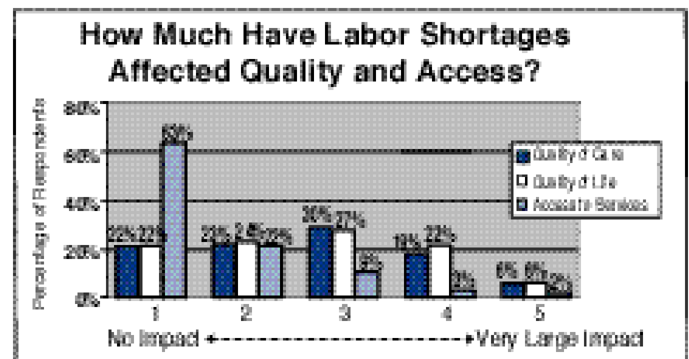
EFFECTS OF SHORTAGES ON QUALITY AND ACCESS

It stands to reason that employee recruitment and retention problems pose a major potential threat to quality of care, quality of life and access to services.

In this part of the survey, we asked respondents to identify to what extent labor shortages have already had an impact on: (1) *quality of care* (e.g., less time to assist residents/patients with various activities of daily living, etc.); (2) *quality of life* (e.g., less time for activities and visiting, etc.) and (3) *access to services* at their facility/agency (e.g., restrictions on admissions, etc.). Providers were asked to answer using a numeric scale ranging from 1 (no impact) to 5 (very large impact).

As shown in Figure 16, only 22 percent of the respondents indicated that labor shortages have had no impact on quality of care or quality of life. In other words, 78 percent of the respondents believe that shortages are affecting quality. Over a third of the respondents (i.e., 37 percent) believed that access to services at their facilities/programs has been negatively affected by labor shortages.

Figure 16



On average, providers in Rochester and the Southern Tier most strongly felt that labor shortages had affected quality of care and quality of life, whereas NYC/LI respondents were least likely to indicate that quality had suffered due to labor shortages. Rural providers were most likely to indicate diminished quality of care and quality of life, followed by suburban and then urban providers.

Among the regions, Southern Tier providers were most concerned that labor shortages were affecting access to services, and Hudson Valley and NYC/LI respondents were the least likely to associate labor shortages with reduced access. Respondents' location types (i.e., urban, suburban and rural) did not seem to make them any more or less likely to indicate that access to services had suffered due to labor shortages.

EMPLOYER MEASURES TO CONFRONT SHORTAGES

Continuing care providers are using a number of strategies to address workforce shortages. Among the most commonly reported are the following:

- increasing employee pay beyond budgeted amounts;
- increasing the use of overtime;
- using temporary staffing from personnel agencies and per diem workers;
- advertising more aggressively;
- using employment agencies;
- paying referral bonuses to employees;
- substituting one type of a worker for another to complete specific tasks;
- restricting admissions; and
- importing workers from abroad.

As suggested by the previous section, survey respondents generally believe that quality and access have not yet been severely compromised by labor shortages. This may be due to the fact that providers have employed a number of strategies to confront the shortages. However, many of these strategies are unsustainable over the longer-term and would be expected to lead to financial difficulties, employee "burnout" and diminished productivity, ultimately threatening quality and access.

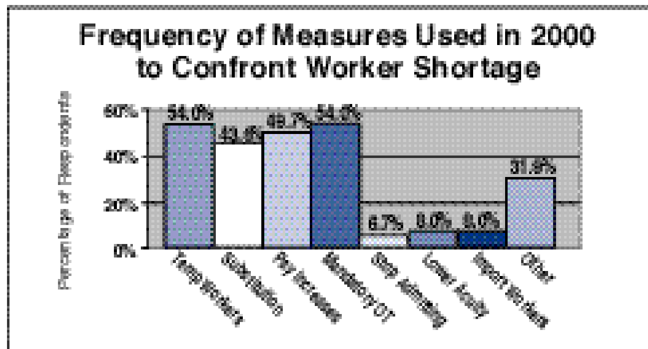
NYAHSA Survey #2 asked respondents whether they had employed any or all of the following strategies during 2000: (1) using temporary workers; (2) substituting one type of worker for another (e.g., LPN for CNA); (3) increasing worker pay beyond budgeted amounts; (4) mandating overtime; (5) stopping admissions; (6) ad-

mitting lower care patients; (7) importing workers from abroad; and (8) taking other measures.

We found strong evidence that providers frequently relied on these strategies during 2000. In fact, 95.1 percent of the total respondents used at least one of these measures, and four out of five of these respondents used more than one strategy.

Figure 17 illustrates the percentage of respondents that used each strategy in 2000.

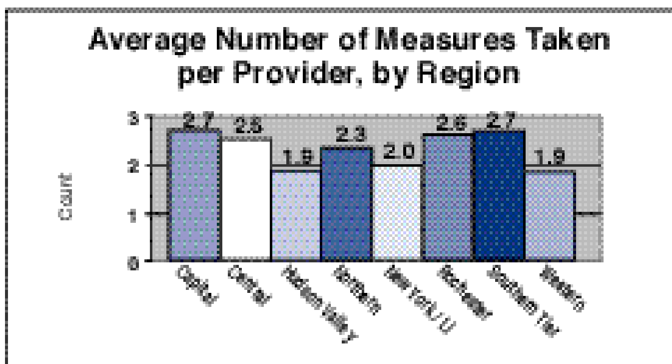
Figure 17



As shown, more than half of the survey respondents reported using temporary workers and mandatory overtime to confront worker shortages. Nearly half provided pay increases that went beyond what was allowed in their annual budgets. Over 40 percent substituted one type of worker for another. Less frequently used measures were stopping admissions, admitting lower care patients and importing workers. Over 30 percent reported various other strategies including voluntary overtime, referral bonuses, more education/training, flexible time, sign-on bonuses, shift/weekend/holiday differentials, recruiting at schools and job fairs, and hiring unlicensed staff to handle additional tasks not requiring licensure.

Figure 18 identifies the average number of measures (among the eight mentioned above) that survey respondents took within each region. The results seem consistent with previously discussed regional variations in hiring difficulties.

Figure 18



We found wide regional variations in the frequency of use of each of these strategies, as shown in Figure 19.

Among location types, urban providers were the most likely to rely on temporary workers and mandatory overtime; suburban providers relied most on substitution and unbudgeted pay increases; and rural providers were most likely to resort to stopping admissions, admitting lower care patients and importing workers.

Figure 19

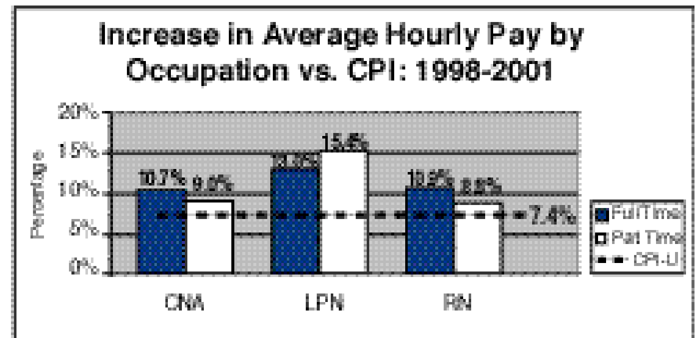
Regional Use of Employer Strategies

Strategy	Region Reporting Most Frequent Use	Region Reporting Least Frequent Use	Average Statewide Frequency
Temporary Workers	Rochester (87.5%)	Northern (20.0%)	54.0%
Substitution of Workers	Southern Tier (66.7%)	NYC/LI (25.6%)	43.6%
Unbudgeted Pay Increases	Southern Tier (75.0%)	Hudson Valley (26.7%)	49.7%
Mandatory Overtime	Hudson Valley (80.0%)	Southern Tier (33.3%)	54.0%
Stopping Admissions	Northern (30.0%)	Capital, Hudson Valley and NYC/LI (0.0%)	6.7%
Admitting Lower Acuity	Northern (20.0%)	Hudson Valley (0.0%)	8.0%
Importing Workers	Northern (20.0%)	Western (0.0%)	8.0%

The data gathered in Survey #1 provide supporting evidence of the extent to which wage increases, overtime pay and temporary workers are being used to combat labor shortages.

Wage increases are a frequently used strategy. As previously indicated, we obtained data on average hourly earnings, and used these data to calculate percentage changes in average hourly earnings for full-time and part-time CNAs, RNs and LPNs during the period 1998-2001[7]. Figure 20 compares these aggregate changes to the change in the consumer price index (CPI)[8] during the same period.

Figure 20



As shown, average hourly earnings increased at a higher rate than the CPI for FT and PT employees in all three occupations. This occurred in spite of relatively high employee turnover, which can reduce average hourly earnings by reducing average employee tenure.

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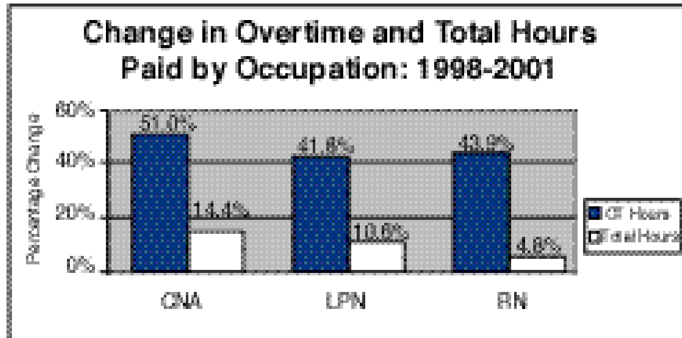
(7) Percentage changes in earnings for HHAs and PCAs/RCAs were not calculated due to small sample sizes for year-to-year comparisons.

(8) The Consumer Price Index for all Urban Consumers (CPI-U) is a commonly used proxy for measuring changes in prices for a fixed market basket of goods and services purchased by consumers. The CPI-U is also used as the Medicaid inflationary factor for nursing home, home health agency and other provider rates of payment for rate periods from April 1, 2000 through March 31, 2003.

Many providers are relying on employees to work overtime. Figure 21 compares the changes in paid overtime hours and overall paid hours reported by Survey #1 respondents for CNAs, LPNs and RNs during the period 1998-2000.

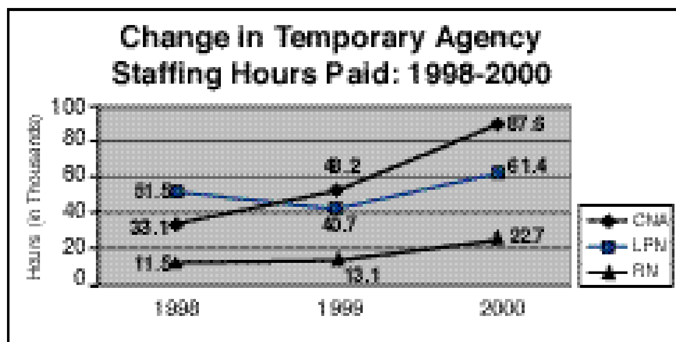
Figure 21



As shown, there were dramatic increases in the number of paid overtime hours for all three occupations during this period. CNA overtime hours grew steadily during the period, whereas most of the growth in LPN and RN overtime occurred from 1999 to 2000. Figure 21 also indicates that in spite of increasing overtime costs, overall paid hours also increased for all three occupations.

As was indicated in Figure 17, providers are also using temporary staffing agencies to compensate for a lack of available workers. Figure 22 illustrates the growth in temporary agency staffing hours paid by Survey #1 respondents during the period 1998-2000. During this time, CNA, LPN and RN temporary staffing hours grew by 165 percent, 19 percent and 97 percent, respectively. Similar to overtime pay, the growth in temporary agency hours accelerated from 1999 to 2000.

Figure 22



NEEDED INTERVENTIONS

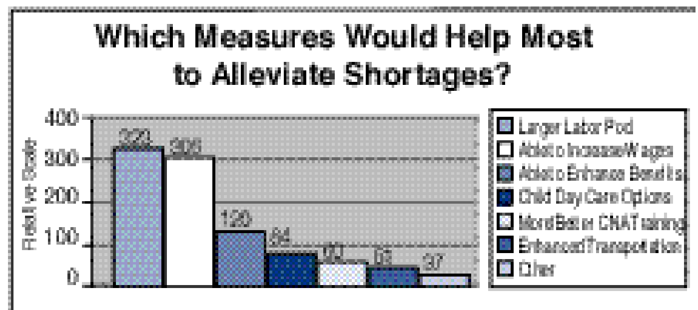
In the final portion of Survey #2, we asked respondents to identify the "top three" interventions needed to improve employee recruitment and retention efforts, from among the following possible options:

- ability to pay higher wages;
- ability to enhance employee fringe benefits;
- increased pool of candidates for positions;
- more/better child care options;
- improved nurse aide training;
- more/better transportation options;
- more respite services for workers' elders;
- funded system of criminal background checks; and
- other options.

We tabulated the responses (possible responses were "1", "2", "3" or blank) for each intervention. To assess the relative importance of each intervention, we then weighted the value of the responses by assigning a value of 3 to the top intervention reported by each respondent, a value of 2 to the second most important and a value of 1 to the third most important. The responses were then scaled to allow comparisons among regions and locations.

The results are shown in Figure 23. By far, respondents saw increasing the pool of available candidates for positions and enhancing the ability to pay higher wages as the most important interventions needed. Other highly-ranked interventions included improving employee fringe benefits and increasing social supports such as child day care and transportation.

Figure 23



We found considerable variation among regions and locations in how respondents evaluated these interventions, as follows:

- *Ability to pay higher wages:* Western region respondents ranked this intervention the highest; Hudson Valley respondents the lowest. The ability to pay higher wages was ranked highest or second highest in every other region. Urban and suburban providers ranked this option much higher than rural providers.
- *Ability to enhance employee fringe benefits:* Respondents in the Northern region ranked this highest of all regions; nearly three times higher than the lowest ranking, which was in Rochester. This intervention ranked third or fourth highest in most other regions. Rural respondents ranked this option much higher than their suburban and urban counterparts.
- *Increased pool of candidates for positions:* This was ranked highest in the Southern Tier and lowest in the Northern region. It was the highest or second highest ranked intervention in every other region. Urban providers were most likely to rate this option high, followed closely by suburban providers.
- *More/better child care options:* This option ranked highest in the Hudson Valley, over three times higher than the lowest ranking, which was in the Western region. Rankings for child care options were fairly consistent among other regions. Rural providers were far more likely than urban or suburban providers to rank this option high on the list.

- *Improved nurse aide training:* Respondents in the Northern region ranked this highest; 10 times higher than their Rochester region counterparts. Rural providers ranked this option twice as high as urban and suburban respondents.
- *More/better transportation options:* Hudson Valley and Rochester region respondents ranked this option higher than all other regions; much higher than the Central region, where it ranked lowest. Not surprisingly, this intervention ranked highest in rural areas, followed by suburban locations and then urban locations.
- *Respite, background checks and other options:* Hudson Valley providers ranked all three of these interventions the highest of any region. In most other regions, these options received low rankings. Rural providers ranked respite care and other options highest; urban providers ranked background checks slightly higher than rural providers.

SUMMARY AND RECOMMENDATIONS

Desperate Times: Labor Shortages in New York's Continuing Care System report provides further evidence that continuing health care providers are facing crisis-level shortages of professional and paraprofessional workers. In spite of stepped-up efforts to recruit and retain staff, continuing care providers—nursing homes, home care agencies and adult care facilities—are encountering serious difficulties in maintaining the levels of personnel required to furnish quality care to their residents and patients.

In addition to overall employment trends, there are multiple and complex factors specifically contributing to the continuing care staffing crisis, including the growing need for continuing care services, workload and working conditions, negative public perceptions, employee turnover and inadequate Medicaid and Medicare reimbursement rates.

Based on the research conducted to produce this report, we have arrived at the following major conclusions:

- Shortages of nurses and aides are widespread and severe, with over 90 percent of providers reporting this problem in 2001. Aides provide the majority of "hands on" care in continuing care settings.
- Non-clinical direct care staff, such as housekeepers and food service workers, are also in short supply in certain areas of the state, but not to the same degree as nurses and aides.
- Suburban providers are experiencing more severe shortages of paraprofessionals—aides and non-clinical staff—than either rural or urban providers, suggesting more keen competition for available workers in these locations.
- Overall employee vacancy rates approximate or exceed 10 percent for nearly all professional and paraprofessional direct care occupations. Vacancy rates for part-time positions greatly exceed those for full-time positions.
- Vacancy levels for direct care professionals and paraprofessionals vary significantly according to geographic region and location type (i.e., urban, suburban, rural).
- Among the various direct caregiver occupations, RN and LPN vacancies take the longest time to fill.
- Employee turnover rates for nurses, aides and non-clinical staff remain relatively high (i.e., 30-40 percent annually), with significant variations at the regional, location-type and provider levels.
- In most regions of the state, worker availability in 2001 is generally worse than it was in 2000.
- Over 75 percent of survey respondents indicated that worker shortages are impacting quality of care and quality of life, whereas about one third reported that such shortages were impacting access to services.
- Providers have generally increased wages beyond established inflationary factors, offered a wide range of employee fringe benefits, and used additional strategies to combat worker shortages, all of which are proving to be costly.
- Providers cited competition with other health care providers and inability to offer higher wages as the biggest barriers to employee recruitment. Wage levels and the physical/emotional demands of the work were reported as the biggest worker retention barriers.
- Urban and suburban providers tended to seek assistance to enhance wages and increase the pool of job applicants, whereas rural providers most often called for worker supports such as enhanced benefits, child and respite care, transportation, and training.

Based on the conclusions of this report and other research, we make the following recommendations to state and federal policymakers to address worker shortages:

1. *Provide new targeted funding to help continuing care providers effectively compete for limited workforce resources.* This funding should be available on a long-term basis, easily accessible and flexible in both how it can be used and the types of employees covered. Providers would be allowed to use the funding for employee wage increases, benefit enhancements, training/ education, transportation and dependent care, as well as promotion of health careers and other recruitment and retention initiatives.
2. *Provide additional funding for scholarship and loan forgiveness programs for students entering health care shortage occupations.* In exchange for receiving such funding, recipients would be expected to work in a direct-care position in the chosen field, potentially in a geographic shortage area.
3. *Establish or fund public relations campaigns and other initiatives to "market" health care career opportunities to students and individuals considering career changes.* Health care occupations should be promoted as attractive and fulfilling career options.
4. *Identify and eliminate laws and regulations that are barriers to the effective deployment of staff.* These barriers exist at both the state and federal levels (e.g., use of trained, non-licensed staff to feed residents in nursing homes).
5. *Establish work redesign programs to study the ways in which work can be reconfigured to better utilize existing personnel.* This effort should target opportunities to eliminate excessive and duplicative documentation requirements that divert direct care staff from patient care.

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Labor Shortages in New York's Continuing Care System

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6. *Revisit existing aide training programs.* Such programs should be streamlined to allow cross-training (thereby affording career ladders), incorporate more state-of-the-art learning techniques, and be updated to accurately reflect current standards of practice.
7. *Provide demonstration grants for labor-saving technology application and evaluation.* Information technology and other capabilities such as telemedicine have major potential for reducing direct labor inputs.
8. *Reconsider current restrictions on employment-based immigration to increase the supply of qualified candidates for professional and paraprofessional positions in continuing care.* With an aging population, the domestic labor market is unlikely to produce enough individuals to meet the growing demand for health care professionals and paraprofessionals.
9. *Conduct or fund research to monitor the extent of health care worker shortages and evaluate the effectiveness of various recruitment and retention initiatives.* Better monitoring systems are needed to ensure that policymakers, providers and other stakeholders are acting on current information, and that interventions are having the desired effects.
10. *Develop an integrated approach to identifying, retraining and deploying displaced workers into professional and paraprofessional openings in continuing care settings.* Such a program would provide opportunities to individuals who are losing their jobs as a result of the overall economic slowdown and in the wake of the terrorist attacks of September 11, 2001.

As the baby-boom generation reaches retirement age in large numbers later this decade, the demand for continuing care services will begin to steadily increase, as the availability of informal caregivers begins to fall. The labor shortages that are already manifesting themselves in the continuing care system are a precursor to an even bigger crisis ahead if serious steps are not taken now. Access to high-quality care directly depends on recruiting, retaining and training enough direct caregivers to provided needed services.

Clearly, the staffing shortage in continuing care is a public health issue that demands immediate and decisive action. The breadth and scope of the problem calls for a range of short-term and long-range solutions to ensure high-quality continuing health care to our state's dependent residents. The government, provider and educational sectors need to work together closely to address this crisis. NYAHSA remains available to participate in this effort.

ABOUT NYAHSA

Founded in 1961, the New York Association of Homes and Services for the Aging (NYAHSA) represents more than 560 not-for-profit, mission-driven and public providers of continuing care services to an estimated 500,000 elderly and disabled New Yorkers. If you have any questions on this issue brief, please contact Daniel J. Heim, NYAHSA's vice president for public policy, at (518) 449-2707, ext. 128, by e-mail to dheim@nyahsa.org, or by fax to (518) 449-8210.