

Who Will Care for Mother *Tomorrow*?

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Within the ongoing discussion of how to save Medicare and Social Security, there is an alarming silence about the looming crisis in long-term care. Few policymakers and politicians are hearing the question foremost in the mind of family member's of someone who needs long-term care: "Who will take care of Mother *tomorrow*?"

Anyone experienced in the long-term care system knows well the fear remote to the uninitiated, that the home care aide or nursing assistant will not arrive on time—or at all—to wash, assist, or feed Mother. Will she be someone Mother knows? Will she be kind and gentle? Competent and respectful? Will she be rushed, or have time to talk and listen?

Health care paraprofessionals—as Genevieve Gipson, the director of the National Network of Career Nurse Assistants, has so keenly observed—are "the point where the system touches the client." In the end, the *quality of the care* received by long-term care consumers is directly related to the *quality of the job* offered to the paraprofessionals who deliver that care on a day-to-day basis. Creating quality jobs for these frontline workers—who provide 80% to 90% of long-term care service—is thus essential to constructing a high-quality, cost-effective, long-term care delivery system.

Unfortunately, health care policymakers have failed to address—or, in many cases, even acknowledge—these frontline issues. As a result, we are in the midst of a growing nationwide shortage of direct-care workers available to meet the mounting needs of millions of Americans who are elderly, chronically ill or living with disabilities (Foltz-Gray, 1997).

To overcome this shortage, we must first understand its causes, and then identify ways to create jobs that are attractive to caregivers—jobs that pay well, provide benefits, offer training and advancement opportunities, and afford respect. To that end, this essay offers a closer look at paraprofessional caregivers and the nature of their jobs, summarizes some of the public policies that currently shape the quality of those jobs, and proposes some possible steps that policymakers could take to start rebuilding our nation's direct-care workforce.

WHO ARE THE PARAPROFESSIONAL CAREGIVERS?

Paraprofessional caregivers are home health aides, certified nursing assistants (CNAs), personal attendants, and other frontline caregivers working in nursing homes, assisted-living facilities, adult-care homes, group homes for the mentally and physically disabled, and individual clients' residences. All told, these workers accounted in 1993 for more than 2.25 million positions, or 20% of our nation's health care workforce (Himmelstein, Lewontin, & Woolhandler, 1996).

Over 90% of these paraprofessionals are women, most of them aged 22 to 45. They are also disproportionately women of color—comprising 30% of direct-care workers nationwide, and the majority of paraprofessionals in many urban centers. In fact, one fifth of African-American women employed in the United States work within health care—many of them in direct-care jobs (Himmelstein et al., 1996). Direct-care jobs are also a common source of employment for many recent immigrants.

Finally, many of these low-income women have entered these health care jobs after a period of time on public assistance—including individuals who have cycled on and off welfare repeatedly to compensate for intermittent stretches of part-time paraprofessional employment. This pool of potential direct-care workers, as we will discuss later, may be attenuating with recent changes in federal welfare policy.

WHAT ARE THEIR JOBS LIKE?

In exchange for their vital work, CNAs and home health aides earn hourly wages averaging between \$6.00 and \$7.00 an hour. Annual incomes for CNAs and home health aides range from \$11,000 for new workers, to \$12,600 (home care), and \$14,500 (CNAs) for experienced workers—putting the typical direct-care worker below the poverty line (Marion Merrell Dow, 1995, SEIU, 1997).

Besides low wages, paraprofessional incomes are also suppressed by the limited availability of full-time jobs. Over 70% of home health aides, and more than 30% of CNAs in nursing homes, are able to secure only part-time work—forcing many of them to attempt juggling two or more such jobs simultaneously with different employers (Crown, 1994).

Employer-paid health insurance is also a rarity within most direct-care workplaces. This is related, in part, to the prevalence of part-time work. But even many full-time paraprofessionals lack an employer-sponsored health plan—or if such a plan is offered, its premium contributions and co-payments make it too expensive to be used by these low-wage workers.

An increasing, but uncountable, number of home care paraprofessionals delivering personal assistance services are not even “employed” in the typical sense of the word. They are working as “independent providers” hired by individual long-term care consumers, who then pay their caregivers with public Medicaid dollars, private

insurance, or their own out-of-pocket cash. Working in such informal settings, these workers have little recourse to Fair Labor Standards Act protections (e.g., minimum wage or overtime pay). They likewise enjoy few, if any, benefits: no health insurance, and often no employer payment into Social Security or state unemployment insurance funds.

Direct care is also literally backbreaking work—particularly, in cases in which caregivers are constantly lifting and moving clients without sufficient equipment or staff assistance. Annually, certified nursing assistants (CNAs) are injured more than workers in mining, construction, or steel mill jobs—and the nursing home industry claims the highest rate of occupational illness and injury of any of the country’s 20 fastest-growing employment sectors (Service Employees International Union, 1995).

Training for direct-care workers—where mandated at all—is usually short (75 to 100 hours) and often inadequate to help caregivers succeed at their demanding jobs. Many categories of direct-care workers receive no formal training at all, even though they are caring for many of the same types of clients as “trained” paraprofessionals. And there are few opportunities for skill upgrading or advancement for incumbent direct-care workers—thereby limiting their access to career paths or their prospects for long-term employment in the sector.

Finally, direct-care workers lack opportunities for involvement in care planning or other quality-assurance activities even though they are the eyes and ears of the client. All of these conditions contribute to high levels of turnover which destroy the valued relationships upon which caregiving is based.

WHAT IS CAUSING THE WORKER SHORTAGE?

From this brief snapshot of direct-care workers and the conditions of their employment, we can begin to sketch a larger picture of why our nation is facing such a mounting paraprofessional labor shortage.

Experienced Caregivers Cannot Earn a Livable Wage from These Jobs

These positions—which are administered mostly by agencies in the private sector, but are paid for primarily with public Medicare and Medicaid dollars—typically offer poverty-level wages and few benefits. As public health care budget cuts continue to depress the real wages of these “public employees once removed,” even the most committed caregivers are being forced to leave the jobs and the clients they love for better-paying positions outside of health care.

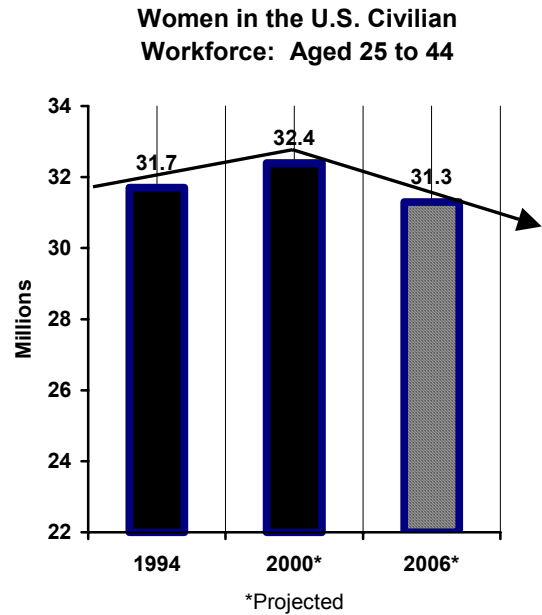
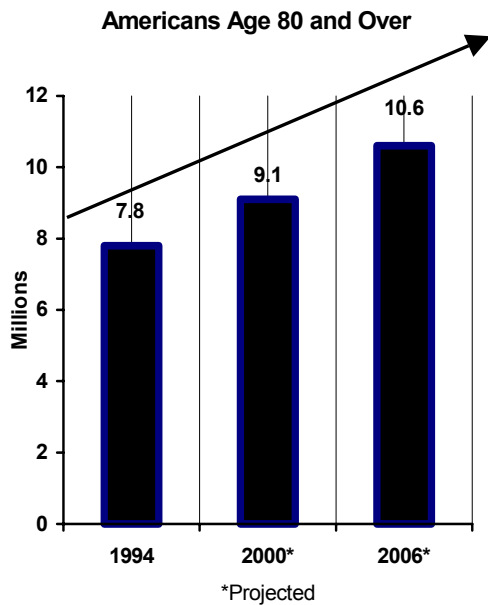
Fewer New Workers Are Entering These Jobs

In today’s economy, there are many lower-skilled jobs that pay more and demand less than positions in long-term care. Again, since this is an employment sector in which wage and benefit levels respond primarily to changes in public policy—not shifts in

market demand—paraprofessional wages are being outpaced by jobs in other sectors like retail and hospitality. In addition, many of the low-income women who once entered these positions through welfare-to-work job training programs can no longer do so because of new, stringent “work first” policies that do not support pre-employment training like that required by home health aide or CNA certification.

Fewer Women Comprise the “Caregiving Workforce”

Many of America’s long-term care workers—especially those who work in nursing homes—are women aged 25-44 years. Yet demographic projections indicate that the number of American working women in this age bracket is now *declining* (Foltz-Gray, 1997). Hence, in the decades ahead, we will see an absolute drop in the number of women who might consider becoming a direct-care worker (see Figure 1).



Increasing Numbers of People Are in Need of Long-Term Care.

Even as the number of potential caregivers is poised to decrease, the number of people requiring caregiving services—and the intensity of the care requirements of clients who are now living longer—is already growing dramatically, and will continue to do so for decades to come.

THE CURRENT ROLE OF PUBLIC POLICY

Our nation's long-term care delivery system is thus facing a significant worker shortage that is likely to become even more critical in the years ahead. So what are federal policymakers doing to close this ever-widening labor gap and to respond to growing consumer demands for a more stable and experienced direct-care workforce? Unfortunately, a range of current federal policies—from reimbursement and regulatory standards within health care policy, to public training programs within welfare and workforce development policy—are only serving to exacerbate the problem.

Health Care Policy

Despite recent budget cutbacks, federal agencies are still the nation's largest payers for long-term care services through Medicare, Medicaid, Older American Act funds, and Social Service Block Grants. As such, the federal government is the "employer once removed" for millions of direct-care workers. Yet these public agencies—despite their interest in tracking down waste and fraud within their programs—have little knowledge of how tax dollars are actually being used (or not) by private contractors to support frontline workers in their hands-on delivery of long-term care services. For example, the Health Care Finance Administration (HCFA) has never asked home health agencies or nursing homes to report on how much a reimbursement for paraprofessional service goes to agency overhead and profit versus to the wages, benefits, or support of the worker actually delivering that service to her client.

What's more, federal health care agencies do not take "labor impact" into account when proposing changes in long-term care policy. While HCFA accompanies any proposed alteration in long-term care reimbursement or regulation with an assessment of the measure's potential impact on providers, consumers, and even the amount of paperwork it might generate, the agency offers no comparable assessment of whether the initiative might lead to lay-offs, wage reductions, or the further destabilization of the workforce expected to deliver those direct-care services.

Welfare / Workforce Development Policy

Many paraprofessional workers, especially those in home care, have supplemented their part-time incomes with public supports such as Medicaid, or assistance with childcare payments and transportation costs. During episodes when they had no work because their clients were hospitalized, had been discharged or had died,

they could easily return to public supports. However, now that welfare reform is moving many of these individuals off of welfare, their opportunities to supplement part-time work with public supports have eroded, and these workers are forced to seek full-time work in other sectors.

The health care system generally takes responsibility for supporting the training of its professionals (e.g., doctors, nurses), but it has largely left the public support of training for direct-care workers to welfare-to-work or workforce development operations funded by programs like the Job Training Partnership Act (JTPA), Jobs Opportunities and Basic Skills (JOBS), and myriad related state and local programs. These programs had helped many low-income adults access health care employment by funding their training to become home health aides or CNAs—positions that, according to federal mandate, require pre-employment skill training and certification.

However, since the 1996 passage of "welfare reform," the federal government, and many states receiving federal welfare funds, have drastically curtailed welfare recipients' enrollment in education or skill training, promoting instead a strict "work first" paradigm that emphasizes getting a job—any job—over gaining skills as the means of entry into the workforce. As a result, many low-income adults who would have received training to become a home health or nursing home worker are now being steered by their caseworkers *away* from such direct-care positions—precisely because of their pre-employment skill-training requirements.

Ironically, the U.S. Department of Health and Human Services (DHHS)—the agency which houses HCFA, where paraprofessional certification standards are set—is also the federal agency implementing welfare reform with training exclusions. As a result, the agency that should be ensuring an adequate supply of direct-care workers is, at the same time, forbidding many potential direct-care workers from receiving the training they need to enter those jobs. Furthermore, DHHS's "labor blind" long-term care policies are doing little to improve the retention levels of those paraprofessional jobs, thereby condemning many low-wage workers to eventually cycle out of these high turnover positions and potentially back onto welfare.

POLICY PRESCRIPTIONS

We believe that federal and state governments—as the primary purchasers and regulators of long-term care services—could use their significant leverage over this sector to effect the changes that could improve the stability and competency of the direct-care workforce and ensure its sufficient size to meet growing consumer demand. Some of the following policy options we propose are budget neutral, requiring only that a portion of current long-term care resources be tracked and earmarked for workforce support and improvement. Other proposals would require new spending—a seemingly untenable option within today's tight budgetary environment, but, when compared to the high costs of staff turnover and instability, an approach that policymakers should seriously consider.

For example, the replacement of a single CNA or home health aide costs between \$3,000 and \$4,000—a sizeable expense, especially for providers with workforce turnover approaching 100 percent a year. Agencies that rely on temporary replacement workers to fill these vacancies likewise spend twice what it would normally cost them to pay an in-house caregiver. Even greater—and more shameful—are the costs in care quality that are shifted onto the backs of long-term care clients. Without the benefit of a sufficient number of trained, competent staff, long-term care clients are more prone to become malnourished, dehydrated, incontinent or depressed, and more likely to require expensive medical interventions or hospitalizations when the quality of day-to-day services breaks down.

Hence, we propose that the federal government take the lead in bringing greater public attention to the issues facing direct-care workers, and consider the following steps to improve this vital workforce.

It Should Convene a Federal Inter-Agency Working Group

Many of the policy problems cited above originate from a general lack of attention to direct-care worker issues, and an absence of communication between individual federal agencies that each influence a different aspect of paraprofessional training and job quality. Health care officials within DHHS want a better long-term care workforce, but they refuse to see these workers as under their purview, disclaiming any responsibility for the quality of their jobs. Welfare officials within DHHS see many direct-care workers as low-income “clients”—many of them people whom the federal government wants to keep off public assistance; yet these officials know very little about the long-term care industry, in which hundreds of thousands of those clients are so tentatively employed. And workforce development officials within the U.S. Department of Labor—likewise concerned about moving people from welfare to work—currently see direct-care jobs as paying too little and offering too few chances of success to warrant a public investment of job-training dollars.

The goals of these agencies could all be served by a more stable direct-care workforce employed by an industry that offers family-sustaining incomes and benefits, long-term job retention, and ongoing opportunities for skill upgrading. But the public policies needed to achieve those ends will never transpire until these various federal actors agree to come together and treat the direct-care workforce as a shared priority. A federal inter-agency working group would be one important step toward creating that foundation for policy changes. The work group should:

Investigate How Our Long-Term Care Dollars Are Being Spent

As a condition of receiving federal Medicare or Medicaid reimbursement, HCFA should require that long-term care providers report on their frontline workforce’s turnover, training, and wages and benefits—and on how public dollars are being used (or not) to achieve those outcomes. This would establish greater accountability from these

private agencies, and it would create a baseline from which the government might begin to assess how to improve more broadly the hands-on delivery of these services. Such data could also be shared with consumers—as part of a provider "report card"—so clients and their families could make more informed choices about different providers based on the stability of their direct-care workforce.

Require and Support Better Training

The federal government has set some standards for paraprofessional certification within nursing homes and Medicare home health, but these have proven largely inadequate. Furthermore, entire segments of the direct-care workforce, particularly under Medicaid, have no training standards at all. The federal government needs to create better and more uniform training standards across a range of comparable direct-care positions. The federal government should allocate training resources—whether through expansions of targeted health care reimbursements, or through the diversion of available welfare and workforce development funds (e.g., customized job training under the Workforce Investment Act, USDOL Welfare-to-Work grants, millions of surplus federal welfare dollars currently sitting in state coffers) toward the training, retention, and upgrading of low-wage health care workers.

Successful use of training dollars should be measured by the percentage of workers who remain in the job past six months or a year. We know that a very high percentage of newly recruited workers are likely to leave these jobs in the first 90 days because they are unprepared, emotionally or technically, to meet the job demands. According to Genevieve Gipson, the real test of a successful agency is the proportion of workers who are long-stayers. Identifying what providers can do to foster long-stayers is essential to creating attractive jobs.

Change the Reimbursement Structures

Several state Medicaid programs have used mechanisms like "wage pass-throughs" to ensure that a certain portion of its long-term care payments to agencies are passed on by employers directly to frontline workers. Such initiatives have multiplied over the past year in response to current labor shortages. The federal government should heed the states' example, and consider how to pass along some of its own Medicare/Medicaid dollars to support frontline wages, training, and so forth.

A second consideration should be the variability in reimbursement rates across different programs (Medicare, Medicaid) and settings (home health, personal services, nursing home) for similar services provided by comparably skilled paraprofessionals. For example, differences in wage rates between home care and nursing home positions have put home care clients at even greater risk of not finding a qualified caregiver—primarily because nursing homes have been more proactive in securing additional public resources to attract workers. Rather than pitting long-term care consumers against each other, the federal government should spearhead an effort to promote equity and consistency in wage rates for caregivers across these settings.

Ensure Health Insurance for Health Care Workers

Through the Children's Health Insurance Program and other initiatives, the federal government has created vehicles to guarantee health coverage for greater numbers of low-income Americans. In addition, some states have expanded coverage for working adults living just above the poverty line—including targeting public health benefits to workers within particular industries that rarely offer employer-paid health insurance (e.g., Rhode Island's childcare workers). The federal government should likewise address the tragic irony of health care workers without health care coverage through an industry-specific "health care for health care workers" initiative—a campaign that could significantly reduce paraprofessional turnover and workforce instability.

WHAT ELSE IS NEEDED?

While it is not the focus of this article, we know that policy change alone will not suddenly eradicate paraprofessional turnover or make direct-care work a sustainable career. Changes in industry practice—the ways home care agencies and nursing homes train and supervise direct-care workers, meaningfully involve paraprofessionals in quality-assurance systems, and structure the delivery of paraprofessional services—will likewise be required to substantially improve the quality of direct-care jobs.

Thankfully, some select nursing home and home health agencies have already begun to reorient their management philosophies and practices in this manner, embarking on "replacing the typical low-investment, temporary personnel approach" prevalent throughout the long-term care industry "with a strategy of high investment in frontline employees, emphasizing careful recruitment, decent wages and benefits, full-time work, extensive training, counseling, and support" (Wilner, 1999).

For example, the *Pioneer Movement*—a growing number of nursing homes nurturing cultures emphasizing community and relationships—have involved their CNAs in care planning, decision-making, and problem-solving. And the *Cooperative Healthcare Network*—a federation of four worker-owned home care cooperatives that employ more than 600 home health aides—have shown that direct-care jobs can become long-term vehicles of employment and advancement through cooperative ownership, extensive training, and support and advancement opportunities (Wilner & Wyatt, 1998).

Of course, such industry-based innovations have required not only a new perspective on how direct-care workers should be valued and respected. Many of them have also relied on grants or other outside funds not typically leveraged by long-term care providers. As we look toward changing industry practice within long-term care, the issue of public resources thus inevitably resurfaces as a factor in supporting such changes. Again, that may seem unlikely when much of the long-term care industry is already reeling from recent Medicare cuts, and state Medicaid programs are struggling to pick up some of the costs previously shouldered by the federal government. Individual consumers are likewise picking up a larger portion of the long-term care bill—whether through out-

of-pocket expenditures or the purchase of long-term care insurance—to pay for services not covered by either Medicare or Medicaid.

But public officials cannot escape the fact that the current workforce shortages will continue to face long-term care providers and consumers for decades to come. In the current full-employment economy, many people are working—they just are not working in direct care. Even if the current economic prosperity subsides, demographics alone point to a gaping hole in our nation's long-term care delivery system. Continued inability to attract, retain, and upgrade our direct-care workforce will put at jeopardy the availability of life-preserving services for millions of Americans who are elderly, chronically ill, or living with disabilities. If our federal and state policymakers are not prepared to abdicate responsibility for supporting long-term care in this country, then they will have to wrestle with what investments will be necessary to attract, hold onto, and upgrade our nation's long-term care workforce.

AUTHOR NOTES

At the time this article was written, Andy Van Kleunen was Director of Workforce Policy for the Paraprofessional Healthcare Institute. Currently, he is executive director of The Workforce Alliance, a collection of workforce development organizations interested in bringing a practitioner's perspective into federal workforce development and welfare-to-work policymaking. The group also presses for public support of effective practices in community-based training and employment that have helped low-income adults access long-term, living-wage jobs.

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The Paraprofessional Healthcare Institute is a national nonprofit health care employment development and advocacy organization, based in the South Bronx, which links a network of worker-owned health care providers specializing in paraprofessional services. Its mission is to 1) provide high-quality healthcare to clients who are elderly, chronically ill, and disabled, and 2) create decent jobs for low-income women.

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